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Review Article

The Educational Value of Outpatient Consultation-Liaison Rotations: A White Paper From the Academy of Consultation-Liaison Psychiatry Residency Education Subcommittee



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Background: As mental health services in outpatient medical clinics expand, psychiatrists must be trained to practice in these settings. **Objectives:** The Academy of Consultation-Liaison Psychiatry residency education subcommittee convened a writing group with the goal of summarizing the current evidence about outpatient consultation-liaison psychiatry (CLP) training and providing a framework for CLP educators who are interested in developing outpatient CLP rotations within their programs. **Method:** MEDLINE (via PubMed), Embase, and PsycINFO (via OVID) were reviewed each from inception to December 2019, for psychiatric CLP services in ambulatory settings that involved residents or fellows. The CLP education guidelines were reviewed for recommendations relevant to outpatient CLP. We also searched MedEd portal for published curriculums relevant to CLP. The group held 2 conferences to reach consensus about recommendations in setting up outpatient CLP rotations. **Results:** Seventeen articles, 3 Academy of Consultation-Liaison Psychiatry-supported guidelines, and 8 online didactic resources were identified as directly reporting on the organization and/or impact of an outpatient CLP rotation. These manuscripts indicated that residents found outpatient CLP rotations effective and relevant to their future careers. However, the literature provided few recommendations for establishing formal outpatient CLP training experiences. **Conclusions:** Outpatient CLP rotations offer multiple benefits for trainees,

including exposure to specific clinical scenarios and therapeutic interventions applicable only in the outpatient setting, increased continuity of care, and the unique experience of providing liaison and education to non-mental health providers. The article outlines recommendations and examples for developing outpatient CLP rotations which CLP educators can incorporate in their programs.

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 INTRODUCTION

Training in consultation-liaison psychiatry (CLP) for residents and fellows has traditionally focused on inpatient medical and surgical units, with most time spent on general consultation services evaluating and managing patients with a wide variety of illnesses.¹ Increasingly, over the past 2 decades, specialty consultation services have developed in many institutions, creating subspecialties within the field of CLP. Owing to the increased knowledge about the prevalence and the impact of psychiatric comorbidity in various populations (Table 1), these specialties have expanded their focus of practice into the outpatient setting, creating opportunities for trainees to provide psychiatric care to very specific populations, often longitudinally over an extended period.

Although there are many educational benefits of an outpatient CLP experience for psychiatry residents and fellows, there is only a limited literature describing the structure, learning objectives, and efficacy of such a rotation. Epstein and Gonzales¹⁸ reviewed the older literature on outpatient CLP clinics, highlighting the role of teaching and trainee supervision mentioned in some of the original reports, dating as far back as 1948. Many of these clinics were “medical-psychiatric” or “CL” clinics, where inpatients could be followed up after discharge. The authors also presented a recently founded outpatient “Medical Illness Clinic” at their institution, describing the role of residents and fellows, clinical structure, supervision process, and logistics of integrating the clinical experience into the residency curriculum.¹⁸

Published Academy of Consultation-Liaison Psychiatry (ACLP)-supported guidelines for resident training in CLP are summarized in Table 2 and reveal brief references to outpatient CLP training. The 1996 ACLP resident guidelines observed the growth of CLP in primary care settings and the importance of continuity of care between inpatient and outpatient settings. These guidelines recommended that psychiatry residents be exposed to an ambulatory primary clinic, an outpatient specialty clinic, or an outpatient CLP clinic.¹⁹ Updated ACLP (at that time, Academy of Psychosomatic Medicine) guidelines for training psychiatry residents in CLP in 2014 expanded on the recommendation for an ambulatory experience, noting the valuable exposure to diverse patient populations

and models of care, and the opportunity to design an outpatient integrated care experience to complement the inpatient CLP experience.²⁰ The authors proposed including ambulatory CLP rotations within the 12-month outpatient residency requirement and allowed for the possibility that the outpatient rotation could serve as the primary exposure to CLP. Core competencies elucidated by the authors referenced an outpatient CLP experience as well.

In contrast, the core competencies for CLP fellowship training, developed in 2009,²¹ make only a brief reference to caring for patients with psychopathology encountered in “outpatient medical-surgical-obstetric settings.”

