Approaches to Postgraduate Education in Psychiatry in Canada

What Educators and Residents Need to Know

Edited by:
John Leverette
Gary Hnatko
Emmanuel Persad

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Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

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What Educators and Residents Need to Know

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Editorial Manager
Hélène Côte

Copy Editors
Jadranka Bacic
Virgina St-Denis
Candace Taylor

Graphic Designer
Smita Hamzeh

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Contents

Chapter 3: General considerations in psychiatric education

Chapter 4: Basic clinical training

Chapter 5: Psychotherapies

Chapter 6: Adult psychiatry

Chapter 7: Child and adolescent psychiatry

Chapter 10: Consultation-liaison psychiatry (psychosomatic medicine)

Chapter 11: Addiction psychiatry

Chapter 12: Shared/collaborative mental health care

Chapter 13: Developmental neuropsychiatry: teaching residents in psychiatry about developmental disabilities

Chapter 14: The treatment and rehabilitation of individuals with severe and persistent mental illness (SPMI)

Chapter 15: The scholar

Chapter 16: Evaluation of resident competency in psychiatry: a Canadian perspective

Contributors

Donald Addington, MD, FRCPC

Professor, Department of Psychiatry, University of Calgary.

Melissa Andrew, MD, MEd, FRCPC

Assistant Professor, Division of Geriatric Psychiatry; Director of Resident Affairs, School of Medicine, Queen's University.

Rajiv Bhatla, MD, FRCPC, DABPN

Associate Chair, Department of Psychiatry, University of Ottawa; Psychiatrist-in-Chief, Royal Ottawa Health Care Group.

Gary Chaimowitz, MB, ChB, MBA, FRCPC, FCPA

Assistant Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University.

David N Crockford, MD, FRCPC

Associate Professor, Department of Psychiatry, University of Calgary.

Nady el-Guebaly, MD, FRCPC, DABAM

Professor and Head, Addictions Division, Department of Psychiatry, University of Calgary.

Jonathon Fleming, MB, FRCPC, FABSM

Associate Professor and Associate Head, Education, Department of Psychiatry, University of British Columbia.

Alison Freeland, MD, FRCPC

Associate Chief, Royal Ottawa Health Care Group; Director of Undergraduate Education, Department of Psychiatry, University of Ottawa; Assistant Professor, University of Ottawa.

Renée Fugère, MD, FRCPC

Assistant Professor, Department of Psychiatry, Université de Montréal; Adjunct Professor, Department of Psychiatry, McGill University; Psychiatrist, Institut Philippe Pinel de Montréal.

Kathryn Fung, MD, FRCPC

Clinical Instructor, Department of Psychiatry, University of British Columbia.

Fabien Gagnon, MD, DPsy, FRCPC, FAPM

Professor, Department of Psychiatry, Université Laval; Service de Médecine Psychosomatique, Centre Hospitalier Universitaire de Québec.

Katharine Gillis, MD, FRCPC

Chair, Department of Psychiatry, University of Ottawa; Clinical Director, Shared Care Mental Health Program, Ottawa Hospital.

Gary S Hnatko, MD, FRCPC

Professor, Department of Psychiatry; Chair, Division of Child and Adolescent Psychiatry, Faculty of Medicine and Dentistry, University of Alberta.

Jessica Jones, DClin Psy, CPsych

Assistant Professor and Associate Chair, Division of Developmental Disabilities, Departments of Psychiatry and Psychology, Queen's University.

Nick Kates, MBBS, FRCPC

Professor, Department of Psychiatry and Behavioural Neursociences, McMaster University.

Alain Labelle, MD, FRCPC, CSPQ

Associate Professor, Department of Psychiatry, University of Ottawa; Clinical Director, Schizophrenia Program, Royal Ottawa Mental Health Centre.

John S Leverette, MD, FRCPC, FCPA

Professor and Deputy Head, Department of Psychiatry; Chair, Division of Child and Adolescent Psychiatry; School of Medicine, Faculty of Health Sciences, Queen's University.

Bruce McCreary, MD, FRCPC

Professor Emeritus and Chair, Division of Developmental Disabilities, Department of Psychiatry, Queen's University.

Emmanuel Persad, MBBS, DPsych, FRCPC, FCPA

Professor Emeritus, Department of Psychiatry, University of Western Ontario.

Renée Roy, MD, FRCPC

Assistant Professor, Department of Psychiatry, Université de Montréal; Psychiatrist, Institut Philippe Pinel de Montréal.

Ruth Russell, MDCM, FRCPC

Child Psychiatrist, Associate Professor Psychiatry, Assistant Professor Pediatrics, Program Director, Postgraduate Education, Division of Child Psychiatry, McGill University; Member, Centre for Medical Education, McGill University; Co-Chair, Education Committee, Canadian Academy of Child and Adolescent Psychiatry.

Catherine Shea, MD, FRCPC

Chair and Associate Professor, Division of Geriatric Psychiatry, University of Ottawa.

Margaret Steele, HBSc, MD, FRCPC, MEd, FCPA

Professor, Departments of Psychiatry, Pediatrics, and Family Medicine; Chair, Division of Child and Adolescent Psychiatry, University of Western Ontario; Assistant Dean, Strategic Initiatives Schulich School of Medicine and Dentistry, The University of Western Ontario Integrated Site; Chief, Child and Adolescent Mental Health Care Programs, London Health Sciences Centre, St. Joseph's Health Centre-Regional Mental Health Care-London.

Richard Swinson, MD, FRCPC, FRCPsych

Professor Emeritus, Department of Psychiatry and Behavioural Neurosciences, McMaster University; Medical Director, Anxiety Treatment and Research Centre, St Joseph's Healthcare.

Priyanthy Weerasekera, MD, MEd, FRCPC

Associate Professor and Postgraduate Psychotherapy Coordinator, Department of Psychiatry and Behavioural Neurosciences, McMaster University.

D Blake Woodside, MD, MSc, FRCPC

Professor, Department of Psychiatry, University of Toronto; Medical Director, Program for Eating Disorders, Toronto General Hospital.

Ari Zaretsky, MD, FRCPC

Director Postgraduate Medical Education and Associate Professor, Department of Psychiatry, University of Toronto.

Foreword

It is a pleasure to have the opportunity to write a foreword for this book, representing so much work by the entire psychiatric community in Canada. The effort that has gone into generating this volume is enormous and has occurred over many years. In some ways, the work within this volume is a natural outgrowth of the enormous increase in educational scholarship within our profession, a development that over the last 15 or 20 years has seen educational scholarship emerge almost as a specialty in its own right within psychiatry.

The primary impetus for this work has been a consensus regarding some shortcomings in the nature of postgraduate training in psychiatry in Canada. In addition to the well-documented difficulties facing many postgraduate training programs across Canada in the latter part of the 20th century, the ongoing growth and development of subspecialties within psychiatry has been a critical catalyst in rendering essential a re-thinking of the nature of psychiatric residency training.

This volume lays out the critical elements in the training of broad generalists in psychiatry. It is meant for trainees and educators alike — all those who have a keen interest in how we will prepare psychiatrists for practice in our increasingly complex health care system.

Individuals from a variety of backgrounds will be interested in this volume. Trainees will use it to help understand the nature of the educational experience that they are undergoing. Teachers of residents will appreciate the careful rationales that underlie the training requirements. Those involved in the design and implementation of postgraduate training programs will use the volume as an indispensable reference for the actual content of the objectives described in the training requirements set by the Royal College of Physicians and Surgeons of Canada (RCPSC). Finally, other specialties may use the volume as a template for enhancing the quality of their own training programs.

This book—the end result of endless hours of consultation, writing and research—is a testament to the community of psychiatry within this country. It is a remarkable achievement to have been able to bring together leaders from all parts of our diverse profession and forge a consensus about a dramatic reorganization of our training system. It speaks to our strength as a profession and to our ability to work together on issues of common interest as well as in the best interest of all.

This work is the work of many, all of whom deserve the thanks of the entire profession. However, I would be remiss if I did not acknowledge the work of Drs. John Leverette and Emmanuel Persad. They agreed to lead the effort

towards a National Strategy for Postgraduate Education (NSPGE). This work would never have been completed without their determined leadership, endless patience and ability to forge consensus amongst many participants. As well, Dr. Gary Hnatko offered a critical element of liaison with the Royal College, without which the project would not have been completed. The entire profession owes them a significant debt, and on behalf of the Canadian Psychiatric Association and the profession as a whole, I would like to offer them our most heartfelt thanks.

Blake Woodside, MD, FRCPC
Chairman of the Board
Canadian Psychiatric Association
August 2009
Ottawa, Ontario, Canada

A message from the editors

The core competencies for the general psychiatrist, rooted in the Royal College of Physicians and Surgeons of Canada (RCPSC) Objectives in Training (OTR) and Specialty Training Requirements (STR) in Psychiatry, came into effect on July 1, 2008 and discussion with psychiatric educators across the country indicated that the opportunity to assist directors of postgraduate education in psychiatry to implement and operationalize these requirements should not be missed. As former program directors ourselves, we understood the difference in resources that exists among the Canadian academic departments of psychiatry and the need to assist program directors in ensuring the standards and the maintenance of RCPSC accreditation requirements are achieved. We also recognized the equally important need for residents to have in-depth knowledge of the competencies required for contemporary practice.

The early chapters of this book provide the reader with the background information necessary to understand the educational process in psychiatry that is taking place in Canada and abroad. In the balance of the book, the concept of a 'toolbox' approach was implemented and the reader will find that most chapters use a standardized template which serves to facilitate consistency and usability. An introduction defines the topic area in question and its relevance to psychiatric practice. A straightforward repetition of the RCPSC statements in the specific area in question follows and, if applicable, is supported by comments about intent and a review of the levels of competency to be obtained. As the RCPSC goals and objectives are general and not specific, a section on *Training Targets/Detailed Goals and Objectives* allows for the elaboration of more detailed training targets—for example, what does it mean to be proficient in cognitive-behaviour therapy including the knowledge requirement, its application and a satisfactory assessment of both—information not included in the RCPSC documents.

The *Suggested Strategies/Enabling Objectives* section is the toolbox which provides an operational description and lists ways to attain the training targets. The intent is to provide different approaches that satisfy the RCPSC OTR and STR. Some approaches use few resources and others, many (the latter generating significant opportunity for elective and selective enrichment), but ultimately the goal is to be creative and to work within the realities of training programs, providing ideas or strategies about how to get to the competency destinations.

The *Other Considerations* section is left to the author's discretion and may include information such as unique methods of evaluation, training site considerations, shared training or overlap with other RCPSC disciplines,

elective and selective experiences and subspecialty considerations where applicable.

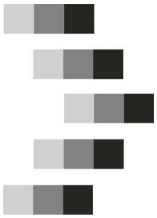
Our sub-editors, Dr Zaretsky and Dr Fung have reviewed the work in development with an eye to implementation—Dr Zaretsky, currently a program director and Dr Fung, a resident in training during the initial drafting of this book and now a newly minted graduate. We are sincerely grateful for their effort and contribution and that of the contributing authors, all of whom are representative experts and leaders in their field.

The editors sincerely appreciate the Board of the Canadian Psychiatric Association for championing and supporting this project and Francine Knoops, CPA's Associate Executive Director, for her general oversight. A very special thanks goes to Hélène Côté, CPA's Communications Officer and a respected member of our team, for her "hands on" leadership and guidance in what has been an enriching learning experience for us.

On reflection, it is evident that this book will assist in educating broadly about the depth and breadth of the competencies and psychiatric practice of the sophisticated generalist in Canada. As such, we hope that the book will have appeal in advancing knowledge about our specialty to the broad community of educators in the medical and surgical disciplines, associate deans of postgraduate medical education in Canada, officials in the provincial ministries of health and education and international psychiatric educators. Finally, we recognize that the work represented in this book is not unlike a living and dynamic organism, subject to change and evolution to reflect the practice of our specialty in the service of our citizens.

John Leverette, Gary Hnatko and Emmanuel Persad
August 2009
Ottawa, Ontario, Canada

Chapter 1



The road to renewal in postgraduate education in psychiatry

John S Leverette

INTRODUCTION

By the early years of the 21st century, the training path template for the general psychiatrist in Canada had remained essentially unaltered for several decades. The five years of postgraduate education included 30 months of mandatory requirements and 18 months of elective and selective training time after PGY1. Limited adjustments were made over the years to the mandatory requirements through supervised experiences. Specialty oversight had been extended to PGY1 in 2003 and the Royal College of Physicians and Surgeons of Canada (RCPSC) Objectives in Training (OTR) in Psychiatry had been revised to reflect the integration of the CanMEDS competencies in psychiatric education. In the absence of formal recognition of psychiatric subspecialties in Canada, the 18 months of elective and selective experiences were used by about one-third of psychiatric residents for subspecialty training. The 'subspecialists' finished in five years and, along with their 'generalist' colleagues, were awarded the RCPSC certificate in the specialty of psychiatry and sought subspecialty 'recognition' by joining their respective academies. In light of this, many wondered how long it took to train the generalist or what separated the generalist from the subspecialist.

In April 2000, with evidence that psychiatric postgraduate education had seriously weakened during the 1990s, the Canadian Psychiatric Association (CPA) Standing Committee on Education (SCE) expressed concerns about the

pressures of rapid educational change on programs. Six of 16 programs had received provisional approval from the RCPSC; health care restructuring had weakened the service infrastructure; the national postgraduate residency complement had been only partially filled for several years; recruiting individuals to the academic departments was difficult; and resident interest in an academic career in psychiatry was at an all time low.

In response, CPA and the Association of Chairs of Psychiatry of Canada (ACPC) hosted a search symposium in April 2001 in order to establish a strategy to enhance the national training infrastructure. Psychiatric educators and residents attended from the Coordinators of Postgraduate Education (COPE), CPA, ACPC, the RCPSC Specialty Committee in Psychiatry, the three subspecialty academies, medical school administration and the Canadian Association of Interns and Residents (CAIR). The four major educational bodies partnering with ACPC and the academies approved an ad hoc 'engine' committee to carry a national strategy forward and the CPA Board of Directors approved initial funding.

In 2002, guided by a vision statement focusing on education to develop a sophisticated generalist capable of life span practice in a variety of settings and four priorities, CPA approved the formation of the Working Group on a National Strategy for Postgraduate Education in Psychiatry (NSPGE), co-chaired by Drs. John Leverette and Emmanuel Persad. The NSPGE received ongoing support from the CPA Board of Directors through to the completion of its tasks in 2007. In its early discussions, two principal foci consumed the energy of the NSPGE and became the agreed priorities: the development of the core competencies for the general psychiatrist and subspecialty recognition in psychiatry.

THE NSPGE PRIORITIES

The first priority involved envisioning the sophisticated generalist in contemporary practice – a clinician with knowledge, skills and attitudes appropriate to practice across the life span of patients with a range of psychiatric disorders in different settings in collaboration with others. It also involved defining the necessary enabling objectives, their delivery and evaluation. Practicing across the life span is considered an important role for the general psychiatrist given the shortage of psychiatric subspecialists in Canada.[1] As subtext to the RCPSC CanMEDS competencies, the group undertook to develop the core content competencies for the general psychiatrist with the understanding that this work would be fundamental to the subsequent development of a training model for general and subspecialty psychiatrists.[2,3] The expected products were to be revised drafts of the RCPSC Specialty

Training Requirements (STR) in Psychiatry and RCPSC OTR to be submitted to the RCPSC Specialty Committee in Psychiatry for review in spring 2005.

The second focus on developing models of subspecialty recognition, while interwoven in the fabric of the first, had to wait until the core competencies for the generalist determined the overall length of training in general psychiatry, the contribution of subspecialty training to that, and the availability of elective and selective time within the primary specialty that might accommodate additional subspecialty training. The subspecialty academies generally supported the completion of subspecialty training within the core curriculum and elective or selective training that had for many years existed in the five-year general psychiatry training program and argued for formal recognition. The RCPSC was at that time questioning the amount of elective and selective time (some 18 months) in general psychiatry training and had not supported any model of subspecialty recognition occurring until the primary specialty had been completed by examination.

SHIFTING THE CULTURE BY CONSENSUS

Visioning the 'sophisticated generalist' in contemporary practice

The core competency task was undertaken with an initial visioning exercise with input from the subspecialty academies and others concerning the content presumed necessary for effective psychiatric practice across the lifespan. Held in the winter/spring of 2004, it included psychiatric educators, general and subspecialty psychiatrists, and confirmed in consensus the role of the general psychiatrist in delivering care across the life span in a wide variety of settings in collaboration with others. The NSPGE participants were guided by agreed goals that included building the educational experience from the ground up; describing the knowledge, skills and attitudes appropriate to the role of the 'sophisticated generalist'; and defining the enabling objectives, their delivery and evaluation. All subspecialty academies and other interest groups completed their initial submissions on core competencies by spring 2004.

Checking with the stakeholders

In spring 2004, in recognition of the difficulty in ascertaining the views of the majority of general psychiatrists in practice, a web-based national survey led by Dr. Gary Hnatko was designed to be as inclusive as possible in reaching all Canadian psychiatrists.[4] The goal was to assess their views concerning the core competencies required for the practice of general psychiatry. All NSPGE participants contributed to the survey content. Over 569 Canadian psychiatrists

responded in the first eight weeks of 2005. With respect to life span practice, 27 per cent of respondents reported seeing children under the age of 12, and of these, 12 per cent were engaged less than 10 per cent of the time. About 41 per cent saw adolescents (12-16 years), and of these, 22 per cent did so less than 10 per cent of the time. Fifty-six per cent spent 40 to 80 per cent of their time attending to 26 to 64 year olds. Twenty-five per cent of respondents saw patients over 65 years of age 20 to 50 per cent of the time.

With respect to training content, an attempt was made to ascertain the practicing psychiatrists' view of the level of competence required to deliver quality service. They were asked to estimate the competencies required in practice areas and were provided with competency definitions to assist them. These included:

- No need to know.
- Basic overview knowledge and recognition.
- Early intermediate working knowledge or basic interview, formulation and treatment skills.
- Late intermediate working knowledge in a developmental, cultural and life span context with detailed interviewing and biopsychosocial formulation skills, and beginning ability to teach, consult and receive basic referrals.
- Advanced detailed knowledge and sophisticated understanding, multimodal, interdisciplinary, effectively teaches and consults on complex referrals.

The results of the survey, available in winter/spring 2005, confirmed the involvement of general psychiatrists in practice across the life span and estimated the level of skill and knowledge required for them to deliver care. In replying to questions on training models, the respondents stressed the importance of maintaining the PGY1 year as a broadly based medical experience, addressed its content and confirmed that a further four years of psychiatric training were necessary to complete generalist training. Practicing psychiatrists affirmed the importance of continuing the medical role of the psychiatrist. They noted the need for increased emphasis in training on addictions and sleep disorders, and called for increased competencies in a wider range of psychotherapies including supportive, crisis, cognitive-behavioural therapy (CBT), family and insight therapies. From their experience they estimated that their needs in the care of children and adolescents, the elderly, forensic patients and those with combined psychiatric and medical/surgical hospitalizations would require knowledge and skill varying from early to late intermediate levels. To accommodate these additional competencies, they suggested reducing elective and selective training to 12 months in total.

Challenged in the survey to select a preferred model of training, they overwhelmingly responded by choosing a model in which there is common

training as a general psychiatrist for all trainees leading to certification in the primary specialty by examination prior to subspecialization. Depending on the time in electives and selectives or other components, the generalist might be described as having special areas of competence – in other words, a generalist with a 'minor' in certain areas.

Finally, they recommended that subspecialty training should be completed subsequent to general training and be no less than one further year ending with its own examination. It would likely require two years of training in total and should build upon relevant electives or selectives undertaken during the training in general psychiatry, which would be credited to subspecialty requirements.

CPA and RCPSC: a meeting of the minds

For a number of years, there had been some tension between the CPA and RCPSC over psychiatry's longstanding drive for recognition of its subspecialties. Canadian child psychiatrists first raised this with RCPSC in the 1970s and the request had been echoed over the years by geriatric, forensic and consultation-liaison psychiatrists. In the absence of progression, subspecialists had formed 'academies' with entry primarily based on completion of certain training requirements during psychiatry residency. Given the relatively limited number of psychiatrists to attend to the psychiatric needs of the country's citizens, concerns about avoiding fragmentation within Canadian psychiatry emerged and academies became CPA affiliates with their own Council and Board representation within CPA's organizational structure. With frustration over formal recognition increasing among the academies, CPA undertook to support and to sponsor the academies in their applications to become subspecialties. This last occurred in 1995 with submissions from the Canadian Academy of Child and Adolescent Psychiatry (CACAP), the Canadian Academy of Geriatric Psychiatry (CAGP) and the Canadian Academy of Psychiatry and the Law (CAPL). In 1996, the RCPSC, increasingly concerned with the inconsistent designation of specialties and subspecialties, the rapid proliferation of subspecialty applications and super-specialization with an erosion of generalism, had placed a moratorium on further subspecialty applications.

However, in the course of the NSPGE's work and for the first time in a long while, organized psychiatry and the RCPSC seemed in some respects to be on the same wavelength. The *de novo* conceptual reflection by psychiatric educators on core competencies was converging with RCPSC interests concerning core competencies within and across specialties. Specifically, this work resonated with the RCPSC Core Competency Project developed to identify competencies common to various disciplines, to consider streaming disciplines and to consider developing a common or core training program. Building on this in the spring of 2005, CPA Board Chair Dr. Blake Woodside met with RCPSC leaders to revisit the importance of subspecialty recognition of psychiatry and to

strongly argue for movement forward. In response, RCPSC indicated willingness to flexibly review models of subspecialty recognition and to consider a 'made in psychiatry' model on completion of the core competencies for the generalist.

A template for generalist training

The NSPGE, armed with this knowledge, held a retreat in April 2005. Facilitated by Dr. Brian Hodges, the goal was to develop 'broad brush stroke' recommendations to take to the RCPSC Specialty Committee in Psychiatry meeting in May 2005. The retreat achieved more than 'broad brush strokes'; it elaborated by consensus a template of the five-year training program for the general psychiatrist. Affirming that five years were required to train the general psychiatrist, the template was based on developmental principles to achieve increasingly complex competencies, stressing practice across the life span and demonstrating graded responsibility with progression. Annual evaluation was to be relevant and focus on training objectives for each year. Competency attainment was to be flexible – attained horizontally in rotations or longitudinally across the postgraduate years with increased patient contact, and, where possible, to be determined by individual progress unrelated to rank or time in training. Its components were:

- PGY1/Basic Clinical Training (BCT) was to be a broadly-based medical experience relevant to psychiatry with core elements in medicine, neurology, emergency medicine and family medicine, including psychiatry as relevant to the practice of general medicine with selectives and a limited elective.
- PGY2 and PGY3 were described as basic and foundational years of training with a focus on the role of the psychiatrist practicing across the lifespan, including rotations in child, adult and geriatric psychiatry.
- PGY4 was to develop competency in providing complex care to the expected volume and variety of patients in contemporary general psychiatric practice with a focus on consultation skills, collaborative care with physicians and other mental health professionals, and to attain proficiency in treatment modalities.
- PGY5 would focus on the resident's ability to function as a junior consultant, the development of career interests, the application of a systems understanding to psychiatric practice and patient care, and the maintenance of certification. The length of selectives and electives would each be six months in duration and occur in PGY5.

A template for subspecialty recognition

Informed of the CPA survey results, the Boards of the various academies participated throughout winter 2005 in the evolving training model for general

psychiatry as their education committees contributed to the core competencies for the general psychiatrist from the subspecialty perspectives. Their active participation in consensus building concerning the model assisted them in overcoming a long held position to include all of subspecialty training within that of the primary specialty and to reject additional training post primary specialty. As the group both operationalizing and receiving training, COPE was valued as a 'reality tester' when such pedagogical methods and directions were examined. The support of COPE's educators and residents in considering a model embracing further training after completion of the primary specialty contributed to the academies' confidence to move forward. As partners in creating the model and with an understanding of the reduction therein of elective and selective time from 18 to 12 months, the academies approved the one-year BCT year preparation, four-year primary specialty and one-year subspecialty formula as a step to achieve recognition. This relieved RCPSC of the need to consider a 'made in psychiatry' model for subspecialty recognition different from their existing ones. Subspecialty training would be undertaken subsequent to attaining the primary specialty in psychiatry and would be a minimum duration of one year and evaluated by a subspecialty examination. It would generally require two years, some of which could be accomplished in the core training, selectives or electives during residency in general psychiatry. Training in the subspecialty year(s) would be demonstrably different and of greater complexity than general training for the latter to be considered a prerequisite for entry into subspecialty training.

Approval to proceed

The templates were presented to the RCPSC Specialty Committee in Psychiatry as the body formally responsible for defining residency training in psychiatry. With the focus primarily on the template for general training and aware that it involved a fundamental change and evolution in residency education, the NSPGE sought endorsement to continue further content development and drafting the enabling objectives necessary to operationalize training. To achieve the latter over the summer and fall of 2005, the NSPGE established five writing groups consisting of members from its core group and Subcommittee on Core Competencies, and augmented these with additional representatives from general psychiatry as recruited by Dr. Pierre Beauséjour, active program directors recruited from COPE, and residents from the CPA Members-in Training Section and COPE.

Moving forward 2006

The NSPGE set goals to arrive at a further consensus among its educators and learners on defining the enabling objectives to achieve the delivery of the competencies and their evaluation. By July, six writing groups, augmented by

program directors and resident representatives, had drafted detailed descriptions for each of the five training years and longitudinal components. From July to October, a single writing group drafted the two proposed RCPSC documents – the STR and the OTR in Psychiatry (the latter in CanMEDs format). Readers are encouraged to access these documents from the RCPSC website at www.rcpsc.medical.org for a full understanding of the developments and will find them helpful as references to the other chapters in this book. The brief synopsis of salient aspects of the STR and initiatives in the OTR that follows will illustrate the progression in thought that occurred to assure the preparation of the sophisticated generalist for a contemporary psychiatric practice to meet societal needs.

Evolution in the STR in Psychiatry resulted in the following elaboration:

One-year (PGY1) of basic clinical training

This is undertaken as a broadly-based medical experience *relevant to psychiatry* with core elements in medicine, pediatrics, family medicine, neurology, emergency medicine and psychiatry. A neuro-imaging experience is strongly recommended. Integrated with the subsequent years, psychiatry rotations or electives now contribute to requirements or to the acquisition of longitudinal components of training.

Junior residency (PGY2–PGY3) - 24 months

Designed as basic and foundational training with a focus on the role of the psychiatrist practicing across the lifespan in a variety of practice settings, it includes 12 months of general adult psychiatry with roughly equal time in ambulatory and general hospital inpatient settings; six months devoted to the psychiatric care of children, adolescents and their families structured to include exposure to all developmental levels and ages and occurring in a variety of clinical settings; and six months devoted to the psychiatric care of the elderly and their families in a variety of clinical settings. During these rotations, patients with developmental delay, with or without comorbid disorder, must be included.

Senior residency (PGY4–PGY5) - 24 months

Here the resident assumes more leadership in the education and supervision of junior colleagues while developing career track interests through electives and selectives, including research. The resident applies a systems understanding to psychiatric practice and patient care; develops competence in the maintenance of certification; and consolidates the CanMEDS roles of communicator, collaborator, manager, health advocate, professional and scholar during the prescribed experiences. The senior residency consolidates the role of medical expert, including attaining proficiency in a range of treatment modalities and promotes independent practice across the life span. The training must include 12 months of providing complex care to the expected volume and variety of adult patients in general psychiatric practice and 12 months of selectives and

electives. Within the 12 months, there are defined supervised experiences in consultation-liaison psychiatry (psychosomatic medicine) with the medically and surgically ill; in collaborative/shared care with family physicians, specialist physicians and other mental health professionals; and in severe and persistent mental illness and its rehabilitation.

The six months of selectives are limited to child and adolescent, geriatric, psychiatry and the law, psychosomatic medicine, psychiatric research, psychotherapies, addictions, developmental disabilities, and psychiatry in rural and/or remote locations. The six months of electives can be taken in any aspect of training relevant to contemporary psychiatric practice, including research, or in any branch of medicine relevant to psychiatry. Up to six months of training may be taken at an approved health care facility or university external to the home program.

Concurrent/longitudinal training

In addition to the use of horizontal components noted above, training may flexibly accommodate competency development through longitudinal components across the 60 months of training. These experiences should be designed to integrate with and enhance training in the companion clinical rotation or horizontal component whose time it shares. All such training is documented and evaluated separately from other rotations.

- *PGY1–PGY5*
  Longitudinal training issues are identified in clinical skills, administration, research and education, and include but are not limited to, research (scholar), psychotherapies (medical expert), education (scholar/communicator), and administration and leadership (manager). The equivalent of up to one day per week can be assigned to these additional experiences. This period must include at least two (subject to change depending on the decision of the RCPSC Specialty Committee) years of supervised treatment of patients (and their families) with a severe and persistent psychotic illness for no less than two direct care hours per month.
- *PGY2–PGY5*
  Across these years, training in evidenced-based psychotherapies occurs involving no less than 32 weeks or eight months. This must be longitudinal, may focus on children and adolescents, adults, the elderly, families and groups, and includes patient hours, supervision and structured learning activities. Also included is a supervised experience in the treatment of patients with addictions in a variety of settings as a discrete rotation or a longitudinal experience equivalent.

Psychiatry competencies

A major initiative involved the development of levels of competency to guide the resident's acquisition of knowledge, skills and attitudes through definition

and behavioural anchoring — these to be included in the OTR document. Inspiration was derived from the definition provided in the component of the national survey that helped to determine the practicing psychiatrists' view of the levels of competence required to deliver quality service. Core competence was understood as the minimum proficiency required to achieve successful completion of training. Higher levels of competence beyond minimum training requirements could be pursued as part of selectives and electives. The NSPGE was aware that in attempting to do so it was breaking new ground in RCPSC documentation. These have been applied primarily in the CanMEDS role of medical expert.

- Introductory knowledge: able to recognize, identify or describe principles.
- Working knowledge: able to demonstrate core aspects of psychiatry, such as basic interviewing, problem formulation and treatment. The resident can understand the scientific literature.
- Proficient: able to demonstrate working knowledge enhanced by a developmental, cultural and lifespan perspective, allowing detailed interviewing and biopsychosocial problem formulation with capacity to teach, consult, assess and manage referrals. The resident can review the scientific literature.
- Advanced: detailed and sophisticated understanding that is multimodal and interdisciplinary, leading to advanced teaching and consultation on complex referrals. The resident is readily able to apply and demonstrate familiarity and apply the scientific literature.
- Expert/Master: requires advanced training beyond core residency, which leads to enhanced skills that enable management of patients with complex comorbidities, treatment resistance or rare conditions. The expert psychiatrist has the capacity to critically review the literature with enhanced expertise and generate new questions for study.

In November, the documents were reviewed by the NSPGE writing groups, the RCPSC Specialty Committee in Psychiatry, and the Council of Academies, and were presented to the CPA membership in a lecture at its Annual Conference. Final drafts of the STR and OTR in Psychiatry were submitted to the CPA Board in December. They were approved in early January 2007 and forwarded to the RCPSC Specialty Committee in Psychiatry.

Moving forward with the RCPSC 2007

Between January and early April, the RCPSC Specialty Committee in Psychiatry refined and approved the documents and consulted with educational officers and staff in the Credentials Section to ensure approval by the Credentials Committee in April. This was a necessary task considering the documents were required to

also serve as a guide to evaluate the training of international medical graduates applying for eligibility to take the primary specialty examinations. Some compromises were made affecting the flexibility in delivery, but no loss of content or direction occurred. Lauded by a RCPSC educational consultant as pedagogically ahead of the curve, revisions to certain aspects were however required to ensure RCPSC acceptance. A more conservative approach was suggested in aspects of the developmental approach and longitudinal training. Progress by flexible competency attainment determined by progress unrelated to rank or time in training, while considered educationally sound, was considered too advanced for current RCPSC operations and this was relegated to the future. The consultation and feedback resulted in some revisions, mostly to refine definitions and better operationalize the documents. Some content was also moved to the Specific Standards of Accreditation document. The RCPSC Education Committee gave its approval in May, and the documents were released publicly in June to take effect July 1, 2008.

The road to psychiatric subspecialization

By spring 2007, and with the CPA's commitment for support in the RCPSC application process for subspecialty recognition, four academies were preparing their initial submissions to the RCPSC Committee on Specialties (COS) to be heard in the spring of 2008. Three academies were successful in part one of the application process and proceeded to submit their part two applications in the fall of 2008. The RCPSC COS met in April 2009 and approved the subspecialties of child and adolescent psychiatry, geriatric psychiatry and forensic psychiatry.

THE PRESENT AND THE FUTURE

The RCPSC STR and OTR in Psychiatry delineating the core competencies took effect for residents entering training on July 1, 2008. Its crafting represented an unusual departure from previous Canadian practices by deliberately attempting to seek consensus on its content and deliverables from a wide range of practitioners, educators and learners. Doing so required considerable time and reflection, and would have been impossible without the foresight, leadership and support of the CPA and its Board of Directors as well as the willingness of the other principal educational bodies (RCPSC Specialty Committee in Psychiatry and COPE) accompanied by the ACPC and academies to partner under the umbrella of the NSPGE. While the RCPSC documents are 'living' documents with opportunity for ongoing revision as necessary, the current iterations are reasonably likely to guide educational practice over the next 10 years.

This work introduces the concept of the sophisticated generalist in contemporary Canadian psychiatric practice – a clinician with knowledge, skills and attitudes appropriate to practice across the lifespan of patients with a range of psychiatric disorders in different settings and in collaboration with others. To achieve this outcome in training, the educational experience has been reorganized into a junior and senior residency, graded responsibility has been emphasized, and a process for longitudinal training over 60 months for specific experiences has been introduced. To meet concerns for competency attainment and to ensure practice readiness, senior residents will train to the expected volume and variety of adult patients seen in general practice. Redefined rotations in consultation-liaison, shared or collaborative care, severe and persistent mental illness, and addictions have been included. A major initiative has been to ensure treatment effectiveness with new skill requirements in psychotherapy. Eight months (15 per cent) of training time has been assigned to this with residents required to attain a competency level of proficiency in five evidence–based therapies. Perhaps the most interesting aspect has been to assist program directors and residents in attaining the core competencies by operationalizing levels of competency in the CanMEDS medical expert knowledge, skills and attitudes by definition and behavioural anchors – placing psychiatry ahead of other specialties at the RCPSC in this endeavour. The training template has been designed with as much flexibility built in as possible to assist programs in its delivery while preserving provincially mandated needs. Finally, the completion of the work opened the door to the recognition of subspecialties.

With its work completed, the NSPGE Working Group requested its dissolution in the fall of 2007 and the CPA Board concurred. The Board's vision with respect to postgraduate education however also included support for a book to assist program directors with implementation and to educate residents in a more fulsome understanding of the education that they would receive. The editors were appointed and the concept of a 'toolbox' for psychiatric educators, taking into account the variation in size and available resources across the country, was born. The contributing authors were chosen as experts in their fields – some new to the project and many who had made previous contributions to the NSPGE. The editors wish to acknowledge the vision and support of the CPA Board, key CPA head office staff and the dedicated contributions of the authors and those who made the work of NSPGE so rewarding and effective.

ACKNOWLEDGEMENTS

The list below is oriented to the NSPGE 2005-2006 activities, however over its lifespan from 2002–2007 membership has varied as the leadership of the contributing psychiatric education bodies changed. Members not serving during 2005–2006 are included in brackets with their respective committees or groups.

Working Group on a National Strategy for Postgraduate Education in Psychiatry 2005-06

Core

ACPC

Dr. Don Addington

CPA Standing Committee on Education (SCE)

Dr. Emmanuel Persad, Co-chair; Dr. Andrea Berntson, (Drs. Krista Boylan, Karen Jablonowski); Member-in-Training Section Chairs; Dr. Wil Fleisher

COPE

Dr. Kathryn Fung, (Drs. Jason Cohen, Sarah Noble), Resident Co-chairs, Dr. Renée Roy (Dr. Dara Charney)

CPA NSPGE

Dr. John Leverette, Dr. Emmanuel Persad, Co-chairs

RCPSC Specialty Committee in Psychiatry

Dr. Richard Swinson

Ad hoc (Subcommittee on Core Competencies)

General Psychiatry Champion

Dr. Pierre Beauséjour, Chair

RCPSC Specialty Committee in Psychiatry

Dr. Fabien Gagnon, Dr. Gary Hnatko

COPE

Dr. Kathy Gillis, Dr. Andrew Harris, (Dr. Lawrence Martin), Dr. Karen Saperson, Dr. Laurie Potter, resident

CACAP

Dr. Margaret Steele, Dr. Ruth Russell, (Dr. Simon Davidson)

CAGP

Dr. Cathy Shea, (Drs. Marie-France Tourigny-Rivard, Martha Donnelly)

CAPL

Dr. Dominique Bourget, Dr. John Bradford, (Dr. Renée Fugère)

Association of Faculties of Medicine of Canada

Dr. Kristen Sivertz, Postgraduate Education Dean

NSPGE Retreat 2005

Dr. Brian Hodges

Writing Groups

PGY1

Dr. Fabien Gagnon,* Dr. Maria Davidson, Dr. Andrea Bernston, Dr. Yvon Garneau, Dr. Donna Malcolm, Dr. Kristin Sivertz, Dr. Doug Watson

PGY2–PGY3

Dr. Kathy Gillis,* Dr. Melissa Andrew,
Dr. Manon Charbonneau, Dr. John Leverette, Dr. Cathy Shea, Dr. Margaret Steele,
Dr. Laurie Potter

PGY4

Dr. Emmanuel Persad,* Dr. John Bradford, Dr. Jonathon Fleming,
Dr. Kathryn Fung, Dr. Nick Kates,
Dr. Ari Zaretsky

PGY5

Dr. Richard Swinson,* Dr. Pierre Beauséjour, Dr. Stella Blackshaw,
Dr. Ian Dawe , Dr. Sandra Demaries,
Dr. Renée Roy, Dr. Karen Saperson

Longitudinal Training

Dr. Gary Hnatko,* Dr. Don Addington,
Dr. Andrew Harris, Dr. Mark Kaluzienski, Dr. Paul Lespérance,
Dr. Henry Leung, Dr. Ruth Russell,
Dr. Prianthy Weerasekera

* Denotes chairperson of writing group

Overview Consultant
Dr. William Fleisher

Support
CPA Head Office:

Francine Knoops, Hélène Côté

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Chapter 2

The evolution of training in general psychiatry and its relationship to subspecialization within psychiatry

Richard P Swinson and John S Leverette

INTRODUCTION

Psychiatry has a relatively short history as an independent medical specialty separate from internal medicine and neurology. Shorter[1] documents the history of psychiatry from the period of "a world without psychiatry" (pp 1–4) prior to the 17th century to the advent of the recent period characterized by the introduction of many new therapeutic methods. His account of this period, that he entitles "From Freud to Prozac," clearly illustrates the enormous change and advances that have occurred in psychiatry since its development into a bona fide medical specialty.[2] The history of the development of Canadian psychiatry specifically has been admirably documented by Rae-Grant.[3]

CURRICULUM, TRAINING GUIDELINES, ASSESSMENT METHODS AND EXAMINATIONS

History and background prior to July 1, 2008

In Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) approved psychiatry as a specialty in the division of medical specialties in 1944 and the first certificates were awarded to Canadian psychiatrists in 1946. Prior to the Second World War, psychiatry in Canada was primarily practiced in and largely limited to large mental hospitals. The first asylum in Ontario was opened in 1850 in Toronto on the site that is now the Centre for Addiction and Mental Health. Many other provincial asylums were opened throughout Canada in that same era. In British Columbia, Riverview Hospital opened in 1913 as a tertiary psychiatric hospital for individuals with serious and persistent mental illness. Due to changes in provincial funding of hospitals, the asylums gradually became less prominent and much of hospital-based psychiatry developed within full service general hospitals. In Ontario, where there were many provincial psychiatric hospitals until the late 1990s, very few remain as directly provincially funded institutions. In most instances, the previous psychiatric hospitals have come under the administration of general hospitals or have become independent public hospitals. Similar changes have occurred across the country.

In Canada, the responsibility for the training of specialist physicians and surgeons is held by residency programs situated in university departments. Historically, the number of residency positions has equaled the number of medical students graduating each year from the medical schools in the country. Entry to the psychiatry residency is competitive and coordinated through the Canadian Resident Matching Service. Programs in Canada vary markedly in size and admit between four and 32 trainees each year. Training lasts for five years after medical school graduation. Every program is subject to accreditation visits by RCPSC assessors on a five-year cycle. Accreditation addresses the performance of each program according to six standards described in the General Standards for Accreditation (GSA).

General Standards for Accreditation (GSA)

The standards relate to the expectation that all of the following will be in place in each specialty training program:

1. An appropriate administrative structure.
2. A clearly worded statement outlining the goals of the residency program and the educational objectives of the residents.

3. An organized program of rotations and other educational experiences, both mandatory and elective, designed to provide each resident with the opportunity to fulfill the educational requirements and achieve competence in the specialty.
4. Sufficient resources, including teaching faculty, the number and variety of patients, physical and technical resources, as well as the supporting facilities and services necessary to provide the opportunity for all residents in the program to achieve the requirements in psychiatry.
5. The clinical, academic and scholarly content of the program must be appropriate for university postgraduate education and adequately prepare residents to fulfill all of the roles of the specialist. The quality of scholarship in the program will, in part, be demonstrated by a spirit of enquiry during clinical discussions, at the bedside and in clinics, as well as in seminars, rounds and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
6. Mechanisms are in place to ensure the systematic collection and interpretation of evaluation data on each resident enrolled in the program to achieve the educational objectives and receive full training as defined by the specialty training.

The 1970s and 1980s

For a lengthy period there were few changes in psychiatric training in Canada. The curriculum, pedagogical methods and assessments of performance did not change substantially. Supervised experiences in geriatric and consultation-liaison psychiatry were developed and in most centres were interpreted as mandatory three-month rotations. At this time, the total mandatory training period increased to two and a half years in addition to the internship year, leaving 18 months for experiences to meet specific career interests or subspecialty training.

The 1990s

The common rotating internship was eliminated in the 1990s. In its place, PGY1 training was introduced and linked in its content to the specialty training programs. Program directors in psychiatry were required to develop and take responsibility for the content. Although the large majority of PGY1 is spent in training in areas such as internal medicine, neurology and family medicine, the residents remain the responsibility of the department of psychiatry training program. The RCPSC introduced initiatives for all specialties to balance the service/education dichotomy during training and emphasized the role of the trainee as a student. Improvements were made in graded responsibility during

residency, the teaching of ethics, critical appraisal and continuous quality improvement skills.

The RCPSC identified psychiatry as one of several specialties that should develop community learning experiences. Provincial governments in Canada generally favoured mandatory training, but it was introduced as a selective experience allowing trainees to meet societal need for competency in this area. A number of mandatory rotations were introduced at the urging of provincial governments intent on reshaping practice patterns.[4] The provincial government of Quebec's requirements led the RCPSC Specialty Committee to restructure PGY1 experiences in order to integrate PGY1 psychiatry rotations with mandatory requirements in PGY2–PGY3.

The early 2000s

Increased focus on resident safety, research training, and training in alcohol and substance use disorders were championed from within the specialty.[5] Program directors became concerned that further mandatory experiences to the curriculum would imperil the current RCPSC training goals. Also, some initiatives were introduced into the RCPSC training objectives and some were not. In the early 2000s, a supervised experience in alcohol and substance use disorders was introduced but without success in many programs due to their resource deficiencies.[6]

Programs are responsible for developing curriculum based in the CanMEDS 2005 Physician Competency Framework, which defines the seven competencies necessary for successful completion of training across the 60 medical and surgical specialty areas. These competencies relate to the roles of medical expert, communicator, collaborator, manager, health advocate, scholar and professional.[7]

Standards four and five of the GSA require that postgraduate training meet all the training needs to prepare residents to be able to fulfill all the roles of the specialist. The expectations of the specialist in psychiatry include competence to work in any appropriate treatment setting, with persons of any age and with any mental disorder. Until 2009, subspecialization within psychiatry had not been recognized by the RCPSC in contrast to the situation in many other specialties within Canada and within other countries. As the fields of study in life stage related disorders (child and adolescent psychiatry or geriatric psychiatry) and psychiatry and the law have developed in Canada, subspecialty interest academies in these areas have been formed independent of the Royal College. These academies have defined their own areas of study, curriculum and necessary additional training in order for a psychiatrist to be recognized as sufficiently competent to practice as a subspecialist.

The overall objective of training psychiatrists in Canada is to produce a cohort of appropriately trained specialists to meet the needs of the population of the country. Canada is distinguished from many other countries by its size, geography and climate; its bilingual foundation; the presence of significantly large aboriginal populations; and by its acceptance of immigrants and refugees from all over the world. The range of practice settings for which a Canadian psychiatrist has to be prepared is very wide.

Evaluation of training

There have been many developments in the formal evaluation of training and competence in Canadian psychiatry in the past decade. The director of postgraduate education in each university department of psychiatry is responsible for ensuring the standards of education and learning for their resident trainees. Residents are evaluated formally during and at the end of each rotation by their supervisors. Observed Structured Clinical Examinations (OSCE) are held each year for all residents regardless of their level of training. In most departments, residents are exposed to practice oral examinations in which actual patients, who have given fully informed consent, are interviewed in the presence of an examiner and frequently with other residents from the same year observing through a one-way mirror. In order to complete training, a resident has to successfully achieve a satisfactory level of competence in a minimum of two formal clinical oral examinations observed by two examiners. Each examination consists of a 50-minute interview with the patient, 10 minutes for the resident to integrate their findings and to construct a treatment and management plan followed by a 45-minute discussion with the two examiners. Residents are eligible to present themselves at these examinations within one year of the anticipated end of training. Many residents also take the Psychiatry Residents in Training Examination (PRITE) of the American College of Psychiatrists each year. This is a 300-item multiple choice question (MCQ) examination covering the major content areas of psychiatry and behavioural science.

When clinical training is completed and the clinical orals are successfully passed by residents, a record of their performance and readiness to take the Royal College certification examination comprises the Final In-Training Evaluation Report (FITER).

The Royal College certification examination in psychiatry has changed considerably in structure and content during the past decade. Until 2001, the examination was taken in two separate parts. The first portion was a written examination consisting of two papers that had to be successfully passed before the candidate could proceed to the oral examination portion. The two written papers are a 175-item MCQ, one best answer of five paper, lasting three hours and covering the fundamentals of psychiatry, and a second paper consisting of

10 short answer questions (SAQ) requiring approximately 20 minutes per answer. These examinations were written at a centre close to the residents training sites across Canada and in the candidates' official language of choice. A specialty specific Test Committee ensures the standards of the papers each year and also balances the content of the questions to address the content of the whole curriculum. Success on the written papers allowed the candidates to present themselves for the oral portion some months later.

Approximately 150 to 170 candidates sat the oral examinations each year. The examination was held twice a year. The spring examinations for English-speaking candidates were held in Toronto and Edmonton, and the fall examination in Montreal. French-speaking candidates' examinations rotated across university sites within the province of Quebec. Some years ago, the examinations were reduced to one opportunity each year in the spring. In the long standing format of the oral examination dating back at least 30 years, candidates interviewed a real patient volunteer for up to 55 minutes observed by two examiners, one in the room and one behind a mirror. The second hour was devoted to reviewing the case with the resident and also spending 15 minutes of that time on vignettes produced by the examiners. The logistics of arranging space, travel and appropriate patients across a country as large as Canada were challenging. The examinations were also expensive for the candidates. Examiners are volunteer certified psychiatrists, primarily from academic departments plus some community-based psychiatrists, who do not receive remuneration for their time.

The two-part structure of the examination was reviewed and it was determined that a single condensed examination would be more advantageous for the candidates. In this format the candidates apply to take the whole examination in one block. The Board of Examiners assigns a single final mark for each candidate's performance as a composite from the results of all the components from the written and oral sections. A significant change has been the removal of the "Royal College long case" from the summative examination. In addition to the logistic difficulties and costs of mounting the examinations, there were concerns that the long case as a single event was not sufficiently reliable and valid enough to determine pass and fail at the end of five years of training. The responsibility for the assessment of the candidates' clinical performance is now held by the training site. The directors of postgraduate psychiatric education in each university department determine the readiness of residents to apply for the Royal College examination after feedback from the residents' supervisors.

The current examination is a single annual event with two written papers (MCQ and short answer) and an oral examination consisting of approximately nine OSCE stations. All candidates have to travel to the Royal College site in Ottawa where the examination is available in French and English. The separate language specific examination boards have been amalgamated into one.

INTERNATIONAL TRAINING IN PSYCHIATRY

United States of America

In North America, there is a considerable flow of students and professionals back and forth across national boundaries for educational purposes. Canada's position as the northernmost country in North America dictates an awareness of comparable training available with a focus on the United States rather than Mexico. There is reciprocity in the recognition of training in psychiatry between Canada and the United States. The American Board of Psychiatry and Neurology (ABPN) is the examining body equivalent to the RCPSC. Training in psychiatry in the United States extends for four years in contrast to the five years of Canadian training. Reciprocity is offered to U.S. qualified candidates to enable them to sit the RCPSC examination when they have attained certification in psychiatry by the ABPN, have an unrestricted licence to practice in the U.S. or Canada, have completed four years in a psychiatry program accredited by the U.S. Accreditation Council for Graduate Medical Education (ACGME), and also have one year of specialty experience.

Canadian trained psychiatrists are eligible to sit the ABPN examinations in psychiatry and neurology if they have completed their training in a Canadian program accredited by the RCPSC (as all Canadian programs are), achieved certification by the RCPSC, and possess an unrestricted licence to practice medicine in a Canadian province.

Residency training in the U.S. follows two major patterns:

1. A four-year program in an ACGME-accredited program in psychiatry with PGY1, including at least four months in internal medicine, family medicine and/or pediatrics that provides comprehensive and continuous patient care. Neurology rotations are not acceptable to fulfill this four-month requirement.
2. A three-year psychiatry residency program with the first year consisting of a broad-based clinical year of ACGME-accredited training in internal medicine, family medicine, or pediatrics; or a transitional year program including a minimum of four months of primary care; or a residency in a clinical specialty requiring comprehensive and continuous patient care followed by three full years of postgraduate specialized residency training in a psychiatry program accredited by the ACGME.

The ABPN examination comprises two parts. The first is a computer administered MCQ time-limited examination available at specific testing centres. The content areas are very similar to those of the RCPSC examination with the addition of the diagnostic and clinical evaluation of neurologic disorders/syndromes and the management and treatment of neurologic disorders.

The second part has two sections: a 30-minute clinical case interview with a real patient observed by a single examiner, followed by a 30-minute discussion with two examiners and an hour-long oral examination consisting of four vignettes. These are presented as videos or in written form and provide the basis for discussion with examiners.

Since 1994, U.S. certification has been time-limited and expires 10 years after it is awarded. Continuing certification is dependent on meeting the ABPN's criteria for continuing competence. Interestingly, certification in child and adolescent psychiatry requires maintenance of competence in that subspecialty without continued demonstration of competence in general psychiatry. This contrasts with recertification in addiction psychiatry, forensic psychiatry, geriatric psychiatry and other areas related to neurology that require recertification in general psychiatry plus the subspecialty.

United Kingdom

Specialist training in psychiatry in the United Kingdom has repeatedly undergone major changes in the past decade (Personal communication, Malik A, 2009). Specialist training in psychiatry in the UK is under the authority of the Postgraduate Medical Education and Training Board (PMETB). The PTEMB is the independent regulatory body responsible for postgraduate medical education and training across all medical and surgical specialties. It came into being in 2005 in response to concerns about the setting of standards in UK medical training. PMETB sets the overarching standards within which selection for specialist training must operate. It is not responsible for the operational aspects of selection, or for workforce issues like the number of training posts. By 2010, the functions of PTEMB and the General Medical Council will be merged. The curriculum is founded in the domains of Good Medical Practice. These are Good Clinical Care, Working with Colleagues, Probity and Health. Training takes place over six years and is described in the published curriculum (Royal College of Psychiatrists, 2007), which is a very detailed document describing the expected development of competencies. Competency levels develop from "under supervision" through "competent," and finally to "mastery."

The evaluation components of the curriculum and examination process are very comprehensive in variety and scope. They are detailed in the assessment program that describes 10 different workplace-based assessment methods. These include observations of a variety of clinical encounters, feedback from co-workers, case presentations and patient satisfaction questionnaires.

