Acad Psychiatry (2015) 39:448–456
DOI 10.1007/s40596-015-0360-7

EMPIRICAL REPORT

Perceived Educational Needs of the Integrated Care Psychiatric Consultant

Anna Ratzliff[1] · Kathryn Norfleet[1] · Ya-Fen Chan[1] · Lori Raney[2] · Jurgen Unützer[1]

Received: 25 September 2014 / Accepted: 30 April 2015 / Published online: 27 June 2015

Abstract
Objective With the increased implementation of models that integrate behavioral health with other medical care, there is a need for a workforce of integrated care providers, including psychiatrists, who are trained to deliver mental health care in new ways and meet the needs of a primary care population. However, little is known about the educational needs of psychiatrists in practice delivering integrated care to inform the development of integrated care training experiences.
Method The educational needs of the integrated care team were assessed by surveying psychiatric consultants who work in integrated care.
Results A convenience sample of 52 psychiatrists working in integrated care responded to the survey. The majority of the topics included in the survey were considered educational priorities (>50 % of the psychiatrists rated them as essential) for the psychiatric consultant role. Psychiatrists' perspectives on educational priorities for behavioral health providers (BHPs) and primary care providers (PCPs) were also identified. Almost all psychiatrists reported that they provide educational support for PCPs and BHPs (for PCP 92 %; for BHP 96 %).
Conclusions The information provided in this report suggests likely educational needs of the integrated care psychiatric consultant and provides insight into the learning needs of other integrated care team members. Defining clear priorities related to the three roles of the integrated care psychiatric consultant (clinical consultant, clinical educator, and clinical team leader) will be helpful to inform residency training programs to prepare psychiatrists for work in this emerging field of psychiatry.

Keywords C/L psychiatry · Residents: ambulatory C/L · Careers in psychiatry · Interdisciplinary training · Primary care: family practice · Psychoeducation

There is now a strong evidence base for providing mental health care for patients with common disorders such as depression or anxiety in primary care settings using integrated care models [1, 2]. Integrated care is delivered by a psychiatric consultant who works closely with a team including primary care providers (PCPs) and behavioral health providers (BHPs) using a shared workflow. With the increased implementation of integrated care models, there is a need for a workforce of integrated care providers, including psychiatrists, who are trained to deliver mental health care in new ways and meet the needs of a primary care population [3].

Psychiatry residency programs teach psychiatrists to be able to perform a direct consultation in which the patient is referred by a medical specialist for a diagnostic evaluation and treatment recommendations. However, to deliver integrated care will require the development or refinement of additional proficiencies that have not traditionally been part of current psychiatry residency programs. Some of these proficiencies can be inferred from evidence-based integrated care models. For example, psychiatrists will need to learn approaches such as measurement-based care or the systematic use of outcomes measures to track response to treatment and treatment to target, meaning the stepwise addition of progressively more intensive treatment or augmentation strategies to optimize

Electronic supplementary material The online version of this article (doi:10.1007/s40596-015-0360-7) contains supplementary material, which is available to authorized users.

✉ Anna Ratzliff
annar22@uw.edu

[1] University of Washington, Seattle, WA, USA

[2] Collaborative Care Consulting, Dolores, CO, USA

treatment response and reach a predefined target for improvement in symptoms and functioning [4]. For some integrated care models, such as Collaborative Care, psychiatrists will also need to learn population-based care principles, such as systems of care in which a psychiatrist supports the work of BHPs to deliver routine mental health care and reserves direct assessment and intervention for more complex and/or refractory cases. This approach leverages the expertise of a psychiatric consultant to increase efficiency and effectively care for a larger panel of patients in primary care [5, 6].

Although the studies related to integrated care would argue for teaching these topics to psychiatrists interested in an integrated care career, the actual real-world educational needs for the integrated care psychiatric consultant are just starting to be defined [7]. The current study was conducted to survey psychiatrists working in real-world integrated care settings with the goal of better understanding what psychiatrists need to learn in order to work effectively within integrated care teams and settings. A second goal was to better understand the psychiatric consultant perspective on the training needs of the typical integrated team members (psychiatric consultant, primary care providers, and behavioral health professionals).

