Mental Health Training in Family Practice Residency Programs

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This paper presents a national survey of psychiatric and behavioral science training in approved family medicine residency programs. A 64 percent response rate resulted in data describing residency programs approved by the American Academy of Family Physicians: the residents, faculty, and curriculum content, and the teaching-learning format utilized in mental health training. Though improvement in the mental health services of primary care providers is a major health issue, training is typically provided by part-time or volunteer faculty; less than 5 percent of the total faculty are full-time psychiatrists. Critical elements of effective curriculum design and content that are inadequate or omitted are discussed.

Until the past decade, the principal objective of training programs in psychiatry, psychology, social work, and the allied mental health specialties was to provide qualified professionals for the mental health sector of health services. Meanwhile, demand steadily increased for access to comprehensive and humanistic medical care provided by generalists, especially in those areas where health services were in short supply.[1,2] Despite the spectacular growth of tertiary care centers and services, 90 to 95 percent of all physician-patient contacts continued to be with family physicians, internists, and pediatricians.[3] In 1969 the American Academy of Family Physicians (AAFP) was established, and in the 1970s family medicine became the most rapidly growing medical specialty. Concurrently there was a mandate for mental health specialists to adapt their curricula to define the essential elements of an active mental health role for the family physician, such as that outlined by the Willard report[1]:

> to diagnose most psychosomatic and emotional problems . . . to deal with common tensions, anxieties and depressions that initiate or complicate a substantial proportion of the problems with which the family physician will be faced . . . learn how to recognize major psychoses, to deal with psychiatric emergencies, and to provide for many patients the aftercare they need following discharge from a mental institution.

In 1978, the report of the President's Commission on Mental Health provided further compelling evidence for strengthening the mental health role of primary care physicians with its finding that, of the 15 percent of the general population affected with mental disorders, 60 percent were served entirely in the primary care sector.[4] It emerged that family physicians were providing a large quantity of mental health care, using whatever skills and intuitions they possessed to help their patients cope with psychiatric problems.

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0094-3509/82/080329-07$01.75

The goals of recent research have been to bring the needs and the characteristics of mental health services in primary care into sharper focus. Although the prevalence of mental disorders in family practice is high,[5] clinical recognition is low.[6,7] At least one third of patients with mental disorders escape detection.[8,9] Of patients with recognized psychiatric illness, formal diagnosis may not occur because of perceived stigma, pessimism about outcome, or nonavailability of reimbursement.[10] Physicians surveyed by Cassata and Kirkman-Liff[11] estimated that 33 percent of their patients meet criteria for psychiatric diagnosis. Referral access was readily available, but only 2 to 4 percent of patient encounters involved referral or mental health services. These physicians seemed to feel inadequately trained or equipped to treat patients with psychiatric disorders. Hull[12] found that despite the widespread opinion that family physicians should take responsibility for the psychiatric disorders of their patients, only about one half of the family physician respondents in his study agreed. The most potent prediction variable of psychiatric interest and acceptance of a mental health role was perceived adequacy of training.

There is widespread support for augmentation of mental health training of family physicians and for integration of health and mental health services.[1,2,4-19] The National Institute of Mental Health (NIMH) work group on the mental health training of primary care providers has outlined the necessary knowledge, attitudes, and skills for construction of educational goals in training programs.[17] Training programs have been subsequently designed to weave behavioral, psychosocial, and psychiatric elements into the entire fabric of family medicine residency curricula. The AAFP has recommended that 16 percent of total training time, or about six months, should be directed to psychiatric and psychosocial aspects of family medicine.[20]

During the 1978-79 academic year, the psychiatry faculty in the University of Alabama College of Community Health Sciences undertook extensive curriculum development and evaluation of its training programs in psychiatry and behavioral science for family physicians.[21] During the process, numerous questions were raised to which there were no available answers. It was concluded that a national survey of the curricula of residency programs would enhance the specific needs assessment of the department and characterize the reality of mental health training of primary care physicians nationally.

Methods

A questionnaire was mailed in the spring of 1981 to the 382 approved United States family practice residency programs. The questionnaire contained 383 variables that requested objective information about the residency program, residents, faculty, curriculum content, and teaching or training format of the psychiatric and behavioral science curriculum. Two hundred forty-six programs (64 percent) returned completed questionnaires; 16 programs not yet fully operational were excluded from the analysis. The geographical distribution and the distribution of program types represented by the returned questionnaires resulted in distributions nearly identical to the survey population and therefore allow inferences to family practice residencies in general.

