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Senior house officer training in liaison psychiatry – are College guidelines being implemented?

AIMS AND METHODS
To determine whether the College guidelines in liaison psychiatry are being implemented, a survey of training opportunities at senior house officer (SHO) level was undertaken. A detailed postal survey was conducted in January 2000. Information was collected about the number and nature of SHO liaison psychiatry posts from a wide range of sources.

RESULTS
Nationally, 45.5 SHO posts in liaison psychiatry were identified. These were unevenly distributed, with a high number in London. Only five posts were available to general practitioner trainees. Nine regions anticipated an increase in training opportunities. Regional liaison representatives had incomplete knowledge of the availability of liaison training opportunities in their region.

CLINICAL IMPLICATIONS
The College guidelines to incorporate liaison experience into all training schemes have not been implemented. In four regions no training opportunities were identified whatsoever. A national database is needed to monitor training opportunities and inform further development of training posts.

Liaison psychiatry is an emerging speciality and there has been a recent increase in consultant posts in this area (Guthrie, 1998). Liaison psychiatry involves the psychological assessment and treatment of patients with physical and psychiatric disorder. The skills necessary for liaison psychiatry are of as much relevance to physicians and general practitioners as to psychiatrists, but have often been neglected, leaving doctors at a disadvantage when trying to manage patients. This clearly has implications for patient care as psychological difficulties often go undetected, causing patient morbidity and unnecessary medical expenditure (Mayou & Hawton, 1986; Feldman *et al*, 1987; Royal College of Physicians and Royal College of Psychiatrists, 1995). More innovative medical schools are trying to improve this situation by introducing awareness of psychological issues at an early stage in the undergraduate curriculum (Guthrie & O'Neil, 1999).

Opportunities to gain liaison psychiatry experience at senior house officer (SHO) level would be useful to both general practice and psychiatry trainees. Many general practitioners (GPs) see patients with a combination of physical and psychological problems and the core skills gained in liaison psychiatry would facilitate their management of this patient population. In addition, liaison skills are as relevant to psychiatric trainees seeking a career in general adult psychiatry who may end up working in areas with limited access to liaison psychiatrists, as to those considering specialising in liaison psychiatry.

Specific recommendations of the Liaison Psychiatry Group Executive Committee for postgraduate training are that every training scheme should offer at least one 6-month placement in liaison psychiatry with a minimum of four, but preferably up to 10, liaison sessions. This should be supervised by a consultant with a special commitment to liaison psychiatry (House & Creed, 1993).

There is currently no national database of SHO liaison training posts. The College census does not indicate sub-specialty at SHO level or differentiate psychiatry from GP trainees. This makes it hard to assess whether College recommendations are being implemented. This lack of central information makes it difficult to monitor the development and argue the case for an expansion of liaison psychiatry training.

We performed a national survey of SHO training posts in liaison psychiatry to assess whether College guidelines are being implemented and to get a baseline of the opportunities available.

The study

A postal survey was conducted during January 2000 and additional information was collected over the following few months. The survey was sent to all level II programme directors (scheme organisers) and regional advisers listed in the *Basic Specialist Training List of Recognised College Tutors, Specialist Tutors and Course*

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Organisers (available upon request from The Postgraduate Department, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PB) and all Regional Representatives in Liaison Psychiatry (available from authors upon request). In addition, it was distributed to delegates at the Royal College of Psychiatrists' annual liaison conference in March 2000.

The following items were enquired about:

(a) The presence of SHO placements in liaison psychiatry (i.e. full-time posts of general hospital psychiatry, which may include, but do not consist solely of, deliberate self-harm work).

(b) Whether the trainers for these posts were liaison psychiatrists (i.e. had a recognised post in liaison psychiatry with protected sessions for general hospital work).

(c) Whether the liaison psychiatry posts were occupied by GPs or psychiatry trainees.

(d) Whether there were any general adult psychiatry SHO placements with specialised liaison sessions, apart from deliberate self-harm.

(e) Whether there were any plans to alter the number of SHO training slots in liaison psychiatry.

In addition, the regional representatives in liaison psychiatry were asked if they thought there might be any SHO posts of which they may be unaware in their region.

Findings

Distribution of posts

In liaison psychiatry nationally, 45.5 SHO posts were identified. All of these had trainers who identified themselves as liaison psychiatrists. The regional distribution was very unequal and is detailed in Table 1. Of these 45.5 posts, four were identified as being posts occupied purely by GP trainees, 40.5 by psychiatry trainees and one occupied by either. Twenty general adult posts with specific sessions in liaison psychiatry were identified.

Expansion of training opportunities

In nine regions an increase in training opportunities is expected, mainly following the development of new consultant posts in liaison psychiatry (Table 1). In eight of these regions new SHO posts are anticipated and in another the number of liaison sessions in a general adult post are expected to increase. All regions that had identified liaison consultant posts in 1996 had SHO posts in 2000, except for the North Western. Regions with the highest number of consultant posts in 1996 had the highest number of SHO posts in 2000, for example, in London there were 15 consultant posts in 1996 and 15.5 SHO posts in 2000.

Knowledge of regional liaison representatives

The knowledge of the regional liaison representatives regarding SHO liaison posts in their region was variable, with six admitting there may be posts of which they were unaware. In many regions there are no clear systems for identifying posts. This problem is confounded by the difficulty in defining a liaison post, for example, should a post that is half-time neuropsychiatry and half-time general adult be included?

Table 1. Location and number of senior house officer (SHO) posts in liaison psychiatry in 2000 and consultant posts in 1996

Region	Number of SHO posts (2000)	Number of consultant posts (1996)[1]
East Anglia	1.0	1
Mersey	2.0[2]	1
London[3]	15.5[2]	15
North Western	0	4
Northern Ireland	0	–
Northern region	0[2]	0
Oxford region	2.0	3
Scotland[3]	10.0[2]	7
South and West (South)	0[2]	0
South and West (West)	1.0[2]	0
Trent	3.0	4
Wales	1.5	3
West Midlands	3.5[2]	1
Yorkshire	6.0[2]	4

1. Based on Guthrie, 1998, *Psychiatric Bulletin*, **22**, 291–293.

2. Regions in which an increase in training opportunities is expected.

3. Regions within London and Scotland, respectively, are grouped together.

Discussion

The guidelines regarding postgraduate training in liaison psychiatry issued by the Royal Colleges of Physicians and Psychiatrists in 1995 have not been implemented. Only 45.5 posts nationally were identified by this survey. It is of particular concern that four regions do not have any training opportunities for liaison psychiatry. Over one-quarter of regions in England and Wales have no SHO liaison posts. This situation undoubtedly causes bias in the decision-making process of trainees when deciding whether to enter the field of liaison psychiatry.

The distribution of posts is patchy and opportunities for gaining experience unequal across the country. This variation reflects the regional variation in consultant posts in this speciality. There are few general adult posts that offer liaison experience and even fewer liaison posts available to general practice trainees. This will reduce the skills of general adult psychiatrists and GPs, and consequently have an impact on patient care. The lack of a national database of SHO, specialist registrar and consultant posts makes it difficult to monitor the expansion of, and training standards in, liaison psychiatry. The greater movement of psychiatrists at consultant level confounds this. In this era of clinical governance this should be addressed as a priority. If we are to maintain and improve

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standards in our own practice we need to have ready access to this information.

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