Postgraduate Year-1 Residency Training in Emergency Psychiatry: An Acute Care Psychiatric Clinic at a Community Mental Health Center

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Abstract

Objective The purpose of this study was to determine resident satisfaction with an acute care psychiatric clinic designed in collaboration with a nearby community mental health center. We also sought to demonstrate that this rotation helps meet program requirements for emergency psychiatry training, provides direct assessments of resident interviewing skills and clinical knowledge in the postgraduate year-1, and provides exposure to public sector systems of care.

Methods We developed a resident satisfaction questionnaire and fielded it to each of the residents who participated in the clinic over the first 3 years. Data were collected, organized, and analyzed.

Results Of the 15 residents in the acute care psychiatric clinic, 12 completed and returned the satisfaction questionnaires. Educational aspects of the clinic experience were rated favorably.

Conclusions This postgraduate year-1 acute care psychiatric clinic provides a mechanism for the fulfillment of emergency psychiatry training as well as direct supervision of clinical encounters, which is a satisfactory and useful educational experience for trainees.

Background

Residency programs should provide training that incorporates recent developments in the field, and helps residents meet the changing needs of their patients. With the development of emergency psychiatry and the increase of acute psychiatric interventions, academic psychiatry has struggled to adequately incorporate emergency psychiatric education into the curriculum.[1–3] In response, recent revisions to the Accreditation Council for Graduate Medical Education program requirements for psychiatry have moved toward more intensive training in emergency psychiatry, in addition to on-call duties

This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.[4]

Many programs have developed model acute care psychiatric clinics as an alternative to emergency department on-site training. These clinics can provide an emergency psychiatry training experience as well as better access for patient evaluation and intervention.[5]

Acute care clinics require residency programs to be flexible and innovative to provide requisite training and service that realistically address the community's health care needs. Public sector mental health clinics often service a more vulnerable and chronically ill patient population. Trainees in such settings therefore may be exposed to more

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severe psychiatric acuity. In addition, exposure to the public sector mental health system provides trainees with experiences increasingly more important to newer residency program graduates as this is becoming the most common care setting.[6] Community mental health services have also tended to become a casualty to state or local budget limitations, and services rendered by trainees are often highly valued.

In conjunction with newer emergency psychiatry training requirements, there has been a demand for documented ''direct supervision'' in psychiatric residency training. During direct supervision, faculty supervisors monitor real-time resident-patient interactions and provide immediate feedback regarding interviewing and examination technique, clinical knowledge base, diagnostic skills, and treatment planning.[4] Early direct observation and evaluation of residents can help to tailor individual training plans, but coordinating direct supervision in the busy postgraduate year-1 (PGY-1) can be elusive. The purpose of this article is to provide the description of an acute care psychiatric clinic that was designed to provide direct supervision and train residents in emergency psychiatry during their first year, simultaneously exposing them to community mental health center systems of care. This description is supplemented by resident satisfaction ratings.

Methods

Need for an Acute Care Psychiatric Clinic

The development of this clinical experience was expedited by the general need of the community mental health center for psychiatric services. There was a need for more urgent care to many of the clients who received services through the center's various programs, which included routine psychiatric appointments, an 8-bed crisis center, a homeless outreach case management program, a long-stay residential psychosocial rehabilitation program, and a linkage program from local area psychiatric inpatient services. The addition of an acute care psychiatric clinic in which waiting times could be reduced to only a few days or less was seen as a potential asset in avoiding referrals to the emergency departments, hospitalizations, and providing rapid evaluation and management of patients in crisis.

