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Education and training

A training experience in the voluntary housing sector

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It is 25 years since the Royal Commission on Medical Education recommended that "every psychiatrist should be familiar with the conduct of community psychiatry". This is now more important than ever. As the National Health Service and Community Care Act (1990) comes into force and community care initiatives are developed throughout the country, psychiatrists are at risk of being left behind. To be effective players in these developments, psychiatrists need to be armed with a thorough knowledge and understanding of the workings of community care. Training future consultants in all aspects of community care must be a continual priority.

In this article we discuss the benefits open to senior registrars from becoming members of local management committees. It is based on our own experiences of sitting on two separate committees. One of us (KL) is a committee member of a housing association which provides a range of supported accommodation for 29 mentally ill people, while MP is on the committee of an individual hostel which provides 24 hour care for 12 women.

Training needs

What exactly do psychiatrists need to know to work effectively in the community? The report from the Royal College of Psychiatrists (1990) emphasised how any training related to community care should be supplementary to established hospital-based training, not an alternative, and that community psychiatry is a way of working with patients, not a specific specialty. Littlejohns *et al* (1992) stressed how trainees need experience in the planning and development of services, as well as having the traditional skills of a clinician, researcher and teacher. The importance of management skills has been stressed, but there is uncertainty about how they can best be obtained (Jadresic, 1992). In addition, senior trainees need to have a firm grasp of the new legislation concerning community care, have an understanding of the consumer's view and the importance of this in shaping services, and to understand the complex role of the voluntary sector in providing services. It is also now essential that psychiatrists have a detailed knowledge of the range of accommodation needed for a district service. We believe that one of the best ways to gain some of these insights is through attachments to services outside the National Health Service.

Residential management committees

Management committees of hostels and housing associations are usually composed of between six and ten people, from a range of different professional backgrounds. Ideally the composition of the committee should be representative of the local population, and have a users' representative. The committees serve a number of important roles.

(a) Advocates for the residents. The main role of the committee members is to look after the interests of the residents. In order to do this they need to keep themselves informed about all the needs of the residents, and be aware of any areas of conflict between residents and staff. The residents should be aware of the existence of the management committee, and feel able to approach members directly.

(b) Long-term policy issues, such as the type of future residents who are going to have priority, the development of more accommodation, and the ethos of the organisation,

(c) Staff supervision and support. As well as providing a formal structure for staff supervision and dealing with recruitment and disciplinary matters, committees have an important role in helping staff to feel that their work is valued and important.

(d) Finances. Committees have responsibility to oversee budgets and spending, and are usually involved in fund raising. Members with experience in this field are always required.

(e) Liaison. Hostels cannot operate in isolation, and committees have a vital role in developing relationships with other agencies, such as social services and local mental health teams.

(f) Visits. Management committees of registered hostels are obliged under The Residential Care Homes Regulations (1984) to endure that at least one

of their members visits the hostel each month and provides a written report back to the committee on the "conduct of the home". This report should cover specific safety aspects such as the storage of medication and fire precautions, as well as record any comments or complaints from residents. These visits are usually shared among committee members with each person visiting every six months or so.

A psychiatrist, depending on his or her experience, will contribute to all or some of the above tasks, and can focus the committee's attention on important health issues, such as ensuring all the residents are registered with a local GP. They will also have some specific roles. They may often be asked for information, by other members of the committee, about psychiatric diagnoses and treatments, and be asked about residents who give concern to the staff. An informal second opinion is often valued by the staff, but it is vital to establish that the resident's GP and psychiatrist have full clinical responsibility, and that a psychiatrist on the committee cannot take over this role. However, the psychiatrist can play a very useful role in liaising with local mental health teams, and representing the views of the hostel staff; he or she may also want to be involved in assessing potential residents, and advising on their psychiatric state. Another area where they might be asked to get involved in is staff training. This may be just advising on topics that should be covered, and potential teachers, but often will also involve actual teaching. A psychiatrist may also want to get involved in simple audit or research projects, related to the hostel.