Accrediting organizations, such as the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology, provide minimal guidance to training directors about the inclusion of outpatient CLP experiences. The Accreditation Council for Graduate Medical Education established the requirement for a minimum 2-month-long CLP experience for psychiatry residents in 1994 but has not provided specific recommendations about the setting or nature of this experience.²² The CLP fellowship guidelines are the most inclusive and directive, noting that fellows must participate in continuity of patient care between acute general hospital and ambulatory care.²² No further details are provided regarding the type of facility or duration of the rotation. The Accreditation Council for Graduate Medical Education program requirements for Child and Adolescent Psychiatry fellows allow for the consultation experience to take place in “outpatient and/or inpatient nonpsychiatric medical facilities.”²³

Outpatient CLP training is not specifically mentioned in the Psychiatry or CLP Milestones, but many psychiatry training requirements can be met through outpatient CLP rotations. For example, the fellowship milestone, “MK3 – Practice of psychosomatic medicine,” requires fellows to demonstrate knowledge of consultation and collaborative care models.²⁴ By contrast, Child and Adolescent Psychiatry fellows would need to provide “integrated care for psychiatric patients and families through collaboration with physicians and other healthcare providers at community-based sites” to achieve level 4 on the System Based Practice competency 4 milestone: “consultation to and integration with

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nonpsychiatric medical providers and nonmedical systems.”²⁵

Despite mention in the previous training guidelines about the educational value of ambulatory CLP experiences, only 30% of adult psychiatry and combined residency programs* offered an ambulatory CL rotation when surveyed in 2013.¹ Fellowship programs fare much better in this regard. A review of an unpublished survey of program directors available on the ACLP website reveals that 100% of responding programs offer outpatient rotations, with some fellows spending the majority of their training year doing outpatient CLP work.²⁶ Crude analysis of these data indicate that fellows spend an average of 10.6 hours per week on outpatient CLP work, as compared with 29.9 hours per week of inpatient CLP work (range 3–28 h/wk).

To address the need for outpatient CLP training in the view of expanded clinical demands, the ACLP residency education subcommittee formed a writing group with the goal to summarize the current evidence about outpatient CLP training and provide a framework for CLP educators who are interested in developing outpatient CLP rotations within their programs. For this discussion, “outpatient CLP” was defined as any practice of psychiatry in an outpatient medical, surgical, or primary care setting. We included all models used to provide outpatient CLP services: collaborative care,[†] colocated care,[‡] and integrated care.[§]

Although our discussion focused mostly on training for psychiatry residents, we believe some of the principles presented in the following paragraphs can be easily applied to teaching medical students or CLP fellows who complete rotations in this setting.

METHODS

The ACLP residency education subcommittee convened a writing group of 8 psychiatrists with

* Internal medicine-psychiatry, family medicine-psychiatry and neurology-psychiatry.¹

† Behavioral health care management (via care manager) and consultations with a psychiatrist.

‡ Psychiatrists provide services in the same location but practice independently using a traditional referral model.

§ medical and psychiatric providers working simultaneously to treat a patient’s mental health and medical needs with shared medical record access in one setting.

experience in outpatient CL clinical practice and/or medical education. Members of the group conducted a review of MEDLINE (via PubMed), Embase, and PsycINFO (via OVID), each from inception to December 2019, for psychiatric CL services in ambulatory settings that involved residents or fellows. The inclusion criteria were¹ outpatient clinical settings with psychiatric consultation, collaborative care, integrated care, or colocated care,¹⁸ postgraduate trainees in psychiatry, primary care, family medicine or CL fellowship, and¹⁹ assessment of the impact of these training environments. Each database search combined 3 sets of terms: (1) (psychiat* AND (consult* OR liaison)); (2) (residen* OR trainee* OR fellow*); and (3) (outpatient OR ambulatory OR clinic). Limiting searches to title/abstract, English, and human subjects, the PubMed search resulted in $n = 79$ and the OVID search $n = 323$. Eligible articles were identified by careful review of titles and available abstracts. Duplicate articles were removed, and studies that met inclusion criteria were evaluated and synthesized. Additional eligible publications were identified by reviewing the references of included studies. The search was narrowed down to 17 articles (see Table 3).

The CLP education guidelines were reviewed for recommendations relevant to outpatient CLP. We also searched MedEd portal for published curriculums relevant to CLP. After reviewing the literature search findings, the writing group members met via Zoom conference on January 9, 2020 and February 28, 2020 to reach consensus over the discussion points.