Development of an Acute Care Psychiatric Clinic

The Department of Psychiatry at Southern Illinois University's community-based residency training program developed a community mental health center acute care psychiatric clinic. The clinic was staffed for 2 hours twice each week during late afternoons. Postgraduate year-1 residents were excused from other clinical commitments during each of their month-long psychiatry rotations to attend the clinic singly or in pairs. For residents in the categorical psychiatry program, this constituted 4 months distributed throughout the year (3 months of inpatient adult psychiatry and 1 month of substance abuse evaluation and management). Residents in an affiliated combined medicine and psychiatry training program spent 2 months at the clinic (1 month of inpatient adult psychiatry and 1 month of substance abuse evaluation and management). Faculty supervised no more than 2 residents at any given time. Patient appointments were staggered to enable direct supervision of each resident. At their first mental health center visit, residents were given a 45-minute orientation session by the mental health center staff on the various services and populations served by the center, the clinic structure, patient flow, and medical documentation methods.

Clinic costs were the contractual hourly rate for the attending faculty clinic director and were similar to the amounts paid to the other psychiatrists who worked at the facility. Resident stipend costs were borne by 2 of the participating teaching hospitals, one of which was affiliated with the community mental health center. Both hospitals were supportive of the added aspects of the clinic service. Travel time for residents was approximately 5 minutes to and from the clinic site. Nursing and other staff resources and materials were provided through the community mental health center.

Curriculum

This clinic experience differs from the usual emergency psychiatry experience provided to residents, which took place predominantly during on-call periods. Residents evaluated patients presenting to the emergency departments of 2 busy university-affiliated general city hospitals. These patients were first seen and evaluated by the emergency department physicians and then referred to mental health staff, who provided assessments and then discussed these cases with the resident on call. The resident would then interview and examine the patient and discuss the case with the attending faculty supervisor via telephone to determine the disposition and treatment plan. Residents from the PGY-1, -2, and -3 levels were expected to perform on-call duties, taking call approximately 5 to 6 times each month.

Residents conducted 60-minute evaluations of new patients and, where necessary, 30-minute follow-up appointments. Each 60-minute session was directly supervised by the clinic director, a faculty psychiatrist. The clinic director was present in the room with the resident and patient for the first 15 minutes of each session. For new patients, the clinic director also attended for at least the last 15 minutes in order to guide the treatment discussion and disposition. Residents were given immediate verbal feedback regarding their interview (conduct, rapport, controlling flow, and content covered), examination approach, focused psychiatric interviewing, and *Diagnostic and Statistical Manual*, Fourth Edition, Text Revision-based diagnosis and treatment. Interventions included the use of acutely acting anxiolytic and antipsychotic agents, initiating

or continuing longer-acting psychotropic medications, the use of the locally available diagnostic laboratories, psychotherapy, case management, or transfer to a hospital.[5]

Survey

A 25-item resident acute care psychiatric clinic satisfaction questionnaire, modeled after a previously published and validated instrument,[7] was developed. Answers were rated on a 5-point Likert scale (1 = "Very dissatisfied"; 2 = "Dissatisfied"; 3 = "Neither satisfied nor dissatisfied"; 4 = "Satisfied"; or 5 = "Very satisfied"). The questionnaire was intended to measure resident satisfaction with educational aspects of the clinic experience, including diversity of the patient population and presenting psychopathology, exposure to public sector systems of care, biological and psychosocial interventions, medical knowledge, and improvement in psychiatric interviewing skills. Respondents were also asked to make comments about any aspect of the clinical rotation experience at the end of the questionnaire. Questionnaires were distributed to each of the 15 residents who participated in the clinic, and were anonymously completed. Data were analyzed using SPSS 14.0 software (SPSS Inc, Chicago, IL). A retrospective chart review provided patient demographics. Patient demographic data were analyzed in SPSS 14.0, and standard descriptive statistics were calculated.[8] The institutional review board granted this project exempt status prior to data collection.

Results

A total of 158 patients (70 women) attended the clinic over the first year. The mean age of the patients was 36.4 years (range, 19–69); ethnicity was 70.5% white, 23.9% African American, and 5.6% other. Reasons for referral were decompensating, 41.1%; no access to psychiatrist, 29.8%; acutely suicidal, 6.3%; acutely psychotic, 5.1%; and unspecified, 17.7%. Axis I pathology included mood disorders, 59.8%; psychotic disorders, 28.3%; anxiety disorders, 5.1%; and other diagnoses, 6.8%. Comorbid medical conditions were present in 70.4% of the patients. The mean Global Assessment of Functioning score for patients on presentation was 48.5 (range, 29–75).