Each of the competency areas has detailed expectations related to knowledge, skills and attitudes. At the completion of training, all psychiatrists are expected to be knowledgeable and competent to a basic degree in subspecialty areas of psychiatry. This level of knowledge and practice is to enable the individual

doctor to deal with the majority of routine cases and emergencies that may be referred, but is less than the level required to practice as a subspecialist in a given field.

Specialty training in the UK spans six years in four phases of ST1, 2/3, 4/5 and ST6. Completion of training requires success in:

1. Three written papers that comprise an assessment of the knowledge base underpinning psychiatric practice. These have to be completed before the candidate can proceed to the Clinical Examination.
2. The Clinical Examination is an OSCE-type examination of two parts, completed in one day.
3. The Workplace Based Assessment (WPBA), the assessment of a doctor's performance, in those areas of professional practice best tested in the workplace. The assessment of performance by WPBA is constructed to provide feedback on areas of strength and development needs, identify trainees in difficulty, drive learning in important areas of competency and contribute evidence for decisions regarding a trainee's fitness to progress to the next stage of their career. These assessments are mandatory and are recorded electronically with the College. Additionally, a paper portfolio is necessary and records self-appraisal, professional development planning, reflective learning, and a record of publications, audit, research and teaching.

The written examinations are each three hours long and contain 200 questions. The papers include both "best answer one of five" style MCQs and Extended Matching Items (EMIs). In EMIs, a set of items is provided and used to answer a sequence of questions. This format is used to examine areas such as critical appraisal.

Training for a minimum of 30 months is necessary after success in the three-part examination to be eligible to take the MRCPsych Clinical Assessment of Skills and Competencies (CASC) examination. The CASCs are very similar to OSCE stations. Each candidate completes two circuits of eight stations lasting seven minutes per station. In one circuit, the CASCs are independent of each other, and in the second pairs of CASCs are linked with one scenario carrying over to the next station with a change of focus.

Australia and New Zealand

Training in psychiatry is under the purview of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). It is competency-based and founded in the same seven competencies as used by the RCPSC. There is a very strong emphasis on the promotion of a consumer-focused approach in which the consumer is able to work towards management of their condition in active

partnership with their psychiatrist and other mental health professionals. Entry into the training program begins after two years of internship/house officer experience following medical school completion. Basic training occurs in three years of initial training, followed by a further two years required for advanced training. The first year of basic training is devoted to adult psychiatry with six months in acute clinical services. During this time, the trainee has to complete 10 observed clinical interviews. At the end of three years, there are two three-hour written papers. A second phase of advanced training is available in general psychiatry or one of seven specialty areas. There are also longitudinal experiences that cut across all the specialty areas and include continuity of care, psychotherapy, biological, social and cultural management. Completion of training requires passing an examination consisting of one observed clinical interview and six OSCE stations.

South Africa

Training in psychiatry occurs within approved departments that have the responsibility for determining the curriculum in contrast to the development of the curriculum being centralized, as is the case in most other countries reviewed here. Training is expected to meet international standards and to be relevant for practice in South Africa. Registrar training begins after completion of two years of internship and one year of community service. Assessment of training occurs throughout a minimum of three years full-time experience in a clinical appointment or registrar post acceptable to the Colleges of Medicine of South Africa (CMSA) Senate or its Examinations and Credentials Committee.

Part I of training focuses on neurosciences and behavioural sciences, including basic psychiatry. In order to be able to sit the Part I examination, residents have to complete a single case presentation describing the assessment and management of an acute case in their own training department or have to have submitted a written case history to the CMSA. The part one examination comprises three written papers of three hours each. Two of these papers relate to neurosciences and the third to behavioural sciences.

Training for Part II of the examination is at least 36 months beyond successful completion of the Part 1 examination. The content of the curriculum and the expected clinical training are very similar to that found in North America. There is a greater focus on neuropsychiatry and research than Canadian residents are expected to develop. Each candidate has to write up three psychotherapy cases and to successfully complete and pass a research dissertation or produce a manuscript that has been accepted for publication in a recognized peer reviewed scientific journal.

The Part II examination focuses on three areas:

1. General psychiatry, including therapeutics.

2. Special psychiatry (child and adolescent, old age psychiatry, mental handicap, forensic, community, cultural, ethics and research issues).
3. Neuropsychiatry, neurology relevant to psychiatry, and general medicine relevant to psychiatry. Each of these areas is examined separately in three-hour written papers. There are clinical and oral examinations in both psychiatry and neuropsychiatry. The OSCE format with 12 stations appears to be available as an option within the clinical examination.

Europe

The European Union of Medical Specialists (UEMS) was created by professional organizations of medical specialists of the original six member countries of the European Economic Community (EEC). An aim of UEMS is to encourage the implementation of uniform training requirements in the whole of Europe. In 1993, the Charter on Training of Medical Specialists in the European Community (EC) was adopted. In 1992, UEMS Board of Psychiatry was established as a working group of the UEMS Section of Psychiatry with a particular focus on training matters. Over the intervening years there has been concerted effort to harmonize training across the EU to deal with the wide discrepancies that existed at the outset of the Section.

An extensive comparison of psychiatric training in 31 European countries was undertaken in 2003 to assess whether the development of training requirements had had an impact on the actual conditions of training in psychiatry in the member countries.[10] Twenty-two of 31 countries responded. Training has a duration of five years in all but one country. Training takes place in a variety of sites, including psychiatric non-university hospitals (43.3 per cent), departments of a general hospital (37.5 per cent) and psychiatric university hospitals (35.7 per cent). Most centres are quite small. Experience in outpatient settings occurs in 93 per cent of training centres, but only 70.7 per cent of the centres have a community care program. Even less offered are experiences in ‘mandatory’ rotations such as child and adolescent psychiatry (60 per cent), old age psychiatry (54 per cent) and mental handicap (27 per cent).

Subspecialty training was offered in less than half the countries. The most common subspecialty was child and adolescent psychiatry in eight of 22 countries, followed by forensic (five) and addictions (four). Psychiatry of old age was offered in only three countries.

Analysis

The length of training necessary in Canada is equal to or shorter than the training in the other international sites reviewed, with the exception of United States. Methods of assessment vary greatly across countries. Canada is unusual in having a single condensed examination at the end of training. Many other

countries have an assessment at roughly the midpoint of training that has to be completed successfully for the trainee to continue to the next stage of the program. A minority of countries have competency-based training or examinations.

WHAT WAS HAPPENING IN PSYCHIATRY TO NECESSITATE CONSIDERATION OF CHANGE?

Changes such as those noted above have altered both public and professional perceptions of the nature of psychiatry, its therapeutic methods, and its roles. Psychiatrists across Canada are now seen as part of the physician body interacting with their medical colleagues and with the staff of other professional disciplines on a daily basis. Hospital-based treatment is largely focused on short-term treatments in both inpatient care and outpatient services. Although there still are psychiatrists functioning in the community in single person offices with a psychotherapy orientation, that model of practice has become much less common.

The settings in which psychiatrists practice have increased enormously. Community agencies for children, adolescents and the elderly frequently have psychiatrists as part of their teams. In parts of Canada, psychiatrists are working in primary care settings directly with family physicians and mental health counsellors of various professional backgrounds. Patients with emotional or behavioural problems are identified and seen rapidly in these settings. They are assessed and treated by a multidisciplinary team and many previously necessary admissions to hospital are avoided.

Within academic health science settings the roles of many psychiatrists have become very specialized. The specialization may be based on age cohort, diagnosis, service setting (e.g. forensic psychiatry), or an interest in a specific research area (e.g. imaging studies). In the community the roles of psychiatrists have also changed. The demands on their time and the expected range of expertise have increased significantly in the past two decades. This complexity has come along at a time when the populations served are increasingly demanding effective treatments. There are raised expectations for positive outcomes of treatment, rapid access to treatment, the use of evidence-based procedures, and fiscal accountability in managing available resources.

Canadian psychiatry has undergone a great deal of scrutiny in the past decade. Psychiatry in Canada went through a period in which medical student applications to the specialty dropped well below the previous national rates. As a consequence, residency programs had difficulty attracting the calibre of applicants that they customarily received. Training spaces were left unfilled and

were surrendered to other medical and surgical specialties. At the same time, the demand for mental health services increased rapidly in Canada in a period in which it was recognized that physicians and surgeons of all specialties were in short supply.

The Canadian Psychiatric Association (CPA), together with other educational bodies including the RCPSC Specialty Committee in Psychiatry, formed the Working Group on a National Strategy for Postgraduate Education in Psychiatry (NSPGE) that took on the task of examining the state of psychiatry training, including factors such as the length of training, the necessary curriculum and the role of subspecialty training. At the same time the RCPSC Specialty Committee, with the support of postgraduate directors of the training programs, introduced the changes in the examination structures and methods referred to above.

There was pressure to reduce the length of training from five to four years. This was based in part on the need to produce greater output of psychiatrists and also to come into line with the length of training in the U.S. As noted above, in the vast majority of countries the length of training is at least five years and the short length of training in the U.S. is an outlier. A corollary of maintaining five years as the necessary training for the "sophisticated general psychiatrist" was that specialized educational activities to meet the needs of the proposed subspecialties would have to occur after the initial certification in psychiatry. Prior to this time, residents could take advantage of core training time as well as selectives and electives to meet all the requirements for completing training in child and adolescent, geriatric, forensic and consultation-liaison psychiatry necessary for academy admission. This route to formal subspecialty recognition was not accepted by the RCPSC. Although there was initial resistance to the move to subspecialization through approved Royal College routes, there was gradual acceptance by the interested Canadian Academies of Child and Adolescent Psychiatry, Geriatric Psychiatry and Psychiatry and the Law of a year's further training beyond the RCPSC certification.

ROYAL COLLEGE EXPECTATIONS

The last two decades have seen significant RCPSC activity with initiatives in competency-based postgraduate education and continuing professional development to reflect accountability with respect to societal need; concerns about the proliferation of subspecialties and the erosion of generalism; and focus on the recognition of common training elements or core competencies extending across specialties to improve the structure and provide optimal flexibility for trainees in postgraduate education.

In 1995, the RCPSC Task Force to Review Fundamental Issues in Specialty Education emphasized the need for the development of generic competencies common to all physicians that would form the base for specialty differentiation. In its 1996 report from the Societal Needs Working Group, the RCPSC signaled an approach to societal accountability in training with the development of CanMEDS 2000 that described a list of generic competencies for specialists: *medical expert/clinical decision maker*, *communicator*, *collaborator*, *manager*, *health advocate*, *scholar*, and *professional*. In accordance with RCPSC timelines, the RCPSC Objectives of Training (OTR) in Psychiatry was rewritten in 2005 to reflect the CanMEDS competencies and their application to the specialty.

In addition, the report of the Task Force to Review Fundamental Issues in Specialty Education and CanMEDS 2000 both identified the need for postgraduate education to produce autonomous, self-directed learners. Psychiatry has, with several other specialties, been in the forefront in the development and introduction of the Royal College's early MOCOMP® and current Maintenance of Certification Programs in continuing professional development. The Task Force also recommended that the principles of self-directed learning be introduced in PGY1, that this be assessed in accreditation, and that MOCOMP® be instituted in senior residency. A specific objective in the 2007 RCPSC Specialty Training Requirements (STR) in Psychiatry ensures that the senior resident develops competence in the maintenance of certification.

The Task Force to Review Fundamental Issues in Specialty Education also suggested a revision by the RCPSC Committee on Specialties (COS) of the criteria for specialty recognition with a subsequent evaluation of all specialties emphasizing the principle of generalism proceeding to specialization. The RCPSC Langer Report[14] entitled, "A Reexamination of the Royal College Specialties and Subspecialties" identified concern about inconsistencies in duration and content of training, inconsistent designation of specialties and subspecialties, fragmentation and problems with early career choice for trainees. It proposed a model in which all specialties would be accredited, certified, and categorized with core training and where subspecialties would arise from specialties and be recognized by Accreditation without Certification (AWC). Shortly thereafter, the RCPSC position paper from the Committee on Specialties[15] raised concerns regarding super-specialization, the rapid proliferation of subspecialty applications, and the erosion of generalism. It recommended that all specialties be based on broad and basic knowledge and suggested removal of all certification for subspecialties and amalgamation of AWC and Certificates of Special Competence. It was these concerns that retarded subspecialty recognition in psychiatry and led to the RCPSC agreement with the CPA to flexibly review models of subspecialty recognition and to

consider a ‘made in psychiatry’ model on completion of the core competencies for the generalist.

The RCPSC Core Competency Project, on a timeline from 2005 to 2009, was designed in response to concerns about the structure and organization of Canadian medical education leading to early uninformed career choices for trainees and demonstrating limited flexibility due to lack of recognition of common training elements. It was designed to improve the structure of postgraduate education in order to facilitate optimal flexibility in training, to provide high quality residency education aligned with societal needs and to assist with appropriate timing of career choice. Driven by educational principles, it seeks to identify competencies common to various disciplines, to reshape and/or increase generalist training, and where substantial overlap in training can be demonstrated, to consider opportunities to stream disciplines and develop a common or core training program.

As noted in the introduction, psychiatry’s focus on core competencies for its generalists, while in part shaped by these RCPSC expectations, arose primarily from concerns internal to the specialty and its educators and practitioners. The confluence of the specialty’s interests and those of the RCPSC was, however, fortuitously synergistic and, in the climate of creativity and anticipation that resulted, psychiatry’s specialty-specific core competencies clearly met the RCPSC COS principles of alignment with societal need and provision of quality care, the required inclusion in the primary specialty of a period of core training in order to develop a base of generalist competencies and the incorporation of these into the specialty’s OTR. With the primary specialty’s core competencies further operationalized with levels of competency attainment, the progression from generalism to specialization could be clearly demonstrated and the stage set for subspecialty recognition.

WHAT IS A GENERAL PSYCHIATRIST AND WHAT SHOULD HE/SHE BE ABLE TO DO?

In the late 1990s, in deliberations concerning the role of the psychiatrist in the 21st century, the CPA Standing Committee on Education documented factors influencing postgraduate training. These included accommodating new knowledge from clinical, technological and research advances, societal health needs expectations, shared care with family physicians, the emergence of the multidisciplinary team and the need for community-based care. In recognition of the increased demands on the role of the psychiatrist and the relatively small numbers of practitioners in relation to the population, it coined the term ‘sophisticated generalist’[16] to reflect the wide range of competencies required by

the general psychiatrist in Canada to practice across the life span of patients with a range of psychiatric disorders in different settings and in collaboration with others.

An important part of affirming this direction was to understand from a practical perspective the role of the general psychiatrist in practice. In the course of its work, the CPA NSPGE conducted a national survey of all psychiatrists[17] to elicit curriculum requirements in current Canadian practice and opinions regarding necessary training experiences. Practicing psychiatrists reaffirmed the position of psychiatry within medicine and supported the necessity of a basic clinical training (BCT) year that was a broadly based medical experience and suggested content for emerging developments (e.g. neuroimaging). Reporting on their practices, the respondents reinforced key aspects of sophisticated generalism demonstrating practice across the lifespan in a variety of settings and estimated the levels of skill and knowledge that they required in general psychiatric practice. The feedback from the survey stressed the need for curriculum adjustments in training in order to enhance competency attainment in the delivery of care in alcohol and substance use disorders, sleep disorders and a range of psychotherapies. Practitioners strongly supported the need for four years of psychiatric training after the BCT year to attain generalist competencies and to accommodate the additional training they deemed necessary. They suggested reducing elective and selective training from 18 months to 12 months in total. The survey results affirmed the retention of core experiences in child and adolescent and geriatric psychiatry, and estimated the knowledge and skill needs with these populations, forensic patients and those hospitalized with combined psychiatric and medical/surgical illness.

Practicing psychiatrists then concurred with the direction being considered by the CPA NSPGE to enhance training to ensure the broad range of competencies required by the sophisticated generalist. These competencies and the levels of competency attainment required are described in detail in the 2007 RCPSC OTR[18] and STR[19] in Psychiatry. A summary of these is presented in chapter one, and the strategies and enabling objectives to reach them follow in later chapters of this book.

THE RELATIONSHIP OF SUBSPECIALIZATION TO GENERALISM

Canadian subspecialists in child and adolescent, geriatric and forensic psychiatry, and joined recently by consultation-liaison psychiatrists, have been pursuing formal recognition by the RCPSC for many years. Child psychiatrists first began exploring this in the late 1960s, but dedicated applications did not

begin until the early 1990s and it is only in the last two years that opportunities for this have materialized. Psychiatry's drive for subspecialization could be characterized as one of inopportune timing as invariably, when formal applications were made, the RCPSC would be raising legitimate concerns that would derail the submissions. Alternatively at other times, subspecialists did not wish to pursue the matter given RCPSC models for recognition that were felt to unnecessarily prolong training or otherwise discourage enrolment.

Given that formal psychiatric subspecialization exists in the U.S.[20,21] and many countries, this has resulted in a unique situation in Canada. Here subspecialism is strongly rooted in generalism. Over the years the lack of formal RCPSC recognition has led to the mandatory requirements in subspecialties in the RCPSC training program for general psychiatrists (i.e. rotations in child and adolescent and geriatric psychiatry, and supervised experiences in consultation–liaison psychiatry and substance use disorders) and the inclusion of selective and elective training time that has supported attaining advanced competencies in subspecialty work. While the drive to subspecialization has been viewed in this country as logical and necessary, under the umbrella of the CPA there has been a consensus among generalists and subspecialists that this should occur in an orderly and controlled fashion to avoid fragmentation. While the time for this evolution may be seen by most as too lengthy for the reasons noted previously, the result within psychiatry has been an avoidance of the RCPSC fears pertaining to super-specialization and the erosion of generalism that occurred in other primary specialties. Rather it can be seen that the integration of subspecialty competencies in training in the primary specialty has strengthened and enhanced general psychiatry and contributed to its sophistication.

Indeed, for over 35 years subspecialists have provided leadership in academic departments of psychiatry, directed undergraduate and postgraduate programs in the primary specialty, and have been pivotal in defining the knowledge, skills and attitudes attained by generalists referable to their areas of expertise. In a number of Canadian academic departments of psychiatry of small to medium size, subspecialists and generalists share lifespan on-call emergency department and ward coverage. During the CPA NSPGE visioning exercise on sophisticated generalism, it was recognized that while subspecialists would provide consultation to generalists and other providers of tertiary care in their practice area, they would still continue to practice lifespan psychiatry where appropriate.

Throughout the period of development, all residents finished training in five years and, if successful in examination, received the RCPSC certificate in the Specialty of Psychiatry. Subspecialty mandatory rotations in child and geriatric psychiatry as well as 18 months of electives and selectives for enrichment experiences continued to be required for all. In essence then, psychiatry has always graduated generalists differentiated to some degree by a range of

'minors' in particular practice areas. Those wishing to be subspecialists would take as much of this time as necessary to satisfy the relevant subspecialty academy requirements. This will continue using the new subspecialty training template leading to RCPSC recognition. This approach in training has contributed to the development of the range of practice competencies and competency levels that underscores sophisticated generalism and will continue to do so with additional mandatory experiences and elective and selective experiences of 12 months in the revised 2007 RCPSC OTR and STR in Psychiatry.

With formal subspecialty recognition now achieved, just as CPA is the National Specialty Society (NSS) for Psychiatry, the academies become the NSSs for their respective constituencies in the eyes of the RSPSC. While on one hand emancipating, organizational mechanisms are already underway to avoid fragmentation and to maintain the relationships that have mutually benefited the primary specialty and the subspecialties. By way of example, the academies were previously CPA affiliates and members of the CPA Council of Academies. Those that have attained formal RCPSC recognition have received voting membership on CPA's Board of Directors.

Finally from a developmental perspective, subspecialty leadership in determining the core competencies for the generalist and the competency levels to train to in their areas of interest has provided a clear reference point for the development of the subspecialty RCPSC STRs and OTRs. With respect to the STR, two of the three recognized subspecialties will credit up to 12 months of approved training in the primary specialty toward subspecialty completion taken within PGY4–PGY5.[20] The attainment of competency levels progresses smoothly from primary specialty to subspecialty. Subspecialty competencies are specifically rooted in those of the primary specialty and are designed to flow in extension to higher levels, either proficient or advanced, in the field. In psychiatry, the close educational relationship between generalists and subspecialists, coupled with opportunity to develop both primary and subspecialty RCPSC OTRs and STRs at the same time, has resulted in a visible and deliberate progression from generalism to specialization.

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Chapter 3

General considerations in psychiatric education

Gary S Hnatko and Emmanuel Persad

INTRODUCTION

We are often challenged to determine which is more important: the destination or the journey. In the first two chapters of this book, insights are provided into the roads travelled and destinations reached in Canadian psychiatric education.

The Royal College of Physicians and Surgeons of Canada (RCPSC) was established by an Act of Parliament nearly a century ago. The mission of the RCPSC is the development of excellent specialty medical care through the highest standards in medical education, lifelong learning and the promotion of sound health policy. The RCPSC achieves its mission by prescribing the requirements for specialty education and accrediting specialty training programs. It also assesses the acceptability of resident education and training and conducts certifying examinations. Finally, high standards of specialist care would not be possible without maintenance of certification programs that uphold professional development, lifelong learning and advocacy for the support and development of sound health policy.[1] These principles provide the solid footing and direction from which specialty programs develop and evolve.

All RCPSC specialty programs must maintain awareness of societal need in order to remain relevant and current. For psychiatry, this includes knowledge of the mental health care and psychiatric specialist requirements of Canadians. Close partnerships with and knowledge of the work of clinicians, epidemiologists, policy makers, researchers, professional associations, learned societies, health advocates, public forums and economists help develop awareness. The Canadian Psychiatric Association (CPA) has been instrumental

in the process and thus has informed the outcome. Without doubt, the newly established Mental Health Commission of Canada (2007) will also enhance awareness, speak to societal need and advance understanding.

The RCPSC Objectives of Training (OTR) (2007) defines psychiatry as "the branch of medicine concerned with the biopsychosocial study of the etiology, assessment, diagnosis, treatment, and prevention of mental, emotional and behavioural disorders alone or as they coexist with other medical or surgical disorders across the life span." The OTR establishes the destination for Canadian psychiatrists, or more specifically the minimum expected competencies that residents must achieve by the end of training, in each of *medical expert*, *professional*, *scholar*, *communicator*, *manager*, *collaborator* and *health advocate* — the Canadian Medical Education Directions for Specialists (CanMEDS) roles.[2] The Specific Standards of Training (STR) specifies the possible path(s) to reach the destination.

As research advances understanding and societies change, the need for and the delivery of mental health care, will change. In kind, so must the roles and responsibilities of the psychiatrist. The OTR and STR are not static, but rather live documents, that evolve over time to reflect both societal needs and scientific advances. They are continually reviewed and when they need to evolve, the RCPSC Specialty Committee in Psychiatry, in consultation with its partners, will develop a new destination (OTR) and path(s) (STR) to that destination. Advances in educational theory, design or other innovations supported by evidence may also contribute to changes in the recommended path.

It is important to note that there are opportunities for flexibility within the boundaries of the OTR and STR. There are many paths to the destination — and each resident can construct a journey, in consultation with their program director, that meets both societal need and personal professional interest and goals. It is essential then, that just as the Specialty Committee must continuously evaluate and monitor the profession in the context of societal needs and scientific advances, that individual residents and program directors must monitor and evaluate the resident's progress along their journey. More specifically residents, with the support of their program directors, must evaluate where they are versus where they should be in their professional development and progress at any point in time. They must always consider the destination — a sophisticated generalist capable of practicing across the lifespan with a range of specific competencies in multiple CanMEDS roles.[3] Where there are gaps, they must be corrected.

Society, training requirements, residents, training programs and health care environments all evolve. RCPSC accreditation standards require training programs to regularly review the training environment. This review must include such items as adequacy of clinical teaching resources, the organization and structure of the program, evaluation strategies and both program goals and

individual rotation objectives, amongst others. Residents must be educated in environments that are adequate to meet the needs of training, allow for high quality ethical patient care and be organized in a fashion that articulates the vision of "the sophisticated generalist practicing across the life span." Ideally, the training environment should mimic the practice environment. Training programs must adapt each time there is revision of the OTR and STR. Forces both internal and external to the training program impact the program's capacity to adapt and these forces often prove challenging. For example, psychiatry training programs deliver a good deal of clinical education in a health care delivery system that does not always have the educational imperative at hand, nor reflect health policy considerations, future resourcing issues, or perspectives on unmet societal need that drive the evolution of postgraduate training.

When training goals and objectives are revised to better meet societal need, consultation and communication with government does not usually take place in advance of the revision. Such discussions could include considerations of educational resources including funding, space and human resources. For these discussions to be meaningful, however, they would need to take place with ministries in each province as that is where responsibility for health-care delivery and education exists. Although these factors are considered and consultations are held with universities, regions and the CPA, changes in the OTR and STR are made knowing there will likely be gaps — but hopefully manageable gaps. Some programs will experience more burden than others.

Curriculum revision may facilitate broader system change that might not occur otherwise. Changes in the curricula may therefore be the initiator of change in the health-care system. The enhanced notion of generalism and core competency reflects a paradigm shift that may lead to change in the way health care is delivered.

To remain current, programs must also analyze the gap that exists between where they are on the journey and where they should be to realize excellence in education. Partners in the process include residents, educators, administrators, university departments, faculties of medicine, governments and the RCPSC. Competing interests, strategic goals and operational agendas must be managed skilfully. As an example, the development of an incentive program for educators would likely involve multiple partners and resources. Not all partners may be motivated to act in the same fashion, and not all resources may be available within the same time frame, if at all. The responsibility for program maintenance, evaluation and development essentially falls to the psychiatry residency program director (PD) who, in partnership with a residency program committee (RPC), manages the journey for the resident and indeed the department and faculty. All are evaluated on the path and the outcome. But this requires significant dedication of time and support.

The role of the PD is central, essential and critical to departments of psychiatry and their educational mandate. They help navigate the journey, always with their eye on the destination. The evolution of objectives leading to the introduction of more rigorously defined competency-based outcomes, and the eventual development and implementation of genuine competency-based assessment will further challenge the PD and psychiatric faculties. Other factors will also contribute to the complexity of the PD role, not the least of which will be the projected significant increase in medical school enrolment with an eventual and subsequent increase in specialty program enrolment. Both will challenge educational resources. The role, training and mentorship of the PD, the time allotted to tasks, and the support offered will likely need to be enhanced in the future.

It is also pertinent to offer commentary on the challenges and changes that occur and regularly confront health care delivery and research. Psychiatrists and psychiatric educators may not feel heard or empowered in processes that manage health care delivery challenge or change. Change may have a deleterious impact on education and research. The educational impact that changes in psychiatric health care delivery bring may not be fully considered or realized, and therefore not communicated. Training programs must have active surveillance to accurately assess the health care, research and thus educational environment. Educational delivery cannot exist outside of clinical service delivery and research at this level of training. Surveillance should lead to proactive rather than reactive adjustments. Again the education system may be effective in leading health care change rather than simply responding or adjusting to it.

From wherever change comes, gaps may be created where none previously existed. The RCPSC policy paper "Safeguarding the Quality of the Educational Continuum and Medical Workforce in Canada's Complex Health Care System" serves to address this issue.[4] Specifically, greater regionalization, distributive models of medical education, and utilization of non traditional sites may "put at risk the ability to provide an appropriate case mix for residents, quality assurance, support for basic and clinical research, and ensured access to the highest standards of care through equitable distribution of physician human resources." Not considered at the time of the policy paper, but currently relevant, is the additional pressure increasing medical school enrolment in Canada will place on educational delivery.

The chapters following this one will focus on the core competencies (OTR) and the paths or strategies to get there (STR). Each chapter will elaborate upon and provide detail about training to the RCPSC OTR and STR, and beyond. The chapters will breathe life into the documents, enhancing interpretation and hopefully providing tools or direction for program directors, residents and psychiatric educators. The material should be considered as strategies to help

develop and realize the training objectives at any university in consideration of the unique resources there. No matter how good the toolbox however, there will be other options, strategies and considerations in reaching the destination.

An approach to the development of competence is to designate a minimum number of case contacts in a variety of conditions. Case numbers presented in the following chapters are derived based on considerations of prevalence, burden, day-to-day practice, pre-existing competencies, expected workloads, opportunities for training and the number of supervisors. The ultimate number decided upon must be sufficient to assure and maintain the final expected level of competence, as established by the OTR, to be realized for a particular resident. These numbers may vary depending on the resident.

The balance of this chapter will review what is not covered elsewhere in this book, including some factors or overarching themes that influence the educational process including characteristics of the learner, principles of adult education, the significance of CanMEDS, societal need and cultural context, and general program considerations (program evolution, service/education balance, integration and organization of longitudinal and horizontal components, reclaiming, repatriating and reintegrating the psychotherapies, lessons from accreditation, lessons from examination and the development of academic scholarship).

THE CHARACTERISTICS OF THE LEARNER

The face of medicine is changing. This is apparent to educators who meet residents in the educational endeavour daily. What of the difference? How, if at all, will it impact the educational process?

The National Physician Survey indicates that the median age for medical students has not changed significantly from 2004 through 2007, remaining at 25 years over the four years of medical school.[5,6] In fact, first- and second-year medical students may be slightly younger today than five years ago. The median age of the fourth-year student remains at 26 years. However, the document "Physician Workforce in Canada: Literature Review and Gap Analysis" observes that the average age of medical students has risen, so that between 1978 and 2000 the proportion of applicants over 28 years of age to medical schools increased from 7.4 per cent to 12.5 per cent.[7] Medical students start the medical education journey with significant past educational experience — 60 per cent will have a Bachelors degree, 10 per cent will have achieved to the Masters level and two per cent to the Doctoral level.[6]

There is no published data that speaks to the average age of the psychiatric resident cohort. The Canadian Post-M.D. Education Registry (CAPER) reports

that the average age of the practice entry cohort for all Canadian medical specialty graduates was 32 years of age and for international medical graduates (IMG) 39.7 years of age as at July 1, 2008.[8] The average age for all Canadian medical specialty graduates, irrespective of where their MD was obtained, was 33.2 years of age. The later age of entry into medicine contributes to the decline in the number of young specialists entering practice. This decline is also related to general trends that have lengthened postgraduate training through fellowships and other opportunities. RCPSC recognition of subspecialties in psychiatry will promote this trend.

The gender distribution of medical students responding to the National Physician Survey reflects a growing proportion of women in medicine across the four years of medical school, from 57 per cent in 2004 to 65 per cent in 2007.[5,6] In psychiatry, 71.9 per cent of first-year trainees were women in 2008-2009, irrespective of whether they were Canadian citizens or permanent residents.[8] The percentage of women in the psychiatry practice entry cohort averaged 58.2 per cent from 2004 through 2008 (high of 62.6 per cent in 2007, low of 51.8 per cent in 2006).[8] The number of women in psychiatry measured across all five years of training has shown a steady and persistent increase from 2004 through 2008, from 57.9 per cent to 64.5 per cent respectively.[8]

About 22.7 per cent of Canada's doctors earned their MD outside of Canada.[7] The vast majority of psychiatric residents in Canadian medical schools earned their MD at Canadian universities. However, the trend is for more residents to enter psychiatric residency who have received their MD from outside Canada (18.4 per cent in 2004-2005 to 24.8 per cent in 2008-2009). This data is not inclusive of residents in psychiatry training programs who are sponsored by their respective countries or universities to train in Canada with the intent of returning home. From 2004 through 2008, this cohort accounts for between two to six per cent of all first-year trainees.[8] The National Physician Survey tells us what is self-evident — the cultural background of medical students and residents reflects the multicultural fabric of Canadian society. It is now more important than ever that we understand the context and dynamics of IMGs. Rao et al,[9] in an annotated bibliography about the IMG, speaks to issues of acculturation, education and training, discrimination, competence and language.

What are the educational implications of the current demographic? In summary, residents entering psychiatry are in their mid-20s, most commonly female, participate in more postgraduate training, may have obtained their MD from a non-Canadian medical school, and more than ever represent the diversity of the Canadian ethno-cultural fabric. They are entering training in psychiatry at a time when requirements have increased, competencies are more precisely defined, and subspecialization is occurring.

They have also entered training at a time when faculties of medicine, provincial licensing authorities, and professional associations have become more cognizant

of life/work balance. There is a renewed emphasis on journeys and destinations that exist outside of or alongside one's professional career. "Part of the trend toward a balanced lifestyle is younger physicians indicating a preference for non-fee-for-service remuneration, in part or altogether, to have more predictable incomes."[7] Incentives for new entry cohort physicians are generally different than incentives for older physicians, as evidenced by observations that new graduates are less likely to maintain or increase income through increasing workload volumes once in practice. Whether driven by differing values, changing demographics, greater academic expectations, more longitudinal exposure in training or postgraduate training contracts that eliminate clinical exposure post call, psychiatric educators have become concerned about the adequacy of patient contact during training.[10] This resulted in the following statement being placed in the STR — senior residents must see "the expected volume and variety of adult patients." Although not specific, the intent is clear — competencies cannot be realized without meaningful clinical immersion.

The training envelope remains at five years. Competencies and selective training experiences were added to better meet societal need and elective training opportunities reduced. Although we might assume that medical students who select psychiatry as a career have good knowledge of psychiatry, the 2007 National Physician Survey revealed that only 48 per cent of all medical students were very familiar with psychiatric specialists. The cohort is also older and ranks priorities and incentives differently. The recent trend amongst Canadian medical students and residents has been away from generalism toward specialization and subspecialization.[7] In part, this trend may be contributed to by more subspecialists providing core training to residents in subspecialty clinics rather than by generalists practicing across the diagnostic spectrum and lifespan.

Residents are also being trained by psychiatrists who are showing their age and are likely older than 49–51 years, the average age of practicing psychiatrists in 1997.[11] The number of women psychiatric educators does not yet reflect the growing number of women residents, and in the U.S. the academic rank achieved of those educators is proportionately less than should otherwise be expected.[12] A number of factors contribute to the discrepancy, including gender schemas, lack of effective mentorship and limits of social capital. The issues are more pronounced when cultural diversity is factored in to the equation. Female physicians also tend to practice less than their male counterparts to achieve better personal life/professional balance.[7] This is also reflected in the Canadian Practice Profile Survey, which noted that 94 per cent of men and 74 per cent of women in psychiatric practice worked full time.[11] All of these factors will have considerable implications for residency programs now and into the future.

PRINCIPLES OF ADULT EDUCATION

Residents entering psychiatry arrive with considerable knowledge and experience which is further developed in medical school. For the most part, the evolution in undergraduate medical education has followed many of the principles of adult education. This section is not intended to be a treatise on adult education, rather a brief synopsis. Detail on the topic is to be found elsewhere.

The first wave of medical curriculum revision began with Flexner 100 years ago.[13] Structure and process were emphasized and enhanced — the medical student provided specific content for specified periods of time.[14] The student's role was limited and for the most part consisted of simply depositing the knowledge provided by the expert. Freire commented that simply accepting a gift of knowledge leads to intellectual and social passivity.[15]

All physicians learn in the classroom and at the bedside. Mentorship is essential. Lomax states that the teaching alliance or the explicit contract between teacher and learner "is a fundamental dimension of all education and of particular importance in psychiatry and psychotherapy education."[16] Ursano et al[17] observe that the teaching alliance is similar to the therapeutic alliance requiring development, structure and a safe enough environment so that uncertainty can be modelled in ways that promotes curiosity and learning. These constructs are as important in mentoring new faculty as in teaching residents.

DasGupta et al[18,19] note that the traditional banking model of education has evolved to incorporate adult learning theory, first introduced by Knowles in the 1970s. Around the same time, problem-based learning was first initiated at McMaster.[18] Some 40 years have passed and questions about how to best apply learning theory to medical education remain. Shannon states that adult learning theory has not been critically evaluated, and that the difference between adult and child learners may be more situational than psychological.[20,21]

The principles of adult learning theory, as developed by Knowles, contrast the concept of pedagogy (the art and science of helping children learn) and andragogy (the art and science of helping adults learn). Adult learners bring substantial experience and draw upon that experience. They are also characterized as self-directing rather than dependent and are ready to learn and immediately apply that which relates to new roles. They are motivated internally.[19] These principles have significantly modified the approaches pursued in medical education. Yet Shannon argues that these assumptions have not been tested, positing that differences of culture, cognitive style, life experience and gender may be far more important to learning than age.[20] She goes on to state that for adult learners experience with feedback is most effective. This is supported by the work of Cantillon and Jones.[22]

Evidence-based medical education is undergoing a rapid transformation and more articles are published daily. Medical education has become a new area of expertise.

Rushton addresses the paradigm shift in assessment. Assessment now emphasizes the importance of formative assessment and the central role feedback plays in closing the gap between actual and desired levels of performance.[23] This paradigm resonates with principles of adult learning. However feedback, like any skill, must be learned and practiced. The trainers must be trained.

We learn at the leading edge of capacity—if the gap is too great, the challenge seems insurmountable, if the gap is too small the task becomes boring or is perceived to be accomplished. The introduction of competency-based perspectives in psychiatric education implies that the evaluation of outcomes is more important than the simple acquisition of knowledge or spending an allotted period of time on a particular service.

The revised OTR identifies the competencies to be attained by the general psychiatrist across all CanMEDS domains. It includes behavioural descriptors of competence levels. What the OTR does not do is specify the tasks that make up the competency. In other words, there are no necessary and specified performance indicators which set the threshold for demonstrating competence.[14] The RCPSC Specific Standards of Accreditation require that an organized program of education activities must be offered, but it does not specify the strategies to achieve competence. Nor does the STR specify strategies. To some extent, the STR continues to require time-based rotations. However many of these time-based rotations are now of flexible length which begins to accommodate a competency-based ideology to a greater extent. But to realize the aim of teaching to competency, outcome evaluation must be developed and applied with more rigor and skill. Again, the trainer must be trained. Are the educators comfortable with levels and measures of competence? Is it part of their everyday lexicon? Do they inherently value the shift and does it remain a valid construct?

Whether one uses the competency criteria as defined in the OTR, or that established by Chambers and Glassman,[24] or Miller,[25] competence must lead to internalized patterns of behaviour that are reinforced by practice and enhanced by self-evaluation and feedback. In this regard, student and teacher are alike. The education system must also be open to self-evaluation, gap analysis and feedback.

Feedback is an essential component of quality analysis/outcome measurement. Both educators and students must make themselves available to a process which includes providing accurate, timely, individualized and task- (goal-) centred feedback; receiving feedback; and accurately interpreting and applying

feedback. The collaboration between student and teacher is intended to facilitate the best performance by the student.[23] With the focus on the student (and learning) and less on teaching, anxiety may rise amongst educators who were schooled traditionally, expect more service than necessary to reach competency, and feel increasingly pressured to meet clinical demand when they feel slowed by the educational imperative.

Residents must also feel competent to manage the eventual demands of the real workplace. The clinical expectations and demands in the practice environment are generally much greater than that experienced during residency. A hidden, often unspecified or unspoken competency relates to the value of medicine as vocation as opposed to medicine as job. Failure to provide feedback on these "hidden" values and the culture of medicine runs the risk of compromising the teaching alliance. Unsuccessful attempts at curriculum reform are often related to what is learned versus what is taught. Although a formal (stated, intended and formally offered) curriculum is taught, what is learned may more often relate to either the informal (unscripted, ad hoc, highly interpersonal teaching and learning that takes place between faculty and student) curriculum or more likely the hidden (customs, rituals, value statements, organizational structure) curriculum.[26]

Best practices in education, or correlating what we do with the best external evidence continuously supported by internal program evaluation, is changing education as it has clinical practice. Knowledge transfer and mobilization is as important in medical education as it is clinical practice. The evolution in medical education must also be informed by societal need and scientific advance. However, learning in medicine is complex, and medicine has both borrowed from and contributed to learning theory. No learning theory is, in and of itself, sufficient to inform all of the practices found in medical education.[21] Davenport argues that socio-cultural learning models are powerful alternatives to individualistic models aligned with andragogy. The role for the education specialist is rising as we move from opinion to evidence.

SUCCESS IN CURRICULUM CHANGE (NOT JUST TRAINING THE TRAINER)

Access to medical education expertise, beyond the educational evidence, is more important than ever. We have moved beyond the notion that because someone is a physician they must know how to teach. We are also beyond opinion-based decision making in medical education.[27] Knowledge translation and mobilization is essential. Increasing medical school enrolment will demand a larger supply of competent teachers and teachers with special skills in areas such as evaluation

and remediation. How will we find the time to train the trainers if the residency curriculum is already crowded? Will we have enough competent teachers if we only train residents — what of our current faculty?

Hodges observes that there has been enormous growth in medical education research over the last 50 years. Associations of medical educators, conferences and numerous journals populate the landscape.[28] These include: *Advances in Health Science Education*, *Medical Teacher*, *Academic Medicine*, *Medical Education*, *Teaching and Learning in Medicine* and specifically *Academic Psychiatry*. Collaboration in education scholarship is desirable and helpful, reflective of both interdisciplinary and multidisciplinary partnerships that populate both research and health care delivery. Beyond the journals dedicated solely to education, medical education research publications are populating traditional journals with more frequency, and education workshops, forums and town-hall meetings are finding their way into annual scientific meetings. Kay, Silberamn and Pessar edited the *Handbook of Psychiatric Education and Faculty Development*,[29] a comprehensive book focusing on education, faculty development, research and special problems that may come to the attention of program directors. Departments of psychiatry are developing local expertise, and psychiatrists with a Master of Education degree are more common but still relatively rare in most centres. There is more expert support from faculties of medicine. Yet the success of curricular change is tenuous and dependent on far more than training the trainer and providing educational experts. The growing problem of finding an adequate number of teaching faculty who have necessary teaching time must be resolved or we run the risk of teaching fatigue.

In an excellent review article, Bland et al[30] conduct a systematic literature search and review intended to describe the characteristics associated with successful curricular change. Thirteen categories encompassing 35 features of successful curricular change were identified. Many are self-evident and are bound in dimensions of context, curriculum and process. Many are best stated in the form of a question:

- Is curriculum innovation relevant to the real problems that user's experience?
- Is the innovation compatible with the department's mission, goals and educational philosophy?
- Is there a past history of effective change?
- Is there a strong influential advocate at the forefront who is able to network with essential individuals or informal networks in the department?
- Is the change leader visible, proactive and responsible in communicating a clear vision, including regular updates?

- Does the department have high interaction, connection and networks of participatory teams, or is it too departmentalized, loosely coupled or segmental?
- Are there opportunities for cross-departmental teams to develop?
- Can a balanced approach be developed that is not overly ambitious and engages the members' commitment and support?
- Are there linkages with external drivers and organizations so there is mutuality in the goals and shared vision?
- Are there mechanisms to track success that can be related to funding change?
- Is there a change-conducive environment — interpersonal respect, support and cohesion balanced by constructive criticism and high professional expectations?
- Is the environment positive and respectful?
- Is there collaborative problem-solving, skilful conflict resolution and reward for risk taking?
- Are mechanisms in place for frequent, timely, substantive and forthright communication, formal and informal, written and verbal?
- Is there collective ownership through investment of time and energy, with shared ownership and public opportunities for individuals to declare agreement (retreats, orientation sessions, problem-solving teams)?
- Are there opportunities for demonstration of proposed teaching practices?
- Are dissenters allowed to air objections?
- As interest wanes as innovation implementation draws to a close, are there opportunities to share insights and reflections?

Some of the characteristics of successful change are better stated more categorically:

- For change efforts to be most effective, the organization must be attentive to the particular needs that arise as members move through the change process.
- Training support must be ongoing and of high quality.
- Leadership training is necessary for the continued cultivation of new leaders especially in settings where personnel may not have needed to develop leadership skills.
- New members should be brought up to speed on innovation so they do not inadvertently weaken or disrupt progress made.
- Reward structure must include incentives that reward participation in innovation.

- Evaluate and hold the innovation to standards of analysis that faculty regard as valid and meaningful.
- Formative evaluation is useful in locating difficulties and solving problems.
- Approach curriculum change as an experiment.
- As a new program is implemented a period of decline in organizational performance often occurs.
- Stable leadership is correlated with successful innovation and successful change leaders are able to motivate, influence value and culture, maintain flexibility while maintaining momentum and have a number of perceptual frames.

CULTURE AND CONTEXT

There is little in the OTR and STR that signals the importance, detail and attention that is to be given to cultural, ethnic and spiritual issues in training. Relevance is determined by societal need, in this instance driven by globalization and the complex multicultural fabric of Canadian society, in which one in six Canadians are foreign born.[31] Psychiatrists must be able to identify and appropriately respond to relevant clinical issues arising in patient care, including culture and spirituality. No specific cultural topics or groups are mentioned in the OTR, yet psychiatrists must be able to understand the patient in their family context, developing a biopsychosocial understanding across all learning domains and objectives, inclusive of culture and spirituality. Arguably there could have been a chapter devoted to this topic. The following section is intended to provide initial considerations in the area.

Regulatory and legislative acts set the stage, entrenching individual rights and forbidding discrimination based on race, sex, religion or disability. Evidence supports disparity in access and quality of mental health services based on language and culture in the United States.[32,33] McGill has the longest standing academic program in cultural psychiatry, perhaps motivated by the large number of IMGs who generated questions about the relevance and practice of psychiatric theory and practice in their countries of origin.[31] Beyond access and quality of care, cultural diversity significantly impacts the nature of psychopathology, illness behaviour and healing.[31]

Cultural competence is defined as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations."[34] For the first time, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)

provides an outline for cultural formulation. It is intended to deal with difficulties that might be encountered in applying DSM-IV in a multicultural environment. Beyond identifying the cultural identity of the individual, cultural explanations are to include idioms of distress, meaning and perceived severity of symptoms, perceived causes and explanatory models of illness, interpretations of social stressors and support and cultural elements that influence the relationship between the patient and the clinician (language, meta-communication, physician relationship issues). "A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief, or experience that are particular to the individual's culture."[35]

Fung et al[36] describe the development of a psychiatric curriculum to develop cultural competence in psychiatry at the University of Toronto. The development of the curriculum was motivated by resident interest, much as it had been at McGill. It was also motivated by a survey that revealed 70 per cent of residents had never attended any formal teaching on cultural psychiatry, 85 per cent did not consider cultural factors in psychotherapy and 75 per cent avoided psychotherapy in preference to pharmacotherapy with minority patients. Beyond the development of specific learning objectives, training in cultural psychiatry was envisioned to cut across all other teaching, thus collaborations were formed and cultural issues were taught as part of all other teaching modules. Interestingly, cultural competence was seen as conceptually related to the concept of psychological mindedness. Core lectures, culture-specific rounds, clinical teaching electives, conferences, and a day devoted to culture were implemented into the curriculum. Amongst the didactic material are topics on culture and health, culture and illness, conducting the culturally competent interview, cultural formulation and culture bound syndromes. Ethno-psychopharmacology, culture and psychotherapy are also discussed. Also relevant are issues such as legal aspects of migration, the doctor–patient relationship, religious values, practices and beliefs and working with interpreters. Strategies for implementation are reviewed, including using revised resident evaluation as an agent of change. In other words, evaluation of residents (based on curricula which sets competency) motivates faculty to change what and how they teach.

CANMEDS COMPETENCIES

CanMEDS, well over 10 years old, was updated in 2005 as the CanMEDS 2005 Framework.[37] The role of the physician extends beyond that of a *medical expert* to include *collaborator*, *communicator*, *manager*, *health advocate*, *scholar* and *professional*. Driven by an analysis of societal need, and with input from medical educators, RCPSC fellows and staff as well as family physicians, the roles were developed, behavioural anchors defined, and the initiative gradually

implemented in all specialty training programs. This resulted in a rewriting of all OTR's across all specialties, incorporating CanMEDS goals and objectives which were then implemented and assessed through accreditation.

The *medical expert* role is central to the work of all specialists. However, and without prejudice to the other CanMEDS roles, the role of *communicator* is also central and very significant for the psychiatrist. In many respects it is also part of the role of *medical expert*. *The competencies for this role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care.* This must be delivered in a culturally sensitive fashion, mindful of all forms of communication, verbal and non-verbal, and in a fashion that reflects active listening as well as sensitive and thorough questioning which leads to a comprehensive and biopsychosocial understanding of patient context, adaptation, resilience and burden. A resident's failing in this domain of practice was a frequent cause of failure at the RCPSC exit examinations when the "long case" with a real patient was the standard. It remains a skill that must be practiced and honed with formative feedback, over many trials and over many settings and patients. Programs must assure that residents achieve this standard prior to being put forward for the revised RCPSC exit examination which no longer uses the "long case."

Assessment of the CanMEDS roles is essential. Practical tools are required. The CanMEDS Assessment Tools Handbook states that not every educational setting will lend itself to the assessment of all CanMEDS goals, rather assessment occurs in multiple circumstances over time just as competencies are acquired and developed over time. There is a developmental progression of knowledge, skill and attitude. Learners must be assessed at different points along the journey, utilizing the appropriate tool to measure progress, analyzing gaps and providing formative feedback.[38] Further elaboration is provided in the chapter on evaluation.

CONCURRENT AND LONGITUDINAL TRAINING: INTEGRATION VERSUS FRAGMENTATION

The training requirements set out in the OTR and STR require the integration of vertical and horizontal training components. There are many competing demands on a resident's time. This has lead to a statement of concern about the amount of "off service" work — either to attend seminars, rounds, psychotherapy supervision, or some other activity. It should be of concern that this might compromise the teaching alliance.

It is hoped that, over the long run, as programs accommodate and incorporate the new training requirements, most, if not all, of the training requirements will

be integrated into each rotation or placement. Hopefully, residents will have to travel less to get the majority of their training. It is realized however, that some rotations will need time to accommodate and integrate notions of generalism more fully in practice and thus training. It may not be appropriate or possible in all settings. The challenge to facilitate integration while limiting fragmentation can be daunting, but must be managed. The Specific Accreditation Standards (SSA)[39] in psychiatry are helpful in this context:

> Psychiatric education is composed of a complex array of distinct rotation-based (vertical) experiences and longitudinal (horizontal) experiences. At the minimum, longitudinal experiences include exposure to the long-term psychotherapies and the one- to two-year requirement for the supervised treatment of patients with severe and persistent mental illness. Longitudinal experiences may also include training in other psychotherapies, concurrent versus separate inpatient/outpatient experiences, developmental disabilities, addictions, research, collaborative/shared care or administration. The combination of longitudinal and distinct rotational experiences must be managed by the program so as to provide a balanced approach to support knowledge acquisition, integration and skill development. It must not leave the resident's experience so fragmented as to limit adequate exposure, or the integration of knowledge, skill, teaching or mentorship. This means that a resident's longitudinal experience, whether core, selective and/or elective will need to be carefully scheduled, apportioned and approved. Approved longitudinal experiences must not remove the residents from their distinct rotational experiences for more than one day per week, exclusive of academic half or full days (if offered). In other words, residents must not spend less than three to three and one half days per week on their primary rotation.[40]

Consideration should be afforded the developmental stage or competency of the resident. Senior residents are more likely able to manage multiple longitudinal experiences having developed core competency, and being less dependent on mentorship. The CPA Practice Profile Survey informs us that most psychiatrists practice in more than one setting.[11] A mixture of vertical and horizontal training components contributes to the development of competency in practice, including time management, but must be managed prudently.

LESSONS FROM ACCREDITATION

All training programs in Canada are subject to an RCPSC accreditation visit and review on a regular cycle, partially determined by the accreditation status afforded at the preceding visit. This enables the RCPSC mission of achieving the highest standards in medical specialty education. In between RCPSC external reviews, there must be a regular cycle of internal reviews conducted by each faculty of medicine on each of its specialty training programs. External

reviews can be triggered if sufficient difficulty is identified at an internal review. It is imperative that each training program conduct its own self assessment and curriculum review on an ongoing basis and not wait for internal or RCPSC external reviews. The self-review, faculty of medicine internal review and the RCPSC external review are all intended to assure that the program delivers the OTR and STR according to the established SSA for Psychiatry. Each of the OTR, STR and SSA are available at the RCPSC website at http://www.rcpsc.medical.org.[41]

Accreditation surveys capture both the strengths and weaknesses of programs. As reported in earlier chapters, for a period in the 1990s a number of programs struggled to obtain full accreditation status, a situation that has improved substantively. Attention to identified areas of weakness established at recent surveys is informative, helping programs attend to those areas that are cause for concern. Summative reports of accreditation outcomes are presented for information to the Specialty Committee in Psychiatry following accreditation visits. The Specialty Committee helps to inform the process through a review of pre-survey documentation completed by the PD that addresses each of the accreditation domains of assessment. The pre-survey exercise is an opportunity for formative self-evaluation.