RESULTS

Overall, the literature describing educational models for outpatient CL experiences is limited, with only 17 articles meeting the search criteria (Table 3).^{18,27–42} We found 10 articles describing individual integrated care programs^{18,28,31,32,34,36,38,39,42} and 2 articles providing guidelines on core competencies for integrated care for trainees.^{30,40} As shown in Table 2, the educational opportunities for integrated psychiatric care ranged from colocated services and collaborative care to dedicated outpatient psychiatric clinics for the medically ill. Only 3 of the articles describe training opportunities for advanced psychiatric trainees including 2 for CL fellows and one for child and adolescent fellows. Given

TABLE 1. Knowledge Domains That Have Contributed to the Expansion of Outpatient CLP

Knowledge domain	Examples of clinical population	Examples of outpatient CLP settings addressing these challenges
High prevalence of psychiatric comorbidities in specific chronic diseases	Depression and heart disease ² Depression and diabetes mellitus ³ Depression and cancer ⁴ Depression and COPD ⁵	Psychocardiology Collaborative care and integrated care in primary care settings
Negative impact of untreated psychiatric problems upon medical outcomes	Lower HIV viral suppression rates in patients with psychiatric disorders ⁶ Diagnosis of cancer at a later stage for patients with psychiatric disorders ⁷ Depression impacted prognosis in COPD ^{8,9} Poor glycemic control in DM patients with co-morbid depression ³	HIV psychiatry Psycho-oncology Collaborative care and integrated care in primary care settings
Negative impact of psychiatric disease upon post-surgical outcomes	Patients who underwent weigh loss surgery with psychiatric disease have a higher need for reintervention ¹⁰ Depression after liver transplantation is associated with higher mortality ¹¹	Psychiatry in weight loss surgery clinics Transplant psychiatry
Negative impact of untreated psychiatric problems upon health care utilization	Comorbid psychiatric or substance use condition is associated with high level of hospitalizations ^{12,13} For patients with sickle cell anemia, comorbid depression was associated with longer length of stay, more severe illness and more costly hospitalizations ¹⁴	Med-psych clinics Psychiatry in sickle cell clinics
Low rates of access of mental health services for patients with psychiatric disorders	Evidence that patients with SPMI are primarily seen in primary care and not in specialty clinics ¹⁵	Collaborative care and integrated care in primary care settings
High rate of medical problems and increased mortality in patients with chronic psychiatric disorders	Severe psychiatric disorders such as schizophrenia adversely impact mortality ¹⁶ Patients with bipolar disorder are more likely to die prematurely from multiple causes including cardiovascular disease, diabetes, and COPD relative to those without bipolar disorder ¹⁷	Collaborative care and integrated care in primary care settings

CLP = consultation-liaison psychiatry; COPD = chronic obstructive pulmonary disease; SPMI = serious and persistent mental illness.

the variability in the quality and consistency of the reported outcomes in the identified articles, only summaries of the overall benefits and barriers of the integrated care models are described.

A recent systematic review evaluated 9 published and 5 unpublished interventions to train psychiatry residents in integrated care.⁴¹ The outcomes in all of these interventions were variable and of low-to-moderate quality, and the main conclusions that could be drawn from the outcomes were successful buy-in to the integrated care model and positive learner experience in providing integrated care.⁴¹ A summary of 5 psychiatry training programs that provided integrated care training for residents found that the success of such programs depended on the presence of a supervising psychiatrist with experience in integrated care, funding for faculty time, time within the residency program, office space within the clinical site, and a clinic “champion” who

supports integrated care.³⁰ Overall, residents responded positively to the various integrated care experiences and viewed them as effective and relevant in preparing them for their future careers³⁴ and enhancing their learning on how to assess and manage complex medical-psychiatric patients.^{35,36} Additional benefits of colocated and collaborative care models include increased primary care physician comfort with medication management, increased capacity to care for patients presenting with psychiatric problems, and improved interprofessional communication and education.^{18,29,30,35,36}

The limited literature regarding advanced psychiatric trainees is consistent with that of the resident experience.^{27,38,39} Similar to the psychiatry residents, primary care and family medicine residents who receive training for mental health in an integrated or collaborative care model find that their training is enhanced.^{28–32,42}

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TABLE 2. References to Outpatient CL Psychiatry Rotations in Published Training Guidelines