The 25 questionnaire items and summary statistics related to the quality of the educational experience are presented in the TABLE. The residents rated the educational quality and diversity of the clinical experience favorably, and rated highly the training in emergent interviewing, psychosocial aspects, and biomedical aspects. The highest rated items were those measuring quality of supervision as well as access to direct supervision and feedback as being helpful for the mock board examination. Compared with the other items, residents rated less favorably their perception that the clinic experience improved Psychiatry Resident In-Training Examination (PRITE) scores. Overall, residents regarded the clinical experience as satisfactory.

Discussion

With the initiation and maintenance of this acute care psychiatric clinic, the community mental health center found improvement in client retention, a reduction in emergency referral, and quicker availability of psychiatric services. The clinic was featured in the annual reports of both the affiliated hospital system[9] and the community mental health center,[10] which subsequently applied for and was awarded an innovative community service grant that enhanced the clinic continuity.[11]

The broad emphasis on diversity of both patients and psychopathology in a directly supervised setting likely contributed to a higher sense of confidence in approaching both the program's mock board examination and the PRITE. The varied and integrated aspects of the rotation were likely contributors to the overall positive evaluation of the acute care psychiatry clinic rotation by residents. A small number of respondents chose to provide qualitative comments at the end of the resident satisfaction questionnaire. These comments were positive, providing additional support to our findings that the acute care psychiatry clinic is a beneficial resident educational experience.

Limitations in this study include the single-site location, which limits the generalizability of application, low numbers of residents in the clinic rotation, and use of a questionnaire that was not formally validated elsewhere, despite our use of several items from a previously validated psychiatry resident satisfaction questionnaire. In addition, only one faculty supervisor participated. That faculty member also served as author, but did not participate in distribution of the satisfaction questionnaire in efforts to reduce potential response bias. Some PGY-1 residents experienced this clinic before taking their first PRITE, so further study is needed to determine whether this clinical exposure can help residents improve either global psychiatry or subscale scores in tests of emergency psychiatry. There are no comparable survey statistics to compare with the on-call or traditional hospital emergency department training experience.

Conclusions

Overall, this acute care psychiatric clinic rotation is successful as a collaborative residency training model in public sector-based emergency psychiatry. First-year psychiatric residents indicated an overall satisfaction with the experience. They were exposed to a wide range of acute psychopathology in a public sector system of care. The patient population differed from that seen by residents in their other outpatient rotations. Direct faculty supervision in the setting of acute care psychiatric interviewing provided the trainees with immediate feedback, which they found useful in their emergency psychiatry education. The opportunity to observe PGY-1 residents directly also

TABLE **Descriptive Statistics by Questionnaire Item**

Questionnaire Item	Mean	Median	Standard Deviation
Exposure to nonpsychiatric aspects of medical care (medicine, neurology or others).	3.25	3.00	.622
Responsibility given for patients care.	4.00	4.00	.894
Improvement of PRITE scores.	3.27	3.00	.467
Education prioritized over service.	4.36	4.00	.674
Did access to direct supervision and direct feedback help you for mock board examination?	4.36	5.00	.809
Quality of supervision.	4.50	5.00	.674
Diversity in patient's population (age, gender, ethnicity, socioeconomic status).	3.91	4.00	.539
Exposure to public sector systems of care.	4.08	4.00	.669
Exposure to diverse psychopathology.	4.33	4.00	.651
ACPC's ability to offer a different emergency psychiatry experience compared to working in the hospitals.	4.33	4.00	.492
Support from staff.	4.36	5.00	.809
Support from peers.	3.91	4.00	.831
Respect of supervisor/staff for residents.	4.33	4.50	.778
Responsiveness for feedback from residents.	3.55	3.00	.934
Morale in the ACPC and Mental Health Center.	4.45	5.00	.688
Traveling to another site.	3.17	3.00	.937
Training in emergent interviewing—did it help your skills for evaluating patients in ER?	4.36	5.00	.809
Training in psychosocial aspects of psychiatry.	4.27	4.00	.647
Training in biomedical aspects of psychiatry.	4.18	4.00	.751
Balance between psychosocial and biomedical aspects of psychiatry.	4.09	4.00	.701
Balance between exposure to emergency psychiatry and continuity of care.	3.50	3.00	.905
Experience in disposition of acutely ill patients (apart from hospital admission).	3.92	4.00	.900
Ability to manage overlapping inpatient commitments.	3.64	4.00	.674
Adequacy of medical records.	3.64	3.00	.809
Overall satisfaction	4.18	4.00	.751