Methods

The survey used in the study was developed based on both the extensive clinical experience of the physician investigators and published descriptions of integrated care [1–3] as a needs assessment to inform the development of educational materials for psychiatrists working in integrated care. The complete survey is included in the Supplemental Materials. The Human Subjects Division at the University of Washington determined that this study did not require submission or approval by that body. The survey was distributed electronically as an e-mail invitation to a list of psychiatrists self-identified as working in integrated care and as a link on an infinity group listserv (http://community.networkofcare.org/). The survey was open from November 2011 through January 2012, and a total of 67 respondents completed the survey during this time. This convenience sample represented psychiatrists distributed across the USA and from a variety of practice settings. Only psychiatrists working in integrated care settings at least 5 h a week were included in the study. A total of 15 respondents were excluded because they were psychiatric residents or psychiatrists in leadership positions without direct care responsibilities, leaving a study sample of 52 psychiatrists. The survey was composed of questionnaire items and open-ended questions. Survey questions analyzed for this paper are 16, 22, 25-29 from the survey included in Supplemental Materials, and all other data is presented in another paper [8]. The survey asked psychiatric consultants to report their opinion on which integrated care subjects (clinical topics, treatment strategies, and systems issues) are essential for functioning as a PCP, BHP, or psychiatric consultant (PC) in providing integrated care.

Percentages of each specific learning need (clinical topics, treatment strategies, and systems issues) were calculated and reported by learner group (PCPs, BHPs, and PC). To determine if there was a significant difference among the learning needs priorities for the PCP, BHP, and PC, a Cochran Q test with p value at a significance level of <0.05 was used to compare a group difference. If there was a significant difference among PCP, BHP, and PC groups, a McNemar test was then used to test pairwise comparisons (PCP vs. BHP, PCP vs. PC, and BHP vs. PC). Because there are three pairwise comparisons, the p value was adjusted with Bonferroni correction (alpha=0.05/3=0.0166). This means that any p value less than 0.0166 was considered significant.

Results

Two thirds (64 %) of the respondents were male, and the mean age was 53 years. On average, respondents had been out of residency training for 18 years. With regard to specialty training, psychiatrists completed a fellowship in the following area: 19 % in psychiatry, 8 % in family practice, 4 % in internal medicine, 2 % in pediatrics, and 8 % in another specialty area. Additionally, 46 % completed a fellowship: in particular, 14 % in child and adolescent psychiatry, 4 % in primary care psychiatry or psychosomatic medicine, 2 % in geriatric psychiatry, none in addiction medicine, and 29 % completed an unspecified fellowship.

Table 1 lists a summary of the psychiatric consultant perspective on the essential topics and skills needed for the integrated care team. The majority of the topics included in the study were considered priorities for the psychiatric consultant role if greater than 50 % of the psychiatrists rated them as essential. When examining the importance of each topic for the other team members, four patterns emerged. First, for some topics such as major depressive disorder and knowledge of integrated care, there was no statistical difference indicating an equal importance of these topics to the whole team. Another pattern was defined by the topics that were significantly more essential for the BHP and the PC compared to the PCP (for example, psychotic disorders and providing emotional support for the team). A third pattern consisted of topics that were essentially more important for the PCP and PC than for the BHP (for example, dementia and managing and treating medical comorbidities). The last group, the psychiatric consultant only group, displayed statistically significant differences

Table 1 Summary of psychiatrist perspective on the educational needs of the integrated care team