Although the vast majority of programs achieve full accreditation status, not all standards are realized at all times. Gaps exist between the ideal and the actual delivery of education. The following questions draw attention to gaps identified in more recent accreditation surveys. They may apply in whole, in part or not at all to an individual program's current functioning:

- Is there sufficient administrative support?
- Is educational leadership developed at each site and for each component of the program?
- Does the residency program committee communicate effectively to all constituents?
- Are evaluations reflective of rotation-specific objectives?
- Is fragmentation disruptive?
- Is the core experience too variable and inconsistent to effect the attainment of objectives for all residents?
- Is supervision appropriate to the developmental level of the resident?
- Are safe practices in place for the management of patients? Are they effectively communicated, demonstrated and supported by adequate infrastructure, policy and culture?
- Is there consistent availability of supervisors for each of the components?

- How is learning accomplished in each of the *manager* and *health advocate* roles?
- Does formative feedback of teaching occur for the residents?
- Is formative and summative feedback timely, face to face and task-oriented?

Of the above questions, one deserves additional comment — safety. Psychiatrists practice in a variety of diverse settings, not all of which are urban, hospital-based or necessarily constructed with patients in mind. Assessing risk for patient and staff are essential skills. The issue of safety in training settings has been occasionally challenging for accreditors who may not be psychiatrists and who have functioned without RCPSC operational guidelines and with external documents that are limited in scope. Emergency rooms should be welcoming, yet safe — as all clinical practice environments must be. Programs must focus on policy, procedure and training in addition to infrastructure in the emergency room and other settings. There is not one solution. Training in risk assessment and its application across diverse settings and patient populations is most important, including considerations of best practices. Programs must be vigilant and mindful. In many instances accreditation reviews have resulted in health-care delivery reform and improved infrastructure — education leading the way to better health-care practices. Considerations include the development of program-based safety committees to provide oversight and enhance self evaluation and monitoring (Specialty Committee in Psychiatry 2009, in review).

WHAT ABOUT THE FUTURE?

After a period of relative quiescence, numerous changes have taken place in the psychiatric curriculum. With the major revisions in place, fine tuning is required as implementation informs us of oversights, undiscovered obstacles, opportunities for enhanced practice and training, regional disparity and so on. Each partner in the endeavour must maintain active participation at the local, regional and national levels that inform and are responsible for the educational process. Canadian specialty medical education is well-positioned to move into the future, by learning from the past while enhancing and developing CanMEDS roles, core competency, generalism, societal need in the face of scientific advances and subspecialization. We are well-positioned to both learn from and contribute to medical educational knowledge and initiatives on the international stage.

The future holds promise as the development of technology helps support and improve education. The integration of technology into psychiatric education will be challenging, but may allow for new partnerships between faculties,

universities, and perhaps countries. Hilty et al[40] identify school-based examples of curricular and web-based education innovations, virtual reality environments and applications of telemedicine in psychiatry — the latter well-developed in Canada. The establishment of central education technology offices that also provide opportunities for faculty development and other innovations may help with resource issues.

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Chapter 4

Basic clinical training

Fabien Gagnon

INTRODUCTION

The basic clinical training (BCT) year lays the groundwork for training the sophisticated general psychiatrist. It is during this year that the newly graduated physician begins to consolidate his/her identity as a physician and reflect on psychiatry as a career choice as he/she experiences the first postgraduate experiences in the discipline. For many residents, the non-psychiatric rotations they will experience over the balance of the year, will provide an opportunity to assess how comfortable they feel with their career choice. It is important that psychiatric program directors recognize these early developmental challenges and actively support their residents, both administratively and collegially, during these first medical and psychiatric rotations.

The BCT year has been influenced by a number of factors as evidenced by the numerous labels given to it over the years, including internship, PGY1 or BCT. Differing provincial licensure requirements have influenced the content of PGY1. Within the past 15 to 20 years, licensure requirements have shifted from a one- to two-year multidisciplinary internship requirement (rotating or direct) and specialty training with entry from either the rotating or direct internship, or re-entry to a two-stream licensure model (e.g. family medicine, 24 months), or specialty training (four to six years). The Licensure of the Medical Council of Canada (LMCC) examination has evolved from a one-part examination taken immediately at the end of medical doctorate training to a two-part examination with the second part undertaken after PGY1. These licensure conditions reflect provincial, social and human resource issues. Educators, rightly or wrongly, became concerned that these changes would promote premature career decision making and reduce flexibility for residents who may want to change training programs or career plans. These practical issues of portability and flexibility

must be taken into account when planning the content of the basic clinical training year for residents.

The principle objective of PGY1 is to consolidate the basic medical training of the newly graduated physician through rotations in family medicine, internal medicine, neurology, pediatrics and emergency medicine. These rotations also underscore the fact that many psychiatric patients present with comorbid disorders.[1,2,3] This basic year of training also provides opportunity for an initial understanding and orientation to shared mental health care.[4,5] Finally, the content of PGY1 allows residents to choose rotations with potential for developing psychiatric career stream interests through selective and elective rotations.[6,7,8,9,10]

In the past, PGY1 residents may have experienced ambiguity, fragmentation or poor consolidation of identity because the responsibility and oversight for the BCT year rested with medical and surgical departments. However, the total experience has gradually come under the jurisdiction of psychiatry departments and the BCT year is now fully integrated with the remaining four years of the junior and senior residency. The 2007 Royal College of Physicians and Surgeons of Canada (RCPSC) Objectives of Training (OTR) and Specialty Training Requirements (STR) in psychiatry facilitate the completion of the different provincial requirements, providing desirable flexibility without neglecting the importance of standardizing the clinical training deemed necessary for the development of the general psychiatrist.

The amount of psychiatry training that can be taken during PGY1 is limited to no more than four blocks, including electives and selectives (13 four-week training blocks per year). This is to ensure that psychiatry residents achieve a balance of rotations that facilitate competency and confidence as physicians. The opportunity to choose a certain number of rotations in psychiatry and other medical specialties over the mandatory requirements in BCT allows residency training programs and residents some flexibility, but the choice of medical rotations (up to 12 of 13 blocks of PGY1) and psychiatry rotations (*from one to four blocks*) is designed to contribute to the training of the future general psychiatrist.

As PGY1 is an integral part of the total overall training in psychiatry, each psychiatry postgraduate program is encouraged to define the specific objectives for all rotations. This includes those in non-psychiatric experiences. The CanMEDS objectives remain relevant, but cannot simply be translated to the more defined objectives for PGY2 to PGY5. The developmental level of the BCT resident must be considered when determining the type of experience expected, the type of supervision needed, and the level of competency to be achieved in the first year. As noted above, for all non-psychiatric experiences (e.g. family medicine, medical or surgical), every program must define the specific objectives for residents in psychiatry. These objectives must take into

consideration not only the practical aspects mentioned, but also the contribution that these experiences may make toward the terminal objectives for general psychiatry.[11]

Residents may find the following resources useful, particularly during their early training:

Books

- Gelder MG, Lopez-Ibor JJ, Andreasen N. New Oxford textbook of psychiatry, New York (NY): Oxford University Press; 2003.
- Hales RE, Yudofsky SC, Gabbard GO. The American Psychiatric Publishing textbook of psychiatry. 5th ed. Arlington (VA): American Psychiatric Publishing, Inc; 2008.
- Lalonde P, Aubut J, Grunberg F. Psychiatrie clinique : une approche biopsychosociale. Tome 1 : Introduction et syndrome clinique. Montreal (QC): Gaëtan Morin; 1999.
- Lalonde P, Aubut J, Grunberg F. Psychiatrie clinique : une approche biopsychosociale. Tome II : Spécialités, traitements, sciences fondamentales et sujets d'intérêt. Montreal (QC): Gaëtan Morin; 2001.
- Sadock BJ, Sadock VA. Kaplan and Sadock's comprehensive textbook of psychiatry. 8th ed. Philadelphia (PA): Lippincott, Williams and Wilkins; 2004.

Journals

- *The Canadian Journal of Psychiatry*
- *American Journal of Psychiatry*
- *Archives of General Psychiatry*
- *British Journal of Psychiatry*

Societies

- Canadian Psychiatric Association
- Royal College of Physicians and Surgeons of Canada
- Provincial psychiatric associations
- American Psychiatric Association

REVIEW OF THE RCPSC OTR/STR

The 2007 RCPSC STR requires that residents in their BCT (PGY1) complete "one year of basic clinical residency, under the direction of academic departments of psychiatry, the majority of which must be completed before section two (re: PGY2 and PGY3) begins. This training year must be a broadly based medical experience relevant to psychiatry with core elements in medicine,

pediatrics, family medicine, neurology (neuroimaging is strongly recommended), emergency medicine and psychiatry. The basic clinical year (PGY1) is integrated with the subsequent years of psychiatric training. Psychiatry rotations or electives in psychiatry may contribute to the completion of core requirements or the acquisition of longitudinal components of training under section two or four ..."[12]

The 2007 RCPSC STR distinguishes itself from its predecessor on four points:

1. PGY1 is under the direction of academic departments of psychiatry, even though most rotations will have to be negotiated with other departments (e.g. internal medicine, neurology).

2. The majority of PGY1 content must be completed before beginning junior residency (PGY2 to PGY3).

3. PGY1 must be a broadly-based medical experience relevant to psychiatry. The proposed content allows some flexibility, but must be delivered over 13 four-week blocks and must include:

    a. Seven to nine blocks of core training composed of:

        i. Three blocks of internal medicine, family medicine and/or pediatrics. The entire three blocks may be taken in internal medicine or family medicine, or in any combination of the three, but only one block in pediatrics is permitted. An endocrinology experience is strongly recommended.

        ii. One block of neurology and one block of neuroimaging, or two blocks of neurology. A neuroimaging experience is strongly recommended.

        iii. One block of emergency medicine.

        iv. No more than three blocks of psychiatry that preferably includes clinical experience in emergency psychiatry and in shared or collaborative psychiatric care. If more than one block of psychiatry is taken, it must contribute to the core experience of general psychiatry and must be approved by the residency program director. Under no circumstances can psychiatry training in PGY1 be used to replace or shorten the duration of training in PGY4 or PGY5.

    b. Two to four blocks of selective training drawn from geriatric medicine, pediatrics, obstetrics and gynecology, general surgery, internal medicine, neurology, neuroimaging, family medicine, palliative care, psychiatry or research. No more than two blocks may be selected in any one area, except for psychiatry, which will be limited to one block.

    c. One block of elective training drawn from any medical or surgical rotation, including research.

4. The basic clinical year is now integrated with the subsequent years of psychiatric training so that rotations or electives in psychiatry during PGY1 may contribute to the completion of core requirements or the acquisition of longitudinal components of training such as research (*scholar*); psychotherapies (*medical expert*); education (*scholar*/*communicator*); administration and leadership (*manager*); and addiction training. If this occurs, the contribution to core/longitudinal requirements must be specified and separately documented (i.e. The goals and objectives must be purposefully and proactively developed, and not detract from the developmental progression of training documented elsewhere.)

The required experiences are based on the recognition of the importance of PGY1 in consolidating basic medical training (particularly in neurology, neuroimaging and endocrinology) within the context of its relevance toward the requirements of the general psychiatrist now and in the foreseeable future. The importance of collaborating with other colleagues, particularly from medical disciplines in a context of shared comprehensive care,[5] is reflected by the variable requirements of family medicine, pediatrics and internal medicine. Finally, the opportunity for selectives and an elective allows residents to choose rotations that will allow them to develop and explore specific interests and possible career choices (e.g. child psychiatry, geriatric psychiatry or consultation-liaison psychiatry).

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

Training in medical-surgical rotations during basic clinical training in psychiatry

Undergraduate medical experience does not sufficiently prepare the student for autonomous medical practice, nor does it consolidate medical identity and competency. It is therefore essential to continue teaching and training in medical disciplines in the PGY1 program and beyond. During PGY1 rotations, clinical experiences should be offered on a broader and more advanced level than those gained during medical clerkship rotations. The main objectives of medical rotations during the PGY1 in psychiatry are:

1. To expand or consolidate the knowledge and clinical skills (including physical/neurological examination) gained during medical clerkship.

2. To provide residents with sufficient knowledge and skills to become confident in the detection and management, at least at a primary care level, of the most frequent forms of medical illnesses encountered in general psychiatry.

3. To learn to identify medical illnesses that may mimic and/or commonly occur concurrently with psychiatric disorders.

4. To develop an understanding and awareness of the roles and responsibilities of other health-care providers in the delivery of care.

Even though the availability of most non-psychiatric rotations will have to be negotiated with other departments (e.g. internal medicine, neurology), it is imperative that each residency program in psychiatry elaborates specific rotation objectives for non-psychiatric rotations. Each program may have to incorporate provincial objectives into their PGY1 objectives since there may be specific provincial requirements to meet. Table 4.1 presents a basic template for PGY1 medical rotations for residents in psychiatry.

Training in psychiatry during BCT in psychiatry

PGY1 residents are permitted to take one to three blocks of psychiatry, which preferably includes a clinical experience in emergency psychiatry and in shared or collaborative psychiatric care. If more than one block of psychiatry is taken, it must contribute to the core experience of general psychiatry and be approved by the residency program director. Residents may also take one block of training as a selective. *Therefore, the maximum number of blocks in psychiatry during PGY1 is no more than four*.

If more than one block is chosen, the rotation should contribute to the core experience of general psychiatry. The type of experience, quality and time accorded to supervision, and level of competency expected to be attained by the PGY1 resident during these psychiatric rotations should be clearly defined. Programs are encouraged to develop specific rotation objectives for other PGY1 rotations in psychiatry (e.g. emergency psychiatry and shared/collaborative psychiatric care). The reader is referred to chapter 12 on shared/collaborative care for relevant objectives. An article by Brasch et al[13] also offers suggestions for objectives and curriculum development in emergency psychiatry. Table 4.2 presents an example of the *medical expert* objectives for a rotation in emergency psychiatry.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

As previously noted, PGY1 is a BCT year that forms part of a five-year training residency program and, as such, it can be used as an opportunity to develop clinical training experiences toward the terminal objective (i.e. a sophisticated general psychiatrist). PGY1 contains medical components that may help reach licensure requirements, but the primary objective for the year should be educational developments toward the endpoint – a competent general psychiatrist. Therefore, medical rotations should not only involve time spent in

Table 4.1 Basic template for PGY1 medical rotations objectives (residents in psychiatry)

Overall objectives of medical rotations

The overall objective of training in medical rotations is to allow residents to acquire or consolidate the knowledge and skills of internal medicine that would be helpful to the general psychiatrist. The rotation aims to achieve the following:

1. To expand and consolidate the knowledge, clinical skills and abilities gained during clinical clerkship.
2. To provide clinical experience in emergency care, ambulatory care, in-hospital care, continuing care and palliative care.
3. To provide residents with sufficient knowledge and skills to be confident in the detection and management of the most frequent forms of medical illnesses encountered in general psychiatry at a primary care level. Residents should also become familiar with providing a well-informed reference for appropriate specialist consultation.

Medical expert

At the end of the rotation, the resident will:

1. Demonstrate knowledge of common medical problems and medical emergencies as they present in various settings (ambulatory care, emergency care, hospital and palliative care), including but not limited to:

   a. Neurology rotation

   - Altered level of consciousness secondary to a medical condition
   - Cerebrovascular accidents
   - Seizure disorders
   - Dementia and related syndromes
   - Multiple sclerosis
   - Headaches
   - Parkinson's disease

   b. Internal medicine, pediatrics and family medicine rotations

   - Aging and its influence on illness presentation, diagnosis and management
   - Thyroid disorders, myxedema and thyrotoxicosis
   - Acute and chronic renal failure
   - Diabetes/hypoglycemia
   - Peripheral nerve disorders
   - Acid base, fluid and electrolyte balance
   - Anemias, bleeding disorders (blood dyscrasias)
   - Obesity and metabolic disorders
   - Gastrointestinal bleeding/peptic ulcer disease
   - Jaundice/hepatitis
   - Infections such as pneumonia and pyelonephritis
   - Pain (acute, chronic)

continued

Table 4.1 continued

c. Emergency medicine

- Sexually transmitted diseases (e.g. HIV/AIDS, gonorrhea)
- Drug overdose and poisoning
- Hypertension, hypotension
- Myocardial infarction, angina
- Cardiac arrhythmias and cardiac arrest
- Congestive heart failure
- Bronchial asthma, exacerbation of chronic obstructive lung disease
- Deep vein thrombosis/pulmonary embolism

2. Identify other serious medical problems, including leukemia, lymphoma and various carcinomas.
3. Demonstrate knowledge of the indications/contraindications for laboratory, imaging (mainly neuroimaging) and other medical investigations.
4. Identify the side effects of the main medical treatments, including drug toxicities/interactions.

Skills

At the end of the rotation, the resident will be able to:

1. Perform an appropriate history and physical examination (particularly a neurological exam).
2. Formulate a differential diagnosis and appropriate treatment plan for major medical problems.
3. Perform the following:
   - Insertion and management of intravenous lines
   - Nasogastric tube insertion
   - Bladder catheterization
   - Read an electrocardiogram

medical disciplines, but should also contain specific objectives allowing residents in psychiatry to become competent physicians and competent general psychiatrists. Some guidelines are provided on allocated times for mandatory, selective and elective rotations, but each residency program should define how each rotation chosen by a resident can be useful in contributing to the specialty's CanMEDS objectives. By being proactive in the determination of specific objectives for each PGY1 rotation, the residency program will optimize the residents' clinical experience in psychiatric and non-psychiatric rotations and will help supervisors facilitate the residents' exposure to pertinent clinical material. This will help to provide residents with a more comprehensive assessment within the CanMEDS framework at the end of each rotation.

Table 4.2 PGY1 rotation objectives for emergency psychiatry (*medical expert*)

Knowledge

1. At the end of the rotation, the resident will demonstrate an effective level of clinical knowledge and understanding relevant to emergency psychiatry, especially concerning acute psychiatric intervention (i.e. in the assessment and management of):
   a. The patient with disturbed or dangerous/violent behaviour
   b. The seriously and persistently mentally ill patient
   c. The severely anxious or depressed patient
   d. The substance abusing patient
   e. The severe personality disordered patient
   f. The geriatric patient
   g. Family crises
2. At the end of the rotation, the resident will understand and be able to explain:
   a. Biopsychosocial factors influencing patients to present to the emergency department
   b. The role of comorbid substance abuse in patients presenting to the emergency department
   c. Risk factors associated with suicide and homicide
   d. Causes, presentation and management of delirium/toxic psychosis
   e. The Mental Health Act (or its equivalent) and how to complete forms associated with certification
   f. How to obtain informed consent
   g. The principle of the duty to protect

continued

Programs are encouraged to organize lectures or seminars on the medical–psychiatric interface in order to help PGY1 residents integrate into psychiatric residency. This allows residents to better understand the relevance and contribution of this basic clinical year to their future career. These lectures/seminars may serve to underline some aspects of patient care that may not have been identified by their non-psychiatric supervisors during the medical rotations. Nested within the psychiatric residency program as ‘call back’ training experiences, these lectures/seminars may also provide the opportunity for PGY1 residents to meet with more senior psychiatric residents with whom they will continue in training. Such encounters may also serve as a tool to promote their identification as psychiatrists and foster a sense of belonging to the department of psychiatry.

Table 4.2 continued

Clinical Skills

At the end of the rotation, the resident will demonstrate the general ability to assess, diagnose and treat the most frequent psychiatric disorders in males and females of all ages and cultures that present to the emergency room, and will demonstrate the following specific skills:

1. Perform an appropriate focused interview
2. Perform a complete substance use history
3. Elicit and describe a detailed mental status examination
4. Assess and manage potentially violent patients (suicide, homicide, toxic psychosis)
5. Assess and manage drug and alcohol intoxication, and withdrawal states
6. Assess and manage delirium
7. Assess and manage severely personality disordered patients through:
   a. Crisis identification
   b. Affect containment
   c. Managing personal counter-transference and intense team reactions
   d. Evaluating need for, benefits and risks of admission versus discharge, and safety measures
   e. Setting goals for admission
8. Order appropriate investigations, including laboratory tests, computed tomography scans, electroencephalography and neuroimaging tests
9. Assess suitability for, prescribe and use appropriate psychopharmacological treatments
10. Maintain accurate and timely medical records

Medical-surgical training

It may appear on first impression that the contents of the PGY1 non-psychiatric experiences are not well defined; therefore it is important for psychiatric program directors to define the content and objectives of rotations and to negotiate the acceptance of these with program directors from the other disciplines. To encourage this, an example of objectives[13,14] for medical rotations is provided (Table 4.1).

Despite differing provincial requirements, the main stimulus behind the development of specific objectives for non-psychiatric rotations should be to improve the understanding and relevance of this aspect of training and to accelerate the development of an educational platform for non-psychiatric rotations. As such, it could be interesting for residency programs in psychiatry which have developed CanMEDS objectives for PGY1 non-psychiatric rotations to share their experiences with colleagues through an academic group such as the Coordinators of Postgraduate Education (COPE). The expected level of competency to be attained by residents at the end of the rotation should be

clarified. Expectations about on-call duties by residents in psychiatry during non-psychiatric rotations should also be identified and adhere to the residency's terminal objectives. Working with non-psychiatrists in charge of family medicine, medical or surgical blocks for PGY1 in psychiatry will be essential at this time in the process. Some programs may experience some difficulty in obtaining a substantial level of collaboration from non-psychiatric supervisors. A possible solution to this problem could be to match psychiatry PGY1 residents with a tutor/supervisor from psychiatry who would follow and support residents during medical rotations.

The non-psychiatric block of experiences provide not only an opportunity to consolidate medical knowledge and skills for psychiatric residents, but also an opportunity to gain experience in different aspects of interdisciplinary teamwork, in shared care, in consultation-liaison psychiatry,[15] and the advocacy role that general psychiatrists may be required to undertake on behalf of their patients in the medical–surgical environment.

Psychiatry training

If more than one block in psychiatry is chosen, it is important to remember that those blocks must contribute to the other components of general psychiatry training (PGY2 to PGY5). To enhance recommended training, a template for emergency psychiatry is provided (Table 4.2) and the reader is referred to chapter 12 for guidelines on shared/collaborative psychiatry rotations over the five years of training.

OTHER CONSIDERATIONS

PGY1 residents will have to complete medical-surgical rotations. As mentioned earlier, each program is invited over the next few years to work in collaboration with medical-surgical supervisors to elaborate specific objectives for the medical training of psychiatry residents. Programs should also consider the need for elaborate assessment tools adapted to those objectives early on in the process. The Accreditation Council for Graduate Medical Education (ACGME) has developed a toolbox of assessment methods that may facilitate this process.[16]

Since longitudinal training issues are part of the five-year training program in general psychiatry and are identified in clinical skills (e.g. child and adolescent psychiatry, geriatric psychiatry, consultation-liaison psychiatry, addiction psychiatry, psychotherapy, administration, research and education), it is very important that a data collection process (logbook or similar procedure) be presented to residents at the beginning of PGY1 training.[17] This will allow residents to optimize their training time toward the acquisition of required competencies and may help them to identify the relationship between clinical

material and situations met during their rotations and the situations they could meet in their future role as general psychiatrists.

PGY1 residents in psychiatry may be called upon to provide medical presentations and supervise medical students or other health professionals early in their training. It is important for programs to provide PGY1 residents with basic clinical skills as presenters as well as teachers. Different formats[18,19,20,21,22] have been proposed, from formal lectures and seminars to websites such as http://www.residentteachers.com.

Since PGY1 is now part of the five-year training program in psychiatry, ensuring that PGY1 residents are represented at the Residency Program Committee (RPC) should be considered. The presence of this resident group at the RPC is essential to closely follow the development of specific objectives and assessment tools for each medical and psychiatric rotation during the basic clinical training year.

The BCT year allows for portability and flexibility if residents choose to change specialty, but it is also a required year for residents who wish to prepare for the second part of the LMCC examination. Programs should consider facilitating the preparation of their residents for this examination.

CONCLUSION

The first year of residency training (PGY1) is important and foundational. This is the year when residents first experience their career choice in practice. Since it is a new set of experiences, residents can be sensitive to their supervisors' comments and attitudes, to the structure of rotations, and the organization of service delivery. Many residents may experience a type of imprinting process with the hospital (and supervisors) where they have their first rotations. The resident will want to emulate (or, in some cases, avoid) the practice of psychiatry modelled by psychiatric supervisors. It is important for residency program directors and for supervisors in psychiatry to invest time and attention in planning the PGY1 program. It is also important for them to recognize the importance of basic training in medical rotations as essential to the training of the sophisticated general psychiatrist, and to actively support and monitor the development of their residents during medical rotations.

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Chapter 5

Psychotherapies

Priyanthy Weerasekera and Gary S Hnatko

INTRODUCTION

The psychotherapies are psychological treatments that help relieve symptoms and improve functioning in patients suffering from psychiatric disorders and psychological problems. Empirical evidence supports the use of a variety of psychotherapies in patients with psychiatric disorders across the lifespan.[1] Several meta-analyses and randomized controlled trials support the use of cognitive-behavioural therapies (CBT) in mood, anxiety, eating and psychotic disorders,[2] interpersonal therapy for depression,[3] psychodynamic therapy for a variety of disorders,[4] dialectical behaviour therapy (DBT) for borderline personality disorder (BPD),[5] motivational interviewing for substance abuse conditions,[6] couple and family therapy as an adjunct for child and adult disorders,[7] and group therapies for mood, anxiety, eating and other disorders.[8] Given this mounting evidence, it is highly relevant that the graduating psychiatrist be knowledgeable and sufficiently skilled to deliver some of these treatments to patients with psychiatric disorders across the lifespan. Residency programs must therefore develop the necessary curricula to ensure that broad-based training in the psychotherapies is available.

Developing training programs will be challenging. Residents arrive into psychiatry from medical school, primary care, other subspecialties and as international medical graduates. In most cases, prior exposure to formal psychotherapy is limited, with some having had teaching in “interviewing skills” or “counselling.” International medical graduates may also struggle with language or cultural issues which could make learning psychotherapy challenging. Despite this heterogeneity, programs can be developed to meet the needs of this diverse group. A broad curriculum that exposes the resident to a variety of evidence-based psychotherapies relevant for patients with psychiatric

disorders, and a supervisory experience that ensures the learning of a variety of psychotherapeutic skills is essential for all residents. Texts and manuals provide good outlines on the basic theoretical principles, as well as instructions on how to deliver treatment.[9,10,11]

Once competence is attained at a novice level, opportunities should be provided for those residents who wish to gain further expertise in one or more therapies during the PGY2–PGY5 years or during a fellowship year. Further enrichment of knowledge and skills can also be gained though exploration of the empirical literature (e.g. *Journal of Clinical and Consulting Psychology, Clinical Psychology Review, Psychotherapy Research*), and through membership in professional associations (e.g. Society for Psychotherapy Research, Society for Psychotherapy Integration, Canadian Psychiatric Association, American Psychiatric Association).

This chapter will serve as a toolbox to assist educators in developing psychotherapy programs aimed at training the sophisticated general psychiatrist who is able to deliver comprehensive integrated biological and psychological treatments to patients with psychiatric disorders as deemed appropriate by empirical evidence and best practice standards. The Royal College of Physicians and Surgeons of Canada's (RCPSC) Objectives of Training in Psychiatry (OTR)[12] and Specialty Training Requirements (STR)[13] documents will be reviewed, followed by a description of the training targets and detailed goals and objectives in this area. Specific suggestions on how to reach these training targets will be discussed and other considerations to facilitate enhanced training in the psychotherapies will be explored. An extensive reference list is provided to assist programs with this challenging yet exciting task.

REVIEW OF RCPSC OTR/STR

According to the STR, residents "must receive training in the evidence-based psychotherapies sufficient to meet the Objectives of Training in Psychiatry (STR: June 2007, p. 3)."[13] This training must occur during the PGY2–PGY5 year and "must involve no less than 32 weeks or eight months of the 60-month period of training." However, it is expected that psychotherapy will be integrated into the resident's general psychiatric practice over the entire five-year period. The experience must be longitudinal and should include patient hours, supervision and structured learning. Training may focus on children and adolescents, adults, the elderly, families and groups. It is also expected that the resident's performance in the psychotherapies be documented and evaluated separately from other rotations, either through a logbook or portfolio.

Seminars or structured learning activities are considered sufficient for basic or introductory knowledge; however, working knowledge requires residents to participate as an observer or co-therapist. Proficiency necessitates the resident be the primary therapist with one hour of weekly supervision. Although training in the insight-oriented therapies may require distinct dedicated time coincident with a rotation, it is recommended that training in the other psychotherapies occur concurrently with the resident's regular rotation duties, integrating psychotherapeutic knowledge and skill with daily clinical duties. This would significantly increase the total exposure to psychotherapy training. Acquisition of competence in psychotherapy should also enhance training in the concurrent clinical rotation. Further training can be obtained by special electives or selectives in the different psychotherapies, either across psychiatric disorders (e.g. CBT for mood, anxiety, eating) or within one disorder (e.g. CBT, interpersonal therapy [IPT], family for mood disorders).

Residents must demonstrate proficiency in supportive therapy, crisis intervention, CBT and psychodynamic therapy. Residents must also demonstrate proficiency in either of family therapy or group therapy and working knowledge in the other. In addition, working knowledge must be demonstrated in behavioural therapy, DBT, family or group therapy, and IPT. And finally, residents must also show introductory knowledge in: brief dynamic therapy, mindfulness training, motivational interviewing and relaxation. As part of the general psychiatric training experience emphasis should also be given to the development of empathy, rapport, trust and ethical therapeutic relationships with patients. Although these communicator attributes should be the focus of all doctor–patient relationships, these skills may be finely tuned in the context of psychotherapy education as it is key to a successful outcome in any form of psychotherapy.[14]

Relevant to all psychiatric education, the Specific Standards and Accreditation requires the provision of appropriate space to conduct therapy, adequate teaching resources and access to administer the psychotherapies across the lifespan.[15] In resource poor departments, special arrangements must be made with other universities so that residents can gain access to these resources in order to meet the goals and objectives of training.

Therapeutic alliance

Prior to discussing the specific psychotherapies it is important to look at the therapeutic relationship. The therapeutic alliance is defined as the fundamental relationship between the therapist and the patient, which is made up of three components: a bond (relational component), mutually agreed upon goals and tasks (means to attain goals). Three decades of research demonstrates that a positive therapeutic alliance is essential for good outcomes in psychotherapy.[16]

Research also shows that the alliance is essential for good outcomes in pharmacotherapy.[17]

Therapist attributes (warmth, genuineness, respectfulness, and being empathic) and techniques (empathic reflection, affective exploration, supportiveness, facilitation of the expression of affect, and attention to the patient's experience) have an impact on a positive outcome in therapy and are clear training targets to attain.[14] In addition to these fundamental skills, residents must practice all psychotherapies in an ethical manner, maintaining clear professional boundaries at all times. Therefore it is essential that residents learn and be sufficiently competent in these fundamental skills prior to the learning of specific therapies. Therapies that pay specific attention to these training variables include supportive,[18] client-centred,[19] emotion-focused,[20] supportive-expressive[21] and self-psychologically oriented dynamic therapy.[22] Therapist competence in alliance skills can be assessed by many of the empirically validated alliance measures available in the literature including the Working Alliance Inventory (WAI),[23] the Barrett-Lennard Relationship Inventory[24] and the Truax Accurate Empathy Scale.[25]

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

This section elaborates on more detailed training targets and goals and objectives for the psychotherapies. Any target goal needs to be operationally defined so the end point is clear. This requires a definition of the different levels of competence, and a discussion as to how these will be measured.

Proficiency

Once therapeutic alliance skills are established, training can focus on the specific psychotherapies. In the discussion below each therapy will be operationally defined, followed by a brief presentation of the basic theoretical principles, indications and contraindications in the psychiatric population, and standards for training based on attaining proficiency level. Training to proficiency level is reached by the resident first obtaining a sound knowledge base through didactic seminars or some alternate format of learning (e.g. online learning). Knowledge base can be assessed directly with multiple choice questions, case discussions, formulations and ongoing case discussions. Following this, the resident should be assigned a patient and assume the role of prime therapist with weekly supervision. A majority of the sessions should be audio- or videotaped and played back in supervision so that objective material can be evaluated. An alternate method, if possible, is live supervision. Supervisors should be experts in the field, able to provide corrective feedback to

the resident's general and therapy specific skills. Competence should be assessed by the supervisor and, ideally, an alternate evaluator using objective rating scales whenever possible. Attention should always be paid to general alliance skills and specific therapy skills in each area. Tools to assess competence will be discussed wherever possible.

1. Supportive therapy

Whether one is implementing pharmacotherapy, a specific psychotherapy, or the integration of both types of therapies, it is important that they be delivered in the context of a supportive relationship. It is probably helpful to differentiate "supportive interventions" from "supportive therapy." There are many therapist-delivered interventions that fall under the supportive "umbrella." These include active listening, attending, reflecting of thoughts and emotions, empathizing, problem-solving, advice-giving, providing reassurance and confirming comments. Some or all of these interventions are used in many different forms of psychotherapy. However, in supportive therapy, these interventions predominate and are considered to be the active ingredients of change which contribute to the final outcome of more adaptive functioning, a decrease in symptoms, prevention of relapse, positive self-esteem, improved coping and the increased felt sense of support.[26] Supportive therapy is indicated in patients across the lifespan in times of crisis, when coping with psychiatric illness, or when dealing with any specific psychological problem (abuse situation, losses).[18] In addition, supportive therapy can be integrated with medications to establish a therapeutic relationship and promote alliance, as well as to increase medication compliance.

There are several therapies that fall under the umbrella of "supportive therapy." Some of the these include: client-centred therapy,[19] supportive-expressive therapy[21] and supportive therapy.[18] In cases where supportive and expressive techniques are emphasized it is important that more attention be given to the supportive rather than the expressive dynamic component, as this may make it difficult to attain proficiency in the pure supportive interventions essential to all therapies, as well as to the therapeutic alliance.

For the attainment of proficiency, a resident must be able to deliver supportive therapy for at least 10 to 20 sessions, or longer, and receive supervision by a supervisor competent to assess the resident's supportive skills. Specific instruments which assess therapist competence in this area have been described above.[23–25] The Penn-Adherence Scale,[27] the Interpretive and Supportive Technique Scale,[28] and a more non-validated generic form is also available.[18]

2. Crisis intervention (CI)

A crisis is generally defined as occurring when an individual perceives a change event as insurmountable and pre-existing coping responses fail to contain a catastrophic reaction. Two categories of stressors have been described that

contribute to the onset of a crisis in vulnerable individuals: situational crises (role and status change, rape and physical illness) and lifecycle stressors (i.e. parenthood and retirement). Stressors can in turn be divided into four groups: loss, change, interpersonal and decisional conflict.[29] The acuity of the situation can contribute to significant psychiatric morbidity and necessitates the delivery of appropriate psychological and medical intervention. Prior to learning CI skills, residents should receive didactic seminars that expose them to the basic theoretical principles of CI, its application to psychiatric patients, and the current empirical evidence for its use.[30]

Crisis intervention involves the delivery of specific integrated skills in a defined context within a supportive relationship. The primary goal of CI is to reduce acute distress, facilitate more adaptive coping skills, and return the patient to a normal level of functioning. The process of therapy has been described in six stages: explicit transferring of responsibility, organize takeover of tasks, remove patient from stressful environment, lower arousal and distress, reinforce appropriate communication to encourage normal communication and show concern, warmth and encourage hope.[29] Residents should demonstrate the CI skills discussed above with a wide range of patients.

The emergency room (ER) provides the ideal environment for residents to learn and deliver CI. Ideally, psychiatric ER staff could first model CI in the emergency room and then allow residents to provide CI in selected cases while supervisors observe residents through live supervision or through videos available in many emergency departments. Residents can either carry one or two cases for a few sessions under observed supervision or be viewed to deliver crisis intervention to several patients for one session as this may be more realistic in the emergency room. Patients may also present in outpatient clinics where longer followup is possible. Assessment of crisis intervention skills should focus on the specific skills discussed above. Although therapist competency scales are not readily available, the specific skills outlined above could be used as markers to assess CI skills.

3. Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is an integrated therapy in that it incorporates both cognitive and behavioural components in the conceptualization of patient problems and the delivery of treatment. The fundamental premise of CBT is that psychological distress, whether it is manifested in mood, anxiety or other problematic symptoms, is a result of specific maladaptive thought processes which in turn lead to difficulties in emotions and behaviour. Treatment includes challenging these distortions in the context of a collaborative relationship and a positive therapeutic alliance. Self-monitoring and behavioural techniques which incorporate specific homework exercises expose the patient to alternate interpretations of events and help change behaviour in a positive direction. Helping patients to increase

positive events in depression and decrease avoidance in anxiety (i.e. exposure) reduces maladaptive symptoms respectively. CBT has been applied to many psychiatric disorders with good evidence to support its application in a variety of situations.[2]

Attaining proficiency in CBT necessitates that residents be familiar with the theoretical underpinnings of CBT as it is applied to many conditions, but with a special focus on depression and the anxiety disorders, given the high prevalence of these conditions in the general psychiatric population. Once this knowledge base is acquired residents should be able to offer a cognitive-behavioural formulation of the specific patient problem and deliver specific CBT interventions. For proficiency, residents should be able to develop a collaborative relationship with the patient, use a Socratic method of inquiry, discuss the importance and purpose of homework in treatment, examine and explore situations that create difficulties, identify automatic thoughts and cognitive distortions that contribute to maladaptive emotions and behaviours and teach patients to challenge these distortions and consider alternate plausible explanations. Residents must be able to assign and review homework in each session, deal with homework non-compliance, and deliver a structured, goal-directed therapy under weekly supervision. Numerous manuals and resources are available to assist the supervisor and learner deliver CBT to a variety of patients with psychiatric disorders across the lifespan.[10-11,31-32]

Proficiency can be assessed on a weekly basis by the supervisor who should pay close attention to the general therapeutic alliance, the collaborative relationship, the resident's ability to conceptualize the patient's difficulties from a CBT perspective and to the resident's therapeutic skills in delivering CBT over the course of treatment. The cognitive therapy scale operationalizes the key therapist skills essential in attaining competence in CBT, making this a useful tool to use in assessing proficiency in this area.[33]

4. Psychodynamic therapy

Psychodynamic therapy is probably most familiar to psychiatric educators who have been training residents in this form of therapy for decades. Long-term psychodynamic psychotherapy is usually delivered to patients struggling with interpersonal problems, self-esteem issues, characterological problems and histories of childhood sexual abuse, with a recent meta-analysis supporting its use in patients with complex problems.[4] Although it is not the first line treatment in more severely ill patients with mood, anxiety and psychotic disorders, it may be an adjunctive therapy in treatment resistant cases where more complicated issues cannot be treated with medications alone or other psychological treatments (e.g. childhood sexual abuse).

Despite conceptual differences across different psychodynamic schools, most give clear emphasis to the unconscious, to early developmental relationships

with primary caretakers, and to internal conflicts and defense mechanisms. Perhaps considered the active ingredients of change in psychodynamic therapy are: the analysis and working through of the transference relationship, providing a corrective emotional experience, attending to the counter-transference and how it impacts on therapeutic progress and the use of interpretations to promote insight.[34] Different schools within psychodynamic therapy focus on different aspects of treatment. Self-psychologists emphasize empathic attunement and mirroring and idealizing functions; object-relations therapists attend to splitting, projective identification and the development of mature relational capacities; and classical therapists focus on the interpretation of conflicts and defenses.[35] It is important that residents first be able to attain proficiency at a conceptual level by providing a psychodynamic case formulation and treatment plan. As therapists, residents must be able to understand and interpret the transference when it is appropriate to do so, be capable of examining their counter-transference reactions, be able to provide a corrective emotional experience, and provide interpretations to the patient when this is considered to be helpful.

The assessment of proficiency should focus on basic alliance skills and specific psychodynamic therapy skills. First, residents should be able to present a psychodynamic formulation of the patient's problem prior to initiating therapy.[36] Specific psychodynamic skills acquired will be based on the specific approach followed, but could include interpretive skills (especially interpretation of the transference, defenses and conflicts), clarification skills, ability to show empathic attunement, provide self-object functions and attend to the counter-transference. Therapist rating scales that could be used to assess competence are the Penn-Adherence Scale,[27] the Interpretive and Supportive Technique Scale[28] and Luborsky's Core Conflictual Relationship Theme (CCRT)[37] which assesses the transference relationship.

5. Family therapy

Chronic family dysfunction can precipitate or maintain a patient's psychiatric illness. Family interventions integrated with medication or other therapies have been found to be helpful in decreasing symptoms, increasing medication compliance and maintaining good outcomes in a variety of psychiatric disorders, such as depression, psychotic disorders and child and adolescent disorders.[38] There are several models of family functioning and family therapy, including the McMaster Model of Family Functioning, systems models, psychodynamic models, behavioural models and others.[39]

For working knowledge and proficiency, residents need to be familiar with at least one assessment model so that they are able to assess a family. Following this they should be exposed to the different theoretical approaches and be familiar with the research base that supports the use of specific family treatments in psychiatric disorders across the lifespan. For proficiency purposes

they should be able to assess, formulate and treat a family with ongoing supervision in the context of a child or adult case. Residents pursuing child psychiatry should be encouraged to do their family therapy training in the context of their child psychiatry rotation.

At a fundamental level, residents should be able to obtain collateral information from family members, provide psychoeducation regarding psychiatric illness, assess family functioning on a variety of dimensions and join and deliver basic therapeutic interventions to improve family functioning for patients with psychiatric disorders. Resident competence in family therapy can be assessed by the supervisor, either subjectively using certain markers (ability to join a family, assessment skills, formulation skills and treatment skills), or by using certain instruments such as the Family Therapy Rating Scale which assesses therapist competence in family therapy.[40]

Working knowledge

Working knowledge requires that the resident be familiar with the theoretical principles, empirical research, and indications and contraindications for the psychotherapies discussed below. Assessment of knowledge can be carried out as described in the proficiency section. The resident can then participate as an observer or a co-therapist in order to better understand how these specific therapies are delivered to patients in different situations. Assessment of co-therapist performance can be evaluated in more detail by the supervisor or primary therapist who can observe the resident's performance directly. When assessing the resident's competence as a co-therapist, one needs to consider the training targets in this situation since the resident will not assume primary responsibility for the delivery of treatment. The resident must however learn sufficient skills to assist the primary therapist. Therapeutic skills important to attain for working knowledge at the co-therapist level include general alliance formation skills and those specific to each therapy. The therapies listed below will be discussed in less detail as they do not require attaining proficiency status.

1. Behavioural therapy

Behavioural therapy includes those therapies that developed from learning theory and include relaxation training, systematic desensitization, exposure and response prevention, and others. Components of behavioural therapy (BT) have also been integrated with other treatments such as CBT, DBT, and behavioural marital and family therapy. Behavioural therapies have been successfully used in parent training groups, treating child behavioural problems, mood and anxiety disorders, rehabilitation in chronically ill patients, and many other conditions.[1]

Following didactic seminars, which could be integrated with the CBT section discussed above, residents could either observe therapy being conducted or participate as a co-therapist. This would provide the resident with an opportunity

to observe the key features important to this therapy which include obtaining a baseline, assigning homework, reviewing weekly homework, dealing with homework non-compliance, reinforcing (shaping) approximations to the target goal and evaluating outcome. Assessment of therapist competence in this area could involve using the cognitive therapy scale,[33] as well as assessing the resident's ability to deliver specific behavioural interventions (e.g. obtaining baseline, creating structured activity schedules, assigning homework, reviewing homework, dealing with homework non-compliance and developing hierarchies) to patients with specific psychiatric disorders (i.e. exposure and response prevention in treatment of obsessive–compulsive disorders, relaxation in general anxiety disorders).

2. Dialectical behaviour therapy

Dialectical behaviour therapy, originally developed for patients with borderline personality disorder (BPD), integrates features of cognitive therapy, behavioural therapy and mindfulness to promote emotional regulation, a decrease in parasuicidal behaviour and an increase in adaptive functioning.[41] Empirical research supports the use of dialectical behaviour therapy (DBT) in patients with BPD, as well as in other populations.[42] Didactic seminars should present the resident with basic theoretical concepts of DBT, clinical applications and the empirical literature. For working knowledge requirements, residents could observe ongoing DBT treatment delivered in an individual or group situation, or participate as a co-therapist.

Specific therapist skills to assess include: developing rapport and alliance, delivery of DBT such as describing the model, psychoeducation regarding the disorder, assigning homework, reviewing homework, dealing with disruptive patients in groups that challenge group dynamics, dealing with parasuicidal behaviour, non-compliance as well as other issues. Specific assessment instruments can also be used, including alliance measures and specific measures such as the DBT Expert Rating Scale[41] which can be obtained from Dr.Marsha Linehan. These scales need to be used as tools, keeping in mind that the resident's competence is being evaluated as a co-therapist only.

3. Group therapy

Group therapy involves the delivery of specific treatments to more than one patient at the same time. There are many types of group therapies such as psychoeducation, experiential, psychodynamic, CBT, DBT, IPT and others. Group therapy can be delivered to a wide range of patients suffering from multiple disorders and multiple problems across the lifespan with much fewer resources than individual therapy. There is a significant body of research that supports the use of many group therapies in psychiatry. Some of these include CBT groups for many of the anxiety and mood disorders, IPT groups for adolescents and adults with depression, DBT groups for patients with borderline

personality disorders, social skills training for patients with deficits in this area such as chronic psychotic patients and many others.[8] Group therapy not only delivers specific interventions, it provides a special context that offers patients an additional sense of support from co-patients and, more importantly, a feeling that they are not alone with their problems; a very important active ingredient of any group intervention.[43]

To attain competence at the working knowledge or proficiency level, residents should be familiar with the fundamentals of group principles that are common to all group treatments (e.g. cohesion, universality) as well as the specific treatments available that can be offered in a group format. Residents should also be familiar with the empirical research in this area, indications and contraindications for group treatment, and be provided with opportunities to either observe treatment groups or participate as a co-therapist. In the former, sessions could be videotaped and then presented to residents who can view as an observer after the fact. This will provide residents with an opportunity to assess group dynamics and specific group treatments being delivered.

For proficiency purposes, residents need to participate as the prime therapist or co-therapist with ongoing live or videotaped supervision for at least 16 to 20 sessions. They also need to familiarize themselves more thoroughly with the principles of the specific treatment they are delivering and learn to deal with group dynamics in an experiential manner while in the group, and later in supervision. Supervisors can assess the resident's knowledge base and delivery of therapy with specific markers and also consider using specific instruments to assess group alliances with the therapist.[44]

4. Interpersonal therapy

Interpersonal therapy (IPT) is a structured integrative therapy originally developed for patients suffering from depression. The fundamental assumption in IPT is that the onset, maintenance and recovery of depression is determined by four key interpersonal events: losses, role transitions, interpersonal conflicts and interpersonal deficit. Therapy focuses on integrating a medical model of depression as well as understanding and working through these key interpersonal areas.[45] Empirical research supports the use of IPT for depression in adults, the elderly and adolescents.[46]

To attain competency at the working knowledge level, residents should be familiar with the basic principles of IPT, its application to mood and other disorders, and be familiar with the empirical research in this area. Residents can then go on to either observe therapy in an individual or group format, or participate as a co-therapist. The co-therapist's capacity to form an alliance with the group as well as administer IPT treatment could be assessed using specific markers developed by the supervisors or through the use of specific instruments that were developed for IPT, such as the Therapist Strategy Rating Form.[47]

Introductory knowledge

For purposes of attaining introductory knowledge, residents should be familiar with basic theoretical principles, therapeutic applications in psychiatric populations, and the empirical research base that supports the use of each therapy listed below. Introductory knowledge does not require supervised experience, however, if interested, the resident should be provided with opportunities to explore each area.

1. Brief dynamic therapy

Brief dynamic therapy is a structured, active, goal-focused therapy that is delivered over a shorter time period than long-term psychodynamic therapy, with sessions varying between eight sessions to one year. There are several models of brief dynamic therapy.[48] For introductory knowledge, it is sufficient for residents to be familiar with the different theoretical models and be familiar with how brief dynamic therapy differs from long-term therapy with respect to theory and practice, and when it is indicated and contraindicated. Recent evidence supports the use of brief therapies in a variety of psychiatric disorders, but not as first-line treatment.[49] This is an emerging area and it is important that residents keep up with this literature.

2. Mindfulness training

Mindfulness is not a specific form of therapy, but an ancient Buddhist meditative technique. When practiced frequently, mindfulness produces a state of non-reactivity and detachment from disturbing thoughts and feelings that lead to feelings of depression, anxiety and emotional dysregulation. There are many specific exercises that are considered mindfulness-based. Some of these involve paying attention to the breath, attending to the moment or focusing on an object.[50] Mindfulness training has been incorporated into many treatments such as mindfulness-based cognitive therapy for depression, DBT, the treatment of anxiety disorders and other conditions. For introductory knowledge, residents should be exposed to the basic principles of mindfulness training, its indications for use, and the evidence-base that supports its use in patients with psychiatric disorders.

3. Motivational interviewing

Motivational interviewing (MI) is a specific interviewing technique aimed at assessing a patient's readiness to change to engage in treatment. MI uses an open dialogue to explore whether or not the patient is ready to commit to treatment. The therapist is non-judgmental, empathic and respectful of the patient's state of readiness. Specific client-centred interventions discussed above are used in the interviewing process.[51] For introductory knowledge, it is important that residents understand the basic principles of MI and how this approach can be helpful with all patients as an initial step to engaging in

treatment, and specifically with patients who are more resistant to treatment, such as those suffering from substance abuse disorders. The MI technique can be demonstrated through role-playing or through videotapes demonstrating MI skills with simulated or real patients. MI skills can also be assessed with the Motivational Interviewing Skills Code (MISC).[52]

4. Relaxation

Relaxation techniques have been incorporated in CBT or BT and are used to help patients deal with uncomfortable thoughts or feelings that generate anxiety, depression, pain symptoms, and other distressing physical symptoms. Patients in relaxation training are first taught progressive muscle relaxation or deep breathing exercises. Once these skills are learned they can be applied to any situation when anxiety or discomfort arises. For introductory knowledge, residents should be familiar with the basic principles of relaxation, its connection to behavioural therapy and CBT, indications and contraindications and the evidence that supports the use of these techniques in certain psychiatric conditions.[11]

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The new Royal College requirements for psychotherapy training will likely pose many challenges for programs across the country, particularly if they have limited resources and do not have pre-existing training opportunities in the therapies described above. In departments with limited resources, faculty should be encouraged to pursue training in some of these areas and then, in turn, train their own faculty. Group supervision decreases the need for resources and provides a rich learning experience for residents. Departments should also consider looking outside their departments (psychology, counselling centres, private practice and community) to recruit supervisors. Collaboration with another institution where distance learning methods are used (i.e. webcam supervision) is a creative method of dealing with resource issues.

Regardless of resource issues, some basic principles of training that incorporate evidence-based teaching methods should be followed to ensure that competence is achieved. These include: modelling, rehearsal and feedback in the teaching of therapy skills, audio or videotaping of sessions to encourage the delivery of corrective feedback, and reliable and valid assessment methods for evaluating competence in knowledge and skills. Once these teaching methods are established, specific models or approaches to reach CanMEDS destinations can be followed. Three training models are proposed below, but they are by no means the only models suggested. Different programs may come up with their own approach to reaching each target area.

Developmental training models

A developmental model of training follows a sequence that is in keeping with the psychotherapy training literature which has most experts agreeing that fundamental skills focusing on alliance development should precede the learning of specific skills or therapies, and that the learning of individual therapies should precede the learning of systemic therapies. Therefore training might begin with supportive therapy, then motivational interviewing and crisis intervention; followed by CBT, behavioural, mindfulness, psychodynamic and brief; and then finally, family, group, DBT and IPT. In many cases, therapies requiring only introductory or working knowledge can be integrated with one requiring proficiency (e.g. relaxation and behavioural therapy integrated with CBT). This approach ensures that the resident will gain strong alliance skills early in training before proceeding to more complex skills as training moves through the PGY2 to PGY5 year. This model is easier to organize since didactic seminars and supervision proceed in a step-wise linear progression and can be completed during specific clinical rotations that are best suited for the training.[53]

Clinical placement training models

This approach to training begins with alliance building/supportive therapy and then follows a course that is consistent with the resident's clinical placement. In such a format, training in supportive therapy could begin in inpatient or outpatient rotations, followed by specific individual therapies in general outpatient rotations or specialty (e.g. CBT in mood and anxiety clinics). This could be followed by MI in addictions rotations, family therapy in child psychiatry, and group therapy in general outpatient or specialized clinics. Crisis intervention training is well suited in the ER, and DBT in outpatients or specialty clinics. In such a model, the clinical placements must take an active role in coordinating the training experience and ensure that the resident's progress is evaluated and submitted to a central location.