Guideline	Reference to outpatient CL psychiatry
Gitlin et al. ¹⁹	Goals of consultation-liaison training: “The primary goal of the CLP core rotation is to ensure that residents develop a basic competence in working with patients in inpatient and <i>ambulatory medical settings</i> who have psychiatric presentations.” Objectives for psychiatry residents in CLP: “Interview medically ill patients in a variety of settings.” Structure and integration: “As consultation and liaison in primary care settings has become an important aspect of CLP, exposure in this area is strongly encouraged.” Setting: “An outpatient CL experience is encouraged because it offers exposure to a different population of medical/psychiatric patients ... Outpatient training could be provided in any of the following areas: liaison to outpatient settings (e.g., primary care clinic); consultation to specific patient populations (e.g., outpatient transplant evaluations); and outpatient CL clinics.”
Heinrich et al. ²⁰	Length of rotation: “If an outpatient rotation is the trainee’s primary exposure to CLP, it should be a minimum of 6 months in duration to maximize the possibility of continuity of care.” Rotation site(s): “An ambulatory CL experience provides exposure to different patient populations and models of care and strong consideration should be given to including such experiences as a part of residency training. Models of outpatient CL psychiatry include a free-standing psychosomatic medicine clinic, a psychiatric liaison clinic embedded in a medical home or primary care clinic, or medical/surgical subspecialty clinic.” Core competencies in psychosomatic medicine – medical knowledge: “Psychiatric consultation and or liaison in the outpatient medical or surgical setting.” Core competencies in psychosomatic medicine – systems-based practice: “Understand the various models of CL psychiatry.”
Worley et al. ²¹	Psychosomatic medicine patient care core competencies – the application of knowledge in the clinical setting: “The scope of practice of psychosomatic medicine psychiatrics includes caring for patients with psychopathology encountered in general-medical settings (e.g., inpatient and outpatient medical-surgical-obstetrical settings).”

CLP = consultation-liaison psychiatry.

The identified barriers for success in these integrated care models include the fiscal vulnerabilities of interdisciplinary models, lack of larger system and leadership buy-in, competing clinical demands, lack of space in the outpatient clinics, and limited faculty availability.^{27,29,31,32,34} Specific challenges of the integrated care model with an embedded psychiatry consultant in the primary care settings are uncertainty about appropriate referrals, delayed follow-up with consultation recommendations, and inconsistent patient appointment-keeping.²⁸

DISCUSSION

Experts recommend that programs consider including an ambulatory CLP training experience during residency training.²⁰ However, in a recent survey, only about one-third of the programs offered an outpatient consultation or liaison training experience.¹

Benefits of the CL Outpatient Rotations

Rotations in outpatient CLP settings can complement the traditional inpatient experience and provide the resident with additional unique educational opportunities including exposure to diverse patient populations and various models of care.

Exposure to Specific Clinical Scenarios Occurring at Various Phases of Longitudinal Medical Care

Outpatient CLP may allow the trainee to evaluate and treat patients with medical conditions that are rarely seen in the inpatient setting, such as patients with dermatologic conditions, irritable bowel syndrome, or living organ donors. In addition, patients routinely seen by CLP consultants in the hospital may present with different clinical challenges outside the hospital; the patient seen on the inpatient neurology service for lupus encephalitis may have presented earlier in the rheumatology clinic with depression. The outpatient CLP setting can provide exposure to unique clinical scenarios, such as screening for depression in healthy primary care patients, assessments for risk stratification before surgery, untreated psychosis refusing mental health care and not meeting criteria for commitment, and somatization disorders or functional disorders that do not require hospitalization. The outpatient experience may provide exposure to psychiatric diagnoses more commonly seen in the outpatient setting, including mood, anxiety, adjustment disorders, and somatic symptom, and related disorders.¹⁸ An outpatient CLP rotation may also allow the psychiatrist to assist patients with chronic mental disorders as they cope with the demands of medical care for serious