Benefits to the trainee

From our experience the most valuable aspect for a trainee of being a committee member is the opportunity to view service provisions from the carers' and users' perspective, something that is never possible when working exclusively for the health service. It has emphasised to us just how frustrating dealing with mental health services can be for those working in hostels. Two particular problems which hostel staff complain about are how difficult it is for them to contact appropriate people when one of their residents is having a crisis, and the fact that decisions about residents' care repeatedly made by mental health staff without consultation with the hostel. When confronted by such frustrations the logic behind developing locally based sectorised services becomes very clear.

As well as the chance to view services from another perspective, these attachments offer the trainee the opportunity to become familiar with the workings of committees, and to develop the skills of committee decision making, which are so vital for any future consultant. There is also the opportunity to be introduced to organisational finances and staffing arrangements. Finally, there is the opportunity to gain first hand experience of the difficulties of providing accommodation for people with mental health problems, and to learn how people, often with severe disabilities, survive and enjoy life outside hospital.

Practical issues

Before deciding to try to become a committee member it is worth considering the level of commitment required. Usually it would be expected that you attend a two to three hour meeting, in the evening, every four to six weeks. In addition, you might be expected to visit hostels and go to occasional social events, such as Christmas parties for the residents. It is not fair to other committee members to join unless you expect that you can remain for at least a year and preferably longer, so that they can get to know and trust you, and so that you become familiar with the organisation in order to be able to make a useful contribution.

In order to become a committee member it is probably best first to ask local consultants if they know of any vacancies; if not, find the names of local hostels and housing associations and approach them directly. It is likely that your offer will be greeted warmly. There is a potential conflict of interests if a resident is under the medical care of a psychiatrist on the committee. Although neither of us has had problems in this area, it is essential to be clear about the different roles and responsibilities, and to express any concerns to other committee members.

Comments

We have both found our experience on the committees useful and enjoyable. It has offered us the opportunity to play a role outside the formal psychiatric hierarchy, and to make an independent contribution to hard pressed organisations which serve a vital role in caring for the mentally ill in the community. It has also given us insights into many practical aspects of community care which could never have been formally taught. The Royal College of Psychiatrists should consider recommending such attachments in their guidelines on senior registrar training.

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Resuscitation skills of psychiatric trainees

A suitable case for treatment?

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One of the most unpleasant things that can happen to the senior house officer or registrar on call alone in a psychiatric hospital is a "crash" call. He or she has to get to the patient, institute appropriate immediate management, arrange for disposal to a more suitable facility, and hand over to the responsible team. The problems facing the psychiatrist in this situation may be complicated by several factors, and these come under the following headings.

Difficulty in getting to the patient

Psychiatric hospitals are often large institutions with an illogical layout and illogical naming system. The on-call doctor may be called to a ward he or she has not been to before, especially if the incident occurs at the beginning of their appointment. (Lack of knowledge of local layout is not just the province of psychiatric staff – Sullivan & Guyatt, 1986).

Difficulty in instituting appropriate management

Recent studies of resuscitation skills of various groups of staff in general hospitals have shown some inadequacies (Seraj & Naguib, 1990; Lum & Galletly, 1989). Even cardiologists and anaesthetists were "unable to perform practical steps in the correct order" (Seraj & Naguib, 1990). While these study populations are not directly comparable with our population, there is no reason to suppose that trainee psychiatrists, perhaps some years from their last general medical experience, would show a higher level of competence.

In addition to the doctor's possibly inadequate skills, there are additional problems in resuscitating the patient: appropriately trained nursing staff may be lacking, defibrillator machines and monitors may be slow to arrive and equipment on the "crash" trolley may be inoperative or not the same as the equipment the doctor trained on. These last problems, however, are out of the scope of this paper, as is the issue of communicating with the on call doctor about decisions regarding whether or not to resuscitate a particular patient.

The aim of this paper is to look at the theoretical knowledge and practical skills, and the knowledge of local procedures and equipment of trainee psychiatrists at one hospital.

The study

The study was divided into two parts, the first consisting of a questionnaire and the second of practical resuscitation abilities.