Topic	Psychiatric consultant (%)	BHP (%)	PCP (%)	Comparison PCP vs. BHP vs. PC	Pairwise comparison		
					PCP vs. BHP	PCP vs. PC	BHP vs. PC
Clinical topics							
ADHD	78	63	57	0.0124	0.3173	0.0075	0.0522
Anxiety disorder	84	88	88	0.6065			
Assessing suicide/violence risk	86	86	80	0.4412			
Bipolar disorder	88	84	56	<0.0001	0.001	0.0003	0.4142
Child psychiatry	51	47	41	0.2053			
Chronic pain	74	61	88	0.0009	0.0003	0.0196	0.1088
Dementia	65	35	65	<0.0001	0.0003	1.000	0.0006
Eating disorder	78	45	37	<0.0001	0.3458	<0.0001	0.0001
Major depressive disorder	86	90	90	0.4493			
Personality disorders/difficult patient	82	84	60	0.0002	0.0013	0.0023	0.6547
Psychiatric issues in pediatric populations	51	47	41	0.2053			
Psychiatric issues in pregnancy	72	46	56	0.2053			
Psychotic disorder	80	70	48	0.0004	0.0045	0.0011	0.1655
PTSD	86	88	48	<0.0001	<0.0001	0.0001	0.5637
Somatic symptoms/fatigue	74	66	80	0.1280			
Substance use disorder	88	92	88	0.3679			
Traumatic brain injury	69	31	51	<0.0001	0.0075	0.0126	<0.0001
Unexplained physical symptoms	70	50	78	0.0015	0.0017	0.1573	0.0253
Treatment strategies							
Developing crisis management plans	80	84	37	<0.0001	<0.0001	<0.0001	0.1573
Providing recommendations for evidence-based behavioral/psychosocial interventions	80	86	20	<0.0001	<0.0001	<0.0001	0.3173
Providing recommendations for evidence-based medication treatment	90	25	63	<0.0001	0.0002	0.0008	<0.0001
Monitoring modifiable risk factors (e.g., weight, blood pressure, lipids, etc.)	74	39	86	<0.0001	<0.0001	0.0578	0.0011
Managing and treating medical comorbidities	71	29	82	<0.0001	<0.0001	0.1655	0.0001
Prescribing non-psychotropic medications for hypertension, hyperlipidemia, and diabetes	23	4	73	<0.0001	<0.0001	<0.0001	0.0067
Consultation on and making pharmacologic recommendations for children and adolescents	53	13	32	<0.0001	0.0126	0.0016	<0.0001
System issues							
Knowledge of integrated care models and evidence for these models	77	69	69	0.3442			
Working in integrated care teams	85	88	88	0.1017			
Performing indirect consultation/psychiatric case review without direct examination of patient	88	38	33	<0.0001	0.564	<0.0001	<0.0001
Evaluating patients using tele-video	19	11	2	0.0025	0.046	0.005	0.046
Assessing disability/ability to work	54	23	56	<0.0001	0.0001	0.655	0.0001
Supporting a system approach to crisis management (e.g., suicidal ideation)	77	81	71	0.1778			
Using rating scales to measure outcomes	77	81	73	0.3012			
Understanding HIPPA/charting	79	83	83	0.1353			
Knowledge of liability concerns	83	71	77	0.0859			
Reviewing panels of patients for intensification of treatment	58	38	25	0.0003	0.109	0.0003	0.008
Working with BHPs	79	44	73	<0.0001	0.001	0.317	0.0002
Supervising BHPs	69	19	23	<0.0001	0.593	<0.0001	<0.0001
Working with PCPs	89	75	36	<0.0001			
Communicating recommendations effectively to PCPs	94	77	19	<0.0001	<0.0001	<0.0001	0.005
Providing emotional support for care team members	72	74	39	<0.0001	0.0001	0.0003	0.739
Working with the group dynamics of an integrated care team	77	77	68	0.8187			
Advising teams in health care organizations about behavioral health issues	68	45	34	<0.0001	0.096	0.0003	0.0009
Supporting a clinic/organization to build an effective integrated care team that fits a clinic population/personnel resources	79	60	60	0.0063	0.999	0.0126	0.0126

BHP behavioral health provider

PCP primary care providers

PC psychiatric consultant

between the topics for the PC and the BHP, and the PC and the PCP (for example, performing indirect consultation/psychiatric case review without direct examination of patient) (Fig. 1).

Table 2 summarizes the four distinct learning groups within the integrated care team that were defined through this statistical analysis: all integrated care providers (BHP, PCP, and psychiatric consultant), the medical team (PCP and psychiatric consultant), the mental health team (BHP and psychiatric consultant), and the psychiatric consultant only. Core content topics for the whole team were reported as major depressive disorder, substance use disorder, anxiety, and suicide/violence risk, working in the integrated care team, knowledge of HIPPA and charting, using outcome measures, crisis management, knowledge of integrated care, and working with the team dynamic. The less commonly reported topics were working with somatic symptoms or fatigue and child psychiatry. Mental health core topics were reported as bipolar disorder, PTSD, personality disorders, psychotic disorders, evidence-based interventions, crisis management planning, communicating with PCPs, working with PCPs, providing emotional support to the team, and, less commonly, patient evaluation by tele-video. Common training needs for the medical providers included unexplained physical symptoms, dementia, traumatic brain injury, monitoring modifiable risk factors, managing medical comorbidities, working with BHPs, and disability assessment.

