S22 *Structure quality of mental health care systems in Europe*

**Recent changes in the Hungarian mental health care system.**

Füredy, Janos (Budapest/Hungary)

Hungary is with ist ca 10 millions of inhabitants one of the smaller European country with a glorious past. Allthoug according to its image as a rural country more than the half of the inhabitants live in the five biggest towns. Before the political change during the last decade because of the communistic ideology the mental health area was widely neglected by the Hungarian Government. Inpatient care was provided by bigger state hospitals. whereas the outpatients care has been provided by governmental outpatients clinic. Since the political change and increasing number of psychiatrists begin to work in private practice and postgraduate training is improving. However, because of its famous psychoanalytical tradition for instance Ferency and Balint have been of Hungarian offspring-psychotherapeutic thinking has maintained in our county The orientation of Hungarian psychiatry has been directed more to Germany than to other countries. Now decentralization of hospital care as one form of reforms in Hungarian psychiatry is advancing, though the lack of finances is tremendous and the main obstacle to promote reforms quicker. The main part of psychiatrists is concentrated in the towns with the result of poor outpatient facility equipment in the rural areas A concept of improving the situation will be presented.

S23 *How to teach psychosocial skills to general practitioners?*

**TEACHING PSYCHOSOMATIC MEDICINE - A TWO YEAR CURRICULUM FOR POST-GRADUATE CLINICIANS**

Claus Buddeberg, *Zurich, Switzerland.*

25 to 30% of the patients seen in a general practitioner's office suffer from psychosomatic disorders. In Switzerland there is no structured teaching of a psychosomatic approach to illness, neither in medical school nor during postgraduate training. In this presentation experiences with a two year training program in psychosomatic medicine for post-graduate clinicians are reported. The training program has three parts: Part one consists of 12 training days over a two year period given in seminars with lectures and case presentations using videotapes, one way mirror as well as role plays. Part two is case supervision in small groups. In part three participants are taught and get experiences in a self relaxation technique. In our opinion the two year curriculum serves as a model and example for a certified training in "Psychomatic Medicine". The participants can benefit from their training in various ways: with regard to the organization and atmosphere of their practice, in respect of improved communication skills when treating patients and advanced small group interaction skills. We have just finished the second course and we received excellent feed-back from most of the participants.

S23 *How to teach psychosocial skills to general practitioners?*

**BEHAVIORAL SCIENCE CURRICULA FOR GENERAL INTERNAL MEDICINE: LEADING THE FEARFUL AND PREACHING TO THE CONVERTED**

S. R. Hahn.

The goal of teaching psychiatry and behavioral sciences to primary care physicians is unique in both its importance and in the challenges it presents. The gap between need and actual practice in the delivery of psychiatric treatment in the general medicine setting is wide Medical resident's and faculty's skills and knowledge and willingness to learn about psychiatry and behavior sciences are very heterogeneous ranging from "the fearful" to "the converted". However, the quality of care that will be delivered in general medicine depends on enhancing the skills and knowledge of the majority of practitioners, not merely a handful of enthusiasts. The magnitude of this task dictates that behavioral science and psychiatry curricula be taught by the majority of primary care faculty and not merely a handful of quasi-subspecialized internists or mental health specialists. The behavioral sciences' curriculum for our large (105 residents) "categorical" medicine program was designed to be taught primarily by our "regular" general medicine faculty. Our primary care-trained faculty feel comfortable with the clinical management of most psychiatric problems but are reluctant to teach traditional seminars on these subjects. Therefore we built a curriculum based on patient scenarios, enacted by professional actors playing patients who have combinations of psychopathology, family and medical problems. "Simulated-patients" are interviewed by residents in a small group setting using a number of teaching techniques that take advantage of the simulation. The simulated-patient sessions are supplemented by presentations on specific techniques or topics such as psychiatric diagnosis, psychopharmacology and family systems' assessment that are presented by a small group of quasi-subspecialized faculty. By contrast, the curriculum for our small-scale (12 residents) "Primary Care" medicine program which traditionally attracts residents who are sophisticated in behavioral sciences, is designed to achieve an optimal level of practice. Primary care residents participate in the "categorical" curriculum supplemented by four additional curricular elements: I - A "Balint Group" examining the subjective experience of the provider; II - Supervised interview training; III - Multi disciplinary case management and IV - A two-year seminar series consisting of courses on psychopathology, psychotherapeutic interventions, the doctor-patient relationship and family-systems' intervention in primary care. The primary care curriculum requires highly trained faculty and is therefore taught by quasi-subspecialized internist(s) and mental health specialists. This training program graduates quasi-subspecialized internists who make ideal faculty for categorical behavioral sciences' programs. At the furthest extreme of the educational continuum, the curriculum for our five-year combined medicine and psychiatry residency program adds to the medicine and traditional psychiatric curriculum with a medicine-psychiatry consultation clinic, seminars devoted to the interface of medicine and psychiatry, research and experience co-teaching the categorical medicine behavioral sciences Graduates of this program should be experts in behavioral sciences curriculum development and implementation

S23 *How to teach psychosocial skills to general practitioners?*

**GETTING MEDICAL SPECIALISTS INVOLVED IN PSYCHOSOCIAL CARE: A ROLE FOR GENERAL INTERNISTS?**

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Internal medicine holds a special position in France. Confined to tertiary care settings, it is considered as a speciality among other medical specialities. In the meantime, internists favour a 'holistic' perspective very similar to the GP's approach, and opposed to most specialists' point of view. Since consultation-liaison psychiatry is poorly developed in many hospitals, internists sometimes have to act as consultants for clinical problems situated outside the organ specialities domain, including 'psychosomatic' problems. This means that internists have a special role in educating their fellow specialists on emotional factors in physical disease, attention to psychosocial context, patient-centred approach and emphasis on 'illness' vs. disease perspective in the management of symptoms. Our experience as internists as psychosocial specialists in the general hospital environment will be briefly discussed.

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