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Trainees' forum

Training in community psychiatry – a year's experience

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As the move towards community based psychiatry gathers momentum, it becomes increasingly important that psychiatrists are adequately trained to take on their changing role in the new model of psychiatric care (Sturt & Waters, 1985; *Lancet,* 1985). Indeed, it has been recommended that "every psychiatrist should be familiar with the conduct of community psychiatry" (Freeman, 1985). Difficulties arise, however, due to the fact that there is no accepted definition of the practice of community psychiatry (Fink & Weinstein, 1979) let alone well established training programmes designed to equip future community psychiatrists to practise competently. Not surprisingly, few psychiatrists are satisfied with their community psychiatry training. Brook (1981) reported that only 38% considered their community psychiatry to be adequate in quantity and suitably supervised. Even then, their subjective view may not have reflected the actual adequacy of their training. Nevertheless, useful guidelines have been drawn up by the Collegiate Trainees Committee Working Party (Scott, 1988), outlining what would constitute a rounded training programme in community psychiatry. However, there is scant literature evaluating the usefulness of the few existing posts providing such experience

This article aims to describe a year's experience in community psychiatry at senior registrar level, to comment on the advantages and disadvantages of training in such a post and to stimulate discussion on the best methods of training in community psychiatry.

The post

The one year post forms part of the Sheffield Senior Registrar Psychiatric Training Rotation, and involves attachment to the North East Sector Team, which forms one of five Sheffield sectors. It was the first community psychiatry post to be created in Sheffield, and so I was allowed a good deal of flexibility in deciding, with the senior registrar tutor, how to spend my working time during the year. The catchment area covered by the sector has a population of 118,650 and includes areas of considerable social disadvantage. It contains the majority of Sheffield's ethnic minority population.

The settings

The post primarily involved being a member of a multidisciplinary mental health team. It was agreed that my case-load would not contain any in-patients, unless admitted by myself, in which case I would continue care. Referrals came mainly from two sources. Firstly, via a multidisciplinary referral meeting at which all 'cold' referrals were received and allocated. Secondly, via 'crisis calls' which were dealt with by the multidisciplinary crisis response team, of which I was a member. This involved being rostered one day per week with a trainee crisis worker to assess jointly all emergency referrals to the sector. Patients were usually seen in their own homes for assessment, whether they were referred by the referral meeting or by the crisis call system. However, patients were sometimes initially assessed at the hospital or in settings from which the referral was made, e.g. local authority day centres, sheltered workshops and so forth. Initial hospital assessments were generally made where it was thought likely that laboratory investigations would be necessary at an early stage.

Patients were also seen at a general practice clinic on a fortnightly basis. The clinic was set up and conducted by myself in conjunction with a senior psychologist and a community mental health worker. Monthly visits were made to a local authority residential hostel to assess regularly persons with long-term mental health problems. Visits were also made to the acute day hospital, situated in a house outside the hospital grounds, to liaise with the day hospital staff over patients I had referred there.

The patients

Over the year 76 patients were seen; 44 were female and 32 male. The mean age was 40.17 years, range 19–64. Fifty-one were referred via the referral meeting and 25 seen as emergencies. The numbers of patients in each diagnostic category were: 17 (major depressive disorder); 16 (schizophrenia); 8 (mania); 8

(adjustment disorder); 8 (neuroses); 6 (organic disorders); 3 (alcohol dependence syndrome); and 10 (other disorders).

Requests were, in the main, made by GPs. However, requests were also made by team members for medical or psychiatric assessment of their patients, or sometimes via other agencies such as social services, probation services or the police.

A variety of management strategies were employed to help the patients referred. Community support networks were increased with the aim of preventing admission to hospital. Patients and their relatives were seen for individual psychotherapy and counselling. Medication was rationalised, by weaning patients off inappropriately prescribed medication, increasing the dose of appropriate medication to therapeutic levels, and so forth.

Alternative

The post involved participation in various administrative committees and working parties, which involved among their tasks drafting a strategic plan for development of sector day services, regular sector policy meetings and formation of a multidisciplinary taskforce to promote sector-based community mental health developments. This latter made it necessary to liaise with various statutory and voluntary bodies, e.g. adult education services, MIND, self-help groups for reducing tranquillisers, ethnic minority welfare associations and so forth.

Other duties included supervision of the sector trainee art therapist, conducting training seminars for the crisis team workers, teaching medical students and junior doctors and participating in a training scheme for approved social workers, in which they were attached to a psychiatrist to experience the medical aspects of detaining patients under the Mental Health Act 1983.

