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Training in consultation–liaison psychiatry in Eastern Europe

Joanna Rymaszewska [a,b,*], Wolfgang Söllner [a,b]

[a] Research Unit of Consultation–Liaison Psychiatry & Behavioral Medicine, Department of Psychiatry, Wroclaw Medical University, Poland
[b] Department of Psychosomatic Medicine and Psychotherapy, General Hospital Nuremberg, Germany

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Introduction

Interest in a subject of consultation–liaison psychiatry reached Europe rather late, and included mainly Western European countries. Beginning with the 1960s–1970s, liaison psychiatry acquired credit in Europe, particularly in France, Germany, Italy, the Netherlands, Spain, Switzerland and the United Kingdom. Starting with the 1990s, the term liaison psychiatry has become widely used in the literature [1]. The European activity of liaison psychiatry and psychosomatics was first evaluated in a study commissioned in 1987 by the European Community. The study included 11 countries: Finland, Norway, the United Kingdom, Germany, the Netherlands, Belgium, Greece, Italy, France, Spain and Portugal. The absence of well-developed liaison psychiatry and psychosomatic services in general hospitals led to the conclusion that the patients' mental health needs were not met [2]. In 2002 the European C–L Workgroup Collaborative Study attempted to investigate the organisation of C–LP in Western European countries. A large variation has been found in all aspects of service delivery and size of staffing [3]. Today, liaison psychiatry is striving to become a clinical subspecialty in an increasing number of European countries. In 1997, the European Board of Psychiatry approved the report Consultation–Liaison Psychiatry and Psychosomatic Medicine in the European Union. None of Eastern countries has been included [4]. In 2002, the UEMS Section and Board of Psychiatry approved the Requirements for the Speciality of Psychiatry and defined consultation–liaison psychiatry as "a model or component of the psychiatrist's work that involves attending general hospital wards or outpatients, or alternatively primary care settings to see and/or discuss patients, so as to provide advice on the diagnosis and management of psychiatric disorder in such settings".

The WPA developed a core international curriculum for postgraduate training in psychiatry including C–LP as one of core competencies for residents [5]. It is also recommended to (1) provide 10–12 hours as minimum number of suggested C–LP seminars during second and third year of training, (2) participate in complimentary didactic/clinical rotations which include 6 months minimum in neurology and primary care/internal medicine and 3 months in consultation and liaison psychiatry and (3) reach competency requirement skills for psychiatry residents during second year of training with providing consultation to medical and/or surgical services (at least 6 cases of delirium, 4 of dementia, 5 of psychological response to illness, injury or treatment) [5,6].

In 2009 UEMS developed recommendations on C–L psychiatry which conclude that C–LP is a significant part of the psychiatric field which should be promoted appropriately and contain recommendations for training, organisation and standards of care. The UEMS Section and Board of Psychiatry recommended C–LP training as compulsory for residency gaining knowledge and competency in the field as well as skills, which should be implemented on national level. It also suggests that C–L psychiatry should be recognised as a subspecialty or special competence within psychiatry with own training programmes and certification. Only two Eastern European countries are mentioned in UEMS report: Poland (mandatory rotation to C–LP service) and Hungary (national C–LP associations or sections and working groups within national psychiatric societies) [7].

The European Association of Consultation–Liaison Psychiatry and Psychosomatics (EACLPP) has organised a workgroup to establish consensus on the contents and organisation of training in consultation–liaison psychiatry and psychosomatics. In 2005, a survey among experts has been conducted to assess the status quo of training in C–LP in 14 EU countries [8]. The survey showed a wide variety of training in C–L psychiatry and psychosomatics among Western European countries. No Eastern European countries were included in the survey. Up till now the C–L psychiatry in Eastern Europe was not studied despite single papers describing C–LP organisation in Bulgaria [9], Hungary [10] and Ukraine [11].

The aim of the survey was to describe the situation of C–LP training and services in Eastern European countries.

Method

In our survey to assess the status quo of Eastern European C–LP we used the same questionnaire as in the EACLPP survey in Western

* Corresponding author at: Research Unit of Consultation–Liaison Psychiatry & Behavioral Medicine, Department of Psychiatry, Wroclaw Medical University, Poland.
E-mail address: Joanna.Rymaszewska@am.wroc.pl (J. Rymaszewska).

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European countries [8]. The questionnaire is given as an appendix to the above-mentioned paper [8]. The questionnaire was sent to the experts (mainly national representatives of the EACLPP) at the turn of 2010 and 2011. All answers were received in a written form.

Countries were chosen according to WHO zoning, without those from Asia. The questionnaire was sent to experts in 20 countries, from whom 10 responded, representing Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Lithuania, Poland, Serbia, Romania, Turkey and Ukraine.

Results

Among all responders there is only one national guideline for training in C–LP (Romania—National Training Curricula since 2008). Different levels of education and recommendations for training among the assessed countries had also appeared.