TABLE 3. Literature Describing Outpatient CL Educational Experiences

First author, year published	Type of study/article	Training setting	Care model	Target learner/trainee
Burkey, 2014 ²⁷	Survey of program directors	Pediatric primary care clinic	Integrated care and consultation	Child and adolescent psychiatry fellows
Butler, 2018 ²⁸	Single-site evaluation	Family medicine clinic	Embedded psychiatric consults	Psychiatry and family medicine residents
Coverdale, 2015 ²⁹	Review of 6 programs the integrate psychiatry and obstetrics and gynecology (OB/GYN)	Various settings: day hospital in obstetric setting, integrated primary care-OB/GYN clinic and traditional outpatient OB/GYN clinic	Integrated care, collaborative care	Psychiatry and OB/GYN residents
Cowley, 2014 ³⁰	Review of 5 educational experiences of integrated care	Primary care and subspecialty clinics, outpatient psychiatry clinics	Collaborative care, colocated services, and consultation	Psychiatry, pediatrics, family medicine, and primary care residents; child and adolescent fellows
Delbridge, 2017 ³¹	Single-site evaluation	Family Medicine Federally Qualified Health Center	Colocated care	Family medicine residents
Epstein, 1993 ¹⁸	Single-site evaluation	Outpatient consult-liaison (CL) clinic	Outpatient psychiatric care of the medically ill	Psychiatry residents
Henrich, 2003 ³²	Single-site evaluation	Primary care clinic	Integrated care	Psychiatry, internal medicine, and OB/GYN residents
Huang, 2015 ³³	Pilot testing of collaborative care curriculum delivered at 5 psychiatry residency programs	N/A	Collaborative care workshop	Psychiatry residents
Huang, 2017 ³⁴	Single-site evaluation	Primary care or specialty clinic	Colocated care, collaborative care	Psychiatry residents
Noy, 2018 ³⁵	Online survey of residents	Primary care or specialty clinic	Collaborative care	Psychiatry residents
Onate, 2008 ³⁶	Single-site evaluation	Primary care clinic	Integrated care, consultations	Psychiatry residents
Reed 2016 ³⁷	Survey of program directors of 6 integrated care rotations	Primary care clinic	Integrated care	Psychiatry residents
Rowan, 1984 ³⁸	Single-site evaluation	Outpatient CL clinic	Outpatient psychiatric care of the medically ill	CL fellows, psychiatry residents
Steinberg, 1996 ³⁹	Single-site evaluation	Primary care clinic	Integrated care	CL fellows
Sunderji, 2016 ⁴⁰	Qualitative interviews and quantitative surveys	N/A	Integrated care	Development of core competencies for psychiatry residents
Sunderji, 2018 ⁴¹	Literature review of psychiatry residency programs providing integrated care	Various: family medicine, primary care, psychiatric clinics	Various: integrated care, collaborative care, mentoring networks, brief didactic teaching	Psychiatry, family medicine, and primary care residents
Williamson, 2016 ⁴²	Single-site evaluation	Family medicine clinic	Embedded psychiatric consultation	Family medicine residents

PGY = postgraduate year.

medical conditions (e.g., patients with schizophrenia undergoing chemotherapy or organ transplantation), a task that is difficult to accomplish from a separate mental health clinic. Psychiatric evaluations focused on risk stratification before surgeries (e.g., weight loss surgery) are often performed exclusively in the outpatient setting because they benefit from specialized

knowledge of the course of these complex medical processes.

Experience with Extended Evaluations and Interventions Specific to the Outpatient Setting

In contrast to the inpatient CLP evaluations, which often emphasize quick assessments, crisis interventions,

TABLE 4. Suggested Objectives of Outpatient CL Rotation

General objectives	Examples			
	Primary care	HIV clinic	Transplant psychiatry	Weight loss surgery
<p>Medical and psychiatric knowledge</p> <p>Trainees will be knowledgeable about the medical treatment of most common conditions treated in the particular medical setting, of the common complications of those conditions the psychiatric effect of such treatment; interaction of such treatment with psychiatric medications</p>	<p>Trainees will be knowledgeable about screening, diagnosis and treatment of depression, anxiety and substance use disorders in primary care.</p>	<ul style="list-style-type: none"> • Trainees will be knowledgeable about the medical treatment of HIV disease and common neuropsychiatric complications of HIV; the psychiatric effects of such treatment; interaction of such treatment with psychiatric medications. • Trainees will be familiar with research in the diagnosis and management of HIV-associated neurocognitive disorder. 	<ul style="list-style-type: none"> • Trainees will gain knowledge about the most common psychiatric comorbidities of transplant candidates, recipients, and donors • Trainees will gain knowledge about the psychiatric side effects of immunosuppressant medications 	<ul style="list-style-type: none"> • Trainees will be knowledgeable about the most common psychiatric disorders encountered in patients seeking weight loss surgery. • Trainees will become proficient at assessing eating disorders and eating behaviors, recommending and providing treatment
<p>Patient care</p> <ul style="list-style-type: none"> • Trainees will be familiar with the psychiatric issues common in the different phases of medical conditions treated in that particular setting. • Trainees will be able to conduct a psychiatric evaluation, with special expertise in the issues encountered in this special population. • Trainees will be skillful in working with the multidisciplinary team, and understand how to make appropriate referrals, supervise psychotherapeutic interventions, and work collaboratively. • Trainees will develop expertise in the use of psychotropic medications and psychological therapy in the clinic population. 		<ul style="list-style-type: none"> • Trainees will be aware of common psychiatric comorbidities in patients with HIV and the unique ways in which these may present 	<p>Trainees will become able to conduct a comprehensive psychiatric evaluation in transplant candidates</p> <ul style="list-style-type: none"> • Trainees will gain expertise in discussing psychiatric diagnosis and recommendations for treatment with patients and family in the pre and post transplantation setting 	<ul style="list-style-type: none"> • Trainees will become familiar with the multidisciplinary evaluation for bariatric surgery • Trainees will develop expertise in evaluating patients with eating disorders • Trainees will develop expertise in using psychotropic medications in patients who underwent weight loss surgery