Comment

Overall, the post provided good experience in most of the areas deemed important by those who have written on the matter (Scott, 1988; Baxter, 1984; Sturt & Waters 1985). I was particularly fortunate to be supervised by a consultant who had previously worked in a community setting described as the network system (Peet, 1987), who was thus able not only to advise on the construction of a comprehensive training programme, but also to forewarn me of some of the difficulties that may be encountered in this way of working. The case-load was varied and did not contain an excessive proportion of 'worried well' at the expense of more seriously disabled patients, as feared might be the case by some trainees in Scott's study (1988).

It was beneficial to assess patients at home in most cases; patients seemed more at ease in familiar surroundings and it was possible to gain, from the start, a broader view of the distress that a mentally disturbed person can cause their carers, and, conversely, how family and social difficulties contribute to the aetiology of mental health problems. I was frequently astonished at the way in which family and friends would stoically shoulder the responsibility of caring for a seriously disturbed person without complaint. The strain this places on carers often goes unnoticed in hospital settings where there may be little contact between relatives and professional workers.

Liaising with non-statutory agencies and self-help groups was particularly enjoyable and helped to expand my knowledge of community networks and resources. Voluntary workers often had imaginative and innovative ideas for dealing with mental health difficulties. Their collaborative approach and mutual exchange of ideas was both educative and pleasurable.

My administrative experience was perhaps less enjoyable but nevertheless very instructive! Recent and future developments in the provision of community care require a thorough understanding of the complexities of planning and evaluating service delivery. There is no better way of acquiring this than active particiption in planning groups.

The difficulties I encountered were mostly related to heavy workload. It was hard to set limits on the workload, particularly when requests for assessment were often made by team members with whom I had developed close and friendly working relationships. As service cuts began to bite, posts were left unfilled and pressure on beds began to mount, many team members, including myself, found their caseloads escalating, with the result that an increasing proportion of time was spent conducting assessments or managing crises, at the expense of educative and preventive work promoting mental health.

It has been noted that psychiatrists may feel deskilled and fearful of losing their power when working in non-hierarchical multidisciplinary settings (Peet, 1987; Sturt & Waters, 1985). In my experience this did not seem to be a problem, although this may have been related to the fact that I had previously worked in a community-based mental handicap team at registrar level, and was thus partly prepared for less traditional ways of working. Indeed, rather than feeling de-skilled, I found that I was often deluged with requests for medical 'assessment' by other members of the team, a problem encountered by other community psychiatrists. (Morrison Donovan, 1982). Requests for assessment were sometimes disguised requests for reassurance that the 'right' thing was being done. Some team members found it hard to tolerate the uncertainties and ambiguities in

deciding on the best course of action in a given situation, and wanted to be 'covered' if things went wrong.

There was one aspect of training that was not adequately covered during the year, which was that of supervising junior doctors, as they were hospital based and involved with a different clientele. It is obviously important to gain experience in delegating work appropriately and supervising the results, and this may be difficult to achieve in community-based senior registrar posts, unless the junior staff also move out of the hospital base.

In total, the post was useful and enjoyable. A post such as this can help to clarify ideas of what the practice of community psychiatry entails, which is important if we are to avoid the experience of some authors in the USA who report a steady decline in the numbers of trainees opting to work in community settings, which they ascribe to inadequate preparation for the task and subsequent disillusionment. (Cutler, Bloom & Shore, 1981; Morrison Donovan, 1982).

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Conference report

Symposium on the closure of mental hospitals*

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Psychiatric practice is reaching out into the community, while long established mental asylums contract. Twenty years ago, government health advisers first backed this new approach to psychiatric treatment by sponsoring the Worcester Development Project, which aimed to move psychiatric patients from two of the large mental hospitals into the community. In April, clinicians and managers gathered to mark the closure of one of these institutions by discussing their changing practice.

Researchers are evaluating such moves into the community. They are making a special study of Friern and Claybury hospitals in north London. Baseline assessment has revealed surprisingly similar patient populations in these two institutions. In each, over half the patients were present for at least 20 years. Most of them had case-note diagnoses of schizophrenia and at least a third were still actively psychotic, although few had very socially disturbing behaviour involving violence or sexual disinhibition. Patients vary in their hopes for the future, with some wanting to go and some to stay. Success in settling in the community may relate to an individual's social network, so that those who are more able to interact with others establish themselves more readily outside hospital. Isolated patients tend to remain in hospital. In the new accumulating group, chronic neurotic disorders are increasingly common, a previously little

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