Providing Educational Support to the Team

Almost all psychiatrists report that they provide educational support for PCPs and BHPs (for PCP 92 %; for BHP 96 %). Psychiatrists who responded to the survey indicated that educational support was provided to PCPs and BHPs through similar modes. Educational support is most often provided by integrating education into clinical consultations (PCP 77 %; BHP 85 %). Less common methods of providing support included providing educational materials (PCP 58 %; BHP 56 %), at scheduled trainings (PCP 54 %; BHP 44 %), and by encouraging attendance at educational meetings (PCP 33 %; BHP 35 %).

Psychiatrists who responded to the survey indicated that their most preferred training method was attending conferences (92 %). Other training methods commonly preferred by responding psychiatrists include the use of online materials (81 %), learning on the job (73 %), learning from colleagues (65 %), and courses on integrated care (50 %). Fewer psychiatrists preferred training methods that were podcasts or downloads (35 %), learning community or listserv (33 %), residency training (21 %), texts (14 %), fellowship training (13 %), and other training (12 %).

Discussion

The results of this study provide important information about the educational needs and preferred training methods of the

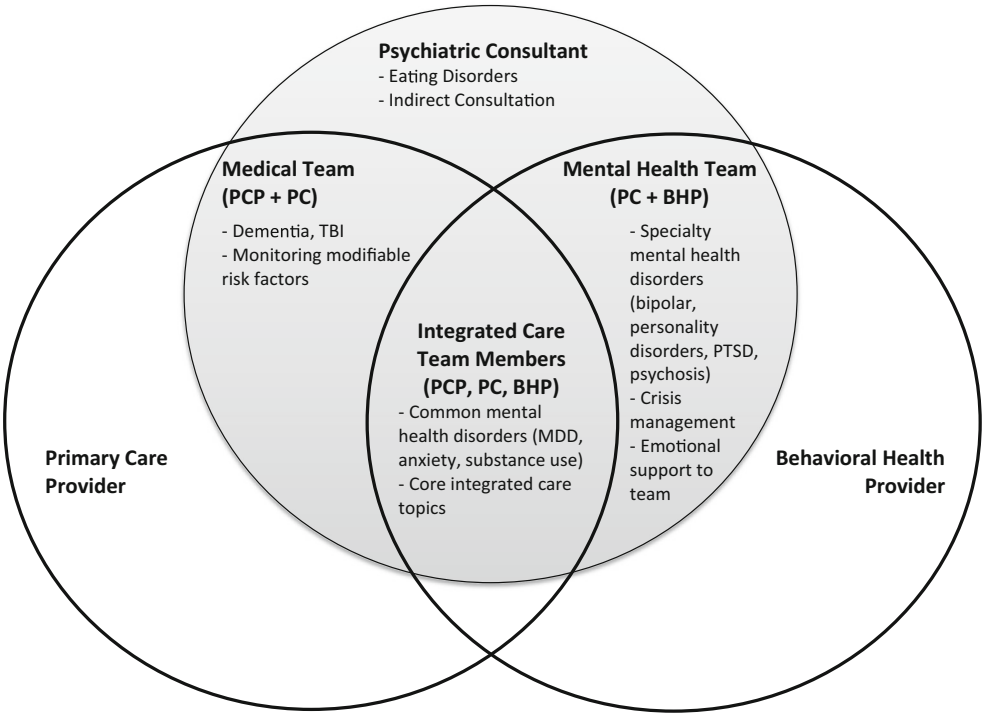

Fig. 1 Team member groups and identified educational needs sorted by role on the primary care team