<p>Systems-based practice</p> <ul style="list-style-type: none"> • Trainees will understand the patterns of care in the relevant clinic/area of medicine • Trainees will develop the skills to communicate the results of their evaluation to referring physicians and providers and develop skills to communicate effectively with the multidisciplinary staff inside and outside the clinic as necessary 	<ul style="list-style-type: none"> • Trainees will become familiar with the most common models for mental health care in the primary care setting (collaborative care, collocated care, integrated care) 	<ul style="list-style-type: none"> • Trainees will understand the need to coordinate HIV care across specialties, with particular attention paid to the effects of psychiatric illness and substance use disorders on adherence to antiretroviral treatment 	<ul style="list-style-type: none"> • Trainees will become familiar of various medical systems involved in the care of transplant patient: pretransplant medical teams (e.g., nephrology, cardiology), surgery, posttransplant clinic • Trainees will actively involved in multidisciplinary meetings focused on decision about listing for transplantation • Trainees will become proficient at communicating with community mental health providers clinical aspects related to transplant candidacy and psychiatric aspects of transplantation 	<ul style="list-style-type: none"> • Trainees will understand the role of multiple discipline in the evaluation and care of weight loss surgery patients before and after surgery
<p>Professionalism</p> <p>Trainees will understand the patterns of care in the relevant clinic/area of medicine, and develop the skills to communicate effectively the results of their evaluations to other professionals inside or outside the clinic.</p>	<p>Trainees will become proficient in understanding and coordinating the roles of primary care staff members in providing mental health services</p>	<p>Trainees will understand the unique vulnerabilities of patients with HIV and the importance of balancing boundary maintenance with flexibility and harm reduction</p>	<p>Trainees will become familiar with role of psychiatrist in various stages and level of acuity of organ transplantation</p>	
<p>Communication</p> <p>Trainees will develop communication skills related to interacting with patients in the specialty area.</p>	<p>Trainees will demonstrate ability to communicate recommendation after direct and indirect consultation to primary care providers</p>	<p>Trainees will become familiar with communicating HIV related information to patients, their families, and medical providers</p>	<p>Trainees will become proficient at communicating findings and recommendations resulting from the psychiatric evaluation and to inform the transplant team about the possible impact of the psychiatric disease upon patient's participation in care</p>	<p>Trainees will participate in multidisciplinary meetings regarding the preoperative and postoperative care of patients who underwent weight loss surgery</p>
<hr/> <p>CL = consult-liaison.</p>				

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and rapid pharmacotherapy,¹⁸ the outpatient setting allows repeated encounters with the patient over a longer period of time. In the outpatient setting, residents may have time to perform a comprehensive biopsychosocial cultural assessment¹⁸ or may have the opportunity to follow up patients over months as they cope with a chronic illness or dying. This allows the psychiatrist to implement a vaster array of interventions, from pharmacotherapy to individual therapy, family interventions, and liaising with outpatient medical providers. These experiences may provide opportunities for residents to develop specific clinical skills (e.g., cognitive behavioral therapy with the medically ill) and exposure to the long-term course of medical illnesses.

Exposure to Various Models of Care and Specific Challenges Related to Systems of Care

Providing mental health services in the outpatient medical setting invariably prompts consideration of existent models of care, from colocated care to collaborative care. In addition, outpatient CLP rotations can help trainees acquire knowledge about community resources available for the medically ill and skills to facilitate communication between medical providers and community mental health centers.

Liaison experiences also differ in the outpatient setting compared with those in the hospital floors. In outpatient settings, multidisciplinary team meetings focused on addressing challenges related to long-term care (e.g., as a part of the collaborative care model in the primary care setting or tumor board meeting in the oncology clinic) can provide valuable learning opportunities. Challenging ambulatory care scenarios may provide psychiatry with the unique opportunity to educate nonpsychiatric providers and sometimes patients and their families about prevention, manifestations, and treatment of mental illness.