C–LP training is included in the psychiatric residency training as mandatory course in Croatia and Hungary, whereas it is optional for students in Belarus, Bosnia and Herzegovina, and Slovenia. In half of the countries post-graduate C–LP training is organised on a national level (Belarus, Bulgaria, Poland, Romania, Slovenia, and Turkey). The time frame of the courses and their particular topics vary a lot among countries. The courses mostly exist within general psychiatry courses and are not based on guidelines.

However, only in three countries residents in psychiatry can get a certificate finalising C–LP training (Romania, Bosnia and Herzegovina, Belarus) or have to pass an exam (Hungary, Slovenia).

Additional postgraduate education is conducted in most of the evaluated countries. In Bulgaria such education is regularly organised in the frame of conferences and national congresses of the Bulgarian Psychiatric Association and the Bulgarian Psychosomatic Society. In Romania such activities are organised from time to time, as in Belarus (e.g. 2 week seminars/training by Medical Academy of Postgraduate Education or psychiatry department).

In most of the responded countries the requirements for theoretical training are similar including "delirium and dementia", "somatisation", "treatment of suicide attempts", and "interaction of psychotropic drugs" but the time frame varies.

There is wide variety of the practical training among countries (see Table 1).

Rotation to C–L units and medical/surgical units are mandatory for psychiatric residents in Croatia and Poland, only (Table 2) [12].

The survey for Eastern European countries also contained three additional questions on organisation of C–LP in each country (about the national programmes, structures and specialised psychiatry units). There are no official national programmes or standards in C–LP organisation in Eastern Europe. In Croatia there's only one C–L psychiatry department in the University Hospital Zagreb with nurses, social workers psychologists and 19 psychiatrists working there part time (approximately 3 hours per week). Each psychiatrist has his or her 'own' department and is "specialised" in the respective medical discipline (i.e. dermatology, oncology, endocrinology, intensive care units, neurology). In other Croatian hospitals there is no formal C–LP department but all hospitals provide psychiatric consultation. In Bosnia and Herzegovina every day one of the (general) psychiatrists from the Department for Psychiatry is appointed as a consultant to different departments. In Bulgaria, new wards for acute psychiatric disorders have appeared at the beginning of 2008 in the general hospitals of Vidin, Vratsa, and Kazanluk. In Romania exists one specialised C–L psychiatry unit. In Poland C–LP services were implemented in most general hospitals. In addition, there is a trend to organise psychosomatic and general psychiatry wards within general hospitals.

Conclusions

The generalisability of the results of this survey is limited because we obtained information from 10 out of 20 Eastern European countries only. However, they show that there is growing interest in the subject of consultation–liaison psychiatry and psychosomatic medicine in Eastern Europe. Nevertheless there is a wide variety of training in C–LP and a strong need for guidelines for C–LP training and organisation of services to be implemented across this part of Europe.

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Table 1
Practical training in C–L psychiatry among different Eastern European countries.

	TRAINING OF SPECIAL SKILLS					CLINICAL EXPERIENCE				
	Focused psychotherapy	Relaxation techniques	Group psychotherapy	Systemic approaches	Team counselling	Supervised clinical practise	Supervision/case conferences	Quality management meetings	Rotation to C–L units	Rotation to medical/surgical units
Belarus	No	Yes (6 h)	No	No	No	NA	Optional	No	No	No
B&H	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes Neurology—6 months Internal med.—3 months Ophtalmology, laryngology—1 month each
Bulgaria	Yes	Yes	Yes	Yes	Yes	No	NA	NA	No	No
Croatia	No	No	Yes	No	Yes	Yes	Yes	No	Yes (3 months)	Neurology (1 month)
Poland	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes (2 months)	Neurology (3 months)
Romania	No	No	No	No	No	Yes	Yes	No	No	No
Ukraine	Yes	Yes	Yes	No	No	Yes	Yes	No	No	No

Table 2
Comparison of training for residents in C–L psychiatry between Eastern and Western European countries.

	Eastern Europe	Western Europe[a]
National guidelines	Romania	Austria, Netherlands, UK, Germany, Spain, Switzerland
Rotation to C–L service	Croatia (3M), Poland (2M)	Mandatory: Portugal (3M), Spain (4M); Recommended: Netherlands, Norway (6M), UK(6M), Germany (half-time 3–6M); Switzerland
Rotation to General Medicine or neurology	Croatia (1M neurology), Poland (2M neurology)	Internal medicine: Austria, Germany—Psychosomatic Medicine, Norway (1 year) Neurology: Austria, Germany—Psychiatry (1 year)
Supervised consultations	B&H: 1 h/month Croatia: 1 h/week (3M) Poland (20) Romania, Ukraine—no time frame Belarus—optionally	Germany: 20 sessions; Italy: 25 sessions

[a] Based on data about Western European countries from the survey in 2010 (results unpublished yet, presented at the EACLPP Annual Scientific Meeting in Budapest in 2011) [12].

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