Mixed models

This model of training incorporates both a developmental sequence with a plan to offer training in placements that are conducive to training in the specific therapy. This requires some guidance in planning so that training can proceed in a logical fashion with some room for flexibility.

Other models

Other models and combinations can certainly be created based on individual differences in programs. For example, family therapy training need not be restricted to child psychiatry rotations, but could also be part of a mood or psychotic disorders rotations where seeing families is an important component

of treatment. Similarly for the child psychiatry resident, training in a specific therapy such as CBT could be carried out in the child psychiatry rotation if supervision is available.

OTHER CONSIDERATIONS

In addition to ensuring that residents are exposed to general psychiatric patients suffering from the most prevalent psychiatric disorders (e.g. mood, anxiety, psychotic), it is important that they have an opportunity to practice specific psychotherapies with special populations such as those suffering from acquired brain injuries (ABI), developmental disorders, eating disorders and other conditions. Psychotherapy in these cases may not be the mainstay of treatment, but specific interventions might offer augmentations to other treatments. An example of this is the use of behavioural interventions to manage behavioural problems in patients with ABI or developmental disorders.

In addition to this, whenever possible, it is important to provide residents with an opportunity to apply their psychotherapy skills in unique situations such as underserviced areas, small communities, native populations and locations where they will have to consider cultural aspects in the delivery of psychotherapy. This will expose residents to unique learning opportunities where they will be able to deliver psychotherapy to a variety of patients, in different situations, and explore the advantages and limitations of each treatment.

Resident learning experiences can also be broadened by exposing them to a wide variety of supervisors. Supervisors and educators in psychotherapy need not be limited to psychiatrists, but should include psychologists, social workers and other medical specialists (such as family physicians), as long as they possess the expertise to teach. This will facilitate a multidisciplinary approach to learning and openness to interacting with teams from different disciplines.

The last few decades have witnessed significant advances in psychotherapy research, with numerous therapies having been found to be effective for patients with psychiatric disorders and psychological problems. The new psychotherapy requirements mandated by the Royal College reflect this research. Although these changes will no doubt pose challenges to educators, it will hopefully result in the training of a more sophisticated general psychiatrist who is able to offer a wide range of integrated treatments to patients suffering from complex psychiatric disorders across the lifespan.

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Chapter 6

Adult psychiatry

Katharine Gillis

INTRODUCTION

Canadian psychiatry residency programs are tasked to train general psychiatrists capable of treating patients across the lifespan. Although general psychiatrists see young adults 20 per cent of the time and seniors 16 per cent of the time,[1] they spend the vast majority of their time addressing the mental health needs of patients aged 25 to 64 years. This is not surprising given the prevalence and impact of mental illness for individuals in this age range.

Major depressive disorder has the highest lifetime prevalence, almost 17 per cent, of any psychiatric disorder.[2] The World Health Organization (WHO) has ranked major depression as the leading cause of years with disability (YDL).[3] The impact on self and family is substantial. The period of risk for the development of many mental disorders is at its peak early in the age range, with 40 per cent developing symptoms in adolescence.

Between 0.6 per cent and one per cent of adults will have a manic episode in their lifetime. WHO has ranked bipolar disorder as the sixth leading cause of YDL.[3] Hospitalization rates for bipolar disorder in general hospital settings are increasing among women and men between 15 and 24 years of age.[4]

Schizophrenia affects one per cent of the Canadian population, and usually has its onset in early adulthood. Fifty-two per cent of hospitalizations for schizophrenia in general hospitals are among adults aged 25 to 44 years. Hospitalization rates for schizophrenia in general hospitals are increasing among young and middle-age men.[4]

General adult psychiatry inpatient training is to occur in the general hospital setting. This is important as 86 per cent of hospitalizations for mental illness in Canada occur in general hospitals. In 1999, 3.8 per cent of all admissions in general hospitals (1.5 million hospital days) were due to anxiety disorders,

bipolar disorders, schizophrenia, major depression, personality disorders, eating disorders and suicidal behaviour.[4]

As the number of blocks dedicated to psychiatry during the PGY1/Basic Clinical Training (BCT) year can vary from one to four blocks, there will be variability across training programs in the clinical knowledge and skills that residents bring to junior residency in PGY2 and PGY3. Additionally, as the goals for training in the BCT year serve important but differing goals than those intending to meet core psychiatry components or longitudinal goals, it must be assumed that junior residency is the first consistent opportunity to begin the integration of biopsychosocial knowledge, skills and attitudes that truly develops the identity of a psychiatrist. Individual program differences and differences among residents in selecting components of the BCT year will complicate the situation further. All of these considerations will need to be reviewed when setting a structure and format for the adult rotation(s) in junior residency. Some rotation variation may be required to meet the differing needs of the cohort.

This chapter outlines how to prepare the junior resident to meet the challenges of senior residency, and develop the exit competencies of a general adult psychiatrist with skills to practice across the lifespan, even though the vast majority of their work will be with 24- to 64-year-olds across a broad spectrum of diagnostic, economic and socio-cultural contexts. The knowledge and skills of the junior resident will be enhanced through the differential experiences and training opportunities in senior residency.

REVIEW OF THE RCPSC OTR/STR/SSA

The following is a consolidation of the relevant Royal College of Physicians and Surgeons of Canada's (RCPSC) Objectives of Training (OTR), Specialty Training Requirements (STR), and Specific Standards of Accreditation (SSA) for general adult psychiatry:

1. Twelve months of general adult psychiatry must occur at some point during PGY2 and PGY3. Roughly equal time must be spent working with patients in accredited ambulatory and general hospital inpatient settings (preferably concurrently). The 12 months can be offered in one continuous block or two six-month blocks. Rotations in adult psychiatry may occur in PGY2 and PGY3.

   Outpatient settings are varied and may include general hospital outpatient clinics, outpatient crisis or urgent care clinics, mobile crisis units, or other community-based ambulatory care settings. Opportunity for broad exposure to patients with many disorders and comorbidities and from a variety of cultural and ethnic backgrounds should occur. Collaborative/shared care may be part of the adult outpatient rotation, but this experience may not

count towards the collaborative/shared care requirement that is to occur in PGY4 or PGY5.

2. Focus during adult outpatient and inpatient rotations should be placed on the introductory skills, which at the outset include learning the etiology, symptoms, course of illness and treatment of the following disorders: anxiety, adjustment disorder, attention-deficit disorder, alcohol and other substance abuse, delusional and other psychosis, dementias, organic brain syndrome/delirium, personality disorders, psychiatric disorders secondary to a medical condition, mood disorders, schizophrenia and disorders of sleep.

   Residents at this stage of training must begin to develop an appreciation, knowledge base and response to many other relevant patient care issues, including normal/abnormal developmental and psychological processes; neurophysiology; principles and practices of psychopharmacology and the psychotherapies (see chapter five); legislative and other relevant health-care regulations (see chapter nine); introductory management concepts; ethical principles and decision making; the role of culture, gender and spirituality; stigma; systems of care and program/outcome evaluation; economic and policy influence; and self evaluation.

To help guide the resident, the following sources are recommended:

Books

- Carlat D. Practical guides in psychiatry — the psychiatric interview. 2nd ed. Philadelphia (PA): Lippincott Williams and Wilkins; 2004. p 316.
- Gelder MG, Lopez-Ibor JJ, Andreasen N. New Oxford textbook of psychiatry. New York (NY): Oxford University Press; 2003.
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- Sadock BJ, Sadock VA. Kaplan and Sadock's comprehensive textbook of psychiatry. 8th ed. Philadelphia (PA): Lippincott Williams and Wilkins; 2004. p 4480.
- Shea S. Psychiatric interviewing: the art of understanding. Philadelphia (PA): Saunders; 1998. p 759.

Journals

- *The Canadian Journal of Psychiatry*
- *American Journal of Psychiatry*
- *Archives of General Psychiatry*
- *British Journal of Psychiatry*

Societies

- Canadian Psychiatric Association
- Royal College of Physicians and Surgeons of Canada
- American Psychiatric Association

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

Residents should achieve introductory knowledge in many aspects of adult psychiatry during PGY1. By completion of the 12-month junior residency rotation in general adult psychiatry, residents should have achieved a level of working knowledge which competently allows them to assess and treat uncomplicated cases of major psychiatric disorders in adults. At the end of PGY3, the resident should have developed a systemic clinical problem approach that allows for the introductory and supervised care of more complex cases.

It is recommended that junior residents in general adult psychiatry focus on the following CanMEDS goals:

1. Diagnostic interview and management

   Residents need to know and develop precise yet flexible and adaptive communication skills that allow for history taking that is patient-centred and sensitive, phenomenologically sophisticated, and driven by a comprehensive nosology. This should lead to an ability to recognize and categorize psychiatric signs and symptoms in the context of gender, age, culture, developmental and spiritual factors leading to a diagnostic hierarchy that can be supported by the collected data. Residents must be able to describe the etiology, clinical features, differential diagnosis and treatment at the level of working knowledge for all major psychiatric disorders including developmental delay.

   A biopsychosocial plan of investigation and treatment must be developed that is consistent with the data and acceptable to the patient, mindful of resources, therapeutic and relevant to the patient's family. Knowledge of best practices should be developed and evidence effectively communicated. This means conveying to the patient an accurate, sensitive, timely, clear and coherent explanation of the diagnosis, investigations, treatment and prognosis.

The resident must be able to assess the suitability for, prescribe and coordinate the delivery of appropriate psychopharmacology and psychological treatment for adult patients, including beginning to deliver individual therapies and, depending on training, family or group therapies (refer to Chapter 5).

2. Interviewing and working with families and community agencies

   The resident must be able to conduct a competent interview of the patients' family where applicable, and with the patient's permission convey to families as well as authorized caregivers and community agencies relevant information in a professional manner.

3. Team work and interprofessional collaboration

   The resident needs to work collaboratively with other members of the health care team, recognizing their roles and responsibilities. They must also contribute to interdisciplinary team activities and convey an attitude of respect and cooperation with other members of the mental health care delivery team.

   The resident should also recognize the need to share responsibility and welcome input from other caregivers on the team, as well as competently address staff concerns, requirements and attitudes to enhance staff morale and effectiveness of the therapeutic milieu.

4. Safety

   The resident must be able to know and recognize risk factors in assessing the patient's dangerousness, and to have knowledge of interventions for suicidal, assaultive, psychotic, intoxicated and disoriented patients.

5. Mental Health Act and competency

   The resident must be able to demonstrate an adequate understanding of the local provincial mental health legislation, including, where relevant, Community Treatment Orders (CTO). Developing familiarity with notions of guardianship, trusteeship, competency, capacity, confidentiality and other legal or forensic matters that pertain to patient rights and their management all begins and develops in junior residency.

   The resident must be able to competently apply mental health legislation, complete the appropriate legal documents, and interact with judicial and other agencies as required in procedures for involuntary hospitalization, declaration of incompetence and consent for treatment. This includes comprehensive risk assessment, including all issues of safety, potential for elopement, need for restriction of ambulatory freedom, the management of patients who resist or refuse treatment, and the requirement for obtaining

general and specific consents for evaluation and treatment from the patient, guardian or next of kin.

6. Electroconvulsive therapy

   The resident needs to have working knowledge of electroconvulsive therapy (ECT), be able to assess a patient for appropriateness of ECT, including side effects and risks/benefits, and to be able to administer ECT under supervision.

7. Discharge planning

   The resident must have knowledge of the procedures and responsibilities for patient admission, maintenance and management on the ward and subsequent discharge. It is also important to be able to estimate approximate length of stay, anticipate disposition difficulties, and be aware of the nature of institutions and community resources providing care for patients who request or require longer stays in general hospitals.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

Residents achieve the goals and objectives of the adult rotation by attending their academic curriculum and working in their clinical rotations. Each of these experiences should enhance the other.

Academic curriculum

Programs across the country vary in how they organize their academic curriculum. In broad terms, consideration could be given to dividing the curriculum into diagnostic interview and management skills (communication skills), medical expert knowledge and skills, and psychotherapy teaching. The academic curriculum in PGY2 and PGY3 should include, but not be limited to, the knowledge, content and skills that residents need in order to achieve the goals and objectives of the general adult psychiatry rotation.

1. The diagnostic interview and management skills

   This is the psychiatrist's most important skill set. The adult inpatient and outpatient rotations offer numerous opportunities for a resident to practice, improve and receive feedback on their interview skills. The diagnostic psychiatric interview should be taught in a methodical way during these foundational years. There are a number of very good books listed under recommended resources to assist this process.[6,7]

   The diagnostic interview and management skills taught during PGY2 should focus on establishing rapport and empathy, attentiveness to

non-verbal communication, diagnostic and safety assessments for the major psychiatric disorders (mood, schizophrenia, anxiety and personality), and working knowledge of the management plan of these disorders. In PGY3, more complicated presentations should be included as well as more sophisticated management plans with more emphasis on formulation. More information on this skill development can be obtained by reading chapter five on the psychotherapies.

It should not be assumed that a resident who picks psychiatry as a career choice has a natural ability to communicate. We should teach communication as a core skill. Residents who have difficulty demonstrating good communication and interviewing skills should be identified very early in training and assisted to improve. When a resident is underperforming in their diagnostic interview skills for their level of training, the use of video recording with feedback, including having the resident assessing themselves, can be very helpful in assisting the resident to improve.

2. Medical expert knowledge and skills

   The academic curriculum should be covering etiology, epidemiology, clinical features, differential diagnosis and treatment of the major psychiatric disorders that occur in adults and for which proficiency is required in the OTR. These include anxiety, adjustment disorder, alcohol and other substance abuse, delusional and other psychosis, dementias, organic brain syndrome/delirium, personality disorders, psychiatric disorders secondary to a medical condition, mood disorders and schizophrenia.

3. Psychotherapy curriculum

   During PGY1 or early PGY2, a resident should be developing working knowledge of supportive psychotherapy and crisis intervention. These skills will be used in their general adult psychiatry rotation as well as in emergency psychiatry clinical work. A resident in PGY3 would be expected to have working knowledge in one or more psychotherapies such as cognitive-behavioural therapy (CBT) or interpersonal therapy (IPT). Programs will vary across the country in terms of the sequencing of when specific psychotherapies are taught. For more detailed information on psychotherapy refer to chapter five.

Clinical rotation

From a clinical teaching services resource perspective, residents seeing patients individually for psychiatric care or psychotherapy in either the inpatient or ambulatory settings need to have access to appropriate and safe space to see the patient.

The amount of direct supervision time in the outpatient setting will vary across the country depending on a number of factors, but in general the resident should receive a minimum of two to eight hours of direct supervision per week. Given the acuity of illness, daily availability of the supervisor (or designate) is important in the inpatient setting.

1. The clinical setting and patient assignment

   Both the inpatient and outpatient settings can provide broad exposure to major psychiatric disorders. Residents and supervisors need to ensure that in both settings residents are assigned an appropriate selection of patients. Particular efforts should be given to exposure to the required diagnoses in which residents must achieve proficiency by the end of their residency.

   For optimal learning, the program should provide residents and supervisors with a guide for the minimum number of diagnostic disorders, psychopharmacology and procedural experiences a resident should obtain while on inpatient and outpatient rotations. Such a guide could enhance the educational experience. When residents and supervisors are unable to meet the recommendations, it should not be a reason for a resident to fail a rotation or to be held back. In such circumstances, details as to why the recommendations could not be met should be provided.

   An example of such a guide is provided in Table 6.1 Inpatients and Table 6.2 Outpatients. A number of the disorders listed in the table are included because they have a significant lifetime prevalence and proficiency level is required by the OTR. These would include major depression with a 17 per cent prevalence; anxiety disorders, which as a group represents the most common group of disorders in psychiatry (30.5 per cent prevalence for women and 19.5 per cent for men); and substance abuse and addiction, which has a very high prevalence rate, is more common in men than women, and with up to 50 per cent of individuals with addictions having a comorbid psychiatric disorder.[2]

   While schizophrenia and bipolar disorder each affect about one per cent of Canadians, they make up a large proportion of admissions to general hospital psychiatry outpatient and inpatient units.[3] It is therefore important that residents are familiar with both antipsychotic and mood stabilizing medications and management. The STR states that exposure to patients with developmental delay must occur in junior residency. Developmental delay is thus included in the recommendations. The procedural and clinical experiences suggested are all based on the OTR document and meant to highlight opportunities that are available on the adult rotation.

   The resident and/or staff could track the number of patients in each diagnostic category. This process can be facilitated by the resident using a log to keep track of the number of patients seen and managed with a

Table 6.1 Recommended guidelines for residents on the adult inpatient rotation

Disorders/symptoms	Minimum patients, *n*
Borderline personality disorder (primary or comorbid)	2–3
Developmental disorder or acquired traumatic brain injury	1–2
Major depression	6
Mania	2–4
Psychosis	6
Substance abuse, excluding nicotine (primary or comorbid)	6
Psychopharmacology clinical experiences	
Start a mood stabilizer, such as lithium or valproic acid, and monitor blood work and side effects.	2–4
Manage acute side effects from antipsychotic medication (not to include neuroleptic malignant syndrome).	4
Start clozapine. Complete the initiation and monitoring protocol.	1
Procedures/Clinical experiences	
Administer ECT with supervision (either 1 patient for the full course or 10 individual ECTs). Some programs may choose to have the ECT experience occur on the geriatric rotation and not during the adult inpatient rotation.	
Observe 2 consent and capacity board hearings. Actively participate in 1 hearing.	
Conduct 4–5 family meetings, after attending or observing such meetings.	
In provinces where community treatment orders (CTO) are in place, follow 1–2 patients starting on a CTO or already on one.	

specific diagnosis and sharing this log with the supervisor and program director. This information can be used during the assignment of new patients so that the resident, where possible, is preferentially assigned patients from diagnostic categories that they have not yet seen. These patient clinical experience logs completed by residents on the adult psychiatry rotation can be useful data for accreditation purposes.

a. Adult inpatients

Clinical experiences with adult inpatients needs to occur in an accredited general hospital setting that can provide patients with a range of diagnoses. The number of inpatients assigned to a junior resident at one time will vary from program to program. The inpatient

load that a junior resident carries should be lower than that of a senior resident. Other factors that need to be considered in assigning volume is the acuity/complexity of patients, availability of supervisor, number of beds that a specific supervisor has and whether or not it is a split inpatient/outpatient continuous rotation. A beginning PGY2 would be potentially expected to carry fewer patients than a resident in the latter part of PGY3. While assigned volume can vary, it is recommended that supervisors and residents be advised by their program of the expected inpatient volume the resident should carry so that consistency can be achieved. Given the above factors, a junior resident may carry between three and seven inpatients at a time. More details are provided in Table 6.1.

b. Adult outpatients

The adult outpatient rotation can occur in a variety of accredited settings, including a general hospital outpatient clinic, outpatient crisis or urgent care clinic, a mobile crisis unit or another community-based ambulatory care setting. Because the opportunity for broad exposure to patients with many disorders and comorbidities and from a variety of cultural and ethnic backgrounds should occur, residents should not be placed in subspecialty clinics. A resident may work in more than one setting during the rotation. Collaborative/shared care may be part of the adult outpatient rotation, but this experience may not count toward the collaborative/shared care requirement that is to occur in PGY4 or PGY5.

A resident is expected to do a minimum of 30 to 35 new assessments while on the adult outpatient rotation. The lower range is recommended for early PGY2 and the higher range for late PGY3. Residents are expected to follow some but not all of these new assessments, as treatment disposition will be variable. Residents are expected to follow some patients they did not initially assess. More details are provided in Table 6.2.

2. Diagnostic interview and management skills

During the adult inpatient and outpatient rotations, residents should be provided with opportunities for their supervisors to assess and give formative feedback on their diagnostic interview and management skills. Intrinsic to the diagnostic interview skill set is the capacity to develop empathy and rapport. For the early PGY2 resident, focus and feedback on their capacity to do this should occur. Supportive therapy and principles of crisis intervention can be taught, modelled and assessed at a very early stage of residency, especially in the inpatient milieu. A resident in PGY3 would be expected to be working on more sophisticated communication skills and

Table 6.2 Recommended guidelines for residents on the adult outpatient rotation

Disorders/symptoms	Minimum patients, *n*
Adjustment disorder	4–5
Anxiety disorders (primary or comorbid): generalized anxiety, obsessive–compulsive, social phobia and/or posttraumatic stress disorder	3
Bipolar disorder	2–3
Borderline personality disorder (primary or comorbid)	1
Developmental disorder or acquired traumatic brain injury (if available)	1
Eating disorder (primary or comorbid), if available	1–2
Major depression	4–5
Schizophrenia and schizoaffective disorder	4–5
Substance abuse, excluding nicotine (primary or comorbid)	4
Psychopharmacology clinical experiences	
Start a mood stabilizer, such as lithium or valproic acid, and monitor blood work and side effects.	1–2
Follow a patient on a mood stabilizer such as lithium or valproic acid.	1–2
Manage acute side effects from antipsychotic medication (not to include neuroleptic malignant syndrome).	2–4
Manage metabolic and chronic side effects of antipsychotic medication.	5
Follow a patient on long-acting intramuscular antipsychotic medication.	3
Follow a patient on clozapine.	1

continued

Table 6.2 continued

Procedures/clinical experiences
Follow 5–10 patients using supportive psychotherapy (can be in addition to medication management).
Follow 6–7 patients using crisis intervention principles.
For PGY3 (and higher), manage 4–6 patients applying CBT or IPT skills (can be in addition to medication management).
Self- and clinician-administered rating scales (e.g. Montgomery Asberg Depression Rating Scale [MADRS], Hamilton Rating Scales for Depression and Anxiety [HRSD and HRSA], Yale Brown Obsessive-Compulsive Scale [Y-BOCS], Beck Depression Inventory). Use one scale to follow a patient with a mood disorder (e.g. MADRS, HDRS) and one scale to follow a patient with an anxiety disorder (e.g. HRSA, Y-BOCS).
Perform and document an Abnormal Involuntary Movement Scale (AIMS) examination on 2 patients.
Follow 1 patient on a Community Treatment Order (CTO) in provinces where CTOs are in place.

psychotherapies. In order for a supervisor to give meaningful formative feedback on psychotherapy skills, he/she needs to be aware of the psychotherapy curriculum and psychotherapy knowledge and skills expected for specific years of training.

Watching a full interview is not the only method of giving valuable formative feedback to a resident on their diagnostic interview skills. Supervisors should be encouraged in either setting to observe parts of an interview and provide formative feedback. Examples could include observing a resident on their capacity for establishing rapport and empathy, screening for mood disorders, performing a safety assessment or providing psychoeducation regarding medication to a patient. This approach can be easily worked into the clinical setting. Programs are encouraged where possible to provide supervising staff with an assessment tool to assist this process. For further reading regarding assessment refer to Chapter 16 on evaluation.

An example of an assessment tool for the full interview is the RCPSC Oral Examination Score Sheet for Psychiatry.[6] If not observing a full interview, the relevant portion of this assessment sheet could be used or programs could develop their own shorter versions. One of the advantages of using an assessment tool is that it guides the supervisor in a more standardized

fashion; the completed sheet can be given to the resident, or kept in the resident's file. Programs can decide whether the assessment sheets are given only to the residents with documentation that the process occurred, or if the original sheets are retained with the resident's In-Training Evaluation Report (ITER).

Programs will have increasing accountability during the Royal College accreditation process in order to show that residents are assessed on their ability to demonstrate that they have achieved the expected skills. One approach to documenting interview and assessment skills on the general adult psychiatry rotation is to ask the supervisor to record the estimated number of full and partial interviews that they observed and on which they provided formative feedback. This information can be incorporated into the adult psychiatry rotation specific ITER.

3. Safety, including emergency care, quality assurance, morbidity and mortality

   Many patients referred to either adult inpatient or outpatient settings come from the emergency room. While there is no discrete mandatory psychiatry emergency rotation, experiences in emergency care are woven throughout the residency, with relatively more frequent on-call duties occurring during PGY2–PGY3.

   The goals and objectives for emergency psychiatry include:

   a. Capacity to perform assessments in acute situations and make management decisions in a timely manner.

   b. Ability to perform a safety assessment of a patient's risk of self-harm or harm to others.

   c. Ability to communicate clearly with patients, families and emergency interdisciplinary team members in the acute care setting.

   d. Ability to implement techniques of non-violent crisis intervention when necessary.

   e. Ability to use seclusion and restraint management when necessary.

   f. Identify and manage situations requiring medical intervention such as drug and alcohol intoxication, overdose and withdrawal, and acute delirium.

   Inpatient rotations and outpatient rotations need to reinforce the teaching of this emergency care skill set and give formative feedback to residents on their ability to demonstrate these goals and objectives. The core curriculum should provide instruction in safety and crisis intervention during these foundational years.

Assigning residents the patients they have already assessed in the emergency room can help achieve continuity of care and an appreciation of the long-term and rehabilitation factors often associated with psychiatric illness. The resident should, where possible, follow the same patient in the outpatient unit. This is easier to facilitate when the adult rotation is done as one continuous and concurrent 12-month block.

By completion of training, psychiatry residents will need to be proficient in contributing to the enhancement of quality care and patient safety in psychiatric practice, integrating the available best evidence and best practices. This is highly relevant to adult inpatient settings. Residents could be encouraged to consider doing a quality assurance project or presentation based on the rotation experience such as morbidity and mortality case rounds. Presentation of rounds that are case-based, including issues of morbidity and mortality, and meant for multiple learners during the general adult rotation can meet some of the CanMEDS *scholar* role expectations. Residents should receive feedback on their presentations. This feedback can be facilitated by having attendees complete a feedback sheet for the resident.

4. The Mental Health Act and competency

   Completion of Mental Health Act forms for clinical care can occur in both inpatient and outpatient settings. Supervisors can review and give feedback. Residents on the inpatient unit can be provided with opportunities to become very familiar with their provincial Mental Health Act. Having the resident involved in review boards should occur when possible as this can be a valuable learning and working experience for the *advocacy* and *manager* roles.

5. Electroconvulsive therapy

   Most inpatient settings can provide an opportunity for learning about and participating in the delivery of ECT. This should be a documented learning experience, which is included in the general adult rotation In-Training Evaluation Report (ITER). The resident can also include ECT experiences in their learning log where applicable. Supervision with formative feedback on ECT administration does not need to be done specifically by the rotation supervisor.

6. Discharge planning and written documentation

   Formative feedback should be given on admission, progress and discharge notes for inpatients and on the initial consultation report, progress notes and discharge letters for outpatients. Discharge plans should demonstrate knowledge and appropriate use of community services, as well as

appropriate liaising with family physicians and/or community psychiatrists.

The use of an assessment tool for evaluating the quality of a resident's written documentation is advisable. A written documentation assessment tool would supply a framework for supervisors to provide feedback to residents and help them learn what is expected in terms of quality written documentation. A small number (one to five) of resident admission, progress or discharge notes could be assessed by the supervisor using this tool while the resident is on the adult rotation. Programs can decide whether the assessment sheets are given only to residents, with documentation that the process occurred, or if the sheets are retained with the residents' ITER.

7. Teamwork

It is recommended that the supervisor assess and give verbal feedback to the resident on how effectively they work with the treating team. This can also be documented in the ITER at the midpoint and end of rotation. Feedback from multidisciplinary team members, where possible, should be incorporated into the evaluation process. A 360-degree assessment tool could be used for this. Programs can decide whether the 360-degree assessment sheets are given only to residents, with documentation that the process occurred, or if the sheets are retained with the residents' ITER.

8. Assessment of family interactions

Observation with formative feedback on interactions with family members can be done by the rotation supervisor or by other mental health care professionals on the inpatient or outpatient services. It is recommended that verbal feedback be given in a timely manner where possible. Written feedback on family interactions can be incorporated into the mid and end of rotation ITER by the supervisor.

9. In-Training Evaluation Report

At the mid and end point of the inpatient and outpatient general adult psychiatry rotations, written evaluation of the trainee (ITER) and feedback on his/her rotation should be discussed in a meeting with the primary psychiatry supervisor (and other supervisors where relevant and possible). The ITER should be anchored in the CanMEDS roles and should be specific to the general adult inpatient and outpatient rotation. Residents and supervisors should be encouraged to book specific times in their mutual calendars at the beginning of the rotation for feedback meetings to occur at the mid and end point of the rotation.

OTHER CONSIDERATIONS

As psychiatry training programs become more explicit in what is expected in terms of the knowledge and clinical skill set of residents at specific levels of training, they will be able to improve their ability to accurately assess and give relevant feedback to residents. A core curriculum that is sequentially-based, teaching foundational principles first then building towards more complexity, is central to achieving this.

Optimal learning can occur when the clinical work and clinical supervision puts the curriculum learning into practice. Each element should reinforce the other. The rotation supervisor and residents should be aware of where a resident is at in the curriculum learning, what they already should know, and what they are expected to learn. Such awareness can assist a supervisor to provide more accurate assessment and feedback to residents who are at different levels on the rotation such as early PGY2 versus late PGY3.

A resident on the general adult psychiatry rotation may have one or more supervisors. When there is more than one supervisor, it is important that they communicate with each other regarding the resident's progress and that it is clear which supervisor is responsible for evaluation completion, or if both are responsible. Residents can find it difficult when there are too many supervisors on a clinical rotation as there is less continuity. The number of supervisors should be limited to one or two; this is separate from the psychotherapy supervisor.

The rotation supervisor role models all aspects of patient care. Residents learn from observing their supervisors at work. This is particularly true on the inpatient rotation where residents will observe their supervisor in the clinical setting on a daily basis. Supervisors should be assessing residents in action, "on the fly" and "at the bedside,"and providing specific teaching tips in the clinical setting. Organized sit-down supervision should also regularly take place, particularly in the outpatient setting. This is an opportunity for the resident and supervisor to meet and review the diagnosis and management of cases, as well as an opportunity for the supervisor to observe the resident doing full or partial interviews.

The amount of time a supervisor meets personally with the resident in the outpatient adult setting will vary. In general, a resident in early PGY2 should have more direct supervision time. The range for direct case and indirect case supervision in the outpatient setting is two to eight hours per week. This can be from a primary supervisor, or split between a primary and secondary supervisor, on the adult outpatient rotation. Given the acuity of illness in the inpatient setting, daily availability of the supervisor (or designate) is important.

Residents in junior residency can also be supervised by residents in senior residency and/or fellows in both the inpatient and outpatient general adult settings. Multidisciplinary team members are also important resources for resident learning and assessment.

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Chapter 7

Child and adolescent psychiatry

Margaret Steele, John S Leverette and Ruth Russell

INTRODUCTION

The teaching and learning of child and adolescent psychiatry (CAP) is a foundational and fundamental component of residency education in general psychiatry. In the Canadian context, the goals of psychiatric postgraduate education focus on the assessment and treatment of patient and family across the lifespan. The aim of this chapter is to examine and recommend approaches to guide medical educators who direct the general psychiatry educational expectations and experiences with respect to CAP.

The medical discipline of CAP attends to pediatric patients and their families within the context of home, school and community. “Childhood” spans the pregnancy and birth period through to the teen years and in some instances young adulthood. CAP focuses on the development of ability and the attendant disturbances in cognition, emotion and behaviour that may occur, which influence the child’s bio-psychosocial, cultural and spiritual development. This understanding guides the formulation of the role of both nature and nurture in the evaluation and management of psychiatric symptoms and disorders in children, adolescents and their families.

The 1987 Ontario Child Health Study (OHCS),[1] a community survey of more than 3,000 children aged four to 16 years, demonstrated a prevalence rate of emotional and behavioural disorders in one out of five children. The common child psychiatry disorders are attention-deficit hyperactivity disorder (ADHD), learning disorder, oppositional defiant disorder, conduct disorder, anxiety disorder, mood disorder, substance abuse (alcohol, drug) and pervasive developmental disorder (Appendix 7A). Suicide is the second leading cause of death in youth aged 15 to 19 years.[2] Comorbidities are present in more than two-thirds of pediatric patients who have a psychiatric disorder. The most

common chronic and persistent mental illnesses (e.g. depression, schizophrenia) tend to show initial symptoms during the post-puberty years of ages 10 to 15.

A major barrier to treatment is the lack of available child and adolescent mental health professionals. The OCHS found that less than one in six children had been seen by any mental health or social service in the previous six months. The numbers of child and adolescent psychiatrists, both current and projected, cannot fully address the mental health treatment needs of children and adolescents. With this shortage, general psychiatrists need to achieve core competencies in child and adolescent mental health and illness in order to provide care to patients across the lifespan and meet societal service expectations. It is anticipated that the generalist training model, with electives and selectives that can be devoted to CAP, will enhance the expertise of the pool of generalists assessing and treating patients in the childhood age span.

Junior residents will begin their postgraduate CAP education with variable prior knowledge, skills and experience about the physical, emotional and developmental needs of the child, family functioning and the impact of medical, surgical and psychiatric illness on pediatric patients and families. Undergraduate medical education in CAP differs widely across Canada. The PGY1 CAP relevant experiences may have included blocks in family medicine, paediatrics or its subspecialties, or in CAP.

Residents can expect to receive education in a variety of hospital and community-based settings where child and adolescent psychiatry patients are commonly seen. These may include CAP inpatient services, non-medical residential services, and pediatric or adolescent medicine inpatient services. Ambulatory direct or consultative education may be experienced in CAP outpatient clinics or day treatment programs, outpatient pediatric services, and program consultations to schools, correctional programs or child, adolescent and family mental health services such as residential services, group/foster home, or community-based children's mental health agencies.

Within the junior residency (PGY2-3), the goal of the six months of mandatory CAP experience is to provide a curriculum and clinical/academic experience so that residents will:

1. Achieve competence levels required to assess and manage common psychiatric problems presenting in CAP.

2. Evaluate and determine the relative contributions of both genetic and environmental factors (nature/nurture) that will facilitate and enhance the assessment, formulation and management of adult psychopathology through prospective experience with children, adolescents and their families.

At the completion of core CAP education, residents will:

1. Interview and assess pediatric psychiatry patients and their families, ably and comfortably.

2. Integrate information and formulate understanding of pediatric patients and families in order to plan relevant CAP-specific interventions.

3. Acquire required skill levels in delivering child/family psychological and pharmacologic treatments.

4. Communicate verbal and written findings and recommendations to children, in an age-appropriate way, and to their families and professionals.

5. Work skilfully with interdisciplinary teams in clinical settings, schools and community agencies.

To help guide the resident, the following sources are recommended:

Textbooks

- Lewis M, editor. Child and adolescent psychiatry: a comprehensive textbook. 4th ed. Philadelphia (PA): Lippincott Williams & Wilkins; 2007.
- Stubbe D. Child and adolescent psychiatry: a practical guide. Philadelphia (PA): Lippincott Williams & Wilkins; 2007.
- Dulcan MK, Weiner JM, editors. Essentials of child and adolescent psychiatry. Washington (DC): American Psychiatric Publication Inc; 2006.

Journals

- *Journal of the American Academy of Child and Adolescent Psychiatry*
- *Journal of Child Psychology and Psychiatry and Allied Disciplines*
- *Journal of Child and Adolescent Psychopharmacology*
- *Journal of the Canadian Academy of Child and Adolescent Psychiatry*

Societies

- American Academy of Child and Adolescent Psychiatry www.aacap.org/index.ww
- Canadian Academy of Child and Adolescent Psychiatry www.cacap-acpea.org
- European Society for Child and Adolescent Psychiatry www.escap-net.org
- International Association for Child and Adolescent Psychiatry and Allied Professions www.iacapap.org

REVIEW OF THE RCPSC OTR/STR

The Royal College of Physicians and Surgeons of Canada (RCPSC) Specialty Training Requirements (STR) in Psychiatry 2007 provides for six months devoted to the care of the child/adolescent and their family within the PGY2–PGY3 junior residency. The one continuous block or two three-month blocks must be structured to include exposure to all developmental levels and ages in both inpatient/residential settings and ambulatory settings. The PGY4–PGY5 senior residency provides for six months each of selectives and electives. These selectives and electives include CAP options. The six-month selective experience is preferably undertaken in one of the designated content areas, but may be comprised of two experiences of no less than three months each. The six-month elective experience, to be approved by psychiatry residency program committees, may include CAP-related psychiatric practice and research, and/or experiences in relevant branches of medicine such as, pediatrics, adolescent medicine, pediatric neurology or developmental pediatrics. More than one of these practice areas may be chosen, but each must be a minimum of two months in duration. Up to six months of CAP selective and elective experiences may occur at other approved centres in clinical/academic opportunities not consistently available in all residency programs, e.g. CAP substance abuse. Supervised experience in evidence-based psychotherapies may focus on children and adolescents for concurrent and longitudinal training.

The RCPSC Objectives of Training (OTR) in Psychiatry 2007 specify that all of the CanMEDS roles are to be learned and practised in the provision of patient-centred care across the lifespan and in a number of settings, including hospital inpatient, outpatient and the community. Within the medical expert role, a number of consultant skills extend to the child and adolescent population and the OTR should be reviewed for these. The psychiatrist will develop lifespan competencies in the care of children and adolescents that will not be to the level of the CAP subspecialist. Working knowledge is required for most lifespan disorders when presenting in childhood (e.g. anxiety disorders where terminal competencies on completion of training are at the proficient level for adults), except for ADHD, which requires a proficient level across the lifespan. For specific disorders first identified in childhood, e.g. pervasive developmental disorder, working knowledge competency is required. Similarly, assessment competency and the use of prevention and therapeutic interventions endorse a lifespan approach that includes childhood and adolescence. The remaining CanMEDS roles also embrace the lifespan, but, as with aspects of the medical expert role, they do not identify aspects of the role that may have particular facets that need to be emphasized for children, adolescents or families. The

training targets in this chapter will elaborate the CAP-specific aspects of the CanMEDS roles.

The RCPSC Specific Standards of Accreditation (SSA) for Residency Programs in Psychiatry 2007 require an adequate volume and variety of inpatients and outpatients for each resident to develop skill in the diagnosis and management of CAP disorders, opportunities for consultations to schools and community agencies, and opportunities for long-term treatment of children with developmental delay in child and adolescent clinics.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

Psychiatry residents must complete six months of training in child and adolescent psychiatry and the 16 Canadian medical schools with postgraduate programs can provide this educational experience. Those wishing to gain added competencies can complete electives and selectives directed to children, adolescents and their families.

This section should be read in conjunction with the RCPSC OTR. It describes the core competencies listed in the OTR pertaining to CAP. It shows where differences occur in CAP competency levels from terminal competencies for the psychiatrist (e.g. sections 3 and 4, where proficiency is required in the treatment of adults but only working knowledge is necessary in CAP to achieve ability to practice across the lifespan). The numbering and some wording indicated in bold in this section follow the RCPSC OTR document for psychiatry.

Medical expert

The medical expert competencies for the general psychiatrist as they pertain to children and adolescents extend from preschool to adolescent individuals and their families.

Key and enabling competencies: psychiatrists are able to . . .

1. **Function effectively as consultants, integrating all of the CanMEDS roles to provide optimal, ethical and patient-centred medical care for CAP patients and their families.**

    1.1. Demonstrate effective use of all CanMEDS competencies relevant to CAP for the general psychiatrist.

    1.2. Identify and appropriately respond to relevant clinical issues arising in patient care including:

- Development and its deviations in children and adolescents, including relevant aspects of neurosciences (e.g. physiology, neuroanatomy, neurochemistry, genetics).
- Evidence-based understanding of normal and abnormal psychology.
- Effects on children of family dysfunction or disruption, including divorce, parental illness and loss.
- Legal and forensic matters pertaining to children and youth arising under legislation (e.g. provincial legislation in Ontario concerning the Child and Family Services Act, Children's Law Reform Act, Young Offenders Act, and Mental Health Act, including legislation pertinent guidelines and literature concerning neglect and verbal/physical/sexual abuse of children).
- Mental retardation either as a primary or a comorbid condition in CAP patients.
- Similarities and differences, continuities and discontinuities between child and adult psychopathology.

2. Establish and maintain clinical knowledge, skills and attitudes appropriate to their practice.

2.1. Acquire evidence-based knowledge (assessment, diagnosis and treatment) to develop competence in the provision of CAP in hospital and community settings.

2.1.1. Be **proficient** in the following CAP competencies:

- Etiology, symptoms, course of illness and treatment of the following Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, disorder:
  - ADHD

2.1.2. Have a **working knowledge** of the following:

- Etiology, symptoms, course of illness and treatment of the following DSM-IV disorders: (alphabetical order)
  - adjustment disorders
  - anxiety disorders (e.g. generalized anxiety disorder, specific phobia, posttraumatic stress disorder, obsessive–compulsive disorder)
  - delirium
  - delusional disorders
  - developmental disabilities including mental retardation

- disruptive behaviour disorders (e.g. conduct, oppositional defiant)
- early onset psychoses (including early onset schizophrenia and early onset bipolar disorder)
- eating disorders (e.g. anorexia nervosa, bulimia nervosa)
- learning disorders (e.g. reading, mathematics)
- mental disorders due to a general medical condition
  mood disorders (e.g. major depressive disorder, bipolar disorder)
- pervasive developmental disorders (e.g. autism spectrum disorders)
- suicidal and self-harm behaviour
- substance-related disorders (e.g. alcohol, marijuana, other)
- tic disorders (e.g.Tourette's disorder)
- V codes (e.g. academic problem, acculturation problem, anti-social behaviour, bereavement, borderline intellectual functioning, identity problem, malingering, noncompliance with treatment, phase of life problem, problems related to abuse or neglect, relational problems, religious or spiritual problem)

2.1.3 Have an **introductory knowledge** of the following:

- Etiology, symptoms, course of illness and treatment of the following DSM-IV-TR disorders:
  - attachment disorders
  - communication disorders (e.g. expressive disorder, mixed receptive–expressive language disorder, stuttering)
  - elimination disorders (e.g. enuresis, encopresis)
  - motor skills disorder (e.g. developmental coordination disorder)
  - sexual disorders
  - sleep disorders
  - somatoform disorders (i.e. unexplained medical symptoms)

3. Perform a complete and appropriate assessment of a patient.

3.1 Have the following competencies at the **working knowledge** level:

- Demonstrate the ability to assess, diagnose and treat common mental health problems in children and adolescents.
- Establish and maintain rapport and an effective working relationship with child and adolescent patients and their families/caregivers.
- Conduct and organize an appropriate interview with children, adolescents and families (or authorized caregivers) taking into account biological, developmental, psychological, social, cultural, spiritual and family factors.
- Perform an age-appropriate mental status examination.
- Conduct acute risk assessments during psychiatric emergencies.
- Minimize risks and discomforts to patients while proceeding with assessment and treatment skills.
- Integrate and present an oral and written biopsychosocial understanding of the child or adolescent patient.
- Integrate an understanding of the child or adolescent patient with assessment of family functioning.
- Acquire competence in ordering appropriate investigations and consultations with allied health professionals as required.
- Integrate information from other sources (e.g. medical chart, teacher reports, standardized questionnaires, neuropsychological testing, and information from other professionals).

3.2 Demonstrate **working knowledge** in effective clinical problem-solving and judgment to address patient problems and to generate differential diagnosis and management plans through interpreting available data and integrating information.

4. Use preventive and therapeutic interventions effectively.

4.1. Demonstrate **working knowledge** in implementing an effective management plan in collaboration with child and adolescent patients and their families:

4.1.1 Developing and implementing an integrated biopsychosocial treatment plan, including psychosocial interventions and medications for acute stabilization during psychiatric emergencies, referring appropriately to a variety of intensive service settings and the

involvement of non-traditional mental health providers (e.g. schools, day cares, after-school programs) in assessment or referral.

4.1.2 Demonstrate **working knowledge** in assessing suitability for, prescribing and delivering appropriate psychological treatments for children and adolescents including:

- cognitive-behavioural
- crisis intervention
- family
- psychodynamic
- supportive
- patient and family education (This is especially important in CAP as the majority of children and youth live with their families. The patient and family receive education about the mental health/illness to help the child's compliance to treatment and outcomes)

4.1.3 Demonstrate **introductory knowledge** in assessing suitability for, prescribing and delivering appropriate psychological treatments to children and adolescents including:

- behavioural
- dialectic behavioural
- group
- interpersonal

4.1.4 Demonstrate **working knowledge** in assessing and managing treatment of emergent side effects for children and adolescents in each of psychopharmacological, somatic and psychological therapies.

4.1.5 Demonstrate **working knowledge** in assessing and managing treatment adherence.

Communicator

Key and enabling competencies: psychiatrists are able to . . .

- Establish developmentally-appropriate therapeutic relationships with CAP patients and their families/caregivers.
- Demonstrate ability to convey to children, adolescents and families (or authorized caregivers) an accurate, sensitive, clear and coherent account of the diagnosis, treatment plan and prognosis in a timely manner.

Collaborator

Key and enabling competencies: psychiatrists are able to . . .

- Provide clinical care for children and adolescents and their families cooperatively with primary care physicians and pediatricians in a "shared care" relationship.
- Collaborate with other relevant professionals, recognizing their roles and responsibilities, in order to effectively evaluate and manage CAP patients and their families.

Manager

Key and enabling competencies: psychiatrists are able to . . .

- Demonstrate knowledge of relevant community resources pertaining to children, adolescents and families/caregivers; and show ability and readiness to direct patients to those resources.

Health Advocate

Key and enabling competencies: psychiatrists are able to . . .

- Contribute effectively to improved health of CAP patients, their families/caregivers and communities.
- Demonstrate awareness of structures of governance in mental health care as pertaining to CAP (e.g. programs, regional/local services)
- Demonstrate awareness of the major regional, national and international advocacy groups which are active in child and adolescent mental health matters.
- Participate in advocacy for the rights of vulnerable child and adolescent patients in a variety of settings.
- Demonstrate adequate understanding of systems-based care services available (e.g. child welfare, adoption, foster care, rehabilitation services).

Scholar

Key and enabling competencies: psychiatrists are able to . . .

- Access and critically appraise current medical/psychiatric/theoretical knowledge about evaluation and intervention in CAP.
- Develop, implement and monitor an individualized and personal medical education strategy pertaining to CAP.

Professional

Key and enabling competencies: psychiatrists are able to . . .

- Demonstrate collaborative and respectful relationships with children, adolescents, and their families/caregivers that include awareness of distinct age, gender, cultural and spiritual factors.
- Demonstrate attitudes consistent with respect, interest, understanding, empathy, compassion and caring for the pediatric psychiatry patient and their families/caregivers in all patient contacts.
- Demonstrate an understanding of issues related to CAP patients and their families/caregivers in relation to access to medical records.
- Demonstrate an understanding of the regulations, and a capacity to apply them, pertaining to access by children, adolescents, parents or others (e.g. school, youth protection) to the child/youth patient's health record.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

Clinical settings

During the mandatory six months of CAP in junior residency, it is important that residents complete this experience in both inpatient/residential and outpatient settings. The resident could complete all six months in one placement if they had exposure to inpatient/residential and outpatient/community settings simultaneously. The ability to provide such an integrated six-month experience may be more easily obtained in some of the smaller programs. Where an integrated rotation is not possible, it is recommended that the resident spend three of the six months in inpatient/residential programs and three months in an outpatient/community setting. The inpatient program refers to a hospital-based program in an acute care hospital or tertiary care hospital setting. A residential program refers to a setting where children and adolescents with mental health problems are assessed and treated therapeutically under the supervision of a child and adolescent psychiatrist.

Outpatient settings may include outpatient clinics in a hospital, clinics in a children's mental health agency, or clinics in a shared care program. In these settings, the resident must be supervised by a child and adolescent psychiatrist.

In emergency CAP, residents should have experience in the emergency assessment and management of children and youth under the supervision of a child and adolescent psychiatrist. In support of lifespan practice, residents may have the opportunity to undertake emergency CAP integrated with adult/geriatric emergency call throughout their entire residency. In other

programs, the resident may have regular on call CAP emergency limited to their six months of CAP.

The more settings that the resident can experience without fragmentation of the educational experience, the more rich and true to contemporary practice the training will be.

Patient assessments, followup and supervision

The training requirements will be most easily achieved if the resident actively undertakes new supervised assessments and receives direct supervision on a weekly basis to discuss recent literature, cases and other clinical or academic aspects of CAP. Ideally, the resident could have an academic supervisor and a clinical supervisor. The following guidelines are for minimum expectations of direct patient contact and are derived from all aspects of the resident's supervised practice, including CAP on call experiences, consultations, new assessments and followup visits across all settings.

Guidelines for minimum expectations are on average no less than:

- one new assessment per week, performed and documented by resident and observed by a CAP
- inpatient-follow four cases per week
- outpatient-follow eight cases per week
- one hour of supervision per week by CAP supervisor for clinical and academic topics

Residents will advance in competency at different rates. Programs may consider an initial minimum of 10 new assessments observed by a CAP supervisor with an evaluation pertaining to competency attained. Decisions as to whether the resident needs to be observed in every assessment would be based on graded responsibility and influenced by competency and the nature of the case. CAP supervisors can continue to participate by joining the assessment at the conclusion and feedback point. In such situations, it remains useful to continue at least one observed assessment per month to measure resident progress.

Patient numbers by age range

It is important that the resident see a balance of pre-pubertal children and adolescents over the six months of junior residency. Emphasis is on adolescents since the majority of general psychiatrists are more likely to see adolescents, but some exposure to pre-pubertal and preschool aged children will encourage the life span approach.

Guidelines for minimum expectations:

- pregnancy to five-year-olds: two patients (these patients may be seen in early intervention programs, preschools, outpatient clinics);

Table 7.1 Patient numbers by diagnostic category

Diagnosis	Minimum patient number
• ADHD	20
• Anxiety disorder	10
• Conduct disorder	15
• Developmental disabilities:	
- birth to 12-years-old	2
- 13- to 17-years-old	2
• Learning disorder	10
• Major depressive disorder	10
• Oppositional defiant disorder	15
• Pervasive developmental disorder	5
• Suicidal patients (all ages)	20

- six- to 12-year-olds: seven patients; and
- 13- to 17-year-olds: 15 patients

Latency age children and adolescents may be seen in a variety of clinical settings across the spectrum of care, including inpatients/residential, day treatment, or outpatients.

Patient numbers by diagnostic categories with/without comorbidities

Conditions with higher patient numbers are for the most common problems that present to the general psychiatrist. Numbers are derived in part from prevalence studies (Appendix 7A) and the need to achieve competency levels. Patient contact occurs in all aspects of the resident's supervised practice as previously noted.

To ensure that residents complete their general psychiatry objectives in exposure to children and adolescents with developmental disabilities, options may include resident participation in a developmental disabilities clinic a half-day per week for two months or in a developmental disabilities program with a psychiatrist seeing children and adolescents referred to that program during a one to two week period.

Treatment: psychotherapy and supervision hours/ psychopharmacology

It is important for the resident to have balanced exposure to evidence-based treatments (e.g. cognitive-behavioural therapy, psychopharmacology) in the common child and adolescent psychiatry problems. Residents may consider completing some of their required psychotherapy education with a child and/or adolescent provided this is approved by their program directors. Ideally, family therapy skills training will be embedded within the core CAP rotations with the resident completing at least one family therapy assessment under observation. The resident should understand how the pharmacokinetics of medications differs in children and youth and how this manifests in clinical practice.

Guidelines for minimum expectations:

The resident should have supervised practice with at least two psychotherapeutic modalities achieving the hours designated:

- cognitive-behavioural therapy-10 hours
- crisis intervention-10 hours
- family therapy-10 hours
- psychodynamic psychotherapy-10 hours
- supportive therapy-10 hours
- psychopharmacology treatments (supervised practice with the commonly prescribed psychotropic medications in children and adolescents, including stimulants, antidepressants, antipsychotics, anxiolytics and mood stabilizers)

Curriculum seminars

The focus would be on the major topics in CAP. Programs may offer one series of more "academic"/evidence-based presentations during the centralized protected teaching time in PGY2 or 3 as well as one series of more clinically-related presentations that are unit or rotation-based while the resident is participating in the CAP core rotation.

Guidelines for minimum expectations:

- Coverage of the common CAP topics during the centralized PGY2 or PGY3 weekly protected teaching time.
- Regular case conferences/rounds at which the resident presents one CAP case per week.
- Regular journal clubs/grand rounds at which the resident presents at least one CAP topic during the six months.