Abbreviations: ACPC, acute care psychiatric clinic; ER, emergency room; PRITE, Psychiatry Resident In-Training Examination.

provided formative information on their clinical knowledge and skills needs early in their training.

The acute care psychiatry clinic offers an alternative to the hospital emergency department experience for meeting psychiatry residency training requirements in emergency psychiatry. It is likely that the combination of respect, diversity, emphasis on education, a fair and responsive faculty, and positive morale led to the overall positive evaluation of this rotation. We suggest that iterations of this training clinic be implemented elsewhere and assessed to determine validity and generalizability, using larger samples of trainees as well as more concrete educational outcome variables, including effects on mock board, PRITE subscale scores, and the newly implemented clinical skills verification requirement.[12] This clinic currently provides a successful model experience for psychiatry residency training in emergency psychiatry and is a positive step in academic-public sector collaborative models.

References

1 Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA. Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. *Psychiatr Serv.* 2005;56(6):671–677.

2 Fauman BJ, Fauman MA. Resident Performance on a Psychiatry Emergency Service. *J Med Educ*. 1980;55(12):1033–1036.
3 Brasch J, Glick RL, Cobb TG, Richmond J. Residency training in emergency psychiatry: a model curriculum developed by the education committee of the American Association for Emergency Psychiatry. *Acad Psychiatry*. 2004;28(2):95–103.
4 Accreditation Council for Graduate Medical Education. Program requirements for graduate medical education in psychiatry, effective: July 1, 2007, p 20. Available at: http://acgme.org/acWebsite/downloads/RRC_progReq/400_psychiatry_07012007_u04122008.pdf. Accessed July 26, 2010.
5 Claassen, CA, Hughes, CW, Gilfihlan, S, McIntire, D, Roose, A, Lumpkin, M, et al. Toward a Redefinition of Psychiatric Emergency. Health Services Research 2000;35(3):735–754.
6 Ranz JM, Vergare MJ, Wilk JE, et al. The tipping point from private practice to publicly funded settings for early- and mid-career psychiatrists. *Psychiatr Serv*. 2006;57(11):1640–1643.
7 Elliot RL, Yudkowsky R, Vogel RL. Quality in psychiatric training: development of a resident satisfaction questionnaire. *Acad Psychiat*. 2000;24:41–46.
8 Peat J, Barton B. *Medical Statistics: A Guide to Data Analysis and Critical Appraisal*. Malden, MA: Blackwell Publishing; 2005.
9 Mental Health Centers of Central Illinois. 2008 annual report: July 1, 2007-June 30, 2008. Available at: http://www.mhcci.org/Documents/MHCCI-2008-Annual-Report.pdf. Accessed July 26, 2010.
10 Memorial Health System. Creating a great patient experience: annual report, 2007. Available at: https://www.choosememorial.org/Documents/Annual-Reports/2007-Annual-Report.pdf. Accessed July 26, 2010.
11 United Way of Central Illinois. 2010 program allocations. Available at: http://www.springfieldunitedway.org/program_allocations.php. Accessed July 26, 2010.
12 Juul D. American Board of Psychiatry and Neurology sponsors conference on training faculty to evaluate clinical skills. Available at: http://www.abpn.com/downloads/newsletters/UPDATE_Winter_2008_final.pdf. Accessed July 26, 2010.