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Training matters

Future child and adolescent psychiatrists: a further survey of senior registrar training

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Child and adolescent psychiatry is a growing speciality. Significant increases in workload, the reasons for which have been described elsewhere (Black, 1989), have led to an expansion in consultant posts across the UK. Recently the Joint Planning and Advisory Committee (JPAC) reviewed senior registrar numbers and recommended an increase in the establishment by 38 whole-time equivalents in England and Wales, a rise of 38%, to meet the expected shortfall. How existing senior registrars, as well as this large number of new recruits, are trained is clearly a matter of some importance.

In the United Kingdom, training in child and adolescent psychiatry is governed by the Joint Committee on Higher Psychiatric Training (JCHPT) which was formed in 1973 by the Royal College of Psychiatrists and the Association of University Teachers of Psychiatry. The Committee has responsibility to oversee all aspects of higher training in psychiatry and is assisted in this by five specialist advisory sub-committees. The Committee publishes requirements for training which set out the types of clinical experience, supervision, formal teaching and research opportunities which should be available for trainees (JCHPT, 1987). The Committee also arranges for all training schemes to be inspected regularly to ensure that these requirements are followed. The Committee has the power to remove approval for training, which in turn means that senior registrar posts may be lost.

Senior registrars in child and adolescent psychiatry were first surveyed in 1979. Training experiences were described and concern expressed about the lack of adequate training facilities (Garralda *et al*, 1983). There are a number of reasons why a further survey would be valuable. Firstly, there is to be a large increase in senior registrar numbers, as outlined above. Secondly, since its inception, the JCHPT through its Child and Adolescent Psychiatry Specialist Advisory Committee (CAPSAC) has vigorously pursued its policy to raise training standards. The most recent edition of the JCHPT handbook (JCHPT, 1987) makes a number of changes from previous editions. Most striking is the substitution of "must" for "should" throughout most of the child and adolescent psychiatry section. Thus, direct experience with mentally handicapped children, and consultation to both a paediatric service and to other professionals are now mandatory rather than advised. Another important change since 1979, is that the recommended length of training has been restored to its original four years from the recent three years.

With the above changes in mind, a further survey of all senior registrars in child and adolescent psychiatry was carried out. The findings of this survey are now reported.

The study

During the summer of 1988 a modified version of the 1979 questionnaire (Garralda *et al*, 1983) was sent to the 123 senior registrars (67 women and 56 men) believed to be in post in the United Kingdom and Ireland. A reminder letter was mailed six months later. The original questionnaire was designed to examine training as it was recommended in 1979 so the modifications reflected new training guidelines. The questionnaire consisted of five sections concerned with:

(a) *Background characteristics* Personal details: length of training in; child psychiatry, general psychiatry, paediatrics, mental handicap and post-registration medicine.

(b) *Theoretical orientation* The available choices were psychodynamic-analytical, behavioural, social-community and biological. Respondents were asked to rank these in order of importance. It was stated that equal rankings could be given, so that respondents considering themselves eclectic could rank the four choices equally.

(c) *Present training scheme* Clinical experiences, workload, supervision, formal learning occasions and the role of the clinical tutor.

(d) *Attitudes and availability* Trainees were asked to rate the importance and availability of a range of clinical conditions, therapeutic skills, clinical supervision and educational opportunities. As in the previous enquiry a five point scale was used for each item. (Importance: 1, unnecessary; 2, optional; 3, useful; 4, important; 5, indispensible. Availability: 1, not available; 2, not on site but special arrangements can be made; 3, limited on site; 4, adequate; 5, optimal.)

(e) *Representation* Trainees were asked about their knowledge of trainee representation at the Royal College of Psychiatrists and on the JCHPT.

Findings

Eighty completed questionnaires were returned. The response rate was therefore 65% compared to 69% obtained in 1979.

Background characteristics

The personal characteristics of the trainees from both the current survey and 1979 are shown in Table I. It can be seen that the two groups are similar in most respects. However, in 1988 a greater proportion of trainees were female, 56% compared to 41%. Fewer trainees had paediatric or general medical experience prior to psychiatric training. More trainees had published papers than in 1979.

Theoretical orientation

A majority of trainees did not make an exclusive first choice and the largest grouping of trainees (34 out of 80=43%) ranked all the choices equally. A further 11 trainees ranked two or three of the choices first equal. Of those who did make an exclusive first choice the most popular orientation was psychodynamic-analytical (27 trainees, 34%). This compares with 41 trainees (55%) who made this exclusive first choice in 1979. This left only eight trainees who ranked either social community, behavioural or biological as exclusive first choices.