Table 2 Common educational priorities for the integrated care learning groups

All team members[a]	Mental health providers[b]	Medical providers[c]	Psychiatric consultant[d]
Clinical topics			
ADHD[e] (PC>BHP>PCP)	Bipolar disorder	Dementia	Eating disorder
Anxiety disorder	Personality disorders/difficult patient	Traumatic brain injury	
Assessing suicide/violence risk	Psychotic disorder	Unexplained physical symptoms[e]	
Chronic pain[e] (PCP>PC>BHP)	PTSD		
Major depressive disorder			
Psychiatric issues in pediatric populations			
Psychiatric issues in pregnancy			
Somatic symptoms/fatigue			
Substance use disorder			
Treatment Strategies			
	Developing crisis management plans	Monitoring modifiable risk factors (e.g., weight, blood pressure, lipids, etc.)	Consultation on and making pharmacologic recommendations for children and adolescents
	Providing recommendations for evidence-based behavioral/psychosocial interventions	Managing and treating medical comorbidities	
Systems issues			
Knowledge of integrated care models and evidence for these models	Working with PCPs	Assessing disability/ability to work	Performing indirect consultation/ psychiatric case review without direct examination of patient
Working in integrated care teams	Communicating recommendations effectively to PCPs[e] (PC>BHP)	Working with BHPs	Reviewing panels of patients for intensification of treatment
Supporting a system approach to crisis management (e.g., suicidal ideation)	Providing emotional support for care team members		Supervising BHPs
Using rating scales to measure outcomes			Advising teams in health care organizations about behavioral health issues
Understanding HIPPA/charting			Supporting a clinic/ organization to build an effective integrated care team that fits a clinic population/personnel resources
Knowledge of liability concerns			
Working with the group dynamics of an integrated care team			

Only topics reported for the consulting psychiatrist at >50 % were included in the table.

[a] No statistical difference noted in percent reported for each provider type

[b] Statistically significant difference between percentage reported for behavioral health providers (BHP) and psychiatric consultant (PC) compared to primary care providers (PCP)

[c] Statistically significant difference between percentage reported for PCP and PC compared to BHP

[d] Statistically significant difference between percentage reported for PC compared to PCP and BHP

[e] Clear trend without statistical significance

integrated care psychiatric consultant, based on the perspective of more than 50 real-world integrated care psychiatric consultants. The topics identified by the respondents in this study provide important information to guide psychiatric residency programs about how to evolve current curriculum to prepare psychiatrists for a role in integrated care [3].

Many of the identified learning needs of psychiatric consultants are consistent with previous recommendations from the psychosomatic medicine literature [9] and the emerging integrated care literature [7]. These findings support the notion that there are common key topics regularly encountered by a psychiatric consultant on an integrated care team. The results related to training needs for the psychiatrist can be grouped into three functional roles for the psychiatric consultant on an integrated care team. The first role is related to providing clinical recommendations about common behavioral health disorders as a clinical consultant (both as a direct and caseload consultant). The second potential role for the psychiatric consultant is to provide education to the team as a clinical educator and to provide guidance on the topics that might be important to teach to the BHPs and PCPs from the perspectives of real-world integrated care psychiatrists. The third potential role described by the results encompasses the content related to developing a system of care and providing support to a team of clinicians as a clinical team leader.

Integrated Care Clinical Consultant

The core role of the integrated care psychiatric consultant is to provide clinical consultation to support the work of the primary care team. The surveyed psychiatrists identified that the most important clinical topics for education are topics consistent with the mental health disorders that are commonly managed in primary care settings, such as depression, anxiety, and substance use [10]. Knowledge of how to provide evidence-based care for the common primary care mental health disorders will be core training topics for any integrated care psychiatric consultant (see all clinical topics and treatment strategies listed in Table 2). In addition to providing direct evaluation and treatment recommendations for common primary care clinical conditions, many of the psychiatric consultants in this survey report providing recommendations through indirect consultation or without seeing a patient directly. This role will likely require new skills to build comfort to provide care in this modality.

Ideally, exposure to integrated care would begin in psychiatric residency. At a minimum, residents could be exposed to didactic presentations about the evidence base and spectrum of approaches to integrated care. However, some research suggests that observing an attending physician at work may provide a better learning experience [11]. Some programs have begun to offer electives in integrated care using faculty who are trained in Family Medicine/Psychiatry or Internal Medicine/Psychiatry [12] or using primary care settings for psychiatric clinical rotations [7, 13]. Ideally, these rotations would allow residents to experience working as part of a team and learning skills in consultation, techniques in teamwork, measurement-based practice, and leadership [14]. There are evidence-informed guidelines for creating this type of training experience including outlined potential goals and objectives and teaching methods for integrated care [15] and the description of Shared Mental Health Care efforts at McMaster University in Hamilton, Ontario [16].