Educational Objectives for the Outpatient CL Rotation

The basic competencies necessary for psychiatric trainees providing integrated care described in the available literature include broad clinical expertise of mental health and addictions presentations across the lifespan, along with interpersonal and communication abilities that allow for interprofessional teamwork,

collaborative leadership, and knowledge exchange.^{30,40} Table 4 includes suggested learning objectives for CLP outpatient rotations.

Outpatient CLP Rotation Structure

Training Sites

A high comorbidity of mental illness is present in most patients with chronic medical problems, providing many opportunities for clinical training sites. Current evidence supports integrated models for primary care,⁴³ HIV,^{44,45} cardiology,⁴⁶ oncology,^{47,48} women's health (obstetrics and gynecology),⁴⁹ transplantation,⁵⁰ weight loss surgery,⁵¹ epilepsy clinics,⁵² palliative care,⁵³ and pain clinics.⁵⁴ There are other clinical sites where patients are known to have high comorbidity of psychiatric issues, but to date, there are no reports on colocation or collaboration; these include rheumatology,⁵⁵ endocrinology,⁵⁶ dermatology,⁵⁷ and plastic surgery.⁵⁸ These could also become training sites once psychiatric services are established.

Other specific settings for an outpatient CLP rotation could include medicine-psychiatry clinics⁵⁹ or short-term CLP follow-up clinics. These can be attached to a general hospital and provide direct ongoing care to patients evaluated by the inpatient CLP service or can be sections of outpatient psychiatric clinics focused on treating patients with co-occurring medical problems.⁵⁹ Telepsychiatry is often used to provide consultation to remote primary care clinics using various models of care⁶⁰ and trainees may find this experience useful for practicing psychiatry in times of crisis, as occurred during the coronavirus disease-2019 outbreak.

Year of Training

Ideally, the outpatient CLP rotation should follow or parallel the trainee's experience with outpatient general psychiatry. Prior inpatient CLP experience is recommended. As most residency programs schedule the inpatient CL rotations during the postgraduate year (PGY) 2 year¹ and the general psychiatry outpatient rotations in the PGY3 year, the optimal time for an outpatient CL rotation would be PGY3 or higher.

Length of the Rotation

The exact length will depend on the specifics of the clinical practice and the educational objectives of the

rotation. For clinics focused on evaluation, such as in transplantation or weight loss surgery, short rotations (e.g., a few sessions) may provide enough exposure and opportunity for liaison. For settings focused on long-term care, a 6- to 12-month longitudinal rotation, where the resident or fellow is present in the clinic 0.5–1 day per week may be advisable.

Workflow and the Role of the Psychiatrist in the Outpatient CLP Setting

The training experience will depend considerably on the structure of the clinical services. In most settings, the presence of mental health services in a medical or surgical clinic includes a referral system in which established patients are referred to a mental health provider for evaluation and treatment. This referral can be initiated by clinicians (physicians or midlevel medical providers or sometimes social workers) or can be “per protocol.” For instance, if a primary care clinic provides screening for depression for all patients, the referral may be “automatic” (e.g., without any clinical interpretation of the score) when a certain score is reached. In a transplant clinic, protocols may dictate that all candidates in a certain category (e.g., nondirected organ donors) must undergo psychiatric evaluation.

Work Flow. Integrating mental health services in a medical clinic can be complex, as the work frame is different compared with mental health clinics. The trainee must be made familiar with the work flow, including referral, triage, evaluation, recommendations, implementation of recommendations and of the multiple team members involved in this process, as well as with termination of treatment in the medical setting.

Triaging referrals is an important process for an outpatient CLP service, and it is essential that trainees understand the rationale for this process. Trainees should be encouraged to participate in triaging the referrals. Factors that may be taken into consideration for triage include the clinical problem, acuity of the psychiatric issue, status in the clinic (active patient vs. not seen because of nonadherence; some medical clinics never “discharge” the patient), concurrent participation in outside mental health services, availability of appropriate level of mental health services, previous evaluations, and insurance status.

Role Clarification and Therapeutic Boundaries. In some settings, a specific medical-surgical clinic may have a

multidisciplinary approach to mental health issues, which include participation of psychologists and/or social workers, the primary service (e.g., primary care clinicians) may also provide specific components of the mental health care (e.g., medication refills). It is important that the trainee understands the roles of various staff members in the particular clinical setting, to appreciate how the mental health intervention will be delivered in conjunction with the medical care.³⁷

Common questions regarding professionalism involve the handling of patient phone calls, handling of mental health emergencies, and termination (when patient is discharged from the medical clinic but continues to need psychiatric care). Coverage for the times when the trainee is not in the clinic must be clear to both the psychiatrists involved and to the clinic staff.