Present training scheme

The amount of time spent in various settings in 1988, as compared with 1979, is shown in Figure 1. The 1988 figures were calculated for the 53 trainees who were working full time in the National Health Service.

The mean number of patient interviews and clinical consultations conducted per week for full-time senior registrars was 11.8, while for part-timers it was 7.9 per week. The ranges for these two groups were considerable, from 4 to 25 and from 3 to 12 consultations per week, respectively.

Twenty-two trainees (27%) reported having less than one hour of individual supervision with their consultant each week. Seven of these trainees

TABLE I
Personal characteristics of responding trainees in 1979 and 1988

	1979 (n=74)		1988 (n=80)	
	no.	*(%)*	*no.*	*(%)*
Age 30–35 years	48	(65)	49	(61)
Males	47	(59)	35	(44)
Married	52	(70)	59	(74)
UK graduates	54	(73)	56	(70)
Full time work	63	(85)	63	(79)
Time in child psychiatry:				
0–2 years	23	(31)	27	(34)
2–4 years	35	(47)	37	(46)
Over 4 years	16	(22)	16	(20)
Over 2 years adult psychiatry	70	(95)	76	(95)
Over 1 year paediatrics	22	(30)	16	(20)
Over 2 years general medical experience	27	(36)	15	(19)
Experience in mental handicap	33	(45)	41	(51)
Personal psychotherapy	48	(65)	47	(59)
Published papers	28	(38)	38	(48)

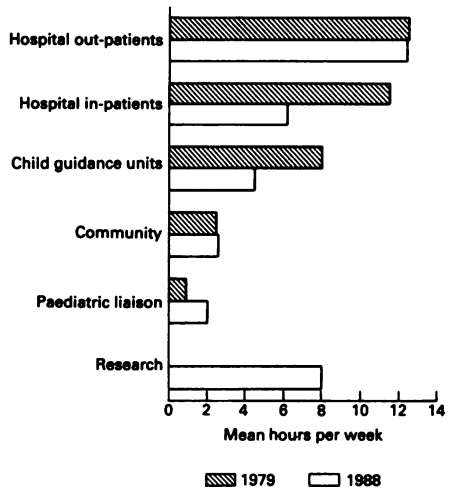

FIG 1. Pattern of clinical work for 74 trainees in 1979 and 80 trainees in 1988.

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reported having no individual supervision at all, and two of these did not receive supervision in a group with their consultant either. Forty-three trainees (54%) received more than an hour per week of supervision with another professional.

Respondents had been asked to estimate the time they had spent in formal learning occasions (organised seminars or lectures on child development or clinical child psychiatry) over the previous exact 12 month period. The mean amount of time spent in these seminars was calculated to be two hours per week in term time (assuming three ten week terms in the year). There was a great variation in the amount of time spent in this way, which ranged from 0 to 120 hours per year (mean = 17) for child development and from 0 to 180 (mean = 39) for child psychiatry. Most trainees, if they reported no seminars in child development, did have them in child psychiatry and vice versa; however, two trainees claimed to have had seminars in neither child development nor psychiatry over the preceding 12 months.

Trainees stated that they met with their tutor-coordinator a mean of 3.8 times per term. Despite the fact that 84% declared satisfaction with the role of their tutor, only 30% said that they received regular feedback about their performance.

Attitudes and availability

Clinical problems

The questionnaire listed: emotional, conduct, and adolescent disorders, psychoses, disorders associated with physical illness, preschool problems, developmental disorders and autism, and mental handicap. All the above were judged to be important by most respondents (rate 4 or 5). By contrast to the 1979 survey, psychotic disorders were *not* ranked as low priority and, whereas in 1979 only one-half of trainees had thought that mental handicap was important we found that three-quarters now rated this as important. Despite this finding only one-quarter of respondents considered that mental handicap experience was adequately available. In addition an adequate experience of developmental disorders (including autism) was only reported by 42% of trainees, even though it was considered by most trainees to be important.

Therapeutic methods

Attitudes towards therapeutic methods are shown in Table II. As in 1979 family therapy remained very popular, but by contrast to 1979, consultation to both paediatricians and to schools was considered important by nine out of ten trainees. It can be seen that the therapeutic approach was eclectic with a high level of interest in a range of therapeutic methods. Marital therapy has suffered a reduction in rated importance since 1979. Behaviour therapy is less available than in 1979.