Only 21 % of respondents reported "Residency Training" as a modality to learn about integrated care, suggesting that the majority of psychiatrists responding to this survey did not receive training as part of their psychiatric residency training or did not find this a preferred method. Currently, the major barriers to developing integrated care experiences for residents are a lack of integrated care clinical settings to host rotations and a lack of attending psychiatrists who are able to teach integrated care. Even when there is the opportunity and support to develop integrated approaches, there are common barriers, such as space, expertise in supervision, and attending time (especially the financial constraints) to provide supervision, which must be considered as an integrated care rotation is designed [17]. To meet this challenge, programs may need to invest in developing this expertise among faculty psychiatrists. Additionally, for psychiatrists in practice or at academic programs without access to integrated care, alternative approaches could be developed to provide the knowledge and skills necessary to practice integrated care, including the use of modalities such as attending conferences and using online materials, which were listed as types of desired training opportunities by the psychiatrists surveyed here.

Clinical Educator for Integrated Care

Psychiatric consultants will also need to be prepared to function in the role of educator to the integrated care team, as almost all psychiatrists report that they provide educational support for PCPs and BHPs, which is consistent with previous studies on educating primary care providers in psychiatry [18, 19]. The results of this survey indicate that integration of clinical education into clinical work during the consultation is the most common mode of teaching by the psychiatric consultant.

The psychiatric consultant is in an ideal position to help PCPs optimize their learning as described in previous PCP educational efforts which combined didactics, application of knowledge and skills in actual practice settings, and feedback sessions [19, 20]. Although there is not an established literature about a psychiatric consultant educating BHPs, the frequent communication in most teams between the psychiatric consultant and the BHP should provide ample opportunity for education. Ideally, in the role of educator, the psychiatric consultant will need to develop comfort and competence to share knowledge about all of the common primary care mental

health topics. The psychiatrists' perspectives on which topics are needed for each team role suggest four different learning groups: all team members, the mental health providers, the medical team providers, and primarily the psychiatric consultant. Knowledge of the learning priorities in each of these groups will help the psychiatric consultant to customize teaching to these different subgroups.

This paper provides some guidance about the education priorities for the different members of the team. However, some studies have shown that validation of these educational priorities for other team members by directly surveying them may be important as there is some evidence that psychiatrist perspectives on the training needs of primary care providers do not always align with the other primary care team members' perspectives [21, 22]. In addition to discussing the learning priorities for the different members of the integrated care team, resident training programs may need to consider more formal didactic training in how to deliver education that is effectively integrated into clinical consultation. Although psychiatrists may provide education as part of a typical ward team to medical students, formal training in how to provide education is not a typical feature of psychiatric resident education [23]. Approaches to address this challenge have been developed [24] and could be adapted to provide development of skills in the role of educator for PCPs and other BHPs engaged in integrated care.

Integrated Care Clinical Team Leader

The clinical leadership role is defined by the identified psychiatric consultant training needs related to systems topics such as supporting the clinic to build an integrated care team, supervising BHPs, advising about behavioral health issues, and assessing need for a higher level of treatment system (see systems issues in Table 2). Developing expertise in systems-based care to support an integrated care team is consistent with several of the new Accreditation Council for Graduate Medical Education (ACGME) milestones:

- System Based Practice 4 Milestone—consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic) especially al Level 4a "Provides integrated care for psychiatric patients through collaboration with other physicians."
- Interpersonal and Communication Skills 1 Milestone—"Relationship development and conflict management with patients, families, colleagues, and members of the health care team," especially level 4b "Leads a multidisciplinary care team" [25]

Developing a strong integrated care rotation may be an ideal way for a psychiatry training program to address these milestones in resident education.

Another important training consideration is how to develop opportunities for psychiatrists to train in teams, including practice leading teams. Exploring the opportunity for psychiatry residents to take ownership of teams, especially in the early years of training, may be one way to address this need [26]. Working on a team will likely have the most impact when paired with didactic information about high functioning teams [27] and reflection on team functioning. Working on interprofessional teams requires additional training opportunities, and there are some published models of interprofessional education which can be used to support efforts to build strong integrated care teams to deliver mental health. For example, Memorial University in Newfoundland, Canada, used a Collaborative Mental Health Practice Interprofessional Education Module which included medical, nursing, and allied health staff and was demonstrated to be feasible and well received by trainees [28]. In another example, University of Rochester School of Medicine and Dentistry found that pediatric graduates who participated in an integrated care experience were more likely to engage in collaborative and coordinated care when in the workforce [29]. Specifically, there is a need for preparation to work with other professionals in primary care settings, as frequent misunderstandings of the psychiatry resident's role and challenges with communication with multiple clinic providers can be encountered in primary care settings [30]. In order to meet these challenges, designing specific didactic experiences to explore the culture of primary care settings and communication strategies for working in these settings would make these educational experiences most successful.

