

## *Training Implications of the Shift to Community-Orientated Psychiatric Services*

### *Collegiate Trainees' Committee Working Party Report*

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Freeman<sup>1</sup> pointed out that in 1968 the Royal Commission on Medical Education suggested that "every psychiatrist should be familiar with the conduct of community psychiatry". In 1987, we still seem to be no nearer achieving this recommendation despite the fact that 60,000 patients have since been discharged into the community, most mental hospitals are being reduced in size and 32% are due to be closed.<sup>2</sup> Whilst doubts have been expressed about the wisdom of these changes, it is unlikely that the process will be reversed. Progress towards adequate training in community psychiatry has been both sluggish and sporadic.

Within the working lifetime of current psychiatric trainees it appears that there will be a fundamental shift in the management of the mentally ill away from hospital-based services into smaller community facilities. As a consequence, the role of the psychiatrist within a much expanded community-based multi-disciplinary team will change in ways that cannot be fully anticipated at this time. Future training should prepare junior psychiatrists to adapt to a changing role and offer them as broad an experience as possible of the existing community approach.

In September 1986 a CTC Working Party was convened with the following remit:

- (1) to outline the training opportunities currently available in 'community' psychiatry;
- (2) to try to establish what special training might equip trainees to become effective consultants in the psychiatric services of the future.
- (3) to define the major advantages and disadvantages of training in a more community-orientated service;
- (4) to outline the major practical difficulties in training that might be precipitated by a move away from predominantly hospital-based schemes.

#### **Sources of information**

(a) *Literature search*: including College documents, published studies and reviews relating to community psychiatry and training, and relevant Social Services reports.

(b) *Trainees' days*: organisers of trainees' meetings surveyed the opinions of attenders and reported back on the views expressed.

(c) *Trainees with community psychiatry experience*: individual approaches were made to trainees known to have

an interest in, knowledge of, or training and experience in aspects of community psychiatry.

(d) *Open letter to the 'Bulletin'*: a letter was published inviting correspondence on the topic.

#### **(1) Current training**

Community psychiatry is not recognised within the College as a subspecialty<sup>3</sup>. To our knowledge there are only five substantive general adult senior registrar posts in community psychiatry in England and Wales,<sup>4</sup> although many others (including those in other subspecialties) offer some community-based experience. The number of SHO/registrar posts in this field is uncertain, although there are some well-known ones, e.g. Dingleton.

In a survey by Peter Brook in 1974,<sup>5</sup> two thirds of senior registrars and the same number of newly appointed consultants had no experience of any community-based work. Of junior and senior trainees, 66% felt that supervision of community work was inadequate. The most recent study,<sup>6</sup> showed modest improvements in this situation. However, 38% of the trainees surveyed thought training in community psychiatry was inadequate. Newly appointed consultants who trained in academic centres complained of less satisfactory experience of community work than those from peripheral hospitals. On the positive side, Strathdee & Williams<sup>7</sup> reported that 19% consultants and juniors are involved in GP liaison clinic work and 13% spend some time in community mental health centres or other facilities where the public have direct access.

Community training in general adult psychiatry is patchy, with many schemes failing to offer any community posts or experience. Our survey suggests that where 'slots' do exist they are viewed with enthusiasm by the trainees. Community experience from training in the subspecialties such as child and adolescent psychiatry, mental handicap and psychogeriatrics was seen as a valuable learning exercise<sup>8</sup> and trainees felt that the principles could for the most part be generalised to adult psychiatry.

#### **(2) The experience required**

We considered what type of experience is needed, where it should be acquired and at what level it should be gained.

(i) *Type of experience*. Although the term community psychiatry remains undefined and many models of community care exist, feedback from trainees gave a broad measure of agreement over the types of experience that would give appropriate training in community-orientated psychiatry. The community approach to psychiatry makes far greater

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use of given types of setting: The patient's home; health centres and GPs' surgeries; hostels and other residential facilities in the community; day hospitals and local authority day centres and voluntary sector facilities (e.g. day centres, counselling services).

The trainee will need to develop skills in the following areas: assessment and treatment of patients in their own homes; working as a member of a non-hierarchical multi-disciplinary team; clinical and non-clinical liaison work with GPs, primary care teams, staff of residential facilities, Area Social Services, self-help and other mental health or voluntary organisations; care of the chronic mentally ill in the community; crisis intervention and supervised work with the families of the mentally ill.

Statutory agencies, voluntary and other community groups will vary somewhat from district to district, but opportunities must exist for trainees to gain an understanding of the facilities offered so that they grasp the significance, the advantages and, in some cases, the possible pitfalls of developing links with such groups.

Trainees require experience of the administration and organisation of services. Special training in management skills was seen as important by many of those surveyed; these can be enhanced by the trainee becoming a member or observer of planning or management committees.

Some trainees suggested that juniors should spend six months working full time in general practice either during or before undertaking their psychiatric training. Not all trainees agreed with this idea, but such schemes already exist in the South West Thames Region and West Midlands.

(ii) *Where to get training.* There are few posts in general adult psychiatry providing the training described. Freeman<sup>1</sup> has suggested that until more community psychiatry posts are available, secondment to schemes which have such posts should be arranged. This creates the practical difficulty of trying to offer placements to 'outsiders' when trainees already on the scheme require training. There may also be problems if the model of community care being practised is not applicable to the sort of population with which the trainee is familiar, e.g. community psychiatry in inner city areas may be significantly different from that practised in rural settings.

If secondment is not feasible, trainees should be offered experience of a community approach in other subspecialties or to gain the requisite experience on a part-time basis wherever opportunities arise. This approach to training can only be seen as a short-term solution and we support the Social and Community Psychiatry Section's recommendation<sup>9</sup> that good registrar and senior registrar schemes should in future have designated posts devoted to community-orientated psychiatry.