Evaluation

Residents will be evaluated based on their knowledge, skills and attitudes for the CAP core competencies for each of the CanMEDS roles. For discussion on methods of evaluation, the reader is referred to Chapter 16.

Completing a log of the ages, gender, diagnosis, assessment and interventions in CAP can assist in resident evaluation (Appendix 7B).

OTHER CONSIDERATIONS

Deficiency remediation

- Specific tutorials to address knowledge deficiencies.
- Additional focused supervision to address specific skill deficits (e.g. psychotherapy modality skills).
- Additional cases of children/youth and their families with supervision of interview, assessment and intervention skills.
- Reassessment after deficiency remediation.

Advanced training for the generalist in child and adolescent psychiatry

Up to 12 months of elective and selective training in the senior residency are available to general psychiatry residents. Goals may include extending competencies completed in PGY2-3 or pursuing specific areas within child and adolescent psychiatry (e.g. eating disorders, early psychosis intervention). The opportunities can be rich and diverse. Given the significant resource deficit in CAP, it is important to consider fitting these not only to resident interest but also to societal need. Such direction will assist the resident in obtaining skills that will be needed and valued in practice. In general, the expectation would be that residents enhance their CAP core competencies. Training decisions can be reached on such goals as well as the obtaining of additional experience in inpatient or residential treatment, outpatient treatment, community services, psychotherapy with children and adolescents, or the gaining of new skills in other areas. In enhancing core competencies, higher competency levels need to be set and the resident would be expected to increase the number of patient and family contacts seen. If residents chose further study in specific types of problems, their knowledge may be increased in the areas of assessment, diagnosis, and treatment strategies. An example may be a placement in a subspecialty ADHD clinic where the resident will see many children with ADHD and its common comorbidities and become immersed in treatment specific to ADHD such as titrating psychopharmacological treatment,

behavioural therapy, social skills training, individual problem-solving skills and parent management.

To achieve enhanced competencies in CAP, it may be helpful for residents to choose electives and selectives that cover a variety of specific common CAP problems in combination with a variety of settings. Common mental health problems may include ADHD, mood disorders, anxiety disorders, disruptive behaviour disorders, learning disorders and developmental disorders. Settings may include children's mental health agencies, schools, day-care centres, specialized inpatient/residential units, and consultation in shared care modalities or through telepsychiatry. Residents may also undertake an approved elective in pediatrics, adolescent medicine, pediatric neurology or developmental pediatrics. Residents who are interested in forensic child and adolescent psychiatry may undertake an elective that may include detention centre assessments, assessments for family court clinics, custody and access, or parenting assessments. If residents are interested in pursuing subspecialty training in forensic psychiatry, they will need to clarify the requirements for a subspecialty year in forensic psychiatry.

Residents may also wish to pursue electives or selectives in particular CAP psychotherapeutic modalities, such as cognitive-behavioural therapy, interpersonal psychotherapy, dialectical behaviour therapy, pharmacotherapy and/or family therapy.

Medical schools with postgraduate programs all have the capacity to provide electives and selectives in CAP. Smaller program rotations may involve a wider variety of patient problems whereas larger programs may have specific subspecialty clinics. Advanced training to achieve specific learning goals could be completed in the resident's home program or, with the permission of program directors, could be attained in another residency program.

Subspecialty considerations during generalist training

Residents wishing to enter subspecialty training should use to the fullest the 12 blocks available for CAP in the electives and selectives and are advised to seek consultation with CAP program directors concerning the relevance of their choices to the subspecialty training requirements. Consultation will be most effective if it occurs during PGY3. This may ensure that subspecialty training, after obtaining the primary specialty of psychiatry, will be no longer than one year in duration. The electives and selectives may be organized in particular areas of CAP, such as specific disorders (e.g. mood disorders, disruptive behavior disorders, the psychotherapies); or in particular settings (e.g. consultation to school boards, children's mental health clinics, residential settings); or in rotations in approved programs outside of but related to the practice of CAP. Planning of such detail is best undertaken with a clear

understanding of the goals with the oversight of the program director in psychiatry and with input from a program director in CAP.

Those residents who decide to pursue a subspecialization in CAP may spend some of their elective time in academic pursuits. These may include educational activities and scholarship (such as teaching medical students or junior residents about common CAP problems, curriculum development, program evaluation or pedagogical research) and supervised research or administrative apprenticeship (such as in mental health agencies or hospital settings).

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APPENDIX 7A: Estimated prevalence rates of child and adolescent psychiatric problems

Psychiatric problems	Minimum case *n*	Estimated prevalence % (years)	Reference
ADHD	20	4.0–12.0 (6–12)	Brown[3]
Anxiety disorder	10	6.4 (0–19)	Waddell[4]
Conduct disorder	15	4.2 (9–19)	Waddell[4]
Learning disorder	10	9.7	Altara,[8] AACAP[9]
Major depressive disorder	10	3.5 (0–19)	Waddell[4]
Mental retardation	4	1	Roeleveld[7]
Oppositional defiant disorder	15	2.2–3.3 (9–16)	Costello,[5] Loeber[6]
Pervasive developmental disorder	5	0.3 (0–19)	Waddell[4]
Substance abuse	4	0.4–9.6, alcohol 3.3–9.8, drug	Bukstein[10]

APPENDIX 7B: General psychiatry resident, CAP core rotation log of patient care experiences

Name of resident: ----------

Dates of rotation: ----------

Patient # or initials	Age	Sex	Clinical settng	Diagnosis and comorbididties	Contact number	Assessment	Treatment interventions	Duration of involvement (weeks, months)

LEGEND OF ABBREVIATIONS

Clinical Settings

Community: family physician office (CFPO)
Community: mental health centre (CMHC)
Consultation: emergency department (CED)
Consultation: paediatric unit (CPU)
Day hospital/Day program: (DH/DP)
Inpatient: adolescent, child (IPA, IPC)
Outpatient: clinic (OPC)
Residential treatment program (RTP)

Assessments (prior to treatment/intervention)

Emergency (E)
Urgent care (UC)
Comprehensive (C) – includes patient, family, other community informants, analysis of other assessments
Testing: psychological (TP), educational (TE)

Treatment interventions

Access to community resources (ACR)
Behaviour therapy (BT)
Cognitive behavioural therapy (CBT)
Crisis intervention (CI)
Dialectical behavioural therapy (DBT)
Family therapy (FT)
Group therapy (GT)
Interpersonal psychotherapy (IPT)
Pharmacotherapy (PCT)
Patient/family education (P/FI)
Play therapy (PT)
Psychodynamic psychotherapy (PPT)
Supportive psychotherapy (ST)

Chapter 8

Geriatric psychiatry

Catherine Shea and Melissa Andrew

INTRODUCTION

Sophisticated general psychiatrists, spread across a wide geographic area, will be needed to provide the bulk of psychiatric care for elderly Canadians with complicated presentations of mental illness.

The percentage of Canadians over age 65 is the fastest growing segment of the population in Canada. The most rapidly expanding subgroup within this cohort, those 80-years-old and over (over 1,000,000 persons in 2008), is the most psychiatrically vulnerable. Although the subspecialty of geriatric psychiatry has just been recognized by the Royal College of Physicians and Surgeons of Canada (RCPSC), the modest number of subspecialist geriatric psychiatrists will be unable to provide direct care for these large numbers of elderly patients.

The new requirement for six months of dedicated geriatric psychiatry training, within the early years of residency, will better prepare the practicing general psychiatrist to assess and manage psychiatric disorders uniquely occurring in late life. The geriatric content in general psychiatry training is focused on providing assessment and care for elderly patients and their caregivers at the end of the life cycle. End-of-life is a time when many physical and mental health issues coalesce, thereby complicating psychiatric care.

Psychiatric illness in a geriatric patient is fundamentally different than psychiatric illness in younger adults, in the following ways:

1. Symptom presentation

Within the older brain there is a complex interplay of structural and neurochemical changes and immunological reactions. Therefore, many disorders (such as depression) present differently in late life compared to younger onset. It is repeatedly demonstrated that easily diagnosed disorders are routinely missed

in elders in most health-care settings. Sensory deficits, coexisting physical symptoms, cognitive changes and stigma of psychiatric illness held by this age group are all factors that obscure diagnoses.

2. Amount of medical contribution to etiology

Many late-onset disorders (e.g. late-onset bipolar, late-onset anxiety disorders) have an organic etiology. Structural brain changes (degenerative, vascular), which occur with aging, can produce psychiatric symptoms. Most patients have multiple chronic and concurrent medical conditions requiring multiple medications.

3. Need for specific treatment considerations

Pharmacological treatment plans must consider different pharmacokinetics, medical comorbid illness and existing medications in the elderly. This is required for any patient, but young patients generally have few associated health issues. It is the norm for geriatric patients to have multiple chronic problems, polypharmacy and high potential for drug interactions Though general psychiatry supports evidence-based treatment guidelines for each of the major psychiatric disorders, the usual treatment algorithms often cannot be applied to the elderly without significant adaptation due to these treatment constraints.

4. Response to treatment

Depression studies show more treatment resistance, need for longer therapeutic trials and longer maintenance to avoid relapse. Cognitive challenges and physical frailty contribute to the inability to comply with recommended treatment regimes.

As in most other areas of medicine, the spectrum of mental health problems in the geriatric population spans a continuum from simple, to complicated, to complex. Primary care physicians focus on prevention and early detection of geriatric mental health issues, and initiate management for simple, straightforward cases (e.g. 65-year-old with depression associated with retirement and role changes). General psychiatrists are expected to assess and treat more complicated cases (e.g. 75-year-old with heart disease and depression, unresponsive to first-line selective serotonin reuptake inhibitor intervention). General psychiatrists also consult with subspecialist geriatric psychiatrists, as required, for older patients at the complex end of the continuum (e.g. 85-year-old with late onset depression and cognitive impairment, who has multiple lucencies on magnetic resonance imaging scans and is refractory to second-level antidepressant medication trials).

In implementing the recently revised curriculum, the expanded amount of time (6 months) dedicated to geriatric psychiatry, the earlier developmental level of the trainee (PGY2–PGY3) during the core geriatric psychiatry experience and the need for support for faculty supervisors as they are oriented to these changes

will require flexibility, creativity and a variety of approaches to meet the needs of the individual general psychiatry programs across Canada.

There are multiple opportunities for learning the competencies in geriatric psychiatry across all CanMEDS roles. They include a variety of settings and a diverse array of resources. These settings offer different perspectives on the needs of the geriatric patient and different relationships with the systems of care. Using this array of opportunities, we anticipate that even smaller programs can provide a meaningful core educational experience for junior residents.

- Emergency rooms providing psychiatric services (exposure to large numbers of elderly patients with physical and mental health issues).
- Dedicated geriatric psychiatry inpatient units (exposure to complex elderly patients).
- Acute adult psychiatry inpatient units (complicated and complex elderly patients with sensory deficits, medical problems or treatment resistance).
- Medical and surgical inpatient units of general hospitals, particularly geriatric medicine units.
- Geriatric psychiatry and general adult psychiatry outpatient clinics (exposure to complicated and complex patients).
- Geriatric psychiatry day programs and dedicated outreach teams (typically seen in larger programs and providing exposure to complicated and complex elderly patients).
- Shared care arrangements in family medicine clinics (opportunities to see simple/typical presentations and to discriminate these from those more complicated and complex patients who might require referral).
- Retirement residences (exposure to simple, complicated and complex patients).
- Long-term care homes (exposure to complex patients at sites with limited resources).

Conferences

To supplement local resources, excellent opportunities exist to attend annual or biannual conferences with geriatric psychiatry content in Canada. They include:

- The Canadian Psychiatric Association (CPA) Annual Conference (including Canadian Academy of Geriatric Psychiatry (CAGP) sponsored symposia)
- CAGP Annual Scientific Meeting
- British Columbia Psychogeriatric Association Annual Meeting
- Geriatric psychiatry sessions held at provincial psychiatric association annual meetings

Guidelines

Recently published Canadian guidelines are available from the Canadian Coalition for Seniors' Mental Health (CCSMH) website (www.ccsmh.ca) on the following topics:

- CCSMH. National guidelines for seniors' mental health: the assessment and treatment of depression.[1]
- CCSMH. National guidelines for seniors' mental health: the assessment and treatment of mental health issues in long-term care (focus on mood and behavioural symptoms).[2]
- CCSMH. National guidelines for seniors' mental health: the assessment of suicide risk and prevention of suicide.[3]
- CCSMH. National guidelines for seniors' mental health: the assessment and treatment of delirium.[4]

Canadian guidelines specific to dementia have been developed at the Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD3) held in March 2006. These guidelines, as well as the relevant background papers, were published in the October 2007 issue of *Alzheimer's and Dementia*[5] and are available at www.cccdtd.ca.

Textbooks

Reference textbooks, some with study guides, devoted to geriatric psychiatry are readily available. Examples include:

- Agronin ME, Maletta GJ, editors. Principles and practice of geriatric psychiatry. New York (NY): Lippincott, Williams & Wilkins; 2006.
- Blazer DG, Steffens DC, editors. The American psychiatric publishing textbook of geriatric psychiatry. 4th ed. Washington (DC): American Psychiatric Publishing; 2009.
- Hales RE, Shahrokh NC, Blazer DB, et al. Study guide to geriatric psychiatry: a companion to the American psychiatric publishing textbook of geriatric psychiatry. 4th ed. Washington (DC): American Psychiatric Publishing; 2009.
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- Sadavoy J, Jarvik LF, Grossberg GT, et al, editors. Comprehensive textbook of geriatric psychiatry. 3rd ed, study guide. New York (NY): WW Norton & Company; 2004.

Journals

Examples of international peer reviewed journals with geriatric psychiatry content include:

- *American Journal of Geriatric Psychiatry* (www.aagponline.org)

- *International Journal of Geriatric Psychiatry* (www.interscience.wiley.com/jpages)
- *International Psychogeriatrics* (http://journals.cambridge.org/displayJournal?jid=IPG#)
- *Journal of the American Geriatrics Society* (www.wiley.com/bw/journal.asp?ref=0002–8614)

Academy

A variety of resource materials and links may also be found on the web site of the CAGP (www.cagp.ca).

REVIEW OF THE RCPSC OTR/STR

The Specialty Training Requirements (STR) in Psychiatry 2007[6] outline minimum training requirements and specify that each general psychiatry trainee will have "six months of training devoted to the psychiatric care of the elderly and their families in a variety of clinical settings. The six months of training can be offered in one continuous block or two 3-month blocks. Rotations may occur in each of the PGY2 and PGY3 years."[6] The Royal College of Physicians and Surgeons of Canada (RCPSC) Objectives of Training (OTR) in Psychiatry 2007[7] emphasizes the importance of learning about common psychiatric conditions as they present across the lifespan. Specific to the elderly patient, it does indicate, that residents will demonstrate proficiency in dementias and delirium at the conclusion of their psychiatry training.

A complete set of Objectives of Training: Geriatric Content in General Psychiatry,[8] is available on the CAGP's website (www.cagp.ca) for use by program directors and/or supervisors of geriatric psychiatry rotations. These adapt and expand the general objectives specific to geriatric rotations that are described in the OTR 2007.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

The 10 competencies highlighted below are adapted from the OTR 2007 and summarize the most salient aspects of a resident's core training in geriatric psychiatry. Emphasis should be placed on helping the trainee to adapt his/her developing clinical knowledge and skills with younger adults to this population and stage in the lifespan. Training programs may find it helpful to focus on the elements of the *medical expert* and *communicator* roles as they pertain to the elderly during the early months of the rotation. As experience grows, the resident will increasingly be able to integrate the relevant *collaborator*, *manager*

and *health advocate* competencies, and increase his/her level of sophistication with the *scholar* role. Particular aspects of the *professional* role that are highlighted through experience with geriatric patients and working across a variety of settings should be developed across the duration of training.

Numbers in parentheses suggest a range of minimum numbers of cases or experiences for each of these issues within the total six-month training period. Whether the lower or higher end of the range should be considered will depend on the setting and the level of experience of the resident (early PGY2 versus late PGY3).

1. Be aware of one's own reactions in dealing with elderly patients, as well as the particular issues of stigma and vulnerability that may be relevant to the care of geriatric patients.
2. Recognize the unique aspects of the assessment, diagnosis and treatment of common psychiatric illness in elderly patients (depression and anxiety disorders [4–5], bipolar disorders [2–3], late onset psychotic disorders [2–3], substance use disorders [2] and delirium [4–5]).
3. Recognize the burden of comorbid medical issues and common psychiatric manifestations of medical illnesses (e.g. Parkinson's disease) in elderly patients (6, including at least two psychiatric manifestations of a medical illness or medication).
4. Identify dementia, including recognition of behavioural and psychological symptoms of dementia (BPSD) (6); identify an approach to treatment of BPSD (3 of the 6). Recognize when dementia may coexist with the other major geriatric psychiatry conditions of delirium and depression (3, including at least one each of the delirium/dementia and depression/dementia combinations).
5. Adapt pharmacological and somatic therapies (including ECT) as appropriate for elderly patients.
6. Understand the central role of family and other support systems, including relevant caregiver issues, and the relevant advanced care planning and end-of-life issues (6).
7. Collaborate effectively with other members of multidisciplinary health-care team, with care providers in other settings where geriatric patients are seen, in shared care models, and with community partners.
8. Experience and appreciate distinct settings/systems of care and their roles in providing and co-ordinating care for patients in this sector (2–3).
9. Work with issues of consent and capacity, and other legislation (including provincial motor vehicle legislation) pertinent to the elderly (4–5).

10. Perform a complete psychiatric assessment of the elderly patient using the above competencies, adapting for sensory and cognitive deficits as necessary and gathering collateral information as appropriate. This would include the ability to conduct a structured cognitive assessment when required (8–10).

We recognize that comorbidity is ubiquitous in geriatric patients. Thus, in treating a single patient, multiple competencies may be addressed. We suggest that community settings provide unique learning opportunities and recommend including long-term care, primary care, and/or other community settings in a residents' core training wherever possible.

In operationalizing the levels of competency expected of students after various stages of training in geriatric psychiatry, we suggest using Miller's triangle[9] (see evaluation Chapter 16, page 244). After completing required core rotations in geriatric psychiatry, junior residents should generally have attained a working knowledge level of competency with respect to geriatric patients. In other words, they will have attained the *knows how* level of Miller, and will be able to demonstrate, in a situation such as a written examination or discussion with a supervisor the following:

- Working knowledge level competency in assessing, diagnosing, treating and managing elderly patients with generally typical or complicated presentations of specific age-related psychiatric disorders, as relevant to the practice of general psychiatry.
- Working knowledge level competency in assessing and managing uncomplicated patients with long-term psychiatric disorders, who have grown older, as relevant to general psychiatry practice.
- Confidence in recognition of situations in the psychiatric care of complex elderly patients that are outside the scope of general psychiatry, and when consultation with a dedicated geriatric psychiatrist would be appropriate for optimal patient care.

Additional experience, as the trainee completes the psychiatric residency, will allow for consolidation and further development of geriatric-specific knowledge and skills. The additional experience with elderly patients in further adult psychiatry rotations, such as consult-liaison, emergency psychiatry, forensic psychiatry and substance misuse, will provide opportunities to advance beyond the working knowledge or *knows how* to proficiency in common psychiatric conditions, including dementia and delirium, as listed in the OTR 2007. The *shows* level in Miller's triangle thus corresponds to a practice-ready level of competence that the resident can demonstrate during a Standardized Assessment of a Clinical Encounter Report (STACER) exam or Objective Structured Clinical Encounter (OSCE). Following certification, a psychiatrist who *does* on a regular basis in practice will be able to comfortably handle complicated situations involving geriatric patients in practice.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

Various strategies are suggested to deliver the demanding breadth and volume of content (to working knowledge level) in the space of six months.

While not every university site will have sufficient resources to access all possible opportunities, it is expected that every university site will have large numbers of elderly patients with psychiatric disorders. It is suggested that individual supervisors of geriatric training experiences focus primarily on helping residents to develop sound skills in clinical assessment and principles of management. It is in these areas where residents will be expected to develop overall proficient levels of competency by the completion of their psychiatry training in order to function as safe and effective consultants. Working knowledge competency in the specific content areas of geriatric psychiatry is intended to support the development of core psychiatric assessment skills in preparation for practice with all patients across the lifespan. Smaller programs may not have access to dedicated geriatric psychiatry inpatient units, but will have adequate numbers of elderly patients on general adult inpatient units. The Canadian Collaborative Mental Health Initiative has published a useful handbook on establishing collaborative initiatives between mental health and primary care services for seniors. This resource may provide assistance in developing the necessary educational partnerships to support the core training.[10]

Although some sites have very few psychiatrists with formal training in geriatric psychiatry, we suggest that these individuals may offer the core residents unique insights into caring for the complex elderly patients. All geriatric psychiatry cases should be supervised by a psychiatrist who sees elderly patients on a regular basis. It would be better if a significant proportion of cases could be reviewed with a geriatric psychiatrist and, in the best scenario, a geriatric psychiatrist be involved for every case.

Residents can utilize personal learning portfolios or logs to track cases and situations to ensure coverage of the objectives of the geriatric experience as summarized under the training targets listed previously. Portfolios would also be useful in assisting residents to track the number and variety of care settings, systems and community resources for the elderly that they have encountered during the rotation. Supervisors may use these logs to help tailor training experiences in order to ensure that residents are as close as possible to the suggested target numbers and breadth of experience. The faculty supervisors in geriatric psychiatry programs will need some orientation to the expected difference in developmental level of the residents and support in making the transition to the new curriculum.

Residents in PGY4 and PGY5 wishing to develop proficient or advanced levels of competency in the geriatric end of the lifespan may choose selectives and/or

electives in settings already visited in the core experience. They may also wish to experience new settings and populations of complicated/complex elderly patients, including non-psychiatric medical rotations not seen during core rotations in the junior years. It may be advantageous to smaller programs to consider partnership arrangements with larger university sites to expand the breadth of exposure and ensure residents are able to meet these advanced learning objectives, which are beyond the scope of the core experience (e.g. smaller sites may not have dedicated geriatric psychiatry inpatient units with multidisciplinary teams focused exclusively on the psychiatric care of the elderly).

Rather than requiring every program to assemble these materials independently, a core curriculum might be supported and regularly updated nationally through the CAGP, the CPA, or the RCPSC, and might include strategies such as:

- Online self-directed modules with geriatric psychiatry content, such as those currently being developed at Dalhousie University.
- Core teaching lectures/workshops/journal clubs by geriatric psychiatry faculty at university sites having divisions of geriatric psychiatry or through telehealth connections for smaller sites without full divisions.
- Internet accessible national guidelines for geriatric mental health, such as those developed by the CCSMH, Canadian Consensus Guidelines for depression, delirium, suicide and mental health issues in long-term care.

OTHER CONSIDERATIONS

Integration of CanMEDS role competencies

A particular strength of geriatric psychiatry rotations exists in the many and varied opportunities to develop and integrate CanMEDS competencies beyond the *medical expert*.

Geriatric patients are a vulnerable group that present numerous and unique opportunities for advocacy, at the individual level, on a daily basis. This group can help the trainee develop competencies in the *health advocate* role of the general psychiatrist. This group also provides experience with many ethical issues that allow for the development of the *professional* role.

Geriatric psychiatry care is typically delivered via multidisciplinary teams. The team environment allows the resident to practice leadership skills and observe and shape team dynamics (*manager*). With geriatric patients, excellence in collaboration within and across disciplines is essential for optimal care. Opportunities for training overlap side-by-side with geriatric medicine colleagues can occur at some sites and enhance learning regarding the complexity of the frail elderly. It is important that geriatric psychiatry specific

supervisors help place these experiences in the mental disorder context. Enhanced skills as a *collaborator* and *communicator* may be developed through work within the team, and further explored when communicating and collaborating with referring physicians and agencies in the circle of care for the elderly patient.

This training experience in geriatric psychiatry offers ample *scholar* considerations. The elderly are a largely unstudied group with limited literature to provide evidence for decision making in specific patient encounters. The physician usually must extrapolate from standard adult literature to a very unique, heterogeneous population. Geriatric psychiatrists rely heavily on teaching to enhance the capacity of the health-care system to provide care to this population. Most divisions of geriatric psychiatry have extensive opportunities to develop teaching skills with a variety of audiences, including students of all disciplines, team members, families, other physicians and the staff of facilities caring for elderly patients.

Approaches to evaluation

Evaluation strategies can be numerous and varied during the geriatric psychiatry training experience. Many excellent strategies are outlined in CanMEDS assessment tools handbook available through the RCPSC.[11]

1. Direct observation and In-Training Evaluation Reports

Traditional tools to evaluate the medical expert role would include direct observation of clinical skills and In-Training Evaluation Reports. These should be modified formally to evaluate ability to adapt to the elderly patient when conducting diagnostic interviews, ordering appropriate investigations, formulating a diagnosis and integrating the literature into treatment plans. Programs may consider adding specific categories that address crucial geriatric elements, such as the resident's abilities to choose and conduct appropriate cognitive assessments, include caregivers in the diagnostic interview, and integrate salient medical issues within proposed investigations and management. The richness of interdisciplinary opportunities to provide feedback to supervisors on the residents' performance is considerable, as the complexity of geriatric cases demands true collaboration between team members.

2. Oral examinations

Formal oral examinations may be used to assess an entire clinical encounter. When physical, cognitive or sensory issues make it challenging to complete a full interview with a geriatric patient, there is often opportunity to specifically and meaningfully evaluate selected segments of the patient encounter, such as the Mental Status Examination, structured cognitive assessments, functional and capacity assessments, and communication with family and caregivers.

3. Teaching and presentation skills

Teaching and presentation skills can be evaluated in varied settings outside of traditional medical education environments, such as long-term care homes, with community care providers, or public education through agencies such as the Alzheimer Society of Canada.

4. Evaluation of literature review skills

Evaluation of literature review skills during the rotation should include the resident's ability to extrapolate from standard adult literature to the rarely studied complex geriatric population.

5. Personal learning portfolios

Personal learning portfolios to document cases and experiences will assist residents as they capture a variety of presentations, diagnoses and responses to treatment. The portfolios will also help guide supervisors as they attempt to provide a rich and varied experience. It is often through reflection on specific experiences with their supervisors that residents are able to consolidate learning of the collaborator, communicator and health advocacy competencies.

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Chapter 9

Forensic and legislative aspects of general psychiatry in Canada

Renée Fugère, Renée Roy and Gary Chaimowitz

INTRODUCTION

All psychiatrists must be able to identify and appropriately respond to legal and forensic matters. Psychiatrists must be proficient in health-care legislation including involuntary assessment and admission, confidentiality, consent and capacity and child welfare legislation. Psychiatrists are only required to have working knowledge of legislative issues related to discrete forensic topics such as fitness to stand trial, criminal responsibility and young offenders.

Forensic psychiatry focuses on the relationship between psychiatry and the law and deals specifically with a multitude of medico–legal issues including fitness to stand trial, capacity/competence, criminal responsibility, assessment of malingering, expert witness testimony, responsibility in civil actions, and risk assessment and management of violence. Psychiatrists specializing in this area require strong clinical skills in the assessment and management of patients with complex clinical presentations, particularly with respect to psychotic illnesses, addictions and personality disorders including psychopathy. Additionally, expert knowledge of provincial and federal legislation that governs all acts pertaining to the assessment and treatment of patients across the lifespan is fundamental to this subspecialty. Finally, expertise in documenting and presenting clinical opinions and recommendations in both criminal and civil settings is essential.

The issue of violence in psychiatric illness is a serious and common problem and often considered to be part of the clinical subspecialty of forensic

psychiatry. The Epidemiologic Catchment Area survey[1] demonstrated that two per cent of subjects with no mental disorder had been violent in the previous 12 months, compared to 13 per cent of subjects with schizophrenia, 12 per cent of those with major depression, 19 per cent of those with cannabis use and 25 per cent of those with alcohol abuse disorder. Other studies have explored the association between violence and psychotic illness. Serious violence was associated with hostility, suspiciousness, persecutory delusions, hallucinations, grandiosity and excitement.[2] Forensic psychiatry brings tools to the assessment and treatment of such patients, including risk assessment and management of violence.

Although there is no mandatory or core forensic psychiatry rotation, legal issues are frequently encountered during core rotations in general psychiatry. The practice of forensic psychiatry takes place in a wide variety of settings including federal and provincial correctional facilities, remand centres, inpatient forensic units with differing levels of security, court rooms and tribunals, private medical offices, outpatient forensic clinics, community resources and halfway houses. These settings provide a variety of unique opportunities for residents who choose to do a rotation in forensic psychiatry.

An elective rotation in forensic psychiatry will enhance knowledge in the areas in which general psychiatrists are expected to develop forensic competencies. Such an experience will also help clarify complex diagnoses, and comprehensive and realistic treatment plans as well as focus on social rehabilitation that takes public safety into account. An additional skill to be mastered is the maintenance of an often fragile alliance with patients in conflict with the law.

Residents bring foundational knowledge that will assist their forensic work in an elective rotation. Experience in assessing patients with severe mental illnesses including schizophrenia, bipolar disorder, personality disorders and addictions in previous outpatient, inpatient and emergency room rotations is essential to the practice of forensic psychiatry. The ability to appropriately assess patients and prepare reports for third parties and for the court will be helped by any related previous clinical experience. Residents also bring foundational knowledge regarding the treatment of patients with severe and persistent mental illness (SPMI) including pharmacology of drug interactions, adverse events and prescription of complex drug regimes to patients who may not respond to monotherapy. Similarly, prior psychotherapy supervision and training affords a strong base from which to provide evidence-based treatment to the forensic population. Finally residents bring foundational knowledge concerning jurisdictional mental health legislation and skills and their application in both hospital and community settings.

In the field of forensic psychiatry, the following publications or resources are especially relevant to general psychiatrists and to residents in training in Canada:

Journals

- *The Journal of the American Academy of Psychiatry and the Law*
- *The International Journal of Law and Psychiatry*
- *The International Journal of Offender Therapy and Comparative Criminology*
- *The Journal of Child Abuse and Neglect*

Textbooks

- Bluglass R, Bowden P, editors. Principles and practice of forensic psychiatry. Avon (UK): Churchill Livingstone; 1990.
- Appelbaum PS and Gutheil T, editors. Clinical handbook of psychiatry and the law. 4th ed. Philadelphia (PA): Williams and Wilkins; 2007.
- Schetky DH, Benedek EP, editors. Principles and practice of child and adolescent forensic psychiatry. Washington (DC): American Psychiatric Publishing; 2002.

Associations

- The Canadian Academy of Psychiatry and the Law
- The American Academy of Psychiatry and the Law
- The Canadian Psychiatric Association Section on Forensic Psychiatry
- International Association of Forensic Mental Health Services
- International Association of Law and Mental Health

REVIEW OF RCPSC OTR/STR

A dedicated core forensic rotation is not required to train a general psychiatrist. However, as indicated in the introduction, general psychiatrists are required to address many issues related to the interaction between psychiatry and the law. As such, it is recommended that senior residents consider completing a three- to six-month rotation in forensic psychiatry to ensure competency in the area of mental health and the law.

The mandatory rotation of SPMI and its rehabilitation may be undertaken in a forensic setting over a three- to six-month period.[3] This rotation focuses on developing skills in the assessment and treatment of patients with SPMI, specifically schizophrenia and bipolar illness. Although a forensic setting would permit a greater exposure to the clinical application of law and psychiatry, the focus of complex and continuing care must remain on developing competency in

the assessment and treatment of SPMI. Therefore a subsequent three- to six-month elective rotation in forensic psychiatry should not be considered duplication in any way and would afford the resident an opportunity to develop skills in this specialized area of psychiatry. Such a rotation may allow the resident to progress to proficiency in some areas.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

In the forensic rotation, as in any rotation, all CanMEDS roles are to be learned and practiced in the provision of patient-centred care, across the lifespan and in a variety of settings. The following objectives in the medical expert and collaborator competencies are set out in the current Royal College of Physicians and Surgeons of Canada (RCPSC) Objectives in Training Requirements (OTR)[4] in psychiatry and may be addressed in a rotation in a forensic psychiatry setting:

Medical expert

1. The resident must demonstrate *proficiency* in the assessment and management of suicide, self-harm or harm directed toward others.

   Various key elements are to be evaluated in the assessment of short-term risk of violence:

   a. Appearance of the patient.
   b. Presence of violent ideation and degree of formulation or planning.
   c. Intent to be violent.
   d. Available means to harm and access to a potential victim.
   e. Past history of violence and other impulsive behaviours.
   f. Alcohol and drug use.
   g. Presence of psychosis.
   h. Presence of certain personality disorders (cluster B traits or disorders i.e. narcissistic, borderline and antisocial).
   i. History of non-compliance with treatment.
   j. Demographic and socio-economic characteristics (young, male, poor, familial disruption or decreased social control as well as the environment from which the patient comes).

2. The resident must demonstrate *proficiency* in legislation, both provincial and federal, as it pertains to the practice of psychiatry. This includes:

a. Provincial mental health acts and associated legislation related to the involuntary assessment and admission of individuals with mental disorders.

   These acts protect individuals whose mental state represents a danger to themselves or others. As detention goes against the individual's right to be free, danger must be a component. Commitment decisions are time-limited, linked to the risk and should be lifted as soon as the risk diminishes or is otherwise manageable. In order to do so, the patient should be examined on a regular basis. The psychiatrist should know the content of this law as it applies directly to clinical practice. Although the basic principles on which the law has been drafted are similar in most provinces, there are provincial variations, some which may be significant. It is the responsibility of the psychiatrist to be aware of the content of the laws and regulations in the province where he/she practices.

b. Provincial mental health acts related to assessment of consent for treatment.

   Legislation across Canada indicates patients must give informed consent to treatments proposed by health practitioners. Consent is an explicit or tacit manifestation of will by which an individual approves an act to be undertaken by another. In recognizing the patient's right to consent, we necessarily and implicitly recognize the patient's right to refuse. To be valid, the consent should be free (voluntary, without pressure, promise or threat) and informed. The individual giving the consent should be capable of giving the consent (competent). With provincial legislation the interpretation of these guiding principles may vary from province to province. In Québec, an individual aged 14 years or older may consent to a medical act. In other provinces and territories, consent depends on the physical, mental and emotional development of the individual so as to be able to fully appreciate the nature and consequences of the proposed treatment and the consequences of refusing it.

   To obtain informed consent, the following information should be given to the patient:

   i. Diagnosis.

   ii. Nature of the proposed treatment.

   iii. Procedures to be performed.

   iv. Benefits and risks (especially the serious and infrequent ones) associated with the procedures.

   v. Consequences of refusal or not intervening.

vi. Other treatment options (including what would happen if the patient does not accept treatment).

The physician must verify that the patient understands the information and give him/her an opportunity to ask questions and obtain satisfactory answers.[5] Written consent is necessary for certain procedures whenever analgesic, narcotic or anesthetic agents will significantly affect the patient's level of consciousness during the treatment.

When judged incapable, the incapable adult needs a third party to give consent in his/her place. This is substitute consent by a substitute decision maker. A trustee or guardian recognized as capable may give this consent. In Québec if an incapable patient refuses treatment, the physician may file a request asking the court to impose treatment on the patient for his/her benefit. The information regarding the incapacity of the patient to consent must be clearly documented and the proposed treatment and its accompanying benefits and risks should be described. The benefits should be superior to the risks incurred. Other provinces may require the physician to use courts, review boards or tribunals to effect treatment. Some provinces link involuntary detention to treatment incapacity (i.e. if you are involuntarily detained you can be treated against your will). Ontario has delinked involuntary detention from treatment capacity. These examples demonstrate the importance of not only understanding the key principles but also appreciating how these may be valued and interpreted differently in different jurisdictions.

c. Legislation related to patient confidentiality.

The clinician is not allowed to divulge facts or confidences that have come to his/her personal attention, except when the patient or the law authorizes him/her to do so. Exceptions to this rule exist when there are compelling and just grounds related to the health and the safety of the patient or of others. Privilege is a patient's right not to have her/his information divulged to third parties. Confidentiality is the psychiatrist's obligation to maintain the patient's confidence. Access to the medical record of a patient by a third party is limited unless the patient authorizes it in writing. There are many exceptions for specific circumstances and reasons to be determined by the court or by provincial and federal legislation. There are also other reasons such as: youth protection, public health protection, attestation of death, highway safety, in case of emergency when the physical integrity of the patient is at stake, when the patient is incompetent (substitute consent), when admitting a patient involuntarily, and discussion with supervisors and collaborators directly involved in the patient's care. Information

regarding other parties contained in the medical record of the patient is to remain confidential and may need to be erased. Patients have a right to access their records unless the record's content, in whole or in part, would cause harm to their health.[5] Duties to third parties overlap with issues of confidentiality (refer to section 3 of this chapter).

d. Child Welfare Acts

These acts are based on the rights of children to have their needs met in terms of development and welfare. Within that law, all citizens, including the physicians, are forced to disclose information to the authorities which lead them to think that the security or development of a vulnerable minor is in danger. This is provincial law and physicians need to comply with the specificity of the law in the regions of their practice. The Department of Youth Protection (Quebec) or the Children's Aid Society (other Canadian provinces) have access to the child's record without further authorization.

e. Young Offenders Act

This legislation is the Parliament's legislative commitment to a special tribunal for young offenders taking into account their needs, their crimes and whether they should serve their term within the juvenile or the adult system. Some of the underlying principles within this Act are:

i. The Youth Justice Court ensures respect while considering the victim's interests.

ii. Taking responsibility through constructive measures is favoured.

iii. Rehabilitation and social reinsertion are considered.

Psychiatrists may be asked by the court to assess and write reports at the various stages of the judicial process (bail, fitness to stand trial, criminal responsibility and pre-sentencing).

3. The resident must demonstrate *proficiency* in managing the duties and responsibilities of psychiatrists regarding third parties.

Some of the exceptions or limits to patient confidentiality relate to the responsibility to others. The historic Tarasoff case in the United States introduced the concept of the duty to protect others to mental health professionals. In 1976, in *Tarasoff v the University of California*[6] it was concluded that, "once a therapist does in fact determine, or . . . reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger." The Tarasoff doctrine was not directly extended into Canadian law until *Smith v Jones* (below).[7]

In 1991, the Alberta case of *Wenden v Trikha*[8] raised legal issues for mental health professionals themselves. A trial court noted that a mental health professional or hospital might be liable for damages that result if a therapist knew that a client was going to harm a third party and did not take the proper steps to protect that party.

In the Supreme Court decision of *Smith v Jones*,[7] the issue of privileged communication versus public interest was addressed. It was specified that in rare circumstances the public interest may be more important than confidentiality. Three criteria need to be considered: identification of a clear risk to an identifiable person or a group of persons, a serious risk of bodily harm or death and imminent risk should be assessed on its own merit.

Following such decisions, the clinical practice of mental health professionals has changed (i.e. warning the victim if possible, taking the necessary steps if clinically indicated to commit and/or treat the patient, and if untreatable, to advise the authorities).

The physician is obliged to disclose information to the authorities which lead him/her to think that the security or development of a vulnerable minor is in danger, as per the Acts previously noted in this chapter.

4. The resident must demonstrate an ability to manage his/her reactions in dealing with patients, including patients who are suicidal, depressed, psychotic, demanding, violent, hostile, silent or withdrawn.

   General psychiatrists are frequently called upon to assess patients who have issues of dangerousness toward others. When the patient threatens others, including individuals under their care, their family, medical staff or themselves, discomfort and risk may arise within the treatment team. The assessment and management of one's reaction to the patient facilitates decisions in treatment, such as a decision to provide a secure environment for the patient.

5. The resident must develop *proficiency* in communicating both verbal and written expert reports at the request of third parties including[9]:

   a. Medical reports requested by third parties for the following:

      i. Public guardianship.

      ii. Insurance companies

      iii. Social assistance compensation.

      iv. Disabilities.

   b. Medical reports pertaining to involuntary hospitalization or treatment at the request of a judge or tribunal.

In forensic psychiatry, collaboration with individuals outside of health care such as lawyers (defense and crown attorneys), judges and probation officers may be a requisite when a report is required for the court. Written reports and verbal testimony[10] must be provided in a manner that is understandable to those who are not mental health professionals. In forensic settings, criminologists may be involved as part of the clinical team. They can provide the resident with interesting insights on criminality, criminogenic factors, the penal system and the actuarial tools used for the evaluation of dangerousness. Additionally, court reports are often generated collaboratively amongst team members and the resident psychiatrist needs to develop expertise in supporting and overseeing the production of an expert document that summarizes both clinical findings and recommendations to the court.

Collaborator

1. The resident must demonstrate an ability to work effectively as part of a multidisciplinary team with respect to the assessment and treatment of patients who often have complex clinical problems. At times the resident will be expected to work with individuals from outside the health-care system. This collaboration may include working with people across several systems at the same time and will require an understanding of different systems and intersectorial work.

2. The resident gains an awareness of his/her roles and potential contribution in the workplace, in schools, in forensic services and in other agencies, as part of a continuum of services offered.

   When evaluation and/or treatment is performed in remand centres, in prisons or in penitentiaries, the resident on a forensic rotation needs to remember the different levels of confidentiality related to discussions with correctional officers and case managers, taking into account their specific roles. The following competencies are expected in the preparation of verbal and/or written medico–legal reports:

   a. *Working knowledge* of the fitness to stand trial examination.

   b. *Working knowledge* of the criminal responsibility examination.

   c. *Working knowledge* of the contents of the fitness to stand trial and of treatment order reports.

   d. *Working knowledge* of court testimony about fitness to stand trial, criminal responsibility and treatment orders.

   e. *Working knowledge* of the criminal legal process from pressing charges to expiration of the sentence.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The following strategies will facilitate the fulfillment of the goals and objectives in forensic psychiatry. Canadian psychiatric residency programs may already include some of these suggested strategies in their curriculum and rotations.

Didactic curriculum

1. PGY1

Three hours of seminar time dedicated to assessment and management of dangerousness should be allocated to the following basic elements[11]:

a. Principles of assessment of the agitated/aggressive patient, including set up of a safe environment in which to assess the patient.

b. Risk factors related to potential for violence.

c. Principles of management of violent behaviour.

d. Assessment of capacity for treatment.

e. Provincial mental health legislation.

2. PGY2–PGY3

A series of didactic seminars on the law and ethics in psychiatry will address the various forensic topics related to the general practice of psychiatry. It will cover more advanced aspects of forensic psychiatry, including three hour seminars in each of:

a. Pertinent provincial and federal legislation as it relates to both general and forensic psychiatry.

b. Assessment and management of dangerousness.

c. Basic court proceedings and the writing of reports.

d. Fitness to stand trial and criminal responsibility issues for general psychiatrists.

e. Capacity, competency and consent.

f. The principles of ethics in psychiatry.

g. Malpractice.

h. Quality assurance.

Rotations (PGY4–PGY5)

Elective rotations in forensic psychiatry are recommended for senior residents who have acquired the appropriate foundational skills outlined in the introductory paragraphs of this chapter.

1. Complex and continuing care rotation in a forensic setting

   Although the main objectives of this rotation are to achieve the goals in managing patients with SPMI, residents will be afforded an opportunity to experience clinical situations relevant to the practice of forensic psychiatry. For example, after having been found not criminally responsible on account of a mental disorder, a psychiatric patient may be hospitalized for many months or years in a secure forensic facility or unit. The care of these patients involves violence risk management and intensive rehabilitation including, at some point, community based treatment and care. Multidisciplinary team work is central to treatment of patients with SPMI and these important clinical skills can be mastered within a forensic setting. While the forensic issues are not foremost in the SPMI rotation, the resident may be interested in further experiences in forensic psychiatry during an elective or selective rotation.

2. Elective and/or selective rotations in forensic psychiatry

   a. Choice of rotations. There may be the opportunity for more than one of the following aspects to be studied in an individual or blended rotation:

      i. Inpatient and outpatient assessments on fitness to stand trial or criminal responsibility.

      ii. Treatment and management of patients found unfit to stand trial or not criminally responsible (NCR).[12,13]

      iii. Consultation and management of patients in detention/correctional settings.

      iv. Inpatient and outpatient settings in adolescent forensic psychiatry.

      v. Family court clinics.

      vi. Third party independent medical examinations.

      vii. Mental health courts.

      viii. Community settings such as those providing court outreach case management.

   b. Rotation objectives:

      i. Develop competence in preparing and communicating forensic assessments regarding fitness, criminal responsibility and pre-sentence evaluation.

ii. Manage and treat patients found unfit to stand trial or not criminally responsible (Review Board jurisdiction).

iii. Assess dangerousness.

iv. Develop competence in the risk management of violence.

v. Demonstrate the clinical skills required for the assessment and treatment of young offenders.

c. Content of rotation:

i. Lectures and seminars

The Residency Training Committee (RTC), in collaboration with forensic supervisors, should determine which learning format (lectures versus seminars) is made available to students. Journal Clubs and special lectures should be available at the site of the rotation. Topics should include:

- Introduction to the Canadian legal system and basic issues.
- Forensic issues related to fitness to stand trial and responsibility, as well as duties of the treating physician regarding Review Board work for patients found NCR or unfit to stand trial.
- Assessments and reports.
- Assessment of violence risk.
- Forensic issues related to sentencing and post-sentencing.
- Capacity/competence and consent.
- Correctional psychiatry: evaluation and treatment of offenders.

ii. Educational rounds and conferences

The academic activities include active participation in educational rounds or conferences. In developing a specific curriculum, for residents in forensic psychiatry the following are considered fundamental:

- Basic knowledge of the legal proceedings.
- Criteria of fitness to stand trial.
- Criteria of criminal responsibility.
- Pre-sentence report preparation.
- Management of medico–legal issues, confidentiality and ethics of dual practice (providing a forensic opinion as well as a psychiatric treatment), therapeutic alliance with patients under legal obligations to treatment.

- Short-term treatment of involuntary patients with comorbid conditions, in various settings.
- Use of actuarial and clinical tools to assess dangerousness and various tools of risk management of an actuarial, such as the Violent Risk Appraisal Guide (VRAG)[14] and Static-99,[15] and/or clinical nature, such as the Historical, Clinical, Risk-20 (HCR-20),[16] Risk for Sexual Violence Protocol (RSVP)[17] and the Psychopathy Checklist—Revised (PCL-R).[18]
- Special issues related to the assessment of youth offenders and their treatment.
- Preparation of oral and/or written medico–legal reports.

An important aspect of a rotation in forensic psychiatry is the preparation of oral and/or written medico–legal reports. The purpose of the report is to help address a legal issue and as such, the question(s) should be clearly defined. The report is addressed to a medical or non-medical audience: such as judges or attorneys. The content should be adapted depending on the source of referral. Such a report is usually composed of the following sections: identification; reason for referral; warnings given to the patient regarding consent, confidentiality and/or information given to a third party; sources of information; psychiatric history; nature and history of the problem; subject's account of the situation; witnesses' accounts of the crime; personal history and family history; medical history; criminal record; mental status examination; psychiatric diagnosis; and forensic opinion. The style of the report should be objective and the forensic evaluator needs to be cautious not to be seen as an advocate for any particular party. Technical language is to be avoided and if necessary, needs to be defined. The presentation has to be professional and free of typographical errors.

Aside from the interactive lecture and readings, practical examples would be provided allowing for the direct observation of the resident in problem-solving situations.

d. Clinical activity tracking tools

To facilitate the tracking of the resident's clinical activities, the following tools are suggested:

i. Logbook

A. For inpatient service, at least three cases in each category during a six-month rotation:

i. Fitness assessment.

ii. NCR assessment and report preparation.

iii. Treatment and management of NCR Review Board patients.

iv. Testifying in court (once for fitness to stand trial and once for a NCR accused).

B. For outpatient service: as above

C. For correctional institutions: at least five consultations involving patients serving or awaiting sentence

ii. Supervision

The resident and preceptor should meet formally once a week for an hour long supervision session to:

A. Discuss readings and clinical issues related to patients.

B. Review the writing of reports.

C. Evaluate the participation of the resident in clinical rounds.

D. Assess the ethical issues related to the practice of forensic psychiatry.

Informal supervision will occur more frequently during the week, when the resident and preceptor meet during clinical rounds on inpatient units or to review outpatient assessments.

iii. Mid-rotation formative evaluation

Half-way during the rotation, a formative evaluation should be provided to the resident. This may be structured to give feedback on the resident's performance, to review if all the objectives are being covered and to set specific goals for the second half of the rotation. Opportunity to address the resident's difficulties, if any, should be undertaken and remediation provided as required.

iv. Mock trial

This teaching tool consists of the role-playing of a legal situation with all parties represented. The resident should have the opportunity of participating in this experience if available at least once during a rotation in forensic psychiatry.

OTHER CONSIDERATIONS

Administration

As forensic psychiatry is not a mandatory rotation during the five years psychiatry training program it may not be represented on the RTC. To help facilitate interest, improve access to rotations and advise interested residents

about forensic psychiatry rotations, it would be helpful to identify a forensic psychiatrist that sits on the RTC and is the educational lead for forensic education including rotations and seminars. Every Canadian postgraduate residency program in psychiatry has access to psychiatrists with expertise in forensic psychiatry.

As objectives of training related to forensic psychiatry are generally acquired during longitudinal training, a logbook listing court reports, testimony, risk evaluations reports and violence risk management cases treated may be helpful for tracking the resident's experience.

Training sites

All Canadian psychiatry programs have access to psychiatrists trained in forensic psychiatry or to those with a practice dedicated mostly to forensic cases. The rotation is enriched by the presence of a secure inpatient unit which receives patients at the request of a judge for psychiatric evaluation and inpatient units that manage patients found "unfit to stand trial" or NCR and who are under the jurisdiction of the provincial Review Board. Those facilities are also potential sites for the SPMI and rehabilitation rotation, or for electives and/or selective rotations in forensic psychiatry.

Any psychiatric inpatient or outpatient unit has, at a given time, involuntary patients whose psychiatric illness increases their risk to others. The clinician educators who practice on these sites provide the structured clinical training experiences related to the goals and objectives listed above.

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Chapter 10

Consultation-liaison psychiatry (psychosomatic medicine)

Jonathan AE Fleming and Fabien Gagnon

INTRODUCTION

Consultation-liaison psychiatry — the practice of psychiatry with medically* ill patients[1] — is an important component of general psychiatric training. Significant numbers of patients in medical settings have unrecognized, but serious neuropsychiatric disorders that are inadequately assessed and managed[2] — delirium is detected in only 10 per cent of all medical inpatients, while the rate of delirium is triple in high-risk groups.[3] Additionally, psychological distress can be induced by the technological and sometimes dehumanizing world of hospital settings where already it has been estimated that as many as 30 per cent of patients will have a psychiatric disorder.[4] Two-thirds of high users of medical services are known to have psychiatric comorbidity (23 per cent with depression, 22 per cent with anxiety and 20 per cent with somatization).[5,6] This, in turn significantly affects health-care economics by increasing length of stay or readmission rates.[7]

To be an effective consultant to other clinicians in these settings, the general psychiatrist must have an extensive clinical understanding of medical disorders and their relationship to usual psychological reactions and abnormal illness behaviour. The general psychiatrist must be a skilled diagnostician capable of formulating a patient's multi-axial diagnoses and, using their knowledge of psychopathology and up-to-date, available psychotherapeutic and psychopharmacological interventions, must be able to develop and communicate

* Throughout, and for simplicity, medical illness refers to all acute or chronic somatic illnesses (medical or surgical) regardless of the specialty or subspecialty charged with their treatment.

a comprehensive, effective and evidence-based treatment plan. The generalist must also be able to effectively operate within a multidisciplinary team and understand the medico–legal complexities of psychiatric and medical illness within the hospital setting.

In this chapter, we use the term consultation-liaison psychiatry as used within the Specialty Training Requirements (STR) in Psychiatry of the Royal College of Physicians and Surgeons of Canada (RCPSC).[8] Even though only a minority will go on to get full training as consultation-liaison psychiatrists, most psychiatrists will be required to assess and treat medically compromised patients with psychiatric illnesses in a variety of care settings. It is imperative that general psychiatry include a minimum of three months training in consultation-liaison psychiatry, a reality that is recognized by the Royal College. Residency training in consultation-liaison psychiatry typically occurs in general hospital settings using a team approach with consultation-liaison psychiatrists that provide services to medical patients and health-care professionals with supervision to trainees. These services provide traditional, 24-hour psychiatric consultations to medical services and, through liaison services, educate the medical team about — and encourage sensitivity to — present or emerging psychological or psychiatric problems thereby facilitating early detection and proper management.