Limitations

There are limitations to this study, including that the participants are a convenience sample of self-identified integrated care psychiatrists who may not be representative of all psychiatric consultants in integrated care settings, and the data reported is based on self-report and may not represent the actual workload of a psychiatric consultant working in integrated care. Despite these limitations, the results present important challenges to psychiatry training programs and other educators developing training to prepare psychiatrists to work in integrated care.

Conclusion

Findings of this study provide valuable information in formulating the learning objectives for training psychiatric residents in general residency training for the emerging role of

psychiatric consultant in integrated care. Clear priorities related to the three roles of the integrated care psychiatric consultant (clinical consultant, clinical educator, and clinical team leader) give important direction to residency programs to consider how to tailor current rotations and develop new rotations to prepare residents for this emerging role in psychiatry. Examining the actual practice of integrated care psychiatrists (including current skills deficits), the best methods for teaching integrated care skills in residency, and testing of emerging integrated curricula teaching are all important directions to consider for future work in this area. Residency training programs will likely continue to explore how to optimize educational experiences to support the development of integrated care psychiatrists to perform in these new roles.

Implications for Academic Leaders

- To prepare for a role in integrated care clinical consultation, residents will need to develop clinical expertise in treating common psychiatric disorders in primary care settings (especially treating substance use disorders), comfort in providing indirect consultation, and skill in applying systematic approaches to deliver clinical care including use of mental health measures to deliver evidence-based treatment to target.
- The integrated care consulting psychiatrist often provides education as part of clinical consultation, and practicing this skill can be a part of most traditional consultation-liaison rotations.
- Expanding opportunities to develop skills with systems of care and leading clinical teams in current clinical rotations may be another way to support residents in developing skills for work as an integrated care psychiatrist.
- Faculty may need support to identify opportunities in current psychiatry resident rotations to teach the key topics in integrated care and develop new rotations in integrated care.

Acknowledgments The authors would like to acknowledge the technical support from Tess Grover and Melissa Farnum.

Disclosures Dr. Anna Ratzliff, Dr. Jurgen Unutzer, and Dr. Ya-Fen Chan receive support in the form of contract for implementation support for the Community Health Plan of Washington. Dr. Kathryn Norfleet has no competing interests. Dr. Lori Raney is the owner of Collaborative Care Consulting.