TABLE II
Importance and availability of therapeutic methods by 1988 rank order

	Rated important		*Adequate availability*	
	% 1988	(% 1979)	% 1988	(% 1979)
Paediatric consultation	90	(76)	70	(50)
Family therapy	89	(97)	80	(86)
Schools consultation	88	(78)	66	(69)
Psychodynamic	84	(89)	60	(64)
Behaviour therapy	81	(73)	43	(50)
Drug therapy	65	(62)	59	(61)
Consultation with adult psychiatrists	60	(54)	40	(51)
Marital therapy	49	(74)	30	(62)

Not surprisingly, trainees rated supervision of a number of different therapies as important. In rank order there were; family therapy, consultation, psychodynamic therapy, behaviour therapy and drug therapy. As in 1979 there was a discrepancy between the importance accorded to such supervision and its perceived availability. It is of interest to note that the perceived importance of supervision of drug therapy has risen, and that the availability of supervision has risen in all areas except behaviour therapy.

Opportunities to teach other psychiatrists and medical students were considered to be important and were available to two-thirds of respondents. Only one-quarter of the trainees thought that supervision of their teaching of others was adequately available. While research time and supervision were considered to be essential by over 90% of respondents, almost one-half thought supervision to be inadequate.

Representation

Most respondents (94%) claimed to know about the functions of CAPSAC, and most (80%) were aware of comments from the last visiting team. Only 5 of the 17 part-timers knew that informal advice about part-time training is available from a member of CAPSAC. A majority of trainees did not know who their representatives were on the Collegiate Trainees Committee.

Comment

This is an incomplete survey as the response rate was only 65%. The fact that senior registrars regularly move post on the rotation and leave to take up

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consultant appointments is a partial explanation of this figure, which is nevertheless comparable with the earlier study of Garralda *et al* (1983). The questions asked were about the training scheme, not the trainee's particular post, and it is therefore likely that our replies refer to the majority, if not all training schemes. However, with anonymous replies this remains uncertain.

The proportion of female trainees has increased and this is only partly accounted for by part-time training recommendations introduced by the DHSS in circular PM(79)3 which have been implemented in most regions (Collegiate Trainees Committee, 1987; Gath, 1988). Almost all trainees taking up this scheme are women and because training is part-time it takes longer than four years.

It is surprising that the number of trainees with a year's paediatric experience has dropped by one-third, especially in light of the importance attached by trainees to paediatric liaison. This fall has not been matched by an increase in trainees with a brief paediatric experience, only a further six trainees had completed six months in paediatrics. Registrar and SHO posts are increasingly linked to specialist training rotations and it is becoming more difficult for future child psychiatrists to find posts where they can do 6–12 months of paediatrics. One of the benefits of *Achieving a Balance* (DHSS, 1986) may be that trainees can obtain a more varied experience at senior house officer level. It is encouraging that more trainees have published papers.

There have been considerable changes since 1979 concerning where the trainees spend the bulk of their time. The move from child guidance clinics to hospital out-patient departments probably reflects changing clinical practice. The move out of in-patient units most likely results from the view that, although in-patient units have many resources, they are not the best places for trainees to receive the bulk of their training, since most will go on to provide mostly out-patient services at consultant level. The mean number of clinical contracts might seem low, at 12 per week, but it must be remembered that trainees only have seven sessions for clinical work and that a good proportion of this time is spent in consultation and other forms of indirect contact. Nevertheless, there is a wide range of clinical contacts per week, suggesting that some trainees are underworked and others overworked. It is encouraging that all trainees said they were able to take two sessions a week for research as per JCHPT requirements.

It is of concern that one-quarter of trainees received less than one hour of supervision per week. This is unacceptable by CAPSAC standards and of itself should warrent removal of accreditation from the training scheme, unless rectified. Also of concern is the reported wide range of formal teaching provided, with some trainees receiving very little. Although satisfaction with tutors was reported to be good, most trainees did not receive regular feedback. It would seem to be uncertain whether tutors have taken on this possibly useful, but certainly difficult role.

In the last nine years, it is notable that there has been a change in attitude towards psychosis, mental handicap and other developmental disorders. That these are now seen as more important and that nothing is seen as less important, suggests trainees have a broader view today of what constitutes child psychiatry. Unfortunately, as nine years ago, availability of experience does not match up to interest. This is particularly so with respect to mental handicap where only one-quarter of trainees feel they have adequate experience. As CAPSAC now states that experience of working with children with mental handicap is a mandatory training requirement, this suggests either that come schemes do not meet these requirements or that experience acceptable to CAPSAC seems inadequate to trainees. There are clearly problems with providing training in this area – if an under-developed service exists (as is often the case for children with mental handicap and psychiatric disorder) who is to train the trainee? A Joint Working Party has recently made recommendations concerning this important area (Joint Working Party, 1989).

