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Training matters

Community psychiatry in Scotland

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Several trainees have described their experiences of training in community psychiatry (Lock, 1991; Malcolm, 1989; Naismith, 1989; Shah, 1991). Their reports indicate disadvantages as well as advantages in this type of training but are generally positive.

In 1990 the College produced guidelines on the training implications of the move towards community orientated treatment. The Working Group acknowledged that there is no generally accepted description of the necessary components for this form of training but highlighted certain knowledge and skills that trainees should aim to acquire. They noted the extensive overlap with good hospital-based practice and also identified particular differences: the variety of assessment settings, more explicit liaison and the emphasis on local issues. They concluded that community psychiatry should be viewed not as a separate specialty but as a way of working with patients.

This is a report of a survey to identify the range of training experiences in community psychiatry available to trainees in Scotland at the present time. The aim was to find out whether a cohesive view exists about training and also whether the training available reflected the College Working Group's recommendations.

The study

A questionnaire was sent to the 30 general psychiatric tutors in Scotland, enquiring about training in community psychiatry for each particular scheme.

Findings

There was a high response rate (94%). Adequate information was available from co-tutors in the same area as the two non-respondents so that information covering the whole of Scotland was obtained. Twenty-eight replies were analysed.

The questionnaire referred to training at SHO/registrar level.

A. For training purposes, should community psychiatry be regarded as:

(a) a separate specialty , or
(b) part of general psychiatry?

Three respondents (11%) thought it should be regarded as a separate specialty, two (7%) answered yes to both (a) and (b), and the remaining 23 (82%) regarded it as part of general psychiatry. This latter view is in keeping with the College Working Group's recommendations.

B. Is training in community psychiatry currently offered?

Twenty-three responded in the affirmative, one said 'probably' and four said there was no training currently offered. There appeared to be some confusion in two of these responses; one answered 'no' but subsequently added that there was some community element in all posts. The second answered 'no' while the other tutors on the same scheme answered 'yes' to this question.

Of those who answered 'no' three had plans to develop training by means of community mental health teams starting up or a newly approved consultant appointment.

Of those who said that they did offer training experience, only five had dedicated placements. Two of these were attached to a community mental health team and three were day hospital or community clinic based. All offered close links with other disciplines.

Other placements which were reported to offer a community orientated approach included the following: attachments in mental handicap, rehabilitation, health centre out-patient clinics and two descriptions of fully developed community-orientated services. Other training opportunities reported were: domiciliary visits with consultants, visits with community psychiatric nurses and visits to group homes. In one case in the Highlands a travelling day hospital was described.

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C. Have you any plans to develop training?

Seventeen had plans, seven had no plans and four did not answer the question. Of those who had no plans, reasons were either positive in that the training was already developed or negative due to registrar numbers contracting or uncertainty about service developments. Of those with plans, proposals related to changes in line with service developments and to increased research and management training opportunities.

D. Have you any general comments about training in community psychiatry?

Apart from one or two enthusiasts, comments revealed ambivalence and a degree of anxiety about possible developments. Some examples of the responses given were: "Is it necessary to detach trainees from hospital to call it community psychiatry?"

"With few consultant posts in community psychiatry in Scotland, are College recommendations for training realistic for what the trainee may expect in the future?"

"Important that community psychiatry is *part* of a general service complementing other aspects of care and not something which replaces it".

"Training will inevitably have to follow service developments"

"Good growth experience – gives confidence and allows trainees to see the interface between the community and appearances in hospital."

Comment

The questionnaire used was brief. It was not designed to be fully comprehensive but to give an impression of the approach taken to training provision around Scotland. The majority of schemes in Scotland aim to provide experience in community psychiatry but there is wide variation in content. The subspecialties of mental handicap and rehabilitation have more fully developed community training placements than general psychiatry. Definition of the term community psychiatry remains a problem. Different tutors interpret training in community psychiatry in different ways: for example, visits with community nurses or domiciliary visiting with consultants may be regarded as training in community psychiatry by some, whereas others may regard these experiences as routine in general psychiatry. The questionnaire was simple to complete and it is likely that discrepancies between tutors in a large scheme indicate a lack of cohesive viewpoint by these tutors regarding training in community psychiatry. Ambivalence about community psychiatry was a feature of several responses. This may reflect uncertainty about service developments in general rather than in training alone. There was some recognition that, in spite of College aspirations for training, the reality inevitably depended on local service provision. It remains an issue whether dedicated training slots do have a place in providing a clear-cut community training experience at least until some of the current uncertainties about community orientated working are resolved.

The overall impression gained was one of variation rather than similarity of training opportunities. While the majority of tutors were clear that community orientated experience should be part of general psychiatry training, there was no consensus as to what this experience should comprise.

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