Within a Canadian residency, the principal opportunity for training in consultation-liaison psychiatry occurs after the junior residency when skills in general adult psychiatry (one year of training), child psychiatry (six months of training) and geriatric psychiatry (six months of training) have been consolidated. Upon entering senior residency, it is expected that the resident should already be competent in history-taking, recognizing and categorizing psychiatric signs and symptoms, formulating diagnoses and the differential diagnoses of the major psychiatric disorders in all age groups, and assessing and addressing safety issues. The resident will also be competent in the use of biological therapies, know their indications, limitations and side effects. The resident will be familiar with drug-drug interactions, will have a working knowledge of, and the indications for, the major psychotherapies, and will be able to assess and manage interpersonal and family issues. By this stage of training, the resident will have obtained many of the key competencies of the CanMEDS framework[9] and will continue their lifetime development in the scholar and professional roles.

Training in consultation-liaison psychiatry will allow residents to learn how to apply those basic competencies with medical patients and will significantly augment competency in the specific areas of *medical expert* (e.g. performing a consultation and presenting well-documented assessments and recommendations); *communicator* (e.g. developing ethical therapeutic relationships with patients and families and developing shared care plans);

collaborator (e.g. participating effectively and appropriately in interprofessional health teams); *manager* (e.g. participate in patient safety, well-being initiatives and resource utilization); and *health advocate* (e.g. advocate for health promotion and distress prevention for medical patients and for psychiatric patients needing medical care).[10]

On this foundation, training in consultation-liaison psychiatry will address the additional skills required of the generalist when providing consultation-liaison services in medical settings. These include the abilities to assess neurological dysfunction; to recognize the need for and interpretation of psychological tests; and to make medico–legal determinations and apply ethical decisions. The general psychiatrist must obtain four particular skills to be an effective psychiatric consultant to colleagues managing patients with medical illness:

1. The ability to assess and manage agitation (e.g. delirium).
2. The ability to assess and manage pain (e.g. chronic or palliative pain management).
3. The ability to administer basic drug detoxification protocols.
4. The ability to coordinate and work effectively within multidisciplinary teams.

Additional skills related to medical hospitalization that require emphasis during general training include the ability to:

1. Recognize and understand the significance and unique impact of specific medical or surgical illness on mental health.
2. Assist patients in managing hospital stressors.
3. Apply systems and interpersonal theories.
4. Resolve conflicts (problem-solving skills).
5. Assist patients in placing the course of their hospitalization and treatment in perspective.
6. Initiate transfers to a psychiatry service when indicated.
7. Assist with general disposition planning.

Resources (texts, journals and societies):

Books

- Leigh H, Streltzer J, editors. Handbook of consultation-liaison psychiatry. New York (NY): Springer; 2008.
- Porcelli P, Sonino N, editors. Psychological factors affecting medical conditions: a new classification for DSM-V. Basel (CH): S Karger AG; 2007.

- Lloyd G, Guthrie E, editors. Handbook of liaison psychiatry. Cambridge (UK): Cambridge University Press; 2007.

Journals

- *Psychosomatics* (http://psy.psychiatryonline.org/current.dtl)
- *Psychosomatic Medicine* (http://www.psychosomaticmedicine.org/)
- *Journal of Psychosomatic Research* (http://tinyurl.com/8vhv6b)
- *Psychotherapy and Psychosomatics* (http://tinyurl.com/cpjyk)

Societies

- The Canadian Academy of Psychosomatic Medicine
- The American Psychosomatic Society (http://www.psychosomatic.org/)
- The Academy of Psychosomatic Medicine (http://www.apm.org/)
- The European Association for Consultation-Liaison Psychiatry and Psychosomatics (http://www.eaclpp.org/)

REVIEW OF THE RCPSC OTR/STR

The new STR in psychiatry of the RCPSC require that residents in their senior residency (PGY4 and PGY5) obtain a "supervised experience in consultation and liaison psychiatry (psychosomatic medicine) . . . with medically and surgically ill patients."[8] This experience must be in an adult-specific rotation at least three months in duration (either as a block or as a three-month part-time equivalent), but cannot exceed six months duration.

Clearly, the terminal objective of this training is to ensure that graduating residents have the necessary skills to complete a consultation in adult medical patients. However, to meet this objective they must also be able to work effectively within a multidisciplinary team. Unfortunately, there are some guidelines,[2] but no official, specific recommendations about the extent and content of the training required to meet this objective from either the Royal College or the formal associations that promote consultation-liaison psychiatry (e.g. Canadian Academy of Psychosomatic Medicine, American Psychosomatic Society and Academy of Psychosomatic Medicine). The European Association of Consultation-Liaison Psychiatry and Psychosomatics Workgroup, acknowledges significant training resource issues, including the absence of objectives and guidelines for training, a relative paucity of well-structured consultation-liaison units to provide that training, and the heterogeneous quality of teaching programs both within a given department and within a given country yet recommends a six-month, full-time or equivalent rotation with trainees performing "100 referrals during this rotation."[11]

To be competent as a general psychiatrist, residents should at minimum, have exposure to the common psychiatric presentations of patients in different medical settings. This could be accomplished by ensuring a blanket quota of total referrals within a rotation, as the European Association suggests, but we believe that setting case targets (e.g. the resident should document the history and management of 10 patients with delirium) is the best way to ensure competency within various training sites and programs in managing the common presentations of this practice area.

By using patient logs within a learning portfolio, meeting agreed upon targets provides some flexibility as not all of the targets may be obtained on a consultation-liaison psychiatry service during the mandatory consultation-liaison rotation. For example, part of demonstrating competency in providing consultations across the lifespan could include one or more detailed reports in the resident's portfolio of the assessment and management of a delirious or brain-injured patient during early rotations. If some competencies are realized prior to the rotation this may alter the balance of content of the rotation but cannot replace the core rotation. Furthermore, as training is preferentially delivered in blocks, but in some cases as a part-time equivalent, case targets will ensure true equivalence across these differing training durations and exposures. Also, in programs where there are resource limitations, different teaching tools (e.g. standardized patients, video and written cases) can be used to ensure that the quota for target cases has been met.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

These objectives are proposed as a guide to trainees, supervisors and program directors involved in general psychiatry training. They represent minimal expectations of a resident in training as a general psychiatrist using the CanMEDS format[9] and subsume the enabling objectives for each CanMEDS role as stated in that document.

The attainment of these objectives should be easily confirmed by the resident's performance on the rotation In-Training Evaluation Report (ITER) and by reviewing the resident's portfolio. The use of "in house" practice OSCE (Objective Structured Clinical Examination) and formal STACER (Standardized Assessments of Clinical Evaluation Report) examinations can confirm attainment more objectively.

Table 10.1 Patient numbers by diagnosis to achieve working knowledge[12] in the assessment and management of disorders

Diagnosis	Minimum patient number
• Delirium	10
• Dementia	5
• Mood misorders in the medically ill	3
• Anxiety disorders in the medically ill	3
• Adjustment disorders in the medically ill	5
• Somatoform disorders	5
• Abnormal illness behaviour in medically ill patients	5
• Self-harm and suicide with a special emphasis on their management in a medical-surgical unit, including countertransference and transference issues	5
• Addiction problems in medical settings	5
• Coping with chronic and terminal illnesses	10
• Assessing and managing patients with complex pain syndromes	5
• Cultural, gender, social and age specific theoretical, clinical and therapeutic issues in medical-surgical patients	5

Medical expert

1. By the end of the training period (three to six months; full- or part-time) in consultation-liaison psychiatry, the resident will have demonstrated, in response to a request from another health care professional, the ability to perform, on medically ill patients, a timely, comprehensive consultation with documentation of the assessment and recommendations in written and/or verbal form.

   To reach this objective, the resident will have documented (Table 10.1), under appropriate supervision, at least 10 consultations on patients with delirium; five consultations in each of dementia and somatoform disorders; three cases in each of mood disorders and anxiety disorders in the medically ill; five cases of adjustment disorders in the medically ill; five cases where self-harm and suicidal behaviour within the context of a medical illness has been assessed and managed; and five cases where addiction problems in medical settings have been assessed and managed. The resident will describe the presentation and management of five cases where abnormal illness behaviour has influenced the clinical presentation; 10 cases identifying the coping strategies of patients with chronic and terminal illnesses (three of which must be terminal); five cases demonstrating the assessment and management of complex pain syndromes; and five cases

where specific cultural, gender, social or age-specific theoretical, clinical and therapeutic issues have been identified.

2. The resident will demonstrate an ability to accurately and appropriately assess and document the cognitive ability (mental state) of patients with medical illnesses. This ability will include familiarity in the indications, use and interpretation of bedside screening tools such as the Mini-Mental State Examination, the Montreal Cognitive Assessment, and mood and anxiety assessment scales.

3. Through working on and coordinating medical teams, the resident will demonstrate an ability to enhance the quality of care and safety of patients with comorbid medical and psychiatric illnesses by using and integrating the best available evidence and practices.

4. The resident will demonstrate the ability to arrange appropriate followup care services for patients with comorbid psychiatric and medical illnesses and their families or care providers.

5. The resident will demonstrate a command of evidence-based therapies used in the management of psychiatric complications of medical illness, and recognize their limitations, side-effects, contraindications and interactions with other treatments in this patient population.

6. The resident will demonstrate an understanding of the unique aspects of managing patients with terminal illnesses, including a detailed understanding of the adaptations and psychological issues associated with death and dying and the use of advance directives such as a living will, health-care proxy and power of attorney.

Communicator

1. The resident will demonstrate the ability to effectively facilitate the doctor–patient relationship with patients experiencing medical and psychiatric illnesses in the complex environment of various general hospital and medical institutional settings, and manage the dynamic exchanges that occur before, during and after the medical encounter. As required, the resident will communicate the unique psychological needs and psychodynamics of the patient to members of the health-care team in order to enhance treatment and ensure compliance.

2. The resident will demonstrate a consistent ability to:

    a. Develop rapport, trust and ethical therapeutic relationships with patients and their families in all medical settings.

b. Accurately elicit and synthesize the relevant information and perspectives of patients and families, colleagues and other professionals in all medical environments.

c. Convey relevant information and explanations to patients and families, colleagues and other professionals.

d. Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals that will result in a comprehensive shared plan of care.

e. Develop and concisely convey effective oral and written information about a medical encounter.

Collaborator

1. The resident will be able to participate effectively and appropriately in an interprofessional health team, recognizing and respecting the diverse roles, responsibilities and competencies of other professionals within that team.
2. The resident will be able to describe team dynamics, be able to resolve conflict or other obstacles preventing the team from providing optimal, patient-centred care and, when appropriate, demonstrate leadership within the team.

Manager

1. The resident will be able to identify the unique role of a consultation-liaison psychiatrist and describe the structure and function of the health-care team(s) in this area of practice.
2. The resident will be able to identify methods to evaluate and improve health care delivery to patients with both medical and psychiatric illnesses in a variety of settings.
3. The resident will be able to triage and manage the consultation workload and meet the time sensitive requirements of different medical services.

Health Advocate

1. The resident will be able to identify the unique health needs of patients in their care (see item 1 under *collaborator*) and identify opportunities for advocacy, health promotion and disease prevention in patients with both medical and psychiatric illnesses in a variety of settings.
2. The resident will demonstrate an appreciation of competing interests in health-care teams and be able to identify vulnerable or marginalized patients who may require advocacy and protection.

Scholar

1. The resident will demonstrate the ability to critically evaluate information and its sources, and integrate critical appraisal conclusions into practice decisions within the consultation model and health-care teams.
2. The resident will be able to facilitate the learning of patients, families, students, fellow residents, health professionals and the public as required, and will contribute to the dissemination, application and translation of new knowledge and practice within medicine and psychiatry.

Professional

1. At all times and in all settings, the resident will demonstrate a commitment to their patients, their profession and society through ethical practice and a commitment to delivering the highest quality care.
2. The resident will exemplify appropriate professional behaviours in practice, especially honesty, integrity, commitment, compassion, respect and altruism.
3. The resident will be able to identify and manage conflicts of interest, and recognize and appropriately respond to ethical issues encountered in this practice area.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

Senior residency training in adult consultation-liaison psychiatry differs from the training in junior residency by the knowledge and skill set the resident brings in addition to its emphasis on a specific patient population (the medically or surgically ill) in a specific setting (hospitals or other medical care facilities) with unique problems associated with medical illnesses. Training residents to reach competency in assessing and managing patients commonly referred to consultation-liaison psychiatry services requires exposure to this special population (see Table 10.2) that may present at any stage of the life cycle. Although exposure to consultation-liaison patients may (and likely will) occur at any time during psychiatric residency, including when residents are on call, during their child and geriatric (PGY3) rotations, or in other settings (e.g. shared care within the senior residency), it is only the three- to six-month dedicated experience in an adult specific rotation with medically and surgically ill patients that will meet RCPSC requirements.

To ensure adequacy of the training opportunity and that residents have working knowledge in these areas, they must maintain patient logs within their learning portfolios so that they, their supervisors and their program director can ensure that they have met the minimum requirement of case targets for the core conditions (Table 10.2).

Table 10.2 Case targets for core conditions in consultation-liaison psychiatry

Condition	Range[a]	Note
Delirium	10–15	Some experience can be accrued outside of the consultation-liaison rotation.
Dementia	5–10	Some experience can be accrued outside of the consultation-liaison rotation.
Mood disorders in the medically ill	3–5	Some experience can be accrued outside of the consultation-liaison rotation.
Anxiety disorders in the medically ill	3–5	Some experience can be accrued outside of the consultation-liaison rotation.
Adjustment disorders in the medically ill	5–10	Some experience can be accrued outside of the consultation-liaison rotation.
Somatoform disorders	5–10	All residents are expected to have a working knowledge of somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder and somatoform disorders not otherwise specified.
Abnormal illness behaviour in medically ill patients	5–15	At least 5 case reports illustrating abnormal illness behavior (e.g. hypochondriasis, irritability, denial, or disease conviction) must be present in the portfolio. Double counting of somatoform cases is permitted (i.e. illustrating illness behaviour from a case counted in the somatoform grouping).
Self-harm and suicide	5–10	Some experience can be accrued outside of the consultation-liaison rotation, but self-harm must be in the context of a medical illness.
Addiction problems in medical settings	5–10	Some experience can be accrued outside of the consultation-liaison rotation, but the addiction problem must be in the context of a medical illness. These cases must be separate to the delirium cases above.
Coping with chronic and terminal illnesses	10–15	At least 3 case reports must include a terminal illness. The reports will identify adaptive and maladaptive coping, and describe the therapeutic interventions that directly assisted coping. Other cases can be accrued outside of the consultation-liaison rotation, but must be in the context of a medical illness.

continued

Table 10.2 continued

Condition	Range[a]	Note
Assessing and managing patients with complex pain syndromes	5–10	Double counting of cases with mood disorders or anxiety disorders featuring pain as a prominent symptom is allowed, but the management of the pain syndrome must be specified clearly and identified as a primary point of intervention.
Cultural, gender, social and age-specific theoretical, clinical and therapeutic issues in medical–surgical patients	5–10	At least 5 cases illustrating specific cultural, gender, age or social issues must be recorded. Double counting of other cases in the portfolio permitted provided the specific issue is elaborated upon.

As noted, some of these targets can be reached in any year from PGY2 to PGY5, and do not have to be accrued only when on a consultation-liaison psychiatry service rotation. They must be recorded and retained in the resident's portfolio.

[a] The minimum of the range must be obtained in each of the case targets.

In addition to the above clinical syndromes or situations, and depending on the clinical setting, the consultation-liaison psychiatrist may also work with special patient populations with unique presentations and needs. These include special age groups (children, adolescents and the elderly) and populations (e.g. immune-compromised patients, kidney- and liver-diseased patients, conditions presenting in pregnancy, physically and psychologically traumatized patients, and cancer patients). Ideally, the competent general psychiatrist will have had exposure to all or most of these training opportunities, but in reality, accessibility will be dependent on variables such as the number of learners (paraprofessionals, medical students, residents, fellows) and the availability of specialized programs and clinical supervisors. In smaller training centres where there may be limitations in the number or variety of cases, using case-based illustrations[13] in paper or video format can be appropriate but must be documented. Arrangements should be made to eventually offer diverse, direct, clinical experiences to residents at that site or in other residency programs.

CONCLUSION

Training of the general psychiatry resident in consultation-liaison psychiatry provides unique opportunities to consolidate both medical knowledge and the skills, knowledge and attitudes attained in the junior residency, as well as provides an opportunity to develop important new skills in the assessment and

management of complex patients with medical illnesses in a variety of health-care settings. For some, it will be an important stepping stone to obtaining additional training in consultation-liaison psychiatry, including specialized post-certification training.

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Chapter 11

Addiction psychiatry

David N Crockford and Nady el-Guebaly

INTRODUCTION

Training in the management of addictions remains disproportionately limited in psychiatric residency training programs compared to other major psychiatric disorders.[1] This continues despite the recognition that concurrent addictive disorders in patients presenting for psychiatric care is the norm rather than the exception.[2–5] The Canadian lifetime prevalence for substance use disorders is 12–14 per cent with an associated annual cost of $40 billion in lost work days and medical and legal costs.[6] Excluding nicotine and caffeine, one-quarter to one-half of patients presenting for psychiatric treatment have a lifetime prevalence of a primary or concurrent substance use disorder.[2,4,7–9]

The interaction between addictive and psychiatric disorders is complex. Differentiating a substance-induced disorder from a concurrent psychiatric disorder requires diagnostic skills and knowledge about how addictions, including potential behavioural ones (e.g. pathological gambling), can precipitate and perpetuate psychiatric symptoms.[2,9–11] The general psychiatrist will require effective knowledge, skills and attitudes in the assessment and management of patients with primary or concurrent addictions. An example of this is cigarette smoking in psychiatric patients. It is estimated that 44 per cent of tobacco in North America is consumed by those with a mental illness and cigarette smoking represents a leading preventable cause of death in psychiatric patients.[12] With hospital smoking bans and the known impact of smoking on psychotropic medication levels, means to implement smoking cessation strategies for nicotine-dependent psychiatric patients while maintaining and/or enhancing psychiatric stability is a skill required by the general psychiatrist.[13–15]

Outcomes improve when patients with concurrent psychiatric and addictive disorders receive integrated care rather than separate treatment in a sequential or

parallel manner.[16–20] However, despite the high prevalence, burden of disease and direct relevance to psychiatric care, few psychiatry residents receive training in this area unless elective experiences are sought out.[1] This is reported to be due to a lack of available experienced faculty, negative attitudes towards addicted patients, lack of adequate curriculum and poorly defined educational goals and requirements.[1]

An addictions curriculum would need to involve clinical rotations and seminars to address the clinical knowledge, skills and attitude requirements that would enable the general psychiatrist to be proficient in the management of patients with primary or concurrent addictions. Clinical rotations could be discrete one month rotations, longitudinal experiences or a blended version of these two options, occurring potentially at any time during residency training.

Each training program will need to determine the optimal positioning of the clinical rotation in addictions based on program- and resident-derived factors. Flexibility in the timing and duration of the addiction rotation would lead to significant variability in the foundational knowledge and skills that each resident would possess at that time in their training, a factor that would need to be considered by program directors when establishing rotations.

Junior residents may be more proficient in the medical management of intoxication and withdrawal states, but less proficient in assessment, diagnostic and psychotherapeutic practices for these chronic disorders, potentially limiting the impact of early addiction training experiences on future psychiatric practice. Senior residents may benefit more from addiction training experiences and/or a selective rotation to develop more enhanced skills and attitudes, but residency training programs may have greater difficulty integrating these experiences in the senior years due to limited availability of concurrent psychiatric and addictive disorder training centres and limited access to primary addiction services. Longitudinal experiences may bridge this divide, but it may also be difficult to ensure a consistent training experience involving evidence-based practices.

In 2007, the Royal College of Physicians and Surgeons of Canada (RCPSC) released new Specialty Training Requirements (STR) in Psychiatry outlining the general expectations in addictions training. While the Objectives of Training (OTR) in Psychiatry mentions alcohol and other substance use disorders, it does not specify behavioural addictions. The authors would include this in the definition reflecting the trends in addiction literature.

Proficiencies in alcohol and other substance use disorders are to be realized over the five years of residency training with there being no less than the equivalent of a one-month clinical experience evaluated separately from other rotations. Although it is unlikely that a one-month experience would fully allow the resident to realize the proficiencies expected, the one-month experience and

seminars should provide an adequate foundation for residents in addictions to be augmented by further training experiences and ongoing continuing medical education to meet the requirements.

The core goals and objectives of this chapter are to review and describe clinical content, potential strategies to changing curriculum, and means to develop clinical experiences in addictions so that psychiatry training programs can meet the RCPSC OTR/STR requirements set out for addictions. From this, it is hoped that programs will be able to train the general psychiatrist to flexibly manage patients with concurrent or primary addictive disorders in psychiatric practice in an evidence-based fashion with appropriate optimism for improvement. The section on clinical content delineates areas of knowledge to be covered in addictions, including substance effects, biopsychosocial understanding of the substance use disorders and their overlap with major psychiatric disorders, addiction epidemiology, assessment and diagnostic skills for addictive and concurrent disorders, stage of change and choice of most appropriate treatment setting, community resources and the role of the family in recovery. The section on potential strategies for curriculum changes describes content and means to develop a skill-based, interactive curriculum and its potential timing or sequencing. The section on clinical experiences describes potential options for programs to meet the required one-month clinical experience in addictions, with the pros and cons of the potential approaches, augmented by a sample logbook and potential administrative needs.

The chapter is based upon resource manuals,[21] practice guidelines,[22] position[23] and research papers[24–31] published on medical and postgraduate education in addictions as well as major textbooks,[32–35] with the following being core references:

- Gunderson EW, Levin FR, Levounis P. Medical education. In: Gallanter M, Kleber D, editors. Textbook of substance abuse treatment. Washington (DC): American Psychiatric Publishing, Inc; 2008. p 665–679.
- American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd ed. Am J Psychiatry. 2007;164(Suppl 4):1–123.
- el-Guebaly N, Garneau Y. Curriculum guideline for residency training of psychiatrists in substance-related disorders. Ottawa (ON): Canadian Psychiatric Association; 1996.
- Renner JA Jr, Quinones J, Wilson A. Training psychiatrists to diagnose and treat substance abuse disorders. Curr Psychiatry Rep. 2005;7:352–9.

Additional resources involve the following:

Textbooks:

- Gallanter M, Kleber D, editors. Textbook of substance abuse treatment. 4th ed. Washington (DC): American Psychiatric Publishing, Inc; 2008.
- Lowinson JH, Ruiz P, Millman RB, et al, editors. Substance abuse: a comprehensive textbook. 4th ed. NewYork (NY): Lippincott, Williams & Wilkins; 2005.
- Graham AW, Schultz TK, Mayo-Smith MF, et al, editors. Principles of addiction medicine, 3rd ed. Chevy Chase (MD): American Society of Addiction Medicine, Inc; 2003.
- Miller WR, Rollnick S, editors. Motivational interviewing: preparing people for change. 2nd ed. New York (NY): Guilford Press; 2002.

Journals:

- *Addiction*
- *Alcoholism: Clinical and Experimental Research*
- *Journal of Addictive Diseases*
- *American Journal on Addictions*

Societies:

- American Academy of Addiction Psychiatry
- American Society of Addiction Medicine
- Canadian Society of Addiction Medicine
- International Society of Addiction Medicine

REVIEW OF THE RCPSC OTR/STR

The following is a consolidation of the OTR/STR in addiction psychiatry:

- Supervised experience in the treatment of patients with addictions in a variety of settings. A learning portfolio or log should be maintained and reviewed by the program director. This experience must be undertaken as a discrete rotation of no less than one month, or incorporated as a longitudinal experience (at any time during PGY2–PGY5) of no less than the equivalent of one month. This must be documented and evaluated separately from other rotations.
- Availability of a selective rotation in addictions of no less than three months, but preferably six months during senior psychiatric residency training (PGY4–PGY5) to develop advanced knowledge in addiction psychiatry.

- Proficient clinical knowledge, skills and attitudes appropriate to their practice in alcohol and other substance use disorders.
- Function effectively as consultants, integrating all of the CanMEDS roles to provide optimal, ethical and patient-centred medical care by identifying and appropriately responding to those patients with substance use comorbidity.
- Demonstrate introductory knowledge in assessing suitability for prescribing and delivering motivational interviewing.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

Canadian psychiatric residents will be expected to have proficient clinical knowledge, skills and attitudes appropriate to their practice to assess, treat and appropriately refer when necessary, patients presenting with primary or comorbid disorders along the continuum, from at risk use and abuse to dependence/addiction.

It is recommended that clinical knowledge in addiction psychiatry involve the following domains.

1. Substance effects
    a. Knowledge of the mechanism of action for the primary drugs of abuse and dependence, including alcohol, nicotine, caffeine, cannabis, sedative-hypnotics (benzodiazepines and barbiturates), stimulants (cocaine and amphetamines), opiates and hallucinogens. This would provide a foundation for understanding how substance dependence develops and the basis for different intoxication/withdrawal syndromes.
    b. Knowledge of substance intoxication/withdrawal syndromes enabling their identification and acute management.
    c. Knowledge of the effects of chronic substance use on the development and perpetuation of psychiatric comorbidity and their potential physical complications.
2. Biopsychosocial understanding of the substance use disorders and their overlap with major psychiatric disorders:
    a. Knowledge of the critical role of the brain's extended dopamine reward pathway being the neurobiological basis for how all substances of dependence develop incentive salience for future behaviour choice over natural rewards balanced with descriptions of other biopsychosocial factors predisposing to risk as well as potential resilience from developing addiction, including factors relating to age of exposure,

genetics, personality traits, expectancies from use, environment, peer use, availability, culture, religion and economics.

b. Knowledge of how initial psychosocial factors contribute to the development of addictive behaviours, then progress to having a more biological and chronic basis once addiction develops. This would help explain to trainees how to recognize when different strategies need to be employed to address the continuum of substance use and related addictive behaviours from at risk use to dependence, balanced with appropriate optimism for improvement/change.

3. Addiction epidemiology

   a. Knowledge of the prevalence of each of the substance use disorders, their comorbidity with the spectrum of major psychiatric disorders (including mood, anxiety, psychotic, cognitive, sleep, attention-deficit hyperactivity, personality and somatic/pain disorders), and what factors promote/protect from the development of substance use disorders and behavioural addictions.

4. Assessment and diagnosis

   a. Knowledge including means to assess for the presence of substance use disorders and how to differentiate substance-induced symptomatology from primary psychiatric disorders. Incumbent with this would be familiarity with the use of screening instruments for substance use disorders (e.g.: CAGE, Alcohol Use Disorders Inventory Test (AUDIT) for alcohol; Drug Abuse Screening Test (DAST) for drugs; Fagerstrom Test for nicotine), minimum cut off values and other red flags to indicate when use is potentially problematic requiring further evaluation, and the importance of screening for tobacco, prescription drugs and over the counter medications in addition to alcohol and illicit drugs.

   b. Knowledge of the role of urine drug screening and its limitations as well as awareness of formal instruments to more thoroughly evaluate the impact of addictive behaviours (e.g.: Addiction Severity Index).

5. Stages of change and choice of treatments

   a. Knowledge of the stages of change reflective of the transtheoretical model, including how and when to deliver brief interventions/ motivational interviewing/cognitive-behavioural therapy (CBT)/relapse prevention; consider when to use contingency management, components of appropriate addiction treatment (setting, duration, provider); means to select best treatments and modify this based on response (i.e.: use of the American Society of Addiction Medicine Patient Placement Criteria [ASAM PPC-2R]); and role of

pharmacotherapy including that for comorbidity, opioid substitution, craving reduction, relapse prevention, tapering off of opiods and sedative-hypnotics.

6. Community resources
    a. Knowledge of the spectrum of community resources available to help manage addictions, including mutual help (e.g.: Alcoholics Anonymous, Rational Recovery) and how to facilitate involvement in these resources (e.g.: 12-step facilitation).
7. Role of family
    a. Knowledge of the impact of addiction on the addicted person's family and how to support and involve family in the recovery process.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The following are potential strategies for the modification of current Canadian psychiatric residency training programs, seminars and clinical rotations to incorporate adequate addiction psychiatry training.

1. Curriculum

Emphasize a skills-based curriculum that is interactive and experiential in nature to progressively increase knowledge, skills and attitudes toward patients along the continuum of at-risk use and abuse to dependence/addiction. The curriculum would recognize the lifelong process of learning, building from medical school and reinforced through continuing medical education (CME). The timing and duration of the addictions curriculum could be incorporated into current seminars or stand alone, depending on the needs of each individual program and their available resources. Incorporating addictions curriculum into current seminars (an integrated format) may facilitate greater teaching and discussion around comorbidities, but may limit time available for discussion of specific evidence-based addiction practices and come at the expense of consistency. Stand alone seminars may better allow for in depth discussion of addictions topics and be able to sequence education in addictions to better match trainees foundational knowledge, skills and attitudes as their training progresses, but potentially limit incorporation of practices with patients presenting with prominent psychiatric syndromes. Stand alone or an integrated set of seminars could involve the following:

    a. Basic principles of addiction psychiatry

    In PGY1 or PGY2, three hours of separate or integrated seminar time dedicated to basic principles of addiction psychiatry as they pertain to:

mechanism of action of substances of abuse/dependence, typical intoxication/withdrawal syndromes, biopsychosocial etiology of addiction, awareness of means to identify and screen for harmful substance use, basic assessment skills (including diagnostic criteria and means to help differentiate substance-induced syndromes from underlying psychiatric disorders), and knowledge of brief interventions for substance use disorders and other addictive behaviours.

b. Advanced principles of addiction psychiatry

In PGY2–PGY5, six hours of separate or integrated seminar time dedicated to more advanced principles of addiction psychiatry as they pertain to the following topics:

i. The mechanism of action of substances of abuse/dependence including the effects of substance use acutely and chronically on psychiatric status and cognitive functioning.

ii. Further exploration of the biopsychosocial basis of addiction, linking the neurobiologic effects of substances and the specific brain regions affected with their functional relevance (emphasizing the critical role of dopamine in the acquisition of addictive behaviour and other neurobiological mechanisms involved in relapse) to psychosocial factors that confer risk and resilience.

iii. Review of the epidemiology of addiction and its overlap with psychiatric disorders to better identify the continuum of substance use – from no use, non-problem use and at-risk use, to abuse/dependence, chronicity of substance dependence, and specific means to identify, differentiate and diagnose substance use disorders in psychiatric patients.

iv. Knowledge of specific instruments to screen for substance use disorders and cut-off values indicative of further assessment and attention being required.

v. Means to identify not only alcohol and illicit drug use, but also prescription, over the counter and tobacco use.

vi. Knowledge of urine drug testing, involving when to use, duration of positive tests and limitations to use.

vii. Knowledge of stage of change, how to identify in what stage a patient is, and how to tailor treatment to meet their stage of change.

viii. Knowledge of the differences between abstinence and harm reduction approaches and when they are optimally used.

ix. Knowledge of evidence-based psychotherapies for substance use disorders, including brief interventions/motivational interviewing,

relapse prevention/CBT/behaviour therapy, contingency management, 12-step facilitation, case management and family support.

x. Understanding the concept of recovery with knowledge of mutual support.

xi. Knowledge of evidence-based pharmacotherapies for addictions, including those to manage acute withdrawal, gradual tapers, smoking cessation, opioid maintenance/substitution, protracted withdrawal states, cravings and psychiatric/physical (i.e.: pain) comorbidity.

xii. Knowledge of how to determine the most appropriate treatment setting for intoxication/withdrawal syndromes as well as initial and followup addiction treatment (i.e.: using the ASAM PPC-2R).

xiii. Identification of the importance of involving family members to help further engage patients and address the consequences that addiction has had on the family, but also review the evidence behind behavioural couples counselling.

xiv. Awareness of prevention strategies as they apply to themselves as physicians and colleagues reflecting models of physician health.

c. Addiction psychotherapies

In PGY2–PGY5, either occurring separately, integrated into existing psychotherapy seminars, or part of the addictions lectures, include an introductory seminar equivalent to about three hours, introducing core concepts behind brief interventions/motivational interviewing and relapse prevention that, ideally, incorporate case scenarios or real/simulated patients for practice of techniques and feedback. Concepts inherent to motivational interviewing involving ambivalence as being a normal process of change; the role of therapist as facilitator with the patient having innate ability to change; resistance as an indicator of needing to change therapeutic approach rather than emanating from static patient defenses (rolling with resistance); and how change is facilitated by encouraging the patient to discuss the pros and cons of the status quo, the pros and cons of change, their confidence to change, and their plans to change including specific associated techniques and timing of interventions. Brief interventions would emphasize the FRAMES mnemonic (FRAMES: personalized Feedback, Responsibility, Advice to change, Menu of options, Empathy, and Self-efficacy). Relapse prevention would review means to bring up and address warning signs and triggers for use (cravings, social pressures, high risk situations), as well as how to develop a recovery network and coping skills to manage triggers and negative affect states.

d. Hospital/university rounds programs

An addiction psychiatry focus at least twice annually available to residents at their training sites could not only reinforce content covered in seminars

and clinical rotations, but also emphasize the role of lifelong learning via CME in addictions practice.

2. Rotations

   a. One-month mandatory rotation

      The mandatory one-month rotation in addiction psychiatry may be met by one or more of the following three options involving a supervisor with certification, training or adequate experience in addiction psychiatry or addiction medicine. Preferably rotation experiences would involve multiple treatment types and settings that are inclusive of diversity as it relates to gender, socioeconomic status and ethnicity. Ideally, structured outpatient experiences (e.g.: addiction day treatment settings, established outpatient clinics) would be emphasized to best impart appropriate optimism for change in patients with substance use disorders. This is recommended as inpatient rotations often see the most recalcitrant patients and may inadvertently promote a sense of therapeutic futility, whereas unstructured outpatient experiences would be prone to frequent patient non-attendance. Each option has relative strengths and weaknesses.

      i. An intensive one-month addiction rotation

         Such a rotation may fit best in PGY1 or during one month of the mandatory PGY2 six-month inpatient or six-month outpatient general psychiatric training experience, occurring at a dual diagnosis residential or outpatient treatment facility structured like a day program (the program's primary focus is on addictions, but is able to treat patients with stable Axis I or II disorders via on-site psychiatric care or available consultation with staff able to understand and identify signs of psychiatric disturbance); an inpatient or outpatient dual diagnosis enhanced addiction treatment program (program treats mental disorders and addictions in an integrated fashion with psychiatry present on-site and staff cross-trained to identify and treat both disorders); or with the individual practice of a full-time addiction psychiatrist or specialist in addiction medicine. This type of experience would allow for intensive but brief exposure to addiction treatment of a variety of patients, but may not provide a long enough experience to see adequate change in individual patients, provide an adequate understanding of the long-term course and evolution of addictive disorders, and potentially more positive outcomes with ongoing intervention.

      ii. A longitudinal training experience

         Training would occur longitudinally at some point during, and potentially over the entire five years of psychiatric residency. The equivalent of a dedicated one-month rotation must be obtained. This type of rotation would likely provide the greatest opportunity to see

multiple patients with addictions and comorbidities, a continuum of addictive disorders, the perspectives of a variety of supervisors, and opportunities for trainees to manage acute intoxication and withdrawal syndromes. The greatest strength may be that it would allow for residents to manage patients with addictions in a variety of practice settings, particularly one they may work in after completing training, to best allow translation of their learning to practice. However, availability of supervision by physicians with addictions training or experience may be difficult to arrange in this type of rotation. This may compromise evidenced-based training or interfere with mentorship. Continuity of care is also a potential dilemma within the longitudinal rotation, especially as residents change rotations. Patients may drop out or relapse when not having a consistent program to attend and residents may not come to fully appreciate the long-term course and evolution of addictive disorders.

iii. A blended or time-limited longitudinal experience

In this model, residents would attend to patients with addictions at a structured outpatient addiction or concurrent disorder program once a week for a full-day or half-day over six or 12 months, respectively. Such a model would best be scheduled during the mandatory PGY2 six-month inpatient or six-month outpatient general psychiatric training experience. This model would most likely ensure supervision by physicians who follow evidence-based addiction practices and would allow for the involvement with patients over a somewhat longer time frame than an intensive one-month rotation so that change can be observed. However, this model affords less opportunity for the assessment and management of crises or relapses, including the management of acute intoxication and withdrawal syndromes.

In addition to how the addiction psychiatry experience is organized, it is recommended that trainees experience mutual help meetings (i.e.: Alcoholics Anonymous) as part of their one-month rotation. They should visit and be aware of community resources available to patients with addictions, so that they can appropriately use these resources in future clinical situations. Most hospitals have open Alcoholics Anonymous or Narcotics Anonymous meetings on site and attendance by trainees could be negotiated with the leaders of these meetings.

b. Selective (or elective) rotation

A selective (or elective) in addiction psychiatry or addiction medicine of at least three months duration is possible in PGY4 and PGY5. Not all programs may have this opportunity available. If a selective is not available for whatever reason, then arrangements may have to be made with other programs to allow residents to take the selective at a

different site. The selective rotation would be designed to help senior psychiatry residents:

i. Further develop proficiency in the assessment and management of patients with primary and comorbid addictive disorders.

ii. Further modify physician attitudes toward addicted patients.

iii. Allow trainees to better develop appropriate skill sets to routinely and competently manage such patients in their practices after they graduate.

A three-month selective could more easily allow for the attainment of proficiency in addictions set out in the OTR/STR, while a selective (or elective) of up to 12 months could allow for advanced skills to be developed and potentially, with adequate practice experience or fellowship training, to meet addictions certification standards.

3. Administration and evaluation

Given that training in addictions has become more formalized, all programs will need to appoint a training coordinator for this endeavour who hopefully will be an addiction medicine or psychiatry specialist. This individual would help to develop residency training in addictions and identify or develop skilled preceptors who would supervise residents and provide didactic teaching in addiction psychiatry. Ideally, the training coordinator and supervisors would have certification in, fellowship training in, or extensive practice experience involving evidence-based addiction psychiatry/medicine. Supervised addictions training may be available from other specialties like family medicine or community health, which could be used if there are insufficient numbers of psychiatrists to supervise. Training of skilled faculty would be a priority for those programs lacking available and skilled supervisors. Resident interest in addiction psychiatry should be identified to foster faculty growth and development. The addiction training coordinator would also be responsible for developing an evaluation form addressing the CanMEDS roles for all residents in the training program in order to document their completion of an addictions rotation of no less than one month or a longitudinal experience (at any time during PGY2–PGY5) of no less than the equivalent of one month. A logbook of addictions experiences is encouraged to ensure adequate breadth of exposure. A sample logbook with potential content experiences is included at the end of this document as Appendix 11A and 11B.

4. Other considerations

Programs without psychiatrists active in the ongoing care of patients with addictions who have prior fellowship training in addictions, substantial expertise in, or certification in addiction psychiatry/medicine will need to identify and collaborate with other residency training programs at their institution or clinicians in their community (i.e.: family practice and/or internal medicine specialists with certification in addiction medicine or extensive experience in addiction medicine). Affiliations with off-site residential, day treatment, and

outpatient addiction treatment programs could also be established if there is a current lack of on-site programs capable of providing the described structured addiction training experiences. In addition, the training of clinician educators in addiction psychiatry/medicine would be a priority for sites that currently have limited to no resources of this type.

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Appendix 11A: Sample logbook		
Addiction experience	Date (yy/mm/dd)	List 2 learning points from each addiction experience
1. Acute intoxication/withdrawal management a. Alcohol b. Sedative-hypnotic c. Stimulant d. Opiate		
2. Chronic addictions management a. Alcohol dependence b. Sedative-hypnotic dependence c. Opiate dependence d. Stimulant dependence e. Cannabis dependence f. Nicotine dependence		
3. Special populations a. Comorbid addiction and psychotic disorder b. Comorbid addiction and depression disorder c. Comorbid addiction and anxiety disorder d. Geriatric addiction e. Child and adolescent addiction f. Behavioural addiction		
4. Mutual help attendance		
5. Addiction psychotherapy experience a. Motivational interviewing b. Relapse prevention/ CBT for addictions c. 12-step facilitation		

Appendix 11B: Logbook entry format

Major content areas in addictions for trainees to experience applicable to their practice as a consulting psychiatrist are identified in the logbook, with greater description of each area below. Roughly equal numbers of male and female patients is preferable as is diversity in exposure to cultural diversity, both of which could be incorporated into the documentation. Dates of each experience and two specific learning points from each is suggested as part of the documentation. An example would be as follows:

Addictions experience	Date	Learning Points
Benzodiazepine	08/02/25	Convert dose of short-acting to (female) dependence equivalent long-acting benzodiazepine, then taper 10 per cent/week. Utilize an anticonvulsant during end of taper to facilitate discontinuation.

Content areas:

1. Acute intoxication/withdrawal management

Trainees would document their experience in managing at least four patients (one of each of the four listed substance types) presenting with acute intoxication or withdrawal from: a) alcohol; b) sedative-hypnotics (benzodiazepines, barbiturates, or other sedative-hypnotic); c) stimulants (cocaine, amphetamines, sympathomimetic amines, MDMA); and d) opiates (heroin, morphine, methadone, codeine, other narcotic analgesics, fentanyl).

2. Chronic addictions management

Trainees would document their management of at least six patients (one of each of the six listed substance types) with dependence to the following substances: a) alcohol; b) sedative-hypnotics; c) opiates; d) stimulants; e) cannabis; and f) nicotine. Management would be biopsychosocial in nature and involve at least four separate contacts with each individual patient where evidence-based practices are utilized and adequate followup arranged as part of the documentation.

3. Special populations

Trainees would document their work-up and management of at least five patients (one of each involving five of the six categories) with: a) comorbid addiction and psychotic disorder; b) comorbid addiction and depressive disorder; c) comorbid addiction and anxiety disorder; d) geriatric (over age 65) addiction; e) child/adolescent addiction; and f) behavioural addiction (i.e.: pathological gambling).

4. Mutual help attendance

Trainees would document their attendance at no less than two mutual help meetings (Alcoholics Anonymous, Narcotics Anonymous).

5. Addiction psychotherapy experience

Trainees would document their learning and use of three typical psychotherapies for addictions with individual patients involving: a) motivational interviewing (need to document both the seminar attended and use with a patient); b) relapse prevention/CBT for addictions; and c) 12-step facilitation.

Chapter 12

Shared/collaborative mental health care

Nick Kates

INTRODUCTION

Collaborative mental health care refers to a family physician or other primary care provider working together with a psychiatrist or other mental health worker in a mutually supportive partnership. The responsibilities of care are shared and apportioned according to the respective skills of the providers and the (changing) treatment needs of the patient.

The focus of this chapter, and of the training objectives for collaborative care, is on collaboration with family physicians and other primary care providers, with the resident spending time working in a primary care setting. However, the principles can be adapted to working with other community agencies. Working in a primary care setting provides opportunities for a resident to work as a consultant and to apply the expertise they have already developed in an integrated manner, developing skills and attitudes which address parts of all the CanMEDS components. It also helps the future psychiatrist to play a role in building well-integrated service networks and using mental health resources as effectively and efficiently as possible. The chapter will also look at how these concepts can be applied to working collaboratively with other community partners and agencies.

These experiences enable the resident to appreciate the range of problems that are seen in primary care and the way they present along the entire spectrum of a disorder. While the diagnostic classifications in primary care are the same as in psychiatry, problems may present in undifferentiated ways or as “subthreshold” disorders. This also provides an understanding of the problems that can (and

cannot) be managed in primary care, as well as the kinds of problems that are managed in primary care without referral to psychiatry, or after treatment in a mental health program has been completed.

Despite the wide array of experiences such a placement offers, the time available for residents for this component of their training is limited. This chapter therefore identifies the "core" skills that every resident should have developed in this area, along with the key concepts with which they should be familiar. It also outlines topics that can arise during these placements, which can be discussed with the resident to help them broaden their understanding of the role of primary care in their community's/province's mental health system. Finally, it identifies activities for residents interested in spending more time in collaborative practice, as an elective or a career path.

In almost every Canadian community the family physician and/or primary care provider plays a key role in delivering mental health care, often with limited support from mental health services. Twenty-five per cent of individuals seen in primary care have identifiable (although not always identified) psychiatric disorders—usually depression and anxiety—and the majority of these individuals are treated in primary care and not referred to mental health services. In addition, while depression and anxiety often accompany general medical problems such as vascular disease or diabetes and, if untreated, can increase morbidity and mortality rates, very few of these individuals receive guideline-based care for their mental health problems or are referred to mental health services. If these problems are to be addressed and treatment initiated, this probably needs to occur within the primary care setting.

Despite the high prevalence of mental illness and the burden of care assumed by primary care providers, the interface between primary care and mental health services is often characterized by poor communication, a lack of understanding of what the other has to offer, and limited collaborative activity. With shortages of mental health resources in many communities, it is important to establish strong collaborative partnerships between mental health and primary care services, where psychiatrists often function as consultants, helping family physicians expand the range of problems they can handle, while allowing rapid access to mental health services when needed. Ideally, care is "shared" with both partners remaining involved in the care of an individual, as required, and each partner supporting the other to optimize the care they can deliver.

In such a partnership, psychiatrists need to think about populations as well as individuals and are expected to provide more than just clinical care to a diverse range of patients. They will be asked to discuss case-related issues where the patient may not need to be seen, to assist with accessing resources outside the primary care setting, to support family physicians when managing more complex cases, and to provide educational interventions that will help family

physicians to increase their skills and comfort in managing mental health problems.

When working well, collaborative partnerships improve access to mental health care (especially for populations that traditionally underuse mental health services), reduce waiting times for care, and lead to better communication and better coordinated, more continuous care, delivered in a location that is more familiar and often easier to reach for a patient. Integrating mental health services into primary care settings also offers opportunities for early detection and treatment of mental health problems, patient and family education, physician education and the integrated treatment of individuals with comorbid mental and physical health problems that may not be possible when working in a mental health clinic. These benefits have been recognized by a growing number of provincial and regional health system planners and funders, who are increasingly incorporating these models in their planning for primary care and mental health services.

To prepare themselves for what is increasingly seen as an expectation of a practicing psychiatrist, residents can gain experience and develop expertise in working collaboratively by:

- A rotation spent working in a primary care setting.
- Communicating routinely with a family physician and involving him/her in the care plans for every patient being seen on every rotation during the training.
- Getting involved in additional elective projects, clinical opportunities (such as outreach consultation visits) or elective rotations during the senior years of their training.
- Spending time working with a community agency such as public health, home nursing services, a street clinic or a community counselling service.

A key to the success of collaborative projects with primary care/family physicians is for psychiatry residency programs to remember that, like the clinical practice itself, the planning for these rotations needs to be seen as a joint venture between the academic departments of psychiatry and family medicine in the same medical school from the outset.

Before starting to work in a collaborative partnership, residents need to have a working knowledge of assessment, the principles of working as a consultant, team functioning and an introductory knowledge of local community resources. More senior residents should also be familiar with the principles of a consultation-liaison relationship, which they will be able to adapt to primary care, and should be able to assess a broad range of cases and provide practical management advice to another health professional.

Programs need to consider how training in collaboration with primary care physicians is linked with training in consultation-liaison psychiatry as there are many common skills and concepts that can be applied to both. Ideally, the onsultation-liaison psychiatry rotation will precede the primary care experience, although this is not essential.

Residents in their senior years of training will be able to gain additional skills as a consultant by taking on additional responsibilities for the management of a collaborative partnership and the planning of new program components.

The introduction of training in this area will be a new activity for many programs, and finding the resources to provide the teaching (human and educational) may be a challenge. To assist with this, it is anticipated that the collaborative working group on shared mental health care of the Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) will coordinate the development and distribution of relevant materials to programs and residents through 2010.

In addition, the shared care website (www.shared-care.ca) will be available to program directors, faculty and residents to submit any materials or readings they have found helpful, with the opportunity to link these on a separate password-protected page on the site. These resources may include:

- Selected key background readings/articles.
- Presentations given to residents in different programs.
- Examples of useful materials/tools already developed.
- Guidelines on how to make a consultation arrangement with primary care work well.
- Links to other useful sites.

Resources

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REVIEW OF THE RCPSC OTR/STR

Residents in PGY1 spend three blocks in family medicine or one to three blocks in collaborative/shared psychiatric care. However, it is only in the PGY4–PGY5 years that a resident will be able to meet the specialty training requirement for collaborative/shared care with family physicians, specialist physicians and other mental health professionals. The senior resident experience may be undertaken as a discrete rotation of no less than two months, or incorporated as a longitudinal experience of no less than the equivalent of two months duration.

CanMEDS objectives that can be best met through these training experiences, or which add a different dimension to the way these objectives can be met in other settings are:

- A *medical expert*, handling a broad array of clinical problems in adults, children, seniors, families and couples.
- A *collaborator*, providing consultation to both the family physician and the system (practice), and bridging the divide between mental health and primary care services.
- An *advocate*, both for patients being seen in primary care and also for the needs of primary care within the mental health system.
- A *communicator*, when preparing clear and useful consultation reports and providing educational interventions with primary care staff as well as patients and their families.
- A *manager*, taking responsibility for overseeing a program in primary care and for addressing issues that arise at the interface between the two systems.
- A *professional*, as the consultation experience helps the resident develop their identity as a psychiatrist in an environment where they are expected to conduct themselves as a representative of their profession.
- A *scholar*, with opportunities to understand the presentations of psychosocial problems and distress in primary care, learn more about the ways in which the partnership can be improved, and to apply data from studies in other settings.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

Specific goals and objectives for the training are as follows. These are not classified by the CanMEDS role they address, as many of these objectives address more than one role.

1. To understand and appreciate the needs and challenges of primary care:
    a. The concept of primary care as the "medical home" of the patient.
    b. The prevalence of mental health problems in primary care.
    c. The role of the family physician and primary care in community health systems.
    d. The role of the family physician and primary care in providing mental health care.
    e. Looking after a population as well as individuals.
    f. Referral patterns to and from mental health and community services.
    g. Problems that can arise at the interface with mental health services.
    h. How mental health services do/could respond to the needs of primary care.
    i. The potential and opportunities in primary care for:
        i. Early detection
        ii. Prevention of relapse
        iii. Identifying individuals at risk
        iv. Working with families
        v. Health promotion
2. To learn from primary care providers about:
    a. How comorbid mental health and physical problems present and are treated.
    b. How mental health problems are handled and why.
    c. Challenges and barriers when accessing the traditional mental health system.
    d. Challenges in introducing behavioural changes within the realities of primary care.
    e. How community services are being used.
    f. What problems family physicians find the most challenging and why.

3. To appreciate the potential and advantages of the clinical consultation when the consultant and consultee are working in the same clinical setting and are in regular contact.

4. To develop an identity as a psychiatrist by consulting to another discipline as a representative of the profession.

5. To develop skills in consulting to a system of care (i.e. addressing issues that are broader than those presented by an individual patient). This includes:

    a. Seeing primary care as a system of care, recognizing and addressing system/organizational issues that may interfere with patient care/outcomes.

    b. The steps and principles in integrating into an existing system as a consultant.

    c. Implementing models for improving care or redesigning specific aspects of the health delivery system, in partnership with the practice.

    d. Assessing unmet needs of populations in a practice and looking at ways these could be met.

    e. Being able to map and discuss a process of care, identifying areas where it could be improved.

    f. Learning when and how to organize a case conference.

    g. Professional and ethical issues when working in another system of care.

6. To assist in the management of a wide variety of clinical problems and populations as they present in primary care, including children, adults, seniors, families and couples, and applying or adapting the skills they have learned in other rotations.

7. To learn about the potential role of primary care in a health-care delivery system, and identifying those problems that can be treated effectively in primary care and those which need a referral to a mental health service.

8. To look at how consultative approaches change the flow of cases into and out of mental health programs, and the implications this has for resource usage.

9. To apply these same skills when working in other community settings such as a community agency.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The primary focus for meeting collaborative care objectives will be through working closely with primary care providers. Generally, this should occur as part of a resident's practice in any setting throughout residency. During every rotation a resident will have the opportunity to communicate with family physicians and involve them in the care of patients being seen in a mental health setting by contacting a family physician to inform them or discuss the case when a patient is admitted to a service, involving the family physician in the development of the discharge plan, and contacting the family physician after discharge to ensure the patient has followed through with the plan. Some rotations may also offer residents the opportunity to work with community agencies on a consultative basis during any ambulatory rotation.