(iii) *When training should be undertaken.* The general view was that trainees would benefit most if they had already reached registrar level before experiencing the increased autonomy offered by a community-orientated service. Thought should be given to introducing a community component into training at SHO level, especially as a number

of these trainees may be destined for a career in general practice. However, trainees probably require at least one year of psychiatric training prior to taking up a community-based post.

Basic and higher training should provide a different quality of experience and it is important that the senior registrar does not function as a junior trainee in the community setting. This is especially likely to occur where a community-based service and a hospital-based service are running in parallel, rather than as a continuum.

*Basic training* should consist of:

- (a) being an active member of the clinical multi-disciplinary team;
- (b) being given regular opportunities to accompany consultants and other professionals in the team on home assessments;
- (c) learning about the alternatives to hospitalisation in the context of emergency work;
- (d) experiencing contacts with statutory bodies, even if only as an observer;
- (e) positive encouragement should be given to liaise with other voluntary and community groups to get an overview of their services;
- (f) liaison clinics carried out in general practice under consultant supervision.

*Higher trainees* should:

- (a) be encouraged to set up links with particular general practices or to take greater responsibility for the teams' established links;
- (b) take the management of patients in their homes and in residential facilities to be an integral part of their post;
- (c) be allowed an active role in service planning and development. Whilst this would often be as an observer it is important that the trainee has the opportunity to discuss concepts and procedures with the consultant representative, even if that consultant is not their trainer;
- (d) be strongly encouraged to make structured evaluations of the effects that changes in the style of service provision create.

### (3) *Advantages and disadvantages*

The advantages of training in a community-orientated service include the opportunities for multi-disciplinary learning, collaborative work with other professional groups, and the development of closer links with primary care teams and other agencies. Community work should help the trainee to see the mentally ill individual in the context of their own social group and community. The effects of earlier assessment and intervention may be seen. Being able to view at first hand the effects of mental illness on the family, experiencing closer contact with the patients' carers and having the opportunities to work with them should offer the trainee a different variety of experiences than those found in hospital-based services. It is hoped they will develop a better understanding of when admission is crucial and what alternatives to in-patient admission exist in a variety of circumstances.

There are many possible disadvantages of training in a

community setting. Problems may arise in balancing training and service requirements. How long will a junior trainee accompany the consultant working in the community before being expected to function independently to meet service needs? Although the latter approach will also provide experience of community psychiatry there is a danger of the trainee becoming too autonomous and receiving insufficient supervision to the detriment of both training and service. On the other hand a junior trainee may become the only hospital-based member of the team and consequently have little contact with a senior trainee or the consultant. Occasional isolation may also be a problem with trainees having less opportunity to engage in peer group learning if they are the sole medical member of a community-based team.

Some trainees surveyed expressed the view that a community-orientated approach might lead to them treating the 'worried well' at the expense of other patient groups. Others feared that training in basic clinical skills might suffer as a result. Crisis intervention interviews in the community setting do not allow trainees to practise detailed history taking as performed in hospital-based diagnostic interviews. If psychiatrists are exposed to working with a different spectrum of patients, will trainees develop an adequate understanding of basic phenomenology? Whilst there is no evidence available to support or allay these fears, most of the working party agreed that seeing seriously ill patients on a daily basis was an excellent way of learning these essential clinical skills.

#### (4) Practical considerations

The changes in style of practice will inevitably affect patterns of working, training and teaching. Split sites may reduce the availability of medical staff in emergencies. Consultants and trainees will spend more time travelling which will reduce their contact with each other. It will also cost a great deal more in travel expenses! Consultant cover for junior staff whose trainers take leave may also be problematical in a more dispersed service. This problem will also extend to junior staff; if their work is distributed on several sites it may be more difficult to arrange cover to allow trainees to take part in educational activities on another site or to plan study/annual leave.

Traditional views of emergency on call duties may have to be radically revised. It will be necessary to re-assess which, if any, facilities need residential medical cover, particularly at night. The role of the on-call psychiatrist and general practitioners in providing an emergency service to residential facilities will have to be clearly defined.

Training and teaching will suffer if consultants are less readily available due to the increasing demands made on their individual time. Trainees may have the opportunity for regular contact with only one trainer. This increases the need to ensure that adequate supervision and training are provided within that clinical attachment. A split site service may lessen the opportunities for many trainees to attend case conferences and journal clubs regularly.

The role of the hospital as a teaching and training

resource will also change. Audio-visual equipment, library facilities, etc. may need to be distributed on different sites to allow ease of access. Will each community base or sector have its own teaching facilities or will there be one provided to serve the whole area? Difficulties will arise in providing material teaching resources to dispersed groups from a limited budget. Careful consideration and planning is needed to overcome a large number of practical consequences of the loss of a natural teaching centre.

#### Conclusion

There is a need to increase training opportunities in community psychiatry so as to make optimal use of the existing potential experiences. Training and exposure of the type outlined in our report should be introduced in all training grades. The introduction of a community orientation to the teaching of general adult psychiatry should be a priority for clinical tutors, scheme organisers and consultant trainers.

Managers and planners need to be made aware of the training needs and implications when designing or purchasing the accommodation to be used by their new community-orientated services. The effects of split site working on the ability to attend training courses and educational activities, the equipping and siting of training centres and the provision of emergency medical cover will need to be addressed prior to agreeing new work patterns for junior staff.

It is clear that in future community psychiatry will not represent a specialist pattern of working but will be an integral part of the whole pattern of psychiatry. Training should be geared to preparing future consultants for their changing role.

#### ACKNOWLEDGEMENTS

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