Results

Characteristics of Residency

The oldest family practice residency program responding to the questionnaire began operation in 1950. The average program is 6 years old; over one half are between 5 and 12 years old. The programs range in size from 0 to 58 residents, although 50 percent of the programs have fewer than 13 residents. Eighty percent of the residents in training in each of the three years are men and 88 percent are white. Only 4 percent of all residents are black, and Hispanic and Native Americans each constitute 3 percent.

Less than 20 percent of the programs reported that they are specifically training their residents, in part at least, for practice in an inner-city setting. Just over 40 percent of the residency programs train residents for practice in urban and suburban settings, and learning experiences for practice in rural settings are reported by 48 percent of programs. Of the 105 programs training residents for rural practice, however, only 34 (32 percent) indicated that "preparation for life in an underserved, rural area" is included in the curriculum.

Characteristics of Faculty

Family practice residents in the reporting programs are trained in behavioral science and psy-

Table 1. Faculty Distribution: Combined Programs

Faculty	n	Range	Programs	Percent of Programs	Percent of Total Faculty
Psychiatrists					
Full-time	75	0-6	37	16	4.6
Part-time	271	0-11	136	59	16.6
Volunteer	346	0-20	97	42	21
Total	692				42.2
Psychologists					
Full-time	106	0-5	79	35	6.5
Part-time	144	0-6	86	36	8
Volunteer	124	0-10	46	20	7.6
Total	374				21.1
Social Workers					
Full-time	97	0-3	83	38	6
Part-time	122	0-8	173	77	7.5
Volunteer	78	0-8	30	12	4.8
Total	297				18.2
Psychiatric Nurses					
Full-time	13	0-3	8	3	.8
Part-time	26	0-10	13	5	1.6
Volunteer	18	0-4	10	4.5	1
Total	57				3.4
Other					
Full-time	104	0-10	42	19	6.4
Part-time	36	0-6	19	9	2.2
Volunteer	63	0-19	15	7	3.8
Total	203				12.4

Note: Of the total faculty (1,623), 395 (24 percent) were full-time, 599 (40 percent) were part-time, and 629 (39 percent) were volunteers
Proportions of programs reporting no full-time faculty from each category: psychiatrists—153/184 (83%); psychologists—93/143 (65%); social workers—82/132 (52%); psychiatric nurses—204/212 (96%); other (residents, clergy, pediatricians, sociologists, biologists, behavioral scientists)—143/178 (81%)

chiatry by 1,623 faculty members, 395 (24 percent) of whom are full-time, 599 (37 percent) of whom are part-time, and 629 (39 percent) of whom are volunteer faculty (Table 1). Full-time, part-time, and volunteer psychiatrists combined represent 42.2 percent of the total faculty. The remaining 57.8 percent of the faculty are nonphysicians. Eighty-three percent of the programs report no full-time psychiatrists on their faculty. Fifteen programs (6.8 percent) report no psychiatric faculty at all, and 54 (23.4 percent) report only volunteer psychiatric faculty, resulting in one third of the programs operating without significant systematic psychiatric input. These 67 programs are training 1,530 residents, 37 percent of all residents.

Psychiatric Curriculum

Behavioral science and psychiatric content are integrated longitudinally into the three-year curriculum in over 90 percent of the programs. Over 60 percent of the programs indicated a block rotation model, and over one half of the block rotations were combined with a consultation-liaison program. Ten percent were combined with competency-based curricula. Less than 13 percent of the programs were solely competency based. A required rotation, typically four weeks in duration, is most frequent in the second residency year (52 percent of programs), and an elective rotation is most frequent in the third year.