The major change in therapeutic activity, aside from the generally more eclectic approach mentioned earlier, is the growth in perceived importance of consultation. The decrease in rated importance of marital therapy is interesting – this may now be seen as part and parcel of family therapy, or it is possible that there are greater opportunities for child psychiatrists to refer on couples with marital difficulties, leaving the child psychiatrist to concentrate on the child and/or family. Behaviour therapy continues to be seen as relatively unavailable. Given the proven relevance of this therapeutic modality to certain child and adolescent disorders, this is an area which needs urgent attention.

Availability of specific supervision has generally improved since 1979 although there are still significant numbers of trainees who feel inadequately supervised in a number of therapies. Availability for supervision in behavioural therapy has actually dropped.

The supervision of teaching and research were both considered to be grossly inadequate. This has serious implications for the way the profession is presented to others and for the future development of practice. Although over the past nine years CAPSAC's standards have risen, it would seem that trainees' expectations have risen even higher. The question arises, as to what, or who makes a good supervisor; should trainees be getting more training techniques of supervision so that they will be better equipped as trainers of the future? Who trains the trainer?

One possible explanation for trainees' high expectation is the widespread knowledge of the role and function of CAPSAC and of the higher training requirements. It was disappointing however, that given the College's encouragement of junior doctor representation at all levels, so few trainees were aware of their representatives on the Collegiate Trainees Committee.

In conclusion, it would seem that today's trainees are more eclectic, more research orientated and more community based. They are willing to see a larger range of clinical problems but lack training opportunities in some of these areas. They do not yet feel adequately supervised, although this has improved over nine years. We suggest that another similar survey is carried out in about five years to indicate changes over that period. We also hope that a parallel survey of the trainers for each scheme will be carried out in the near future.

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Further tabulated results are available from Dr Bools.

References

BLACK, D. (1989) Consultant manpower in child psychiatry. *Psychiatric Bulletin*, **13**, 32–55.

COLLEGIATE TRAINEES' COMMITTEE (1987) Part-time training in psychiatry. A brief guide to the options available. *Bulletin of the Royal College of Psychiatrists*, **11**, 137–142.

DHSS (1986) *Hospital Medical Staffing – Achieving a Balance*. London: DHSS.

GATH, A. (1988) Part-time senior registrar training in child and adolescent psychiatry. *Bulletin of the Royal College of Psychiatrists*, **12**, 368–370.

GARRALDA, M. E., WIESELBERG, M. & MRAZEK, D. A. (1983) A survey of training in child and adolescent psychiatry. *British Journal of Psychiatry*, **143**, 498–504.

JOINT COMMITTEE ON HIGHER PSYCHIATRIC TRAINING (1987) *Handbook*. London: Royal College of Psychiatrists.

JOINT WORKING PARTY (1989) the training required to provide a psychiatric service for children and adolescents with mental handicaps. *Psychiatric Bulletin*, **13**, 326–328.

Psychiatric Bulletin (1990), **14**, 615–617

Child and adolescent psychiatry training schemes: recent developments

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Child and adolescent psychiatry training has progressed considerably in recent years. Additional training posts have been created, as well as senior academic appointments, and some pre-existing rotations have coalesced, allowing innovative schemes of high quality to evolve. CAPSAC (Child and Adolescent Psychiatry Specialist Advisory Sub-Committee) has continued to oversee established standards and encourage these changes.

We were interested to review the present position in order to discover the number of schemes and training posts in existence and the developments that have occurred. This report is based on a questionnaire sent to all post-graduate tutors in child and adolescent psychiatry listed by CAPSAC. We asked each tutor to record the name of the scheme, the number of senior registrars, lecturers, and part-time senior registrars currently training, how long they spend in each leg of the rotation, and how many consultants are available to offer training placements.

We also asked more open-ended questions about specific aspects of the schemes, including experience of child guidance, in-patients, day-patients, mental handicap, paediatric liaison, management skills, the psychological therapies, and the organisation of research and academic components. Finally, we asked the tutors to comment on what they considered the special features of their scheme, significant changes that have occurred in the past two years, and changes they anticipated over the next two years.

All tutors responded, and we are very grateful to them for their co-operation.