References

1. Archer J, Bower P, Gilbody S, Lovell K, Richard D, Gask L, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012. doi:10.1002/14651858.CD006525.pub2.
2. Huffman JC, Niazi SK, Rundell JR, Sharpe M, Katon WJ. Essential articles on collaborative care models for the treatment of psychiatric disorders in medical settings: a publication by the Academy of Psychosomatic Medicine Research and Evidence-Based Practice Committee. Psychosomatics. 2014. doi:10.1016/j.psym.2013.09.002.
3. Raney L. Integrated care: the evolving role of psychiatry in the era of health care reform. Psychiatr Serv. 2013. doi:10.1176/appi.ps.201300311.
4. Rush AJ. STAR*D: what have we learned? Am J Psychiatry. 2007;164:201–4.
5. Thielke S, Vannoy S, Unützer J. Integrating mental health and primary care. Prim Care. 2007;34:571–92.
6. Katon W, Unützer J. Consultation psychiatry in the medical home and accountable care organizations: achieving the triple aim. Gen Hosp Psychiatry. 2011. doi:10.1016/j.genhosppsych.2011.05.011.
7. Cowley D, Dunaway K, Forstein M, Frosch E, Han J, Joseph R, et al. Teaching psychiatry residents to work at the interface of mental health and primary care. Acad Psychiatry. 2014. doi:10.1007/s40596-014-0081-3.
8. Norfleet K, Ratzliff A, Chan Y-F, Raney L, Unützer J. The role of the integrated care psychiatrist in community settings: a survey of psychiatrists' perspectives. 2015. In press.
9. Heinrich TW, Schwartz AC, Zimbrean PC, Lolak S, Wright MT, Brooks KB, et al. Recommendations for training psychiatry residents in psychosomatic medicine. Psychosomatics. 2014. doi:10.1016/j.psym.2013.12.016.
10. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:629–40.
11. De Groot J. Psychiatric residency: an analysis of training activities with recommendations. Acad Psychiatry. 2000. doi:10.1176/appi.ap.24.3.139.
12. Onate J, Hales R, McCarron R, Han J, Pitman D. A novel approach to medicine training for psychiatry residents. Acad Psychiatry. 2008. doi:10.1176/appi.ap.32.6.518.
13. Dobscha SK, Snyder KM, Corson K, Ganzini L. Psychiatry resident graduate comfort with general medical issues: impact of an integrated psychiatry-primary medical care training track. Acad Psychiatry. 2005;29:448–51.
14. Cerimele JM, Popeo DM, Rieder RO. A resident rotation in collaborative care: learning to deliver primary care-based psychiatric services. Acad Psychiatry. 2013. doi:10.1176/appi.ap.12040075.
15. Yudkowsky R. So you want to train psychiatry residents in ambulatory primary care settings. Acad Psychiatry. 2000;24:133–8.
16. Kates N. Sharing mental health care. Training psychiatry residents to work with primary care physicians. Psychosomatics. 2000. doi:10.1016/S0033-3182(00)71173-X.
17. Dobscha SK, Ganzini L. A program for teaching psychiatric residents to provide integrated psychiatric and primary medical care. Psychiatr Serv. 2001;52:1651–3.
18. Thompson TL, Thomas MR. Teaching psychiatry to primary care internists. Gen Hosp Psychiatry. 1985;7:210–3.
19. Hodges B, Inch C, Silver I. Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950-2000: a review. Am J Psychiatry. 2001;158:1579–86.
20. Shaw D, Blue A. Should psychiatry champion interprofessional education? Acad Psychiatry. 2012. doi:10.1176/appi.ap.12020035.
21. Spiegel W, Tönies H, Scherer M, Katschnig H. Learning by doing: a novel approach to improving general practitioners' diagnostic skills for common mental disorders. Wien Klin Wochenschr. 2007;119:117–23.
22. Benthem GH, Heg RR, van Leeuwen YD, Metsemakers JF. Teaching psychiatric diagnostics to general practitioners: educational methods and their perceived efficacy. Med Teach. 2009;31:e279–86.
23. Callen KE, Roberts JM. Psychiatric residents' attitudes toward teaching. Am J Psychiatry. 1980;137:1104–6.
24. Lehmann SW. A longitudinal "teaching-to-teach" curriculum for psychiatric residents. Acad Psychiatry. 2010. doi:10.1176/appi.ap.34.4.282.

25. The Accreditation Council for Graduate Medical Education, The American Board of Psychiatry and Neurology. The psychiatry milestone project. 2013. http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf. Accessed 18 Sept 2014.
26. McLaren K, Lord J, Murray SB, Levy M, Ciechanowski P, Markman J, et al. Ownership of patient care: a behavioural definition and stepwise approach to diagnosing problems in trainees. Perspect Med Educ. 2013;2:72–86.
27. Mitchell P, Wynia M, Golden R, McNellis B, Okun S, Webb CE, Rohrbach V, Von Kohorn I. Core principles & values of effective team-based health care. Institute of Medicine of the National Academies. 2012. https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-values.pdf. Accessed 18 Sept 2014.
28. Curran V, Heath O, Adey T, Callahan T, Craig D, Hearn T, et al. An approach to integrating interprofessional education in collaborative mental health care. Acad Psychiatry. 2012. doi:10.1176/appi.ap.10030045.
29. Garfunkel LC, Pisani AR, leRoux P, Siegel DM. Educating residents in behavioral health care and collaboration: comparison of conventional and integrated training models. Acad Med. 2011. doi:10.1097/ACM.0b013e318204ff1d.
30. Cowley DS, Katon W, Veith RC. Training psychiatry residents as consultants in primary care settings. Acad Psychiatry. 2000;24:124–32.