Table 2. Curriculum Content Areas

Rank*	Subject	Programs Not Included No. (%)	Residents Not Trained No. (%)
1	Depression	13 (6)	181 (4)
2	Physician-patient relationship	17 (8)	272 (4)
3	Social intervention: collaboration with social workers	45 (20)	717 (18)
4	Psychosomatic and somatopsychic illness	31 (14)	510 (12)
5	Family life and family counseling	23 (10)	298 (7)
6	Relationship among psychosocial, environmental, and physical aspects of disease	32 (15)	536 (13)
7	Dying patients, loss and grief	24 (11)	422 (10)
8	Psychopharmacology	23 (10)	291 (7)
9	Interviewing	14 (6)	173 (4)
10	Psychiatric referral	25 (11)	458 (11)
11	Marital problems	22 (10)	340 (8)
12	Crisis counseling; brief therapy	26 (11)	447 (10)
13	Hypochondriasis	30 (14)	498 (12)
14	Diagnosis and differential diagnosis	3 10)	352 (8)
15	Child abuse and neglect	31 (14)	510 (12)
16	Anxiety tension states	39 (18)	637 (16)
17	Substance abuse	25 (11)	416 (10)
18	Sexual behavior	87 (40)	1,606 (37)
19	Suicide evaluation	29 (13)	466 (11)
20	Organic brain syndrome	32 (14)	509 (12)
21	Children and adolescents	32 (14)	642 (15)
22	Psychotherapy	66 (29)	1,222 (22)
23	Management of psychiatric emergencies	19 (9)	296 (7)
24	Geriatric	58 (26)	1,053 (25)
25	Behavioral therapies	49 (22)	789 (18)
26	Chronic illness, disability	62 (27)	1,074 (26)
27	Human psychological development	51 (23)	919 (22)
28	Mental health services and self-help groups	55 (25)	1,029 (24)
29	Causes of mental illness	83 (37)	1,410 (33)
30	Community mental health	74 (33)	1,283 (31)
31	Mental retardation	91 (40)	1,606 (37)
32	Psychological testing	87 (39)	1,548 (36)
33	Deinstitutionalized patients	121 (54)	2,093 (49)
34	Forensic psychiatry	107 (47)	1,828 (43)
35	Psychoanalytic theory	142 (63)	2,645 (62)

*According to number of programs that offer subject during all three residency years; analysis excludes one- and two-year-programs.

Anticipated changes in the psychiatric curriculum were reported by over one half of the programs. Of the 33 categories of change cited, the most frequent were the strengthening of behavioral science subject content (20 programs), an increased training in family therapy and family dynamics (15 programs), and greater utilization of videotapes for teaching purposes (15 programs). Eleven programs planned to increase their emphasis on outpatient psychiatry, 7 programs planned to increase inpatient training, and 8 planned to reduce "straight psychiatric content."

The 35 curriculum content areas included on the questionnaire are listed in Table 2, ranked accord-

Table 3. Training Experience

Rank	Facility	Number of Programs	Percent of Programs	Percent of Programs Utilizing Residency Year 1	2	3
1	General hospital*	145	65.9	36	45	36
2	Acute in-patient psychiatric service*	137	62.3	24	39	24
3	Mental health center	109	49.5	11.8	30.5	22
4	Other**	79	35.9	15	23.6	17
5	Convalescent facility	45	20.5	9	14	16
6	Crisis center	34	15.5	5	10	6
7	Mental retardation facility	20	9.1	4	2.7	5
8	Jail or prison	9	4.1	.8	2.7	2.7

*These figures very likely represent substantial overlap
**In order of frequency: family practice center, alcohol in-patient treatment center, emergency service

ing to the number of programs that indicated including them in all three years of training. Also in Table 2 is the number of programs in which the subject is not covered at any time during the residency and the number of residents attending those programs. Curriculum content areas are typically covered in noon conferences and lectures, which are designed to cover all prescribed areas on a continuing basis over the three-year curriculum. Therefore, first-, second-, and third-year residents attend as a group. Psychiatric case supervision is utilized as a training experience by 90 percent of the programs. Four fifths of the programs provide a clinical experience in which residents are expected to treat psychiatric patients, usually in an inpatient setting (Table 3). Two thirds of the programs provide experiences in mental health team collaboration or clinical case conferences. Participation in psychiatric teaching or in research is available to residents in less than one fourth of the programs (Table 4).