Although many residents will spend part of their PGY1 experience in primary care, this experience will not replace the expectations in years PGY2 to PGY5. It should be framed in such a way that it can help residents to start thinking about the role of primary care from the perspective of a (future) psychiatrist, but will primarily focus on the management of all clinical problems seen in primary care. PGY1 will however also provide the resident with an understanding of the demands and time pressures of primary care, the ways in which mental health problems can present and are managed or referred, the difficulties in accessing the mental health system, and the attitudes of primary care staff to individuals with mental health problems. This will provide a solid context for their work in the final four years of training. In the PGY1 experience the beginning resident roles and responsibilities will be quite different as contrasted to the senior resident experience.

A one-page sheet on the role of primary care in the mental health system and a series of questions to consider during the rotation can be prepared to assist PGY1 residents going into a family medicine rotation to think about these issues. This can also be facilitated by a single PGY1 seminar on this topic.

The specific shared care/collaborative experience as specified in the Royal College of Physicians and Surgeons of Canada's (RCPSC) Specialty Training Requirements (STR) is intended to be a senior experience in which the roles and responsibilities of the resident build upon all previous exposure and training. The most effective way to realize the goals and objectives is a rotation in which the senior resident works in a family physician's office/primary care network. This is the optimal scenario for training a resident because of the central role family physicians play in providing mental health care. However, this may present challenges to some programs because of the lack of available placements. This section will address five educational methods to realize the goals of a shared/collaborative care rotation, including the steps that can be

taken to put such rotations in place within a two-month time frame. It will also look at alternative ways to meet these objectives until two-month family physician rotations are available.

1. Clinical experiences

   a. A clinical rotation in primary care

      Working in primary care allows senior residents to develop new skills as consultants and assess a rich and varied assortment of cases, which challenge them to draw on the knowledge and skills they have developed during the training and integrate these into their case assessments and presentations. A number of important general considerations are relevant to the rotation experience including:

      i. Establishing the role and expectations of the resident during the placement

         - Defining the boundaries and expectations of the resident as well as the partnership at the beginning of rotation.
         - Sitting in on a family physician's day—this should be done at the start of a placement to give the resident an understanding of what happens during his/her day, and to provide a context for the mental health care a resident will deliver.

      ii. Opportunities to work with a psychiatrist who is already providing consultation to family physicians. During this rotation, residents should have the opportunity to:

         - Learn about the pace, demands and needs of primary care and family physicians.
         - Learn about how family physicians approach mental health care/priorize cases.
         - Assess a broad array of cases and come up with comprehensive treatment plans.
         - Assess families as well as individuals.
         - Learn how to conduct an effective consultation.
         - Provide verbal and written summaries for the person requesting the consultation.
         - Observe their supervisor conducting an interview.
         - Be observed conducting an interview. This may also be very good preparation for the long case clinical interview for the final exams (the Standardized Assessment of a Clinical Encounter Report, known as STACER).

- Observe what a family physician does during the course of a day. The resident should spend the first day of a collaborative placement 'shadowing' the family physician to see what he/she does and get an understanding of the kinds of problems seen in primary care.
- Observe how a psychiatrist and family physician conduct a collaborative partnership

iii. Skills to be developed:

- Conduct an assessment in a non-traditional setting.
- Prepare and delivering a verbal report.
- Prepare a succinct written summary of an assessment.
- Participate in team discussions.
- Provide followup to a small number of cases.
- Provide telephone backup.
- Access the mental health system.
- Use available community resources.

iv. Location of the rotation

The ideal location for this rotation is a practice where a group of family physicians work in the same location and deliver comprehensive care as part of an interprofessional primary care team, including one or more mental health counsellors. In reality, this may not be available for every program or rotation, and the activities will need to be adjusted accordingly.

v. Duration of the rotation

Programs can consider two ways of offering the two-month experience in primary care. The first is a full-time placement in a primary care setting for two months and the second is a part-time longitudinal placement in which the resident trains and works in the same practice one to two days a week over the course of six months or a year. There are advantages to both, but a longitudinal rotation allows the resident to build a more multi-faceted relationship with a practice and the staff so as to engender a greater sense of connection to that clinical setting. It also allows for a direct comparison between the primary care experience and the work they are doing in other settings during the same time period.

b. Activities that can complement or take the place of a rotation in a family physician's office

For programs that may not have immediate access to rotations in primary care, alternate clinical experiences can be found by working with community agencies such as public health, home care/home nursing programs and street health clinics. A resident can also spend a two-month rotation working within a community agency, especially one which has a range of programs in which the resident can participate. If no primary care rotation is available, a resident can spend time working with a medical specialist in an ambulatory practice, applying many of the same principles and being available to see and discuss cases as required.

c. Advanced or selective opportunities

- Taking on more administrative responsibility for the consultation relationship.
- Working with different kinds of primary care practices or settings.
- Working with primary care colleagues to advocate for and promote changes in systems of care and organizational functioning.
- Opportunities to work with a community agency as a consultant (clinical or administrative) as a longitudinal elective.
- Conducting an evaluative or research project.
- Taking on specific teaching responsibilities with family medicine residents.

2. Seminars/tutorials

There are two core topics, which need to be addressed in specific half day seminars, if not covered elsewhere in the program. Whenever possible a family physician or family medicine resident should be involved in the seminar. Many other topics can be linked to collaboration with primary care.

a. Seminars with a primary focus on this area

i. In PGY1

The role of primary care in mental health-care system, and the relationship with psychiatry. This would be a one hour introductory seminar that would address one or two topics from the PGY2 seminar list.

ii. In PGY2

- Working collaboratively with primary care providers (PGY2 or PGY3). This would include:
  - The prevalence of mental health problems in primary care.
  - The role of primary care in managing mental health problems.

  - Problems with access to mental health care.
  - Problems at the interface between mental health and primary care services.
  - Principles to guide a collaborative partnership.
  - Examples of effective collaborative models.
  - Evidence from the literature as to what works.
  - How to work effectively in a primary care setting.
  - The benefits of this approach.
  - Implications of this approach for the system.
  - Medical comorbidity.
  - Understanding systems of care and their implications for teams.
- Working effectively as a consultant, including preparing a written report

b. There are many advantages to stimulating residents to think about the role primary care plays in daily clinical practice by discussing or highlighting this role in other seminars. Possible topics include:

- Quality improvement.
- Team functioning.
- Early detection and treatment.
- Medical comorbidity.
- Motivational interviewing and chronic disease management.

c. Related concepts to discuss during a rotation.

These are topics which are likely to arise during a two-month placement, especially if the supervisor is able to help the resident identify them, which highlight some of the differences or potential when working in primary care and which can be instructive to explore. Examples of these include:

- Confidentiality and the circle of care.
- Medico–legal issues within a collaborative model.
- A framework for thinking about wellness.
- Early detection and intervention, and the roles primary care can play.
- Problems with access to mental health services and potential solutions.

- The changing role of the psychiatrist.
- Working with a population as well as individuals.
- Which patients are best treated in which settings and why.
- The limitations of this approach.
- What is patient-centred care and how should that be reflected in clinical plans.
- Ethical issues arising from collaborative practice.

3. Teaching opportunities for a resident

An excellent way for residents to synthesize their knowledge and present it in ways that are easily understood by non-mental health professionals is to take on a teaching role or assignment. This can be with other residents, family physicians, other mental health professionals, patients and families, and can be formal (organized teaching/learning sessions) or informal (brief case-based educational discussions). This can be accomplished in a number of ways.

a. If a psychiatrist is involved in on-site teaching of family medicine residents, a resident may be able to accompany him/her either for a brief period during a rotation, or for a longitudinal elective. He/she would initially observe, but would also be a resource to family medicine residents and would be able to play a more active role in the teaching itself, especially if it is case-based.

b. Through participating in regular rounds in the primary care setting on problem cases. Residents can present cases or information to primary care providers, or psychiatry and family medicine residents can present a case together.

c. Patient teaching, i.e. group visits or presentations to community groups.

This can be supported by:

- The departments of psychiatry and family medicine within an academic department or a hospital, organizing joint educational sessions or rounds once or twice a year. These should be case-based and allow faculty and learners from the two departments to learn together and from each other. One option may be a joint presentation by psychiatrists and family physicians who are already working together in collaborative partnerships.
- Looking for opportunities for psychiatry and family medicine residents to participate in joint learning sessions or seminars, where they can learn from each other, or make a joint presentations at rounds or in the primary care setting—the concept of bidirectional learning.

A more senior psychiatry resident can play a more active role in continuing education events for family physicians on mental health topics, in conjunction

with the psychiatrist who is involved with the program, or can become involved in teaching medical students and other primary care staff.

4. Being mentored

Residents may benefit from visits to programs where this model is working, or to accompany faculty already engaged in such activities. Examples of this could include:

   a. Visiting other communities where such models are in place.
   b. Accompanying a psychiatrist who may be involved in outreach consultative activities to family physicians in other (usually more isolated and underserved) communities.
   c. Attending the national collaborative mental health care conference.

5. Investigative activity/improving care

While there may be opportunities for senior residents to take on investigative or research projects during their final years of training, a more viable activity would be for a resident to identify one small area they wanted to improve during their two-month placement (or equivalent), such as introducing a brief screening tool, using the improvement model and rapid Plan, Do, Study, Act (PDSA) cycles to test and measure the impact of introducing such an improvement.

OTHER CONSIDERATIONS

This will be a relatively new venture for many programs. One of the challenges will be finding (preparing) and supporting psychiatrists to work as teaching faculty in primary care settings.

A starting point when developing effective educational interventions will often be to establish a working partnership with the family medicine department in the same medical school in order to ensure family physicians are involved in the planning of these initiatives from the outset. It may, in some instances, be necessary to highlight why this is an important activity for both specialties. This will make it easier to find appropriate clinical settings, and to ensure that there is no competition for resources and to increase opportunities for family medicine and psychiatry residents to work together.

Other challenges may include:

1. Finding suitable training sites

This can be challenging for programs that do not have such rotations in place, and can take one or two years to develop. Ways to facilitate this include:

- Identifying potential training sites and family physicians who would be willing to host visits from psychiatry residents.

- Developing a number of placement options, as some family physicians may not want a new resident coming to their practice every two months.
- If existing rotations are not in place, a program may need to work with local primary care practices to build appropriate placements. It may take a while for a program to create these rotations and recruit one or more psychiatrists to fill the teaching role, but in the long run a program is better served by building the collaborative partnership first and then adding a resident, rather than putting a resident into a clinical setting that may not be ideal.
- Placements can also be integrated with experiences with specific populations—e.g. child, geriatrics.
- If a placement is based around the work of an individual rather than a location, there may be problems with sustaining a placement if that individual were to leave that site.

2. Practical aspects of implementing collaborative placements
    - Space in primary care can be a potential barrier—this needs to be thought through and residents prepared accordingly.
    - The nature of funding for both primary care and psychiatry may either promote or inhibit education in collaborative care. Ideally, psychiatrists in this arrangement will be funded on an alternate payment basis, such as a sessional fee, which may allow time for teaching, although these rotations can also be organized in fee-for-service situations, as in many other clinical placements.

SUMMARY

With a growing recognition of the importance and benefits of better collaboration between mental health and primary care services in all of Canada's provinces and territories, the opportunity to spend time working in a primary care setting, learning about the role primary care plays in mental health systems and what family physicians are looking for from mental health services, needs to be seen as an integral part of a resident's training. This kind of clinical experience enables the resident to apply many of the skills they have developed in different rotations, to forge their identity as a consultant and to see first-hand the potential and benefits of collaborative partnerships.

Chapter 13

Developmental neuropsychiatry: teaching residents in psychiatry about developmental disabilities

Bruce D McCreary and Jessica Jones

INTRODUCTION

Brian has Down's syndrome. Now 41, his family physician has referred him to the psychiatry clinic with a six-week history of disinterest in normal activities, "absent-mindedness," and apparent depression. At age five, Brian's parents had requested an assessment of his intellectual level and needed advice from the clinic's psychologist about managing his stubbornness. At age 20, the clinic social worker had assisted him and his family in effecting a successful transition for Brian from living at home and attending school to living in a group home and to employment as a busboy in a local restaurant. The clinic psychiatrist, with minimal training in developmental disabilities and no experience in the care of persons with Down's syndrome, is unsure about how to proceed. He phones a developmental disabilities "subspecialist" at the medical school and learns that the differential diagnosis includes dementia, depression, hypothyroidism and sleep apnea.

Two months after treatment for Brian's hypothyroidism is started, the group home counsellor reports that he is "fully recovered."

In Canada, persons with developmental disabilities and those who care for and support them expect help from a variety of health-care professionals. Depending on individual circumstances, physicians, nurses, psychologists, social workers and rehabilitation therapists have something to offer and it is expected that every psychiatrist, like the clinic psychiatrist in the vignette, will have attained a

"working knowledge" of developmental disabilities. Beyond this, it is expected that some psychiatrists, like the subspecialist in the medical school who was consulted about Brian's care, will have enhanced expertise.

Individuals with cognitive and adaptive impairments that commence early in life (i.e. during development) are said to have a "developmental disability" in North America, or a "learning disability" in the United Kingdom. "Mental retardation," the official nosological designation, has developed a stigmatic connotation and is therefore avoided in daily practice, while continuing to be used in scientific investigations around the world. The prevalence of mental retardation is one to three per cent of the general population, peaking in school-aged children when case-finding is maximized.

This chapter is concerned with training psychiatry residents about developmental disabilities. It includes approaches to establishing both "working knowledge" and enhanced levels of expertise. The term developmental disability is broadened from a traditional focus solely on individuals with significant intellectual impairment (i.e. mental retardation or intellectual disability) to include disorders such as fetal alcohol spectrum disorder[1] and autism spectrum disorder,[2] where intelligence may fall in the normal range but lifelong adaptive difficulties are characteristic. By emphasizing the mental health needs of individuals with developmental disabilities, this chapter embraces "dual diagnosis" to recognize that psychiatrists, in particular, provide diagnosis and treatment of the mental disorders that are comorbid in this population. Up to 40 per cent of children and adults with developmental disabilities have psychiatric comorbidities.

Unfortunately, developmental disabilities and dual diagnosis have received less than adequate attention in psychiatry training programs in Canada.[3] Not unexpectedly, a "key informant" survey of the availability of mental health services for individuals with developmental disabilities[4] reveals that generic mental health clinicians are poorly prepared to provide care and that specialized services, although less common, often have excessively long wait times, especially for children and adolescents. Recognizing that contemporary teaching needs improvement, this chapter offers suggestions for Canadian psychiatry training programs about enhancing their ability to do a better job. For each program, there needs to be instruction that ensures "working knowledge" of developmental disabilities for each trainee and an ability to support those who have a subspecialty interest, either through training on site or in another academic centre where appropriate resources are available.

In recent years, "developmental neuropsychiatry" has been adopted as a useful term for conceptualizing the knowledge, skills and attitudes that need emphasis in serving patients with developmental disabilities and dual diagnosis. Knowledge of normal mental development and of how various biomedical and psychosocial insults prevent, delay, or distort it is critically important. And skills

in communicating effectively with disabled patients and their caregivers are equally relevant. Unduly pessimistic attitudes about individuals with developmental disabilities and their mental health problems need to be reversed. With these considerations in mind, a text titled Developmental Neuropsychiatry[5] is a key reference for trainees. For those interested in a Canadian reference text, A Comprehensive Guide to Intellectual and Developmental Disabilities[6] is suggested. Additionally, the *Journal of Intellectual Disability Research* and the *Journal of Applied Research in Intellectual Disabilities* have emerged as important vehicles for communicating advances in the field. *Current Opinion in Psychiatry* publishes an annual update in developmental disabilities to serve as an ongoing review of new literature from a variety of sources. The Canadian Association for Research and Education in Intellectual Disabilities (CARE-ID) is a growing professional organization concerned with the field and the Canadian Psychiatric Association has established a section on developmental disabilities.

REVIEW OF THE RCPSC OTR/STR

Guidance provided by the Royal College of Physicians and Surgeons of Canada (RCPSC) is used in this section to create a framework for considering the training targets and pedagogical strategies relevant to developmental disabilities as outlined in subsequent sections.

The goals for training junior residents (i.e. those in their second and third years of training) and senior residents (i.e. those in their fourth and fifth years of training) can be distinguished in the RCPSC guidelines. With respect to junior residents, “patients with developmental delay across the lifespan, with or without a psychiatric disorder, must be included”[4] in the various clinical rotations that are mandatory. Junior residents are provided with practicum experiences for the development of a “working knowledge” of developmental disabilities and “proficiency” in many of the comorbid disorders involved in “dual diagnosis.”

For senior residents, the RCPSC does not prescribe specific training requirements for developmental disabilities, but it is one of nine options for selective rotations. And amongst elective rotations, options such as developmental paediatrics, genetics and neurology can be seen as particularly relevant to the field of developmental disabilities. Finally, if a senior resident is interested in developmental disabilities and in training for six months in another centre, there are a number of possibilities to consider both in Canada and abroad. Accordingly, selective and elective options can be combined to facilitate enhanced expertise amongst senior residents interested in developmental disabilities as a subspecialty.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

What training is needed to equip a psychiatrist, like the clinic psychiatrist in Brian's case, to provide care for an individual with a developmental disability and mental health problems? And what additional knowledge and skills are desirable for the medical school psychiatrist who provided the telephone advice on differential diagnosis?

An outline of the knowledge relevant to answering these questions is illustrated in Table 13.1. The core knowledge for each of child and adolescent psychiatry, general adult psychiatry and geriatric psychiatry is outlined. As junior residents participate in these required clinical rotations, core knowledge will be taught, leaving senior residents who choose a selective or elective in developmental disabilities to build on what they have already learned. Tables 13.2 and 13.3 list the skills to be acquired during junior and senior clinical rotations respectively.

PGY1 residents are unlikely to experience significant exposure to individuals with developmental disabilities unless they choose an elective rotation on a clinical team with a particular role in serving these patients. Accordingly, it is important to ensure that junior residents acquire the core knowledge identified in Table 13.1 and the clinical skills listed in Table 13.2. Didactic and clinical instruction provided for junior residents should clearly establish that:

- Developmental disabilities involve mental impairments that, although commencing early in life, are associated with lifelong adaptive difficulties.
- Developmental disabilities, although often idiopathic, increasingly can be ascribed to identifiable etiologic factors, many with direct relevance for planning treatment and prevention activities.
- Assessment and treatment, to be successful, require modification of clinical procedures used in the general population, and usually require more professional time than does caring for members of the general population.
- Serving patients with developmental disabilities involves respect for the attitudes and opinions of family and agency providers, and effective professional collaboration across the medical, education and social service sectors.
- Assumptions about prognosis for comorbid mental disorders are often unduly pessimistic because their clinical features are not clearly distinguished from the enduring characteristics of the developmental disability.

It is unlikely that these important goals will be met unless during each of the three mandatory rotations for junior residents a minimum of 10 patients with developmental disabilities are assigned.

Table 13.1 Core knowledge in developmental disabilities

1. Child and adolescent psychiatry
   - i. INTRODUCTION: Overview of definitions, epidemiology, clinical features, etiology and management
   - ii. ASSESSMENT PROCEDURES: Collecting histories, mental status examination, psychological testing, use of special investigations (e.g. imaging, electroencephalogram, genetic testing)
   - iii. DIFFERENTIAL DIAGNOSIS OF DEVELOPMENTAL DELAY: Mental retardation, autism, sensory impairments, specific language or motor delays and learning disabilities
   - iv. GENETICS: Genetic syndromes, behavioural phenotypes, non-genetic causes and investigating idiopathic cases
   - v. MANAGEMENT AND TREATMENT: Working with schools and social agencies, interdisciplinary teamwork, biomedical and psychosocial interventions and informed consent
   - vi. FAMILY ISSUES AND TRANSITION PLANNING: Supporting parents and siblings, physical and sexual maturation, leaving school and leaving home
   - vii. DUAL DIAGNOSIS IN CHILDHOOD AND ADOLESCENTS: attention-deficit hyperactivity disorder, autism spectrum disorders, mood disorders, problem behaviours and effects of abuse/neglect
2. General adult psychiatry
   - viii. NOSOLOGY: Diagnostic manual – intellectual disability: a clinical guide for diagnosis of mental disorders in persons with intellectual disability versus Diagnostic criteria for psychiatric disorders for use in adults with learning disabilities/mental retardation (DC-LD).
   - ix. DUAL DIAGNOSIS IN ADULTS: Psychoses, mood and anxiety disorders, problem behaviours, effects of abuse/neglect, sexual disorders, autism spectrum disorders, conflict with the law, diagnostic overshadowing and behavioural presentations
   - x. FAMILY ISSUES AND PERMANENCY PLANNING: Working with social agencies, marriage and parenting, bereavement and family estate planning
3. Geriatric psychiatry
   - xi. PATTERNS OF AGING: Health care, mortality rates, premature and atypical aging
   - xii. DUAL DIAGNOSIS IN SENIORS: Mood disorders, Diogenes syndrome, dementia and adjustment disorders

Table 13.2 Clinical skills for junior residents

- How to construct a comprehensive clinical and developmental history by interviewing family or agency caregivers, and by reviewing "background" reports on the patient's family/personal history, schooling, psychological testing and hospital visits.
- How to identify physical and behavioural features suggestive or diagnostic of a genetic or other biomedical syndrome associated with a developmental disability.
- How to modify the standard mental status examination to accommodate those with limited or absent verbal communication skills and to be aware of and responsive to non-verbal cues.
- How to engage consultants (e.g. genetics, neurology) and allied health professionals (e.g. clinical psychology, speech-language pathology) in relevant assessments and in the preparation of a treatment plan.
- How to identify and disentangle the clinical features of a developmental disability and a comorbid disorder in preparing a diagnostic formulation and treatment plan.
- How to establish an individual's capacity to provide informed consent for treatment and/or to make personal/financial decisions.
- How to provide psychiatric treatment for individuals with developmental disabilities in emergency, outpatient and inpatient settings.
- How to engage family and agency caregivers in supporting and contributing to the treatment and followup care.
- How to review and understand the psychiatric literature as related to patients with developmental disabilities.

Table 13.3 Clinical skills for senior residents undertaking selectives or electives

- How to assess and manage individuals with rare and complex disorders associated with developmental disabilities and dual diagnosis.
- How to serve as a consultant for medical and psychiatric colleagues who are prepared to provide treatment and followup if "expert" support and guidance are available (e.g. "shared care").
- How to work collaboratively within an interprofessional team to develop multidisciplinary treatment plans.
- How to advocate with health, education and social services on behalf of individuals with developmental disabilities and their caregivers.
- How to complete forensic assessments of individuals with developmental disabilities "in conflict with the law" and to prepare reports for their legal advisors.
- How to inform and teach health-care professionals about developmental disabilities and dual diagnosis.
- How to critically review the literature on developmental disabilities and to generate new questions for study.

Table 13.4 Areas of clinical relevance for elective rotations

Developmental pediatrics
- The differential diagnosis of "developmental delay"
- The roles of rehabilitation therapies and of assistive devices in serving patients with developmental disabilities

Genetics
- Genetic syndromes with characteristic behavioural phenotypes
- Genetic counselling for parents and siblings of persons with developmental disabilities

Neurology
- Congenital anomalies of the brain and spinal cord, and their management
- Seizure disorders and psychiatric issues in the use of anticonvulsant medications

The clinical skills listed in Table 13.3 for senior residents reflect:

- Continuing refinement of the knowledge and skills obtained as a junior resident.
- Experiences that will ensure competency as a consultant, advocate, manager and "academic" (teaching and research) in the subspecialty.

A selective within the training program, or an elective in another, can be individually designed to meet these goals. Alternatively, a senior resident may choose an elective in one or more closely related medical disciplines—three such disciplines and relevant topics for each are illustrated in Table 13.4.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The purpose of this section is to outline various pedagogical strategies that will ensure that the training targets described for junior and senior residents in the previous section can be achieved. It is recognized that some Canadian psychiatry training programs will face significant challenges in implementing these strategies and that others will experience little or no difficulty. This variability needs to be faced squarely by program directors and department heads so that every Canadian resident will develop a working knowledge of developmental disabilities, and that those with subspecialty aspirations can receive the desirable additional training. A training program that does not have the necessary infrastructure and faculty will need to share resources with programs that do, using creative solutions like "visiting" professors, video conferences and resident exchange rotations.

According to the RCPSC guidelines, junior residents will receive their clinical instruction in settings providing "mainstream" mental health care for

children/adolescents, adults and seniors. While these arrangements are supportive of contemporary social policy in Canada to include individuals with developmental disabilities in the same services that are provided for members of the general population, patients with dual diagnosis are unfortunately often neglected. Indeed, at times, stigmatization that is based on limited and distorted perceptions of mental disorders in individuals with developmental disabilities by mainstream providers is passed on to residents, thereby creating another generation of misunderstanding. All instructors need to acknowledge the special efforts, including the extra professional time, required to serve patients with dual diagnosis.

The knowledge outlined in Table 13.1 can be conveyed through a variety of teaching exercises, including assigned reading, lectures and seminars. Seminars would appear to be a preferred approach so that there are opportunities to discuss complex issues such as diagnostic overshadowing,[8] the impact of comorbid medical disorders[9] and a tendency for psychopathology to present behaviourally.[10] Interdisciplinary instruction, involving developmental pediatricians, family physicians, geneticists, neurologists and clinical psychologists will have added benefits in relation to understanding the contributions of professionals from other fields in serving individuals with developmental disabilities. The skills listed in Tables 13.2 and 13.3 are obviously learned "on the job" in hospital and community-based settings, supplemented ideally by spending time in disability specialty clinics, schools and social agencies serving individuals with developmental problems. Residents should be encouraged to select patients with developmental disabilities for "grand rounds" presentations and relevant journal articles for presentation and discussion at journal clubs.

The availability of at least one developmental disability subspecialist, preferably devoted full-time to the field, appears desirable for each training program. Unlike the arrangements for junior residents whose clinical supervisors are not developmental disabilities subspecialists, the senior resident should be directly supervised during a selective by a subspecialist "mentor" in the field. Psychiatrists who serve as mentors in developmental disabilities, in addition to holding hospital privileges that facilitate consulting for colleagues in child/adolescent, adult and geriatric psychiatry, also provide consulting services to schools and various developmental/social agencies. Accordingly, senior residents have supervised experiences in visiting schools and agencies, and in functioning as a member of an interdisciplinary team. There are also opportunities to provide care for patients with dual diagnosis who may require intervals of intensive treatment while, at the same time, continuing in school or a developmental services program. With responsibilities in each of the health, education and social service sectors, the mentor and senior resident can advocate on behalf of patients and their families. Such advocacy is especially important

when there are conflicts at the interface between sectors that prevent optimal care. Patients in conflict with the law may be particularly challenging for care providers. Residents need every opportunity to learn about matters such as fitness to stand trial and the disposition of charges in a manner that will prevent reoffending. In addition to direct clinical supervision, the mentor serves as a coach in teaching opportunities and as a guide in selecting and evaluating the professional literature on developmental disabilities. Some residents will need guidance in choosing elective rotations. Beyond these responsibilities, the subspecialist will assist the program director and other instructors in creating an optimal scholarly environment for learning and extending knowledge about developmental disabilities.

CONCLUSION

This chapter began and will end by considering our clinical vignette. At age 41, Brian has already needed mental health services at three different times during his life. It appears inevitable that as a senior he will require further help. Individuals with Down's syndrome, like Brian, are uniquely predisposed to develop Alzheimer's neuropathology as they age. Based on this predisposition, he will likely develop seizures and a dementia. Indeed, the probability is high that he will die of aspiration pneumonia in the terminal stage of the dementia.

Brian's story illustrates a number of important themes in training psychiatric residents about developmental disabilities:

- Respecting a lifespan approach, even until death.
- Recognizing the differential diagnosis of developmental delay, various genetic disorders and behavioural phenotypes.
- Working collaboratively with family and agency caregivers, the health-care team and representatives of the educational and social service sectors.
- Adjusting assessment and treatment approaches to respect the impact of medical problems and the pathoplastic effects of early onset intellectual impairment on psychiatric symptomatology.

While Down's syndrome may be perceived to be a rare condition, other genetic disorders associated with developmental disabilities (e.g. Smith-Magenis, de Lange, Williams) are even less common. Apart from the biomedical and behavioural complexities associated with these disorders, and regardless of etiologic considerations, individuals with developmental disabilities face a wide array of psychosocial challenges (e.g. neglect, stigmatization, abuse, etc.) that can lead to psychiatric referral. There is an obvious need for clinicians with a

working knowledge of the field and for sophisticated generalists to serve as consultants for mainstream mental health services, schools and social agencies.

To ensure success in training psychiatric residents about developmental disabilities, some particular suggestions have been offered. Many will be challenging to some training programs. The "How to . . ." training targets for junior residents and for selectives in developmental disabilities offer a basis for evaluating the progress of individual trainees and for the arrangements provided by their training program to support this progress. Two Canadian publications also include formats for self-evaluation.[11,12]

Practicing in Canada, like Australia, but unlike the United Kingdom where "learning disabilities" is an established subspeciality of psychiatry,[13] involves expectations that every psychiatrist will be familiar with assessing and treating patients like Brian. So the need for developmental neuropsychiatrist mentors in each psychiatry training program and for flexibility, innovation and resource sharing are important considerations. Assuming success in engaging the interest of trainees and in providing them with high quality instruction, the existing shortcomings in serving individuals with developmental disabilities and mental health problems in Canada can be overcome.

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Chapter 14

The treatment and rehabilitation of individuals with severe and persistent mental illness

Alison Freeland, Alain Labelle and Rajiv Bhatla

INTRODUCTION

Treatment of severe and persistent mental illness (SPMI) is both a challenging and immensely rewarding aspect of psychiatric clinical practice. In Canada, approximately 20 per cent of the population will experience a mental illness during their life. Of those, three per cent of the population or nearly one million Canadians will have a SPMI. Although the definition of SPMI is complex and without consensus, most would agree that the concept encompasses three core features: diagnosis, duration and disability. At the core is mental illness with moderate to severe disability over a prolonged duration that can arise at any point during the lifespan.

There are many variables that add to the complexity of treating individuals with SPMI, including wide range of age of onset, declining or poor community functioning, concurrent addiction or developmental delay, and significant burden to family and caregivers. Given the potential for including an array of diagnostic categories under the auspices of SPMI training and the difficulty that this might have on developing clear training guidelines in a three- to six-month rotation, the Royal College of Physicians and Surgeons of Canada (RCPSC) Specialty Committee in Psychiatry has limited the focus of this rotation to the treatment of schizophrenia and bipolar disorder.

Training in the treatment of SPMI involves a varied knowledge and skill set that includes pharmacological strategies, evidence-based psychotherapeutic

approaches, family therapy and psychoeducation, cognitive remediation, and a comprehensive knowledge of the different rehabilitation and case management approaches available in the community.

Residents bring foundational knowledge to this rotation that will be of assistance. Experience in assessing patients with schizophrenia and bipolar disorder in previous outpatient, inpatient and emergency room rotations will be built upon as residents become more experienced in identifying the full range of psychotic spectrum symptom clusters. In particular, emphasis is placed on identifying the impact that this cluster of illnesses has on individuals who have to struggle with the effect of negative symptoms and cognitive impairment in their day-to-day functioning and on the role of psychiatric rehabilitation in addressing this deficit. Residents will also bring foundational knowledge of basic pharmacology including drug interactions and adverse events. Residents in this rotation will develop skills in treatment resistant illness, including the challenges of prescribing complex drug regimes to patients who may not respond to monotherapy. Similarly, prior psychotherapy supervision and training will provide a strong base on which to develop specific skills around cognitive-behavioural therapy, family therapy and motivational interviewing in this population.

In addition, this chapter will outline the need for awareness of jurisdictional mental health legislation and skills, and its application in both hospital and community settings. Leadership and administrative skills necessary to work effectively with multidisciplinary teams will be emphasized.

The following resources will be helpful to residents and educators:

Papers:

- Wasylenki D, Goering P, Cochrane J, et al. Tertiary mental health services: I. key concepts. Can J Psychiatry. 2000;45(2):179–184.
- Cochrane J, Goering P, Durbin J, et al. Tertiary mental health services: II. Subpopulations and best practices for service delivery. Can J Psychiatry. 2000;45(2):185–190.
- Canadian Health Services Research Foundation. Teamwork in healthcare: promoting effective teamwork in healthcare in Canada. Policy synthesis and recommendations. Ottawa (ON): Canadian Health Services Research Foundation; 2006.

Training guidelines:

- Canadian Psychiatric Association. Clinical practice guidelines: treatment of schizophrenia. Can J Psychiatry. 2005;50(13)S7–S57.

Books:

- Bezchlibnyk-Butler K, Jeffries J. Clinical handbook of psychotropic drugs. Cambridge (MA): Hogrefe and Huber Publishers; 2006.

- Mueser K, Jeste D. Clinical handbook of schizophrenia. New York (NY): Guildford Press; 2008.
- Goodwin F, Jamison K. Manic depressive illness. 2nd ed. New York (NY): Oxford University Press; 2007.
- Stein L, Santos A. Assertive community treatment of persons with serious mental illness. New York (NY): Norton and Company; 1998.

REVIEW OF THE RCPSC OTR/STR

Residents were previously required to complete six months in a "chronic care" rotation, but the new Royal College training requirements now stipulate completion of three to six months training in a setting where the focus is on SPMI and its rehabilitation. This can include a specific SPMI rotation such as a schizophrenia or mood disorders program, a forensic psychiatry rotation (keeping in mind that the focus is on SPMI and not on forensic psychiatry per se), or in a community-based treatment team such as an assertive community treatment (ACT) team. Residents are also required to complete concurrent and longitudinal training consisting of at least one year, or preferably two, of supervised treatment of patients and their families with a severe and persistent psychotic illness for no less than two hours per month of direct care. This longitudinal experience must be documented and evaluated separately from other rotations.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

All CanMEDS roles are to be learned and practiced in the provision of patient-centred care, across the lifespan and in a variety of settings. The role of *medical expert* and *collaborator*, providing comprehensive clinical care including a strong ability to function within a multidisciplinary team setting, are CanMEDS roles that can be well developed within the SPMI rotation.

Medical expert

The assessment of individuals with SPMI is complex given the variety of psychosocial factors involved in a comprehensive review. In addition to assessments generally required in a comprehensive consultation, issues related to the extent of the patients disability and its far reaching impact on activities of daily living (ADLs), vocation, recreation and relationships must be fully explored. Complex, unusual or persistent phenomemology is not uncommon in SPMI. These symptoms (e.g. paranoia, irritability, poor insight, disorganized

thought, paranoid delusions, etc.) may require several evaluations over an extended period of time with input from collateral sources. Additionally, initial and ongoing assessments may also occur in both hospital and community-based settings. Within the community, residents may assess clinical issues at a community health centre, a client's home, a shelter or on a street corner. Each of these settings requires a unique set of skills that allows rapid engagement of the patient, followed by both observation and assessment of mental status, while preserving confidentiality and effectively balancing the safety of the patient and public with one's own personal safety.

1. The resident is expected to be *proficient* in the following competencies as medical expert:
    a. Knowledge of the different symptom dimensions of SPMI, including positive, negative, disorganized, affective and neurocognitive domains of illness.
    b. Formulation of a biopsychosocial model of SPMI, using the concepts of protective, predisposing, precipitating and perpetuating factors.
    c. Knowledge of differences in presentation of individuals in the prodromal, acute and chronic phases of illness as they occur across the lifespan.
    d. Knowledge regarding course of illness and factors that assist in predicting outcome and prognosis of illness.
    e. Development of necessary skills in obtaining collateral information from family members and other individuals involved with supporting or caring for the patient, while respecting the sensitive issues of patient confidentiality.
    f. Development of skills in pharmacological intervention in SPMI related to long-term use of both oral and intramuscular medications, monitoring strategies, augmentation strategies, drug interactions and impact of physical illness on prescription of medications is essential.
    g. Prescription, titration and monitoring of clozapine in treatment resistant illness.
    h. Assessment of risk of harm to self and others in patients with SPMI, including expertise in discerning these concerns in a patient group where at times there is an unwillingness to divulge information about symptom experiences.
    i. Knowledge of principles of crisis and emergency interventions as they pertain to SPMI, including a clear working knowledge of mental health legislation as it applies in community-based settings. Development of effective working relationships with police, mobile crisis teams and psychiatric emergencies is also emphasized.

2. In addition, the resident should have *working knowledge* of the following competencies as medical expert:

    a. Knowledge of treatment strategies to address stabilization of acute phase, prevention of relapse and readmission as well as improvement of functional outcomes.

    b. Development of assessment skills in screening for metabolic disorders in this patient population and linking patients with appropriate treatment.

    c. Knowledge of the neurodevelopmental and neurodegenerative processes associated with progression of SPMI over time.

    d. Awareness of the neurocognitive impairment associated with the disease process found in SPMI and the potential burden these deficits impose on patient recovery and rehabilitation.

    e. Knowledge of and understanding about concurrent disorders in SPMI. This includes further developing skills and knowledge acquired in addictions training, with emphasis placed on appropriate treatment strategies, including harm reduction versus abstinence models.

    f. Knowledge of medical comorbidities in SPMI, including development of skills in assessing cardiovascular risk and morbidity, metabolic risk and morbidity, treatment of obesity, as well as illnesses related to homelessness and poverty. As many patients may not have primary care physicians, residents will develop skills in assessing and triaging medical problems, as well as in promoting shared care arrangements where patient's medical treatment can be arranged.

    g. Familiarization with the roles and responsibilities of multidisciplinary team members to ensure effective leadership in integrating the efforts of all team members to provide best outcomes for the patient.

    h. Development of skills in working with families to reduce relapse and re-hospitalization. Residents should understand the importance of family psychoeducation when dealing with SPMI and become experienced in working with families in this regard. Principles of engagement with family and supervision in active support and therapy with families should occur over the course of training.

    i. Development of abilities to prescribe and undertake individual psychotherapy with patients suffering from SPMI. In addition to supportive psychotherapy, cognitive-behavioural therapy for residual psychotic symptoms and for comorbid anxiety and depressive pathologies is expected to be used. Motivational interviewing in treatment of concurrent disorders in SPMI is also a useful tool to

develop. Skill development in these psychotherapeutic modalities can be undertaken as part of the one-year longitudinal training experience.

j. Awareness of cognitive remediation as a tool for the residual cognitive impairment that significantly impacts on functional outcomes.

k. Awareness of an integrated treatment approach for concurrent SPMI and substance use disorders.

l. Knowledge about case management resources and ACT teams.

m. Familiarization of principles of psychiatric rehabilitation and recovery awareness of when to appropriately refer to these services. Within the framework of psychiatric rehabilitation, experience in assisting patients develop personal goals related to living, learning and working, and the strategies which can be accessed to assist in attainment of goals is essential.

n. Awareness of the concept of recovery. Residents will contribute to a supportive environment that embraces human rights and a positive culture of healing and recovery, which can result in an experience of hope, empowerment and connection for individuals with SPMI.

Collaborator

Given that a multidisciplinary team-based approach is usually the most effective way of treating individuals with SPMI, developing skills to fulfill the role of *collaborator* is essential for residents. When working in a multidisciplinary team setting, residents must enter into an interdependent relationship with other professionals for the provision of high-quality care. Within this framework, residents must learn to clearly describe their roles and responsibilities to other professionals as well as being clear about the roles and responsibilities of other team members. Residents should also be able to teach and learn from other professional colleagues and demonstrate respect for the competencies and skills of team members. An effective multidisciplinary team can work together to assess, plan, provide and integrate care for individual patients. A resident must not only be able to function within this framework, but must also be able to demonstrate and provide appropriate leadership.

1. The following learning objectives apply specifically to the role of collaborator and residents should demonstrate *working knowledge* in each of these areas:

    a. Understanding of social issues affecting individuals with SPMI is important for residents to understand and appreciate. Health Canada identifies 12 determinants of health, many of which must be understood when treating the SPMI population. Issues of income, employment, education and social support networks are particularly relevant. The

stigma associated with mental illness and its impact on individuals with SPMI should also be understood. Individuals with SPMI must often use a variety of community and social supports.

b. Development of knowledge related to the range of community supports and programs (e.g. day programs, workshops, drop-in centres or peer support groups), range of housing and supported housing, and the various treatment supports available such as assertive community treatment, case management and outreach services is expected.

c. Residents must know and apply mental health legislation applicable to their training jurisdiction and understand the interface of the mental health system with the legal system. The application of this legislation will often take place in the community, most notably in areas of financial capacity, community treatment orders and outpatient certification and will require collaboration with other multidisciplinary care givers.

Other CanMEDS roles

The development of *health advocate*, *manager*, *scholar* and *professional* roles are vital parts of resident training in the area of SPMI. Patient needs are diverse and residents must learn to appropriately and effectively advocate on behalf of patients at a variety of levels. This requires understanding of the various governance structures within the health sector (e.g. community agencies, hospitals, governments). In the role of *manager*, residents need to develop the skills to effectively manage clinical priorities, system dynamics and resource allocations. Effectively synthesizing and disseminating information is an important aspect of scholarship, which should be developed and honed throughout one's residency and career. Professional attitude and behaviours in all areas of interactions and endeavors must also be developed and reinforced throughout residency training and beyond.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

Clinical settings

The RCPSC objectives require PGY4–PGY5 residents to complete between three to six months of experience in SPMI and its rehabilitation.

1. ACT teams

A placement with an ACT team is recommended.

Residents should be exposed to rotations that allow them to develop an understanding of rehabilitation and the recovery process, and allow a familiarization with the range of supports necessary to foster patients' illness management and recovery. Rotations that develop the resident as a member of a multidisciplinary treatment team would be most suitable. Residents should be exposed to principles of ACT, illness management and recovery. They should also become familiar with the importance and the range of active community integration and support initiatives, including supported housing, supported education, supported socialization, program of activities of daily living, advocacy efforts, individualized support and support for the development of problem solving skills.

ACT teams typically offer treatment and care to patients primarily with schizophrenia spectrum illness, who have significant complex psychosocial issues such as difficulties with housing, employment, relationships and the criminal justice system. The ACT team works as a multidisciplinary team in the community, providing intensive support and care to these patients who might otherwise spend significant amounts of time in the hospital. Service is flexible and long-term, and provides the range of care from crisis intervention and support to rehabilitation and recovery-focused approaches.

This kind of placement will allow residents to develop skills as *medical experts* since the resident will have opportunities to do consultations in a variety of clinical settings and for a number of different purposes. Admission assessments will provide the experience of doing a formal consultation directly with the patient as well as highlight the importance of gathering collateral information. This will include making recommendations that may or may not include admission to ACT services.

In addition, crisis and emergency assessments are part of the repertoire of the ACT experience, and residents will have the opportunity to develop skills in both community- and office-based assessments of patients in crisis. Experience in dealing with local emergency rooms, police services and knowledge of provincial mental health legislation are also part of this acute assessment process. Finally, residents will develop skills in ongoing management and care

of patients with SPMI with respect to medication management, as well as providing supportive psychotherapy to patients, family support and care. During an ACT rotation, residents will be exposed to patients with schizophrenia spectrum disorders and major mood disorders, and will develop expertise in recommending, prescribing and monitoring a number of classes of pharmacological agents.

ACT also allows the opportunity for students to develop skills and knowledge in principles of psychiatric rehabilitation. In particular, ACT teams provide a focus on the recovery model of mental illness, where patient-centred choices are respected and supported, and where a strengths model of rehabilitation takes precedence. The resident will be expected to play an integral role in assisting the team to develop a short and longer term treatment plan for individual patients based on these principles. ACT embraces a "can-do" attitude whereby patient goals of independent living and functioning in the community are seen as attainable even in the face of significant residual symptoms of illness, as long as careful planning is done and necessary skills are developed in order to make the patient's attainment of goals as successful as possible. For the resident, this means that experience and comfort in learning how to balance necessary treatment and, at times, loss of personal freedom and choice for the patient with issues pertaining to patient autonomy and choice, is mandatory.

ACT teams are places where residents can develop skills as collaborators in the multidisciplinary care of SPMI. Medical leadership on ACT teams is a necessary part of day-to-day practice and residents have the opportunity to develop interest in management and administrative psychiatry. The experience of managing the human resources required to effectively support persons with SPMI in the community is a fundamental aspect of this rotation. Residents will learn to appreciate the role of supervising and coordinating multidisciplinary team members, and dealing with conflict and stress which may arise among team members dealing with severe and persistent mental illness. Part of the resident experience needs to involve actively taking on the *consultant* role, with supervision from the preceptor around participation as a team member and leader.

2. Alternatives to ACT teams

Some programs may be able to offer residents an experience with an ACT team, but there is some variation across the country with respect to funding and therefore availability of these teams to postgraduate training programs. Residents can however acquire similar experiences by becoming involved in multidisciplinary inpatient and outpatient teams working in hospital-based schizophrenia, forensic or mood programs. The important issue is to ensure that the resident does not function just as a *consultant*, but plays an active role in planning treatment and care with the multidisciplinary team, and working with family and community-based caregivers with respect to discharge planning and

ongoing outpatient care. If residents choose to do their rotation in a forensic setting, it is extremely important that the focus of patient care is on the assessment and management of the patient's symptoms as well as on discharge planning, and, ideally, with some experience related to community-based treatment and care. The forensic rotation should not provide a focus on fitness and not criminally responsible assessments. These are areas that pertain to specialty training in forensic psychiatry, and not to developing expertise in management, care and rehabilitation of SPMI.

Rotation duration

With respect to the length of rotation in a placement with an ACT or inpatient or outpatient multidisciplinary team, a minimum of three months, but preferably six months, is recommended if the resident is to gain the full benefit of collaborative team work. It generally takes most residents at least two months to become familiar with the objectives of the rotation, the patients they are following, the team members they will be working with, and their own role within the team. Functioning effectively as a consultant to the team and learning how to manage the resources that contribute to the care of patients with SPMI (e.g. housing providers, addictions services, criminal justice system, emergency care providers, provincial disability support plans) requires a significantly longer period of time. It would be difficult to accomplish this in a meaningful way within three months.

Residents with a chosen career track such as child psychiatry may understandably choose to do a three-month rotation in complex and continuing care. A placement in a schizophrenia, mood or forensic outpatient department may be most appropriate in this case. In this situation the resident will have some exposure to functioning in a multidisciplinary team and will also be able to provide consultation to community agencies and caregivers with respect to making recommendations about both pharmacological and psychosocial treatment strategies.

Otherwise, it is recommended that residents elect to do a full six-month rotation in order to get maximum benefit of learning to integrate in, and then provide leadership and guidance to, a team working with these complex patients. Learning to manage the resources and supports that surround a patient with SPMI is as important as learning to manage the actual symptoms of illness. This cannot be done over a shortened period of time.

Numbers of patients

It is difficult to be specific in terms of recommending specific numbers of patients to see over the course of a three- or six-month rotation. The impact of the clinical setting (e.g. whether travel time has to be accommodated, whether the resident will have the opportunity to do indirect patient consultation or be required to supervise other members of a multidisciplinary team) as well as the

complexity and acuity of the patients being followed will all dictate how many patients are appropriate for the resident to be assigned responsibility. In general however, the resident should be exposed to carrying out two complete assessments per month of a patient with SPMI, which focus not only on psychopathology and psychiatric history, but also emphasize assessment of functional capacity as it pertains to the patient's daily life and the impact it has on those involved in providing support and care. Based on these assessments, the resident must make detailed recommendations about psychopharmacological interventions as well as rehabilitative interventions and appropriately recommend specific treatment and rehabilitative strategies.

Residents should also have exposure to patients where there is a different emphasis on treatments. Although pharmacological, psychotherapeutic and rehabilitative strategies are all important in each and every patient, it would be ideal if the trainee was assigned patients in equal proportion emphasizing each of these treatment domains. It is easy to lapse into a more consultative and traditional medical model of treating patients with SPMI by focusing on the pharmacological treatment of patients with residual symptoms. Every effort must be made to ensure that the trainee has direct and ongoing experience in participating in psychotherapeutic and rehabilitative aspects of care, and not see this as something for which professionals from other disciplines are responsible.

As a guide, residents working in an inpatient setting should be assigned five to seven inpatient beds to manage, with appropriate face-to-face supervision on a minimum biweekly basis. Attendance at a weekly inpatient team meeting for the purposes of reviewing patient care and treatment planning is also recommended. Involvement in any multidisciplinary case conferences or discharge planning meetings should be part of the rotation experience. Ideally, the resident should have time to follow discharged patients for the duration of their rotation in order to obtain a more comprehensive experience in managing SPMI patients. Residents in an outpatient setting should be able to follow a minimum of 10 patients over the course of their rotation, which would include individual sessions with the patient as well as regular attendance at team KARDEX rounds, routine family/caregiver meetings, or case conferences to develop treatment plans. Residents placed on an ACT team should be assigned 15 patients to follow. This would include individual meetings with the patient as well as active involvement in weekly cardexes and case conferences. Regular weekly contact with the supervisor is also necessary in this setting.

Longitudinal experience

Residents are expected to complete a minimum of 12 months, and preferably 24 months, of supervised treatment of patients with a severe and persistent mental illness, as well as their families, for no less than two hours per month of direct care. In theory, this is an excellent addition to the training requirements of

psychiatry residents since it provides the necessary experience of caring for patients, their families and caregivers in a typical outpatient setting. Seeing a patient over a prolonged period of time provides a more "real life" clinical experience and allows time for the resident to assess and understand the impact that SPMI has on a patient's quality of life.

Many patients with schizophrenia and bipolar disorder are difficult to engage in outpatient care. The resident will learn to tackle issues related to poor insight, paranoia, impulsivity and cognitive impairment, all of which can impede the treatment process. Difficulty with housing, involvement with the criminal justice system and dysfunctional family relationships are just a few of the many challenges that patients may experience, and many of these issues can take time to evolve and subsequently solve. For this reason, a full 24 months is ideal in terms of obtaining experience in dealing with the psychosocial consequences of these illnesses. Monitoring and adjusting medications, proposing and implementing augmentation strategies, and in the case of treatment resistant illness, starting and monitoring clozapine are all important pharmacological skills that require 12 to 24 months of experience. Finally, any rehabilitation for the long term impacts of disability in these patients will take time to set up and execute and this presents another excellent reason for promoting the longitudinal training experience in this population.

There are however some challenges that may arise in this type of educational experience. Many patients with SPMI are seen on a biweekly to monthly basis during stable phases of illness. Therefore, the resident may need to assume the management of two to four patients over the one-year period in order to meet the criteria of two direct hours of patient care a month. The difficulty that may then result from this type of experience is that patients may become more acutely ill at unpredictable times, necessitating being seen much more frequently as an outpatient (thus increasing the number of hours per month of direct patient care), or alternatively resulting in an inpatient admission, (thus decreasing the number of hours per month and extending the resident's 12- to 24-month longitudinal experience). Additionally, unlike typical psychotherapy patients who follow residents from one location to the next every six months, these patients frequently have more difficulty with change and the success of continued treatment with the resident will likely have to depend on the resident returning to the same site over the 12- to 24-month duration to provide continued care. Careful planning is needed to ensure that residents will have enough time to complete these training requirements on top of their other commitments. Supervisors will need to be fully apprised of the potential difficulties that may arise with this kind of supervision. Clear communication between resident and supervisor will be essential to ensure that patient care is not in any way compromised. Additionally, available office space, support staff

and so on will need to be taken into consideration and planned for over the long term, in order for the resident to have a satisfactory experience.

Curriculum lecture/seminars

Training of residents in SPMI can be undertaken at several different stages in training. Residents in PGY2 and PGY3 are generally exposed to seminar series that provide education and guidance around acquiring a knowledge base that is essential to developing clinical expertise in the area of SPMI.

1. The following knowledge objectives should be dealt with initially and can be covered in a three-hour lecture series:
    a. Definition of SPMI.
    b. Review of assessment principles related to the diagnosis of SPMI with a focus on schizophrenia and bipolar disorder.
    c. Awareness of comorbidity associated with these conditions.
    d. Awareness of the dimensional aspects of symptoms of illness.
2. Next, a six-hour seminar lecture series that reviews pharmacotherapy of schizophrenia and bipolar disorder, including:
    a. Mechanisms of action of psychotropic medications.
    b. Available formulations.
    c. Use of long acting intramuscular medications.
    d. Optimization and augmentation strategies.
    e. Drug interactions, management of treatment resistance.
    f. Assessment and management of medication noncompliance.
    g. Assessment and management of side effects is essential.
3. Finally a four- to six-hour seminar series that introduces psychosocial aspects of treatment of SPMI, including:
    a. Principles of rehabilitation.
    b. Comparison of case management models and ACT.
    c. Family psychoeducation and support.
    d. Cognitive-behavioural therapy.
    e. Supportive psychotherapy.
4. Other themes are also addressed in seminar teaching throughout the postgraduate curriculum. Some of these will enhance understanding of the possible complexities of SPMI. These would include:
    a. Concurrent substance use disorders.

b. Dual disorders (developmental delay).

c. Impact of social issues such as poverty, homelessness and stigma.

d. Mental health and the law. Residents should be encouraged to review this seminar content if it has been covered prior to starting their SPMI rotation experience.