Documentation and Electronic Health Record. - Standards of medical records confidentiality and policy of sharing records with the patient may be different in the medical settings compared to mental health clinics. The trainee must understand how the electronic health record or the paper medical record is used for communication in the clinic setting. Ideally, a discussion with the patient about the psychiatric diagnosis and treatment is carried out before the medical record is shared with the patient or other providers.

Scheduling. It is important that trainees can spend adequate time for clinical encounters. Some complex evaluations (e.g., before organ transplantation) may require up to 120 minutes for an initial encounter, whereas most follow-ups need at least 30 minutes, owing to the high volume of medical information that must be reviewed for each case.

Supervision

The level of supervision in an outpatient CLP setting depends on the complexity of the patient and on the trainee’s experience with outpatient settings. For residents without prior outpatient experience, a CLP attending should directly examine every patient and discuss cases with the trainee immediately after or during the clinic visit.⁶¹ The level of supervision may be also dictated administratively by the hospital (e.g., ability to bill for services). Whenever possible, trainee independence should be encouraged, but immediate supervision should be available. We agree with prior recommendations²⁰ that the faculty supervisor should be a physician who has completed a CLP fellowship, a

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TABLE 5. Suggested Resources for Didactic Curriculum for Topics Relevant to Outpatient CL

Topic	Sponsor/Institution	Type of educational resource	Target audience	Reference
Collaborative care	University of Washington	Didactic curriculum online	Psychiatry residents	62
Various CL topics	ACLP	Power point slides	Psychiatry residents	63
Various CL topics	ACLP	Video vignettes	Psychiatry residents and CL fellows	https://www.clpsychiatry.org/member-resources/ (requires member access)
Neuroscience	University of Pittsburgh	Didactic curriculum	Psychiatry residents	64
Transplant psychiatry	Yale University	Didactic curriculum online	Various psychiatric providers with interest in transplant psychiatry	65
Postpartum depression	University of South Alabama College of Medicine	Team based learning module	Medical students	66
Binge eating disorder	University of Toronto, University of Chicago	Clinical simulation module	Medical students	67
Somatoform disorders	University of Texas Medical Branch School of Medicine	Team based learning module	Medical students	68

ACLP = Academy of Consultation-Liaison Psychiatry; CL = consult-liaison.

combined residency in internal medicine-psychiatry or family medicine-psychiatry, or be board certified in CLP, though extensive clinical experience in CLP may also be acceptable. The longitudinal presence of psychiatry faculty in the outpatient clinic is essential for the implementation of psychiatric interventions and for liaison activities.

With telepsychiatry, direct supervision and observation of a learner can take place without the attending's presence being a distraction for the patient who will often defer to the "person in charge." An educator can provide recommendations, feedback, and guidance to a resident in real time. This can be performed by being out of the camera's vision while cueing with nonverbal signs or literal written signs with phrases such as "slow down," "empathy," or "trauma history?" Residents in this setting, although on the spot, have found this learning environment especially informative and central to their advanced development. As experience with this innovative clinical setting expands, so too will the opportunities for supervision and learning.

Feedback

Feedback should be given to the trainee as close to the clinical activity as possible and should include interaction with patient, knowledge of psychiatric disorders, integration of medical problems, assessment/intervention in relation to patient's coping with medical illness,

patient education, and communication with other providers. Knowledge, skills, and attitudes that can be uniquely assessed in the outpatient CLP rotation include professionalism with clinic support staff, triaging ability, psychotherapeutic technique in the medically ill, and monitoring and use of psychopharmacology in the medically ill. The rotation also provides a rare opportunity for a true 360-degree evaluation, with nurses, social workers, administrative support staff, other physicians, and even longitudinal patients as potential sources of feedback, especially around communication skills and professionalism.

Didactics

Despite the expansion of clinical outpatient CLP services, there is a paucity of formal didactic curriculum that addresses relevant topics (Table 5).

CONCLUSION

Training in the outpatient CLP setting offers unique benefits to psychiatric trainees by allowing exposure to specific clinical scenarios, implementations of psychiatric interventions in the medically ill and unique liaison opportunities. Skills acquired in this setting are likely to be used in the practice of general psychiatry, not only in a medical clinic. There is a dire need for educational

research that systematically evaluates the impact of outpatient CL rotations on knowledge and practice

skills, to determine the best teaching techniques in this setting.

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