Discussion

There is consensus that most patients with mental disorders will continue to be treated by their family physicians, and the best way to improve the family physicians' services is to improve the educational experiences necessary to assume mental health roles. Today's primary care physicians need to be trained to assume an active psychiatric role, which includes expertise in history taking, psychiatric differential diagnosis and case formulation, appropriate use of psychopharmacologic agents, and the ability to assume leadership of a team of nonphysician health and mental health providers. Most important, their training must stress the importance and the complexity of the physician-patient relationship and the interaction between physical and psychological aspects of illness.[22,23]

Survey results are not encouraging. The number of behavioral science and psychiatry faculty is small, and less than 25 percent are full-time. Effective mental health training requires the resources of all allied mental health professionals, but only a small fraction of faculty training family physicians are psychiatrists. One hundred eighty-four programs (83 percent) have no full-time psychiatrists on their faculty, and one third of the programs, involving over 1,500 residents, have no psychiatrists among full- or part-time faculty. Ninety percent of the programs provide "psychiatric case supervision," which can only be occurring with nonphysician teachers in the majority

Table 4. Resident Activities

Rank	Resident Activity	Number of Programs	Percent of Programs	Percent of Programs Offering During Residency Year 1	2	3
1	Psychiatric case supervision	200	90.9	55	71	59
2	Lectures	193	87.7	74	75	71
3	Treatment of psychiatric patients	183	83.2	51	66	53
4	Seminars	150	68.2	49	57	51
4	Clinical case conferences	150	68.2	37	50	41
4	Mental health team collaboration	151	68.6	44	50	42
7	Psychiatric supervision in nonpsychiatric clinics	121	55.0	38	44	44
8	Psychiatric teaching	51	23.2	7.7	14	15
9	Other	25	11.4			
10	Psychiatric research	22	10.0	3.6	5	6.8

of cases. The importance of psychosocial determinants in health and mental health care is unquestioned, but this composition of faculty omits important medical dimensions of a mental health role from the curricula. As Fink[24] stated:

> Just as it would not be acceptable to hire a cardiac physiologist to provide the major input regarding the diagnosis and care of the cardiac patient, it seems equally inappropriate to have sociologists and other nonphysicians carry the major responsibility for instruction in the myriad of psychosocial issues in the practice of medicine.

Several researchers have surveyed medical practices in order to define the parameters of skills necessary for the delivery of quality psychiatric care within a general practice.[11,25-29] Likewise, educators such as Freeman and Sack,[30] Hodge,[31] the NIMH work group on mental health training in primary care,[17] Houpt et al,[32,33] Fink,[34] and Fink and Strosnider[35] (Fink has reviewed additional authors[36]), have proposed core curricula requirements.

The uneven characteristics found in faculty composition reappear on examination of curriculum content. As Table 3 indicates, the majority of the programs devote substantial curricular time to such advocated subjects as the physician-patient relationship, diagnosis and treatment of depression, psychosomatic illness, and family counseling. What is disturbing is the low priority attached to several of the subjects considered critical by the educators cited above: diagnosis and differential diagnosis (rank 14), substance abuse (rank 17), suicide evaluation (rank 19), and management of psychiatric emergencies (rank 23). The Virginia Study documented the prevalence of anxiety neurosis as the 15th most common diagnosis in family practice,[37] but less than one third of the programs cover anxiety-tension states (rank 16) in a longitudinal, comprehensive format. In fact, 18 percent of the programs do not cover the subject at all. One has to wonder whether these physicians will be able to recognize psychiatric problems and manage them appropriately.

Education in mental health skills needs to occur in a truly longitudinal program that begins early in the residency before attitudes become fixed.[38] Much of learning is "state dependent"; information learned in one state is best recalled in the same state. Traditional curricula reliant on block rotations with "psychiatric patients" in a specialized context generate little carry-over learning of mental health principles referable to nonpsychiatric patients.[39] This exemplifies the need for teaching and learning experiences organized in the

primary care setting, with emphasis on biopsychosocial aspects of illness or injury and on the quality of patient interviewing and case formulation.[16,22]

The field of mental health education of family physicians is new and rapidly developing. One respondent stated that "this survey represents well the difficulties in deciding what it is we want/need residents to know and how important behavioral science and psychiatry are." There was a strong indication among respondents of a commitment and dedication to make their curricula as effective as possible. Most training programs are attempting longitudinal integration into the residency, and there are continuous processes to update the curriculum content. Nonetheless, it is feared that the mental health care delivered by family physicians will be insufficiently comprehensive unless there is greater psychiatrist involvement in teaching core medical/psychiatric knowledge and skills.

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