Supervision and evaluation of residents needs to regularly address the usual issues related to assessment and treatment. It is important to discuss the sense of frustration that residents may feel with respect to slow change in severity of symptoms, repeated episodes of non-compliance with medication that is often seen in this population, and the resulting social upheaval that can occur because of this. The rapid improvement in symptoms and functioning that may be seen in other areas of psychiatric practice are not necessarily seen in this patient population. Support and encouragement of residents to prevent frustration, hopelessness or indifference to these patients is therefore essential. Focusing on patients' individual strengths and accomplishments, however small, can be rewarding and supervisors need to model optimism and hopefulness in their interactions with trainees.

OTHER CONSIDERATIONS

Advanced training in SPMI

Residents with an interest in this population of patients should be strongly encouraged to enhance their training beyond the length of time recommended by the Royal College. Through the use of selectives or electives, these residents should benefit from adequate time to hone both clinical skills as well as increase their knowledge and training in the area of administration and leadership within a multidisciplinary team. The ability to supervise and support team members who deal with this challenging group of patients must be underscored, and ideally a further six months of elective time during PGY5 will complete the necessary training experience to ensure residents are competent in this area.

The assessment and treatment of concurrent disorders (psychiatric illness and addictions) is another area where residents can obtain further skills in treating this population. Specifically, developing skills in assessing stages of change as they relate to motivation for addressing addiction problems, and using harm reduction as a treatment intervention would be beneficial. Training in addictions will certainly complement the skill set necessary to treat SPMI.

Developing assessment skills in screening for metabolic disorders in this patient population is essential and any additional training that residents can obtain is helpful. Learning to incorporate life style interventions, including nutritional

counseling, exercise strategies and smoking cessation practices are helpful clinical skills. These skills could be obtained through interprofessional training (i.e. spending time with a nutritionist or nurse practitioner) or through shared care training experiences, where some exposure to and education from family practitioners may be helpful. Attendance at conferences or education days about smoking cessation and management of diabetes and metabolic syndrome would also be important.

Chapter 15

The scholar

Donald Addington

INTRODUCTION

In their role as *scholars*, physicians demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.[1] The role encompasses four key competencies: enhancing professional competency through lifelong learning, critical appraisal, facilitating learning, and contributing to the creation, dissemination, application and translation of new knowledge. By the end of residency training, the resident will be able to demonstrate that they have fulfilled the training requirements of the scholarly role and will be able to document their involvement in activities relevant to each of the competencies.

The requirement to teach is one of the key competencies in the scholar role, and has its origin in the Hippocratic Oath. Other competencies reflect an evolution in society's expectations of professionals in general and physicians in particular. These expectations include the provision of evidence-based care and the maintenance of competence over the span of a career. The additional competency; to contribute to the development, dissemination and translation of new knowledge and practices; reflects the centrality of research in improving our understanding and treatment of mental disorders. This core belief of the scientific basis of psychiatry was articulated in the United States' National Academy of Sciences report on Research Training in Psychiatry Residency: Strategies for Reform.[2]

Attention to the scholar role provides both balance to the life of individual physicians and improves their performance in the full range of their roles, including that of medical expert. An important aspect of the role is its depth and scope. The issue of research, while important, has often become the focus of this role in the minds of residents and educational administrators. However, some

basic knowledge of research is essential for critical appraisal and the provision of evidence-based care.

Residents will come to the scholar role with varying degrees of knowledge, attitudes and skills. The competencies are now discussed as part of the undergraduate medical curriculum, so at least residents should start with a basic awareness. Many residents will also have completed inquiry-based bachelors degrees involving a research component and a significant group may have completed a masters or doctoral level degree. Despite this variable expertise, it is possible to describe a developmental trajectory for training in the scholar role.

The development of the scholar role is a continuous process that requires structure and support from faculty, department, residency program and resident. This support is required on account of both the nature of the role and the inevitable clinical focus of individual rotations. The more recent requirement for each resident rotation to address all the CanMEDs roles within each rotation means that this training occurs in all rotations and in all locations. In addition, professional associations such as the Canadian Psychiatric Association (CPA), which provides support for the scholar role for clinicians over the long-term, offers free initial membership and other programs to residents.

For the psychiatrist who plans a career in research, the scholar requirements are a prerequisite for further training. The Royal College of Physicians and Surgeons of Canada (RCPSC) does provide accreditation standards and objectives of training for the Clinical Investigator Program.[3] This is a national program offered at 11 faculties of medicine. There are three approaches to obtaining this qualification, which require 24 to 27 months of research training, 12 of which can be part of the regular specialty or subspecialty training. The program can also be linked to a local graduate degree program at the masters or doctoral level.

REVIEW OF THE RCPSC OTR/STR

The RCPSC General Standards, more commonly known as the "B" Standards are applicable to all residency programs. These standards are significant because they outline specific goals and concrete expectations. The Specialty Training Requirements (STR) in Psychiatry and Objectives of Training (OTR) in Psychiatry provide more detail relevant to psychiatry.

Canada has been a leader in the development of competency-based graduate clinical education with its 1996 report Skills for the New Millennium.[4] In order to implement adequate training for the scholar role, important department level accreditation standards apply to all resident programs.[5] These standards are to be

found in the General Standards applicable to all residency programs and include standard B1.[6]

1. An environment of inquiry and scholarship *must* be maintained in the program. A satisfactory level of research and scholarly activity *must* be maintained among the faculty identified with the program, as evidenced by:
    a. Peer-reviewed research funding.
    b. Publication of original research in peer-reviewed journals and/or publication of review articles or textbook chapters.
    c. Involvement by faculty and residents in current research projects.
    d. Recognized innovation in medical education, clinical care or medical administration.

The relevant administrative standards for the scholar role are listed under B5.[6] "The quality of scholarship in the program will, in part, be demonstrated by a spirit of enquiry during clinical discussions, at the bedside and in clinics, in seminars, rounds and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice."

1. The program *must* ensure that there are opportunities for residents to develop effective teaching skills by teaching junior colleagues and students, as well as through conference presentations, clinical and scientific reports, and patient education.
2. The program *must* ensure that there are effective teaching programs in the critical appraisal of medical literature using knowledge of research methodology and biostatistics.
3. The program *must* promote development of skills in self-assessment and self-directed lifelong learning.
4. The program *must* ensure that residents are able to conduct a scholarly project.
5. Residents should be encouraged to participate in research during the course of the residency program. Acceptable research projects may include:
    a. Analysis of a contemporary clinical problem, involving human subjects, using acceptable statistical methods as required, the results of which are reported at local or national meetings and are eligible for publication in scientific journals; or
    b. Supervised participation in an ongoing project in experimental medicine.
    c. Quality assurance study of contemporary practice.

d. Study in medical education.

6. The program *must* provide opportunities for residents to attend conferences outside their own university.

The STR for Psychiatry allows plenty of opportunity for training in the scholar role. Under concurrent longitudinal training it includes some mandatory experiences, but also notes that the "training may flexibly accommodate" training in research for the equivalent of up to one day per week upon the approval of the residency training program and with appropriate documentation.[6] In addition, the resident may take up to six months elective and six months selective for research during the senior residency years of PGY4 and PGY5.

The RCPSC has published a useful guide to continuing professional development. These general principles apply equally to the resident training phase of career development, when the necessary skills and attitudes for continuing professional development should be developed.[7] The OTR in Psychiatry provides more specific detail on the key and enabling competencies.[8] More specifically, by the end of their training psychiatry residents, will be able to:

- Describe the principles of maintenance of competence.
- Describe the principles and strategies for implementing a personal knowledge management system.
- Recognize and reflect learning issues in practice.
- Conduct a personal practice audit.
- Pose an appropriate learning question.
- Access and interpret the relevant evidence.
- Integrate new learning into practice.
- Evaluate the impact of any change in practice.
- Document the learning process.

In order to demonstrate that they can critically evaluate medical information, its sources, and apply this appropriately to practice decisions by the end of their training, psychiatry residents will be able to:

- Describe the principles of critical appraisal.
- Critically appraise retrieved evidence in order to address a clinical question.
- Integrate critical appraisal conclusions into clinical care.

In order to demonstrate that they can facilitate the learning of patients, families, students, residents, other health professionals, the public and others by the end of their training, psychiatry residents will be able to:

- Specify principles of learning relevant to medical education.

- Specify the principles of ethics with respect to teaching professionals, the public and others, as appropriate.
- Collaboratively identify the learning needs and desired learning outcomes of others.
- Select effective teaching strategies and content to facilitate others' learning.
- Deliver an effective lecture or presentation.
- Assess and reflect on a teaching encounter.
- Provide effective feedback to a clinical clerk or junior resident.

In order to demonstrate that they can contribute to the development, dissemination and translation of new knowledge and practices by the end of their training, psychiatry residents will be able to:

- Describe the principles of research and scholarly inquiry.
- Describe the principles of research ethics.
- Pose a scholarly question.
- Conduct a systematic search for evidence.
- Select and apply appropriate methods to address the question.
- Appropriately disseminate the findings of a study.

TRAINING TARGETS/DETAILED GOALS AND OBJECTIVES

The OTR for Psychiatry does not specify the curricular content required for these general objectives. The following section makes suggestions for more detailed goals and objectives.

1. Demonstrate competence in gathering evidence from the published literature.
    a. Identify key indexes for medical publications.
    b. Search key indexes for specific content using keywords and subject headings.
2. Specify the principles of critical appraisal.
    a. Identify common study designs and categories of study designs that are employed in psychiatric research, such as case reports and case-series; case–controls; prospective cohorts; cross-sectional, ecological and intervention studies; clinical trials; structured reviews; and meta-analyses.

b. Identify strategies for subject selection and measurement, as commonly employed in the psychiatric literature.

c. Identify mechanisms by which flawed subject selection and measurement can result in bias in epidemiological research.

d. Identify the role of random error and demonstrate familiarity with statistical procedures used to quantify this in relation to frequencies, measures of association, comparisons between study groups, and different types of data (e.g. categorical, ordinal and continuous).

e. Interpret summary statistics and graphs.

f. Interpret inferential statistics; significance tests, estimation and confidence intervals; and the advantage of confidence intervals over *P* values.

g. Interpret specific statistical hypothesis testing procedures, particularly Student *t* tests, chi-square tests and Mann-Whitney *U* tests.

h. Recognize type I and type II errors.

i. Define confounding—list procedures to control for confounding: restriction, matching, stratification, regression modelling and randomization.

j. Identify the advantages of randomized trials and the problems with alternatives such as historical controls.

k. Demonstrate a familiarity with more complex methods such as factor analysis, logistic regression, survival analysis and meta-analysis—no more than a description of what the techniques aim to achieve.

l. Be aware of problems of measurement in psychiatry, latent traits (constructs) and observed indications (symptoms).

m. Understand the concepts of reliability and validity, sensitivity, specificity and predictive values of research measures. Apply these concepts to clinical problems such as the interpretation of diagnostic tests.

n. Differentiate between key epidemiological concepts of incidence (inception), prevalence, relative risk and population at risk.

3. The resident will be able to access and interpret the relevant evidence in a timely and efficient way (e.g. presenting an evidence-based decision to a learning question at a case rounds, integrating new learning into practice).

4. The resident can demonstrate the impact of any change in practice in a real case.

5. Document the learning process in a learning log.

SUGGESTED STRATEGIES/ENABLING OBJECTIVES

The following section amplifies the general standards applicable to all residency programs which have already been cited.

In order to enhance the resident's ability to maintain and enhance professional activities through ongoing learning, the program can provide formal seminars in the principles of maintenance of competence. The day-to-day learning opportunities of clinical rotations and clinical rounds can be described as learning issues that are applied in practice. Residents should also be encouraged to develop a training portfolio that can be used to track ongoing training and learning objectives. One such program is available online at http://www.rcpsych.ac.uk/training/traineessection.aspx.

Strategies to support the resident's learning to critically evaluate medical information, its sources, and apply this appropriately to practice decisions should include providing formal didactic education in critical appraisal and journal clubs that use critical appraisal.

A number of strategies can be used to facilitate residents acquiring the knowledge and skills for teaching patients, families, students, residents, other health professionals and the public. The faculty or residency program should provide formal didactic education in the principles of adult education and clinical teaching. During the PGY2 and PGY3 years, residents should have the opportunity to provide bedside teaching to clinical clerks while on call and on rotations. They also have the opportunity to present at clinical rounds and grand rounds. There are a number of reliable and valid measures that provide residents feedback on their education skills. During the PGY3 and PGY4 years, residents can provide formal seminars and lectures in psychiatry as part of the undergraduate medical curriculum. They should at this stage also have the opportunity to present the outcomes or their scholarly activities at local research days and provincial or national meetings. Residents should have the opportunity throughout residency to be involved in the educational administration of their own program. This involves evaluation and feedback on individual rotations, seminars and other educational experiences.

It is recommended that, at least once during training, the resident will:

1. Develop and document a learning question or testable hypothesis, document and conduct a systematic search for evidence that addresses the question or reviews the evidence for or against the hypothesis or develop a research proposal to test the hypothesis, and select and apply appropriate methods to address the question.

2. Present a clear and concise summary of care at an audit conducted by an experienced clinician (e.g. review a case for a critical incident review).

3. Pose at least one learning question, the answer to which could affect clinical care. The question should be answered with an examination of the literature.

4. Take on a role in a study that qualifies the resident as an author by making meaningful contributions to some or all of the following: the development of a proposal, obtaining ethics approval, the collection and analysis of data, the writing of a publication and presentation at a scientific meeting.

Contributing to the development, dissemination, and translation of new knowledge and practices can be enhanced in a number of ways. The faculty may choose to provide a number of the more formal didactic educational experiences centrally to all residents in a particular faculty of medicine. This applies especially to general issues such as research ethics, critical appraisal principles of education and lifelong learning. The residency program could appoint a resident research coordinator who has a formal role in resident selection, coordinates research mentorship and reviews the progress of residents in this area.

All residents in PGY2 and PGY3 must have formal seminars that address critical appraisal and the principles of evidenced-based medicine. These should be linked to journal clubs that employ these principles by applying them to papers that are relevant and topical. Individual residents at this level should apply these skills to clinical rounds where even one journal article can address a specific issue or to grand rounds where a presentation can review an issue in some depth. All residents in PGY4 and PGY5 could take the opportunity to undertake a research project, formal review, quality improvement project, or critical incident review. This can be done as part of a longitudinal project with agreed upon time across other rotations, or in the context of a formal research elective or selective.

Dissemination skills can be enhanced by presentations at research days, provincial or national meetings, as well as formal journal publications.

It would be ideal if programs could provide a scholar track for residents with an interest in developing a long-term career as a scholar. It could also set targets for the proportion of residents in the scholar track. This can be linked to local graduate education at either the masters or doctoral level and/or to a national program such as the RCPSC Clinical Investigator Program. Linkages to graduate programs can be enhanced if some of the required resident seminar series addressing research are made into formal graduate classes that can count towards a postgraduate degree.

OTHER CONSIDERATIONS

Enhancing professional competency

The development of the attitude and skills required for lifelong learning starts in medical school, which has a very structured curriculum. During graduate clinical training the curriculum is much less structured and residents may have varying levels of skills and knowledge.

In Canada, the RCPSC provides an online structure for the Maintenance of Certification Program (http://www.mainport.org/). In the United Kingdom, the Royal College of Psychiatrists has developed an online Portfolio Framework for use by trainees (http://www.rcpsych.ac.uk/training/traineessection.aspx). A more specific training scale for self-evaluation has been described in the area of addiction training for psychiatry residents in the United States.[9] The use of online resources for continuing professional development changes as technology changes, but a useful guide for psychiatrists, including five useful "dos and don'ts" as well as guides to buying equipment and useful websites, has been published.[10]

Clinical practice guidelines are usually evidence-based, concise and up-to-date summaries of best practices. They do not directly teach clinical appraisal, but they demonstrate the use of those skills and can usually be found online (http://publications.cpa-apc.org/browse/documents/67). The use of guidelines as a resource for resident group self-learning has been described.[11]

The role of professional societies in continuing professional development has been identified in Canada, where they are often certifiers of programs. Organizations such as the CPA provide reduced rates for residents (http://www.cpa-apc.org/browse/documents/182&xwm=true). Beyond providing certified continuing professional development, professional societies can offer broader opportunities for strategic network building and career development.[12]

Critical appraisal

Canadian academics have played an important role in establishing evidence-based medicine as a central process in education and practice.[13] The Evidence Based Medicine Working Group was established at McMaster University. Following its 1992 publication in the *Journal of the American Medical Association (JAMA)*, the journal published a well regarded series of articles on evidence-based medicine that is now updated and available online from the Centre for Health Evidence (http://www.cche.net/usersguides/main.asp).

Evidence-based medicine has been defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[14]

Goldner[15] applied the evidence-based paradigm to psychiatry and suggested that psychiatrists using this approach would provide superior care and advocated an approach that balanced individualized clinical acumen and information derived from evidence-based reviews. The acceptance of the need for evidence-based practice required a cultural shift from viewing research as a separate activity to one in which it informed practice.[16] As an example, the Royal College of Psychiatrists' MRCPsych Exam III includes a critical review component which is one-third of the exam (http://www.rcpsych.ac.uk/exams/about/mrcpsychpaperiii.aspx).

It has also been suggested that the need for research that better addressed practice questions led to the large pragmatic clinical trials such as CATIE and CUtLASS.[17,18] There is evidence that short courses can be effective in teaching evidenced-based medicine[18,19] and there is a validated scale for the assessment of competence in evidence-based medicine.[20] Osser has described a course on psychopharmacology which integrates a clinical case, a clinical practice guidelines, and a single research study.[21] The course was highly rated, but there was no evidence of outcomes such as attitudes or practice changes.

Facilitating learning

There has been a long standing recognition that psychiatry residents are interested in having an educational role so that they may be involved in the education of medical students, other health-care professionals, other psychiatry residents and non-psychiatrist physicians.[22] The key and enabling competencies defined by CanMEDS are much broader than these historic expectations and include knowledge of principles of learning, identification of learning needs, selection of teaching strategies and the ability to deliver an effective lecture, assessment of their own skills, and the ability to provide effective feedback. The learners identified also include a wide spectrum, from patients and families to students and the public.

A recent systematic review of residents as teachers in psychiatry identified 13 randomized or non-randomized controlled trials of educational interventions designed to enhance the teaching skills of residents.[23] The review concluded that such educational interventions can confer the benefit of residents' teaching skills, although there was a paucity of such research that was specific to psychiatry.

Research on resident education indicates that within the context of a structured educational encounter, such as a clinical encounter, resident educational

performance can be reliably and validly assessed with questionnaires completed by the learner,[24] or by direct observation and the use of a checklist[25] or ratings of tape-recorded clinical teaching sessions.[26] A widely researched scale has identified seven categories of skills: establishing a learning climate, control of the session, communication of goals, understanding and retention, evaluation, feedback and self-directed learning.[24,26] The benefit of feedback based on the scale results was found to differ depending on the baseline skill level. The feedback benefited most of those who already had high baseline scores.[27]

In another randomized controlled study, the content of an education course was based on residents' self-assessed learning needs and the evaluation on a structured Objective Structured Teaching Evaluation. Although the residents found the course very helpful, there was little change shown in the intervention group, but this may have reflected the limitations of the evaluation instrument.[28] More sophisticated assessments based on evaluations by other target groups as envisioned in the CanMEDS roles is possible, but not as well researched.[29]

Contributing to new knowledge

Psychiatry advances through innovation and research. There are many areas of expanding knowledge that are relevant to understanding the nature of mental disorders and improving their treatments and treatment services.[2] As clinicians, psychiatrists have an important attitudinal and knowledge base to contribute to clinical research. The enormous impact of mental disorders on disability[30] should encourage policy makers, health service delivery decision makers and individual researchers to strive for improvements.

There is evidence that up to 60 per cent of Canadian residents indicate upon questioning that they are interested in research,[31] but data are not specifically available for psychiatry residents. A survey of Canadian residency programs in 2000 found that close to one-third had authored or co-authored a publication while in training, yet only 7 per cent planned to continue to a research fellowship.[32] A United States survey found a relatively low number of research training opportunities in residency programs and relatively weak research teaching in seminars.[33] Another study reported that the numbers of psychiatry residents pursuing research fellowships dropped nearly 40 per cent between 1992 and 2001.[34]

In 2003, the United States Institute of Medicine published a report on research training in residency that concluded that more and better residency-based research training may have benefits to all psychiatrists and increase the proportion who would pursue a research career.[2] A developmental model for enhancing research training during residency training has been described.[35] It addressed each of the impediments summarized in the report as regulatory, institutional, or personal factors. It required a scholarly project from each

resident as well as research literacy courses for all residents. It also created a research track for interested residents with a formal application process. It provided protected time for resident's research, appointed a research chief resident, and used research track residents as the research liaisons between regular residents and research faculty. To address the personal issues around research careers and financing, they created a number of formal and informal opportunities for research and financial information sharing. These strategies resulted in a number of residents following an academic career track. All of the components described in this article are being pursued in varying degrees across Canadian residency training programs.

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Chapter 16

Evaluation of resident competency in psychiatry: a Canadian perspective

Ari Zaretsky

INTRODUCTION

Although the enduring central core of 21st-century psychiatry residency training is the close relationship between a resident trainee observing, learning and modelling from his/her own supervisor, this apprenticeship model has recently been influenced and modified by the competency movement. The emerging competency movement attempts to accelerate learning by breaking down the global knowledge, attitudes and skills of a psychiatrist into smaller and smaller teachable units that can be deliberately staged, sequenced and evaluated. The new Royal College of Physicians and Surgeons of Canada's (RCPSC) Objectives of Training (OTR) and Specific Training Requirements (STR) reflect this new zeitgeist in residency education and are notable for their specification of competency levels required as well as some of the methods of evaluation necessary to attest to the achievement of competency. This chapter will begin by describing the rationale and general principles of residency competency evaluation. This will be followed by a critical appraisal of commonly used and recently emerging postgraduate evaluation methodologies. The chapter will conclude with the description of how evaluation should be integrated into a more comprehensive CanMEDS blueprint that should be constantly reviewed and revised by the training program over time.

For more detailed information about postgraduate psychiatric evaluation of CanMEDS competencies, please refer to the CanMEDS Assessment Tools

Handbook by Bandiera, Sherbino and Frank[1] and the recent article in *Academic Psychiatry* by Swick, Hall and Beresin[2] as well as the article by Epstein and Hundert[3] on defining and assessing professional competence.

RATIONALE FOR COMPETENCY EVALUATION

Certification of training to government

It is often said that evaluation drives learning. Although there is a danger of "teaching to the test," competency evaluation can be conceptualized as the hard currency of a training program. The program has only limited resources to expend on evaluation and therefore will attempt to deploy resources on assessing the most important facets of training. Evaluation therefore has the potential to signal to trainees the program's learning priorities — what is truly important and valued by the residency training program. It is critically important to ensure that this "evaluation hidden curriculum" truly reflects the core values and beliefs of the residency program rather than simply reflecting what is simple or expedient to test or evaluate.

PRINCIPLES OF COMPETENCY EVALUATION

There are a number of important principles to follow in evaluation of competency. The most important of these is to recognize that, unfortunately, there is no "one size fits all." No evaluation tool is valid or useful to assess trainee competency in all of the different CanMEDS roles within the OTR document. For example, even when multiple choice or short answer questions are used in a creative manner, they will never accurately tell the program director or the primary supervisor very much about the professionalism of the resident trainee or his/her collaboration skills. Instead, anonymous feedback from patients or families who have actually interacted with or were treated by the resident trainee, or feedback from the resident's peers or from allied mental health staff will provide much more useful information about the resident's professionalism and capacity to collaborate. Evaluation tools therefore are context-dependent and must be tailored to the specific CanMEDS role that one is attempting to measure in any given situation. These assessment tools should aim to examine concrete, observable behaviours using explicit and descriptive items.

The second important principle is that formative feedback (assessment done early to further the learning process) should be emphasized over summative feedback (which is done at the completion of a component of training and used

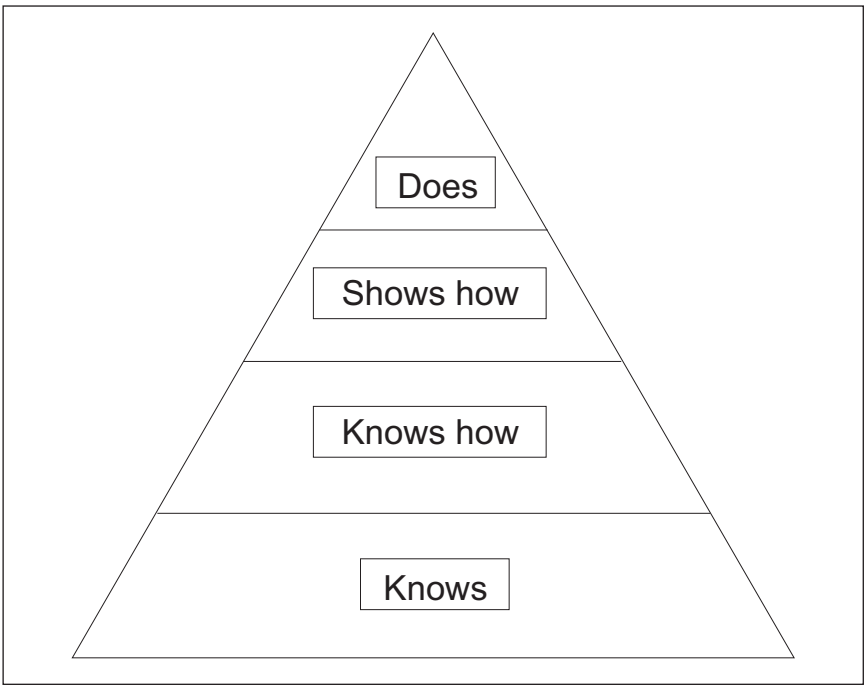
primarily for decision-making related to determination of adequate knowledge, attitudes or skills). Traditionally, formative feedback has been devalued as "fuzzy," "impressionistic" and "inexact" because of its greater informality compared to summative feedback. This, of course, need not be the case. Formative feedback helps the resident and the training program identify areas of weakness both in specific performance and in the resident's actual training. Today, many educators have come to the conclusion that formative feedback is the key to deep learning.[4] Formative feedback, when provided with rich detail, has enormous potential to highlight the gap in performance between what is actually observed and what is optimally desired, thereby reinforcing excellent performance while motivating the trainee to enhance acquisition of specific knowledge, attitudes and skills. Formative feedback, because it naturally occurs in a lower stakes context and occurs more frequently, also has a greater potential to be truly reflective of the trainee's skills and has a greater potential to be metabolized and internalized by the trainee in a non-defensive manner. Truly honest feedback is difficult but achievable when there is trust in the supervisor–resident relationship and when feedback is based on observable, objective data and multiple sources.

All feedback, whether formative or summative, is only useful if it is objective, frequent, ongoing, mutual, timely, face-to-face and based on actual data. Timely and face-to-face feedback is in fact a Royal College standard for program accreditation. This expectation can be a daunting challenge within the larger, distributed programs. In the Basic Clinical Training (BCT) year, where many of the rotations are only four weeks in length and occur outside of the psychiatry program, it is important that there is careful program monitoring of psychiatry residents during this PGY1 in order to ensure that they are receiving formative feedback at the mid-term (which may only be after two weeks in some rotations) as well as final summative evaluations at the end of the rotation. In all PGY1–PGY5 rotations, the training program needs to send out careful instructions to the supervisors to ensure that appropriate formative evaluation occurs at the mid-term of a rotation and summative evaluation occurs at the end. An example of the detailed instructions to supervisors can be downloaded from the University of Toronto Department of Psychiatry website. Program monitoring of adherence with delivering timely and face-to-face feedback to residents can be enhanced by online evaluation software that can be deliberately programmed to provide the postgraduate office with alerts when tardy evaluations are occurring.

Before selecting an evaluation tool, one needs to define what type of performance is expected from the trainee. Competency assessment can be conceptualized along a continuum from the most distal (i.e. *knows*) to the most proximal reflection of real world performance (i.e. *does*). Within the middle of this continuum is *knows how* and *shows*. Because it is extremely difficult to get

an accurate gauge of what the resident really does (even constant direct observation would be inaccurate since this observation would artificially alter the resident and his/her environment), it is important to assess proxy measures of "real world" performance. Acquisition of knowledge (i.e. what a resident *knows*) can be assessed most simply and accurately by a written examination such as a multiple choice test. *Knows how* refers to the ability to manipulate and apply acquired information and think critically. This higher level cognitive skill can be assessed via either a written or oral examination involving short answer

Figure 16.1 Miller's Triangle[5]



questions that often relate to case scenarios (Figure 16.1).

Unlike the assessment tools for *knows* and *knows how*, which are well-established and straightforward, assessment of *shows* and *does* has been much more challenging. *Shows* requires direct observation of a specific skill or competency. *Shows* is often evaluated using simulation via an objective structured clinical examination (OSCE) or a role-playing oral examination. An actual observed patient interview also should be classified under the rubric of *shows* since the behaviours observed may not necessarily be characteristic of

what the trainee does in day-to-day practice. This is especially true if the interview is actually a high-stakes examination such as the Standardized Assessment of a Clinical Encounter Report (STACER). *Does* refers to what the trainee routinely does in the "real world" when they are generally not directly observed or not expecting to be observed. Possible examples of assessment of what a trainee actually does are random samples of videotapes or audiotapes of psychotherapy, random reviews of a trainee's progress notes or consultation notes as well as random patient satisfaction surveys.

Competency thresholds and degree of mastery

The new Royal College OTR for Psychiatry is based on the Dreyfus Brothers' Model of Skill Acquisition,[6] which is a five-step model of professional development from novice to expert/master. The OTR nomenclature is as follows:

- Introductory knowledge
- Working knowledge
- Proficient
- Advanced
- Expert/master

When choosing an evaluation tool, the program should aim for an assessment that is both accurate and general. This requires the program to consider the psychometric qualities of the evaluation tool, including validity and reliability. Validity refers to whether the evaluation instrument or method assesses the intended knowledge, attitudes or skills accepted by both teacher and learner as being legitimate. Predictive validity refers to the ability of the assessment tool to predict future behaviour. Content validity refers to the degree to which the assessment tool actually represents or covers the broader domain that it purports to do. Reliability refers to whether the evaluation instrument delivers consistent results in the same situation time after time. Threats to reliability are rater error and bias, sampling bias and recall bias. Reliability is necessary, but not sufficient for validity. Independent of psychometric properties, the program must also consider feasibility since many excellent assessment tools are expensive and time consuming. The program must constantly ask itself: Is the yield of information from deploying this new assessment tool cost-effective?

Before addressing specific assessment tools, an important general principle to consider when discussing resident evaluation is the issue of confidentiality. Residents require a trusting relationship with their supervisor, however evaluations of a resident's performance may be sought by licensing bodies and might also be requested in a court subpoena if the resident is in a lawsuit. Careful consideration of the format of resident evaluation is therefore required. Programs should have a careful and well thought out process in place to

determine what information should be fed-forward to the next rotation supervisor to minimize bias. The program director and residency program committee should also pay scrupulous attention to descriptive language and should define the deficits of a resident in observable, objective and behavioural terms. Ideally, the resident should be privy to this shared communication and if possible consideration should be given to passing this critical information to the local site coordinator or site director rather than to the primary supervisor.

SPECIFIC ASSESSMENT TOOLS

In-Training Evaluation Report

The In-Training Evaluation Report (ITER) is an assessment instrument to document direct observation and is currently the most popular method for assessment in postgraduate medical education. ITERs generally provide global evaluation and although they are feasible and easy to create they suffer from low content validity and high levels of inaccuracy. In general, the supervisor makes a subjective judgment about the resident's knowledge, attitude and skills within the seven CanMEDS roles. These evaluations are typically completed at the end of a rotation. One of the problems with the ITER is that there is variability between the rating based on how the supervisor actually uses the form. For this reason, ITERs are very prone to the halo effect and millstone effect. The halo effect is a positive skew where there is a positive influence of scoring all of the ITER sub-items based on the overall ITER score. A resident who is perceived to be outstanding will be given outstanding scores on all CanMEDS roles and CanMEDS role sub-items without specific regard to the resident's actual performance on those specific components of the ITER. The millstone effect is the exact opposite — a negative skew where a resident is perceived in negative terms overall and then the supervisor negatively scores the sub-items of the ITER regardless of the real performance of the resident.

To enhance the quality of the ITER and in order to meet standards of accreditation, programs must ensure that their ITERs are actually based on rotation-specific objectives. In addition, ITERs should detail the performance of specific tasks and specify which observations led to the supervisor's conclusions. These details must be presented in narrative form if a resident is functioning below the acceptable standard, but narrative detailed observations are also necessary to assist good residents to improve their performance. There should be more than one ITER within the residency training program rather than a "generic " ITER that simply uses the definitions of CanMEDs roles and a Likert rating scale of one to five. ITERs should also evaluate resident performance based on a developmental model whereby greater expertise and

mastery is expected for senior residents compared to junior residents. These expectations should be made explicit rather than being left up to the subjective judgment of a supervisor. “Off-service” PGY1 ITERs for BCT should be developed by the psychiatry program in consultation with the different medical specialties through which psychiatry residents rotate rather than uncritically adopting the original medical specialty ITER (which may de-emphasize communication and collaboration skills, but have higher performance expectations for residents within the actual program than for off-service residents).

An additional refinement of the ITER is to use behavioural anchors or benchmarks that objectively describe the behaviours expected for each CanMEDS role for different rotations. A behaviourally-anchored ITER reduces some of the inherent subjectivity and avoids peer-referenced scoring, which is notoriously unreliable and often lacking in validity. A sample of a behaviourally-anchored ITER for the general psychiatry year is seen in Table 16.1. To view the full ITER see http://www.utpsychiatry.ca/Education/PostGraduate/ Evaluation/PGY2-GenPsychEval.pdf.

Oral examinations and patient interviews

Oral examinations in psychiatry are often performed through observed patient diagnostic interviews. The STACER Examination, a summative examination, is a prime example of such an assessment. It must be passed by all senior residents as a precondition for sitting the final Royal College examinations.

The resident must pass two of any three STACER examinations within a maximum of six attempts. The STACER is a 50-minute diagnostic interview with a patient observed by two examiners, ideally with one examiner in the same room and one examiner watching via a one-way mirror. After the resident completes the 50-minute interview the patient leaves and the resident is given 10 minutes to generate a diagnosis and etiological formulation of the patient. The two examiners then join the resident in the room. The resident is asked to succinctly present the case, offer a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, diagnostic impression and differential diagnosis as well as a biopsychosocial-cultural formulation. The resident is then asked about their management of the case and additional questions pertaining to the case. The STACER is scored by each examiner independently using the Royal College STACER score card based on the McMaster checklist. In order to enhance resident interviewing skills and skills at formulation and management, most Canadian residency programs require residents to do an oral examination like the STACER at least once every year from PGY2 until PGY4. Some residency programs have increased the frequency of this type of examination to every two months and utilize this experience as a rich opportunity for formative feedback to the resident. The STACER and the practice STACER examinations

Table 16.1 Sample ITER[7, p 3] medical expert knowledge

Please note: The Meets Expectations rating identifies competence at satisfactory levels. The Unsatisfactory and Needs Improvement ratings denote unsatisfactory performance. The Very Good rating, with the symbol + denotes performance beyond satisfactory levels and is inclusive of the elements specified in the Meets Expectations rating. The Excellent rating identified with the symbol ++, includes the Meets Expectations and Very Good ratings.

1 - Unsatisfactory; 2 - Needs Improvement; 3 - Meets Expectations; 4 - Very Good; 5 - Excellent; N/A - Not Applicable	1	2	3	4	5	N/A
1A. Pharmacotherapy Unsatisfactory Major deficiencies, little understanding of basic concepts. Confused about drug classes and indications. Needs Improvement Some deficiencies. Incomplete understanding of significant side-effects and ways to monitor for safety. Meets Expectations Is aware of major medication classes and their indications. Has basic knowledge of management of common side-effects. Very Good + Expanded understanding of therapeutic options, drug-drug interactions. Able to select by applying recent information. Excellent ++ Mastery of drug effects and limits; current with state of the art concepts. Comprehensive understanding of treatment options.	O	O	O	O	O	O
1B. Psychotherapy Unsatisfactory Little knowledge beyond the fact that it involves listening and talking. Needs Improvement Marginal concept of types and indications. Meets Expectations Can name the different types of psychotherapy and their indications. Has some concept of background theories and application. Very Good + Familiar with different types of psychotherapies. Good grasp of theories, application and indications for different types of psychotherapy. Excellent ++ Excellent grasp of theories, application and indication of different types of psychotherapy, especially cognitive-behavioural therapy. Understands complex issues and interactions.	O	O	O	O	O	O

Table 16.1 continued

1 - Unsatisfactory; 2 - Needs Improvement; 3 - Meets Expectations; 4 - Very Good; 5 - Excellent; N/A - Not Applicable	1	2	3	4	5	N/A
1C. Mental health legislation Unsatisfactory Does not comply with legislation. Uses forms inappropriately. Needs Improvement Some minor errors in complying with legislation and using forms. Meets Expectations Complies with legislation and uses forms appropriately. Very Good + Consistently complies with legislation. Uses all mental health forms consistently and appropriately. Able to present to review boards. Excellent ++ Teaches and assists other members of treatment team in complying with mental health legislation. Prepares for and presents well at review boards.	O	O	O	O	O	O
1D. Descriptive psychiatry and differential diagnosis Unsatisfactory Lacks background knowledge to understand common problems. Cannot interpret data. No prioritization. Likely to miss major disorder. Ignores factors contributing to pathology. Needs Improvement Some difficulty with interpretation of data and prioritization of issues. Sometimes ignores factors contributing to pathology. Meets Expectations Knows major DSM-IV categories and can come up with rational differential diagnoses. Familiar with relevant terminology and can define commonly used descriptive terms. Very Good + Can make DSM-IV and biopsychosocial formulations. Well-versed with terminology. Very thorough with differential diagnosis. Excellent ++ Excellent formulation. Synthesizes detailed differential diagnosis with appropriate prioritization of issues. Has an expanded grasp of terminology.	O	O	O	O	O	O
Additional comments						

are excellent evaluation tools for assessing communication skills, interpersonal skills, and diagnostic and formulation skills. They also provide some opportunity to assess management skills, critical reasoning and general clinical knowledge. Videotaping of these examinations greatly enhances the educational value of the examination experience since the trainee can review the videotape and examine the strengths and weaknesses of the diagnostic interview and case presentation.

Some of the drawbacks of the STACER and mock-STACER oral examination are that they are very time-consuming and difficult to organize, particularly for larger programs. In addition, the performance of some trainees may be negatively affected by anxiety. The difficulty of the patient being interviewed can also skew the examination depending on the expectations of the examiners and the anxiety of the resident. Care should be taken to ensure that a broad range of patient populations are chosen for STACER examinations rather than outpatients with unipolar depression. Given the high-stake nature of the STACER, examiners for the STACER also need to be properly trained and calibrated. Many junior and inexperienced examiners can be unrealistically demanding and harsher markers compared to more seasoned and senior clinicians. These problems with the STACER examination have led to recent efforts by program directors within the Coordinators of Postgraduate Education (COPE) to define developmental competencies which would then be assessed earlier in training rather than at the end of training in two high stakes summative evaluations. If one uses the mock-STACER examination as a formative evaluation tool, special efforts should be made to ensure that a wide variety of patients are sampled over time. It is also more useful for the examiner not to be the resident's current supervisor, since unbiased objective assessment of the trainee's skills may be limited. Due to the time demands on the examiner and trainee, it may be more feasible to focus on only one or two aspects of the entire STACER examination, especially for junior residents.

Written examinations

Written examinations provide important ways to assess the CanMEDS *medical expert* role (particularly the *knowledge* domain). An examination blueprint is advisable to ensure that the examination is comprehensive. Generally, 150 multiple choice questions are required to ensure content validity if one is examining a large domain of knowledge (e.g. psychiatric knowledge of all PGY2s based on the half- or full-day didactic core curriculum). In order to preserve examination integrity, one must generate different examinations each year and avoid reusing too many questions over again. To accomplish this, it is advisable that an examination store should contain approximately 300 questions. Although some programs generate their own in-training examinations based on the content of their didactic curriculum, most training programs in Canada also

uses more standardized in-training examinations on an annual basis that provide peer-referencing of the resident based on level of training.

The Psychiatry Resident In-Training Examination (PRITE) is an examination of United States trainees developed by the American College of Psychiatrists. Created in 1978, the PRITE consists of 300 multiple choice questions administered in two parts with 13 sections covering a full range of psychiatric topics. Each section offers references to support and explain correct answers. Nearly all psychiatry residents in the United States and many in Canada take the PRITE three times during their entire residency. Residents receive detailed computer analysis of their test performance in comparison with other residents at comparable levels of training. Training directors also receive results for their individual residents as well as statistical data comparing their training program with other groups of participants. Not only can the information from PRITE performance assess the competency of a resident, it can also provide vital information about gaps in training. This information can assist the residency program director to adjust the training program in order to make it more effective.

One of the drawbacks of the PRITE for Canadian programs is that it is prohibitively expensive for large programs since it must be offered to all trainees in the entire program rather than just a subset (e.g. PGY2s). There are also other notable limitations. The PRITE has a number of sections that focus more on neurology rather than core psychiatric knowledge and the examination does not represent the context of the Canadian health-care system.

The COPE examination, although newer and less methodologically rigorous compared to the PRITE with regards to development and psychometric properties, is still a very useful and more inexpensive Canadian in-training examination which can be offered to all trainees. The examination has been based on an examination blueprint since 2008 and has recently been demonstrated to possess much better psychometric qualities although, unlike the PRITE, it has not yet been evaluated with regards to its ability to predict performance on the Royal College certifcation examination. Like the PRITE, the COPE in-training examination can help trainees recognize gaps in training. The individual resident performance score on the COPE exam should be treated confidentially. Ideally, the resident's annual performance on the COPE exam should be reviewed by the program director and the trainee together. Gaps in performance compared to peers should be addressed by educational prescriptions and informal remediation plans.

Although written examinations traditionally assess competence in the knowledge aspect of the *medical expert* role, examinations should consider novel ways to evaluate the cognitive aspects of non-medical expert roles. For example, questions could focus on population health issues for *health advocate*,

bioethics for *professional*, and principles of conflict resolution and quality assurance for *manager*. Short answer questions can also be used for these same domains, but are more labour-intensive because they require individual marking as well as a marking score sheet. Short answer exams are useful for assessing critical thinking and communication skills, but are far less reliable and possess less content validity compared to multiple choice question examinations.

Objective Structured Clinical Examinations

The Objective Structured Clinical Examinations (OSCE) samples performance of learners as they rotate through a series of stations. Each station focuses on different clinical scenarios and can utilize a standardized patient, an oral examination, a role-play with the examiner, visual information (e.g. viewing a videotape, computed tomography scan or magnetic resonance imaging), or a written task (reading a case history or laboratory results). Learners are asked to demonstrate a number of specific skills such as interviewing skills with a patient or collaboration skills with a colleague. Alternatively, knowledge can be assessed by asking the learner to answer questions based on the presented material. OSCE stations typically involve eight to 15 stations occurring in different rooms and may include a rest station. Learners typically have five minutes between stations and are often given information pertaining to the next station during these breaks. Assessment is typically carried out using a standardized checklist, anchored global rating scales or evaluation of brief narrative responses.

OSCEs are ideal for large scale formative and summative testing of specific knowledge base, history-taking skills, patient communication skills, diagnostic reasoning, patient management and treatment planning. One of the major advantages of the OSCE is that its clinical basis lends a high level of face validity compared to written assessment. The OSCE, because it provides direct observation of performance, is more effective at assessing *knows how* and *shows how* compared to written examinations (OSCEs assess knowledge application rather than knowledge acquisition). OSCEs can be standardized and the medical and surgical literature has established that OSCEs possess an adequate level of reliability of 0.8.[8] Although more stations and different scenarios increase reliability, the need for a greater number of stations can be mitigated by the use of a standardized written examination.

There are a number of important limitations associated with OSCEs. They are time-consuming to develop and complex to administer, requiring many examiners and many rooms. OSCEs are only cost-effective if many learners are assessed. Another disadvantage is that only a few content areas can be sampled and the time-limitations and testing environment are artificial. Although checklists may be a better assessment than global rating for junior learners,

global ratings may be more appropriate for residents with higher levels of expertise. Longer OSCEs (lasting 20 to 25 minutes) may also be more effective in assessing competency in multiple CanMEDS roles, particularly *communicator*, *collaborator*, *manager*, *health advocate* and *professional*. The Royal College Final Oral Examination is composed of nine OSCE stations lasting 20 minutes with each station assessing at least three different CanMEDS roles.

To reduce the level of subjectivity associated with global ratings, it is advised that the OSCE rating scales are anchored in order to enhance consistent assessment. Finally, when using standardized patients, it is noteworthy that ratings by the standardized patients themselves can be very useful for assessing interpersonal communication and professionalism.[9]

Logs and portfolios

Logbooks are structured instruments for documenting that learning has occurred, whereas portfolios provide a more multifaceted, self-reflective and creative way of collecting evidence of competence achievement over a period of time. Both logs and portfolios are becoming popular assessment tools associated with competency-based education. Logbooks are typically used to track the incidence of educationally relevant activities, such as the number of procedures performed (e.g. electroconvulsive therapy) or cases seen (e.g. cognitive behaviour psychotherapy cases). There is minimal opportunity for learner input or reflection because logbooks are essentially counters. The Royal College STR requires that logs be used to document achievement of psychotherapy competence as well as to document participation in longitudinal treatment of patients with severe and persistent mental illness and addiction psychiatry. In addition, any PGY1 psychiatry rotation which is applied towards meeting a more senior psychiatry rotation (i.e. occurring during PGY2 to PGY5) should also be documented by means of a log.

Portfolios are a flexible formative educational assessment approach that can be adapted to meet the needs of many different types of learners within many settings. Portfolios are essentially a collection of the resident's work or evidence of a resident's accomplishments. They can be used to assess complex performance and integrate a number of CanMEDS roles. Within the *professional* and *collaborator* role, portfolios may include multisource feedback and letters from patients, peers and staff with whom residents have been on-call, or administrators with whom they have worked. Portfolios can also include self-reflective essays regarding ethically challenging clinical situations. Within the *communicator* role, portfolios can include process notes and written patient assessment reports. Within the *manager* role, portfolios can include quality improvement projects or efforts to respond to clinical errors and improve clinical practice. Portfolios may be the strongest method to assess the *scholar*

competencies of lifelong learning, research and teaching. The content of a resident's grand rounds, or a research day paper, together with audience performance assessment of these types of presentations may be included in a portfolio. Assessment of resident teaching by medical students or a personal learning plan can also be included within a portfolio.

Although portfolios are an excellent vehicle to promote self-reflective learning, self-directed learning and learner–teacher dialogue, their validity and reliability depend on the instruments used to gather data. They can also be very time-consuming to design. In general, portfolios are notoriously difficult to standardize and to score. Because portfolios are resource intensive, learner compliance may be poor especially if there is a low perceived utility or relevance. Effective use of portfolios sometimes requires a change within the medical culture or the "hidden curriculum" of a program together with careful design, supervisor support and regular periodic review.

Multi-source feedback

Multi-source feedback originated within business settings where they were called 360-degree evaluations. These used assessments from all individuals within the organization who were functionally associated with a specific employee. Multi-source feedback has been piloted in several medical and surgical residency programs in the last several years with preliminary reports of their usefulness being very positive.[9] Multi-source feedback uses specific instruments to gather information about particular behaviours, especially those that fall within the domain of the *communicator*, *collaborator* and *professional* roles. As such, multi-source feedback can be a powerful impetus for resident self-reflection and self-improvement. Evaluators may include other faculty, supervisors, medical students, peers, allied health professionals (e.g. nurses, pharmacists, social workers and psychologists), administrative staff, patients and family members. A self-assessment is usually included in order to measure the resident's own capacity for accurate self-assessment. Multi-source feedback is typically provided by two or more sources completing a questionnaire consisting of 10 to 40 items that are designed to assess observable clinical behaviours that can be remediated. One of the advantages of multi-source feedback is that it can provide input from people who traditionally do not have responsibility for providing feedback on resident performance and yet may have a different but very valuable perspective on how the resident is actually functioning. While multi-source feedback is vulnerable to rater and sampling bias, the array of feedback from many sources can provide rich, reliable and credible information about both a resident's strengths and weaknesses. The Alberta College of Physicians and Surgeons has recently developed a multi-source feedback tool that is used as part of its revalidation process.

BEST PRACTICES IN EVALUATION: PUTTING IT ALL TOGETHER

The new Royal College OTR and STR in Psychiatry are creating exciting challenges for Canadian residency training programs. In order to meet these challenges without becoming overwhelmed, it is strongly advised that each residency program committee create its own CanMEDS residency training blueprint. In this grid, each CanMEDS role is listed and careful consideration is then paid to where, when and by whom the CanMEDS role is taught. The last columns in the training grid should be devoted to how the CanMEDS role is evaluated, when it is evaluated and by whom. The advantage of creating a CanMEDS training blueprint is that it provides a rational way to comprehensively describe the residency education program, both the formal and informal curriculum, as well as the sequence of this curriculum. Resident evaluation is then effectively highlighted in the context of what is taught over the course of the residency.

Global ITERs should be non-generic and related to specific residency rotations. ITERs should also use behavioural anchors rather than norm referencing. All residency training programs must also use a log to track psychotherapy training (see chapter six), training in addiction psychiatry, and training in the treatment of patients with severe and persistent mental illness. Logs are recommended for tracking resident clinical activity in specific rotations where there is a concern that the educational experience is not robust enough (e.g. inadequate mix of patients) to adequately meet the Royal College STR in Psychiatry. In-training examinations should occur at least three times within the residency program in order to provide the trainee with formative feedback and a means of comparing the resident's knowledge to standardized norms based on equivalent levels of training. It is highly recommended that all residency programs use frequent "low stakes" oral examinations involving diagnostic patient interviewing. Frequent observation of diagnostic interviews together with an expectation that the resident provide a diagnosis, formulation and management plan is an excellent strategy to integrate many CanMEDS competencies together within one evaluation tool. Live observation over a two-hour time frame provides rich constructive formative feedback which can help to enhance the clinical skills of interviewing, diagnosis, critical and integrative thinking and management. Performance anxiety during the STACER examinations can also be attenuated. It is recommended that all residency programs also provide trainees with OSCEs, particularly in their senior residency years, since this will help them prepare for the Royal College oral examinations.

It is recommended that programs also pilot new evaluation tools to more effectively evaluate the non-medical expert roles. Multi-source feedback is becoming very popular and, even if not formally used with a written questionnaire, it is very important that the primary supervisor carefully solicits more feedback from allied health-care staff and the chief resident before completing any resident's ITER. Programs are encouraged to creatively pilot portfolios for the *manager*, *health advocate*, *professional* or *scholar* roles, but should also carefully consider content, storage and ongoing review and evaluation.

Programs must have transparent policies regarding resident evaluation and resident promotion. Documentation and tracking that rotation-specific goals and objectives have been reviewed by the supervisor is critical. The resident evaluation process should have defined terms of reference and a clear and consistent, transparent process to handle residents who have failed rotations or performed poorly in specific CanMEDS roles. Even in the absence of failing a rotation, resident promotion to the next residency training level should not occur automatically. Instead, it should be based on the annual review of the resident's performance using evaluation data. Although annual formal promotion assessment procedures may not be feasible in larger programs, oversight of promotion should still occur on an ongoing basis and it is advisable that a more formal oversight process is implemented for resident promotion from junior to senior residency (PGY3 to PGY4). Each resident must be aware of the "due process" and appeals policy of his/her university. Remediation plans can be developed using grids that are organized based on discrete CanMEDS roles. These remediation grids should resemble the CanMEDS residency training blueprint.

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