Psychiatric Bulletin (1990), **14**, 686–693

The College

Report of the Working Group on the training implications of the move towards community oriented treatment

Introduction

In February 1988 the Executive and Finance Committee of the Royal College of Psychiatrists set up a Working Group to consider the training implications of the move towards community oriented treatment. The members were:

Dr D. Julier (Chairman)
Dr T. Burns (Social, Community and Rehabilitation Section)
Dr J. Higgins (Sub-Dean; Manpower Committee)
Dr M. Kenny (CTC)
Professor E. S. Paykel (JCHPT)
Dr J. Scott (Co-opted)
Dr C. Sillince (Education Committee)
Professor A. C. P. Sims (Dean)
Mrs P. Norman and Mrs S. Brant (Secretaries)

The Group met on four occasions and considered relevant College documents, some published literature (including reports on training in the USA), comments invited from Regional Advisers and Divisions and through the *Bulletin*, and notes on an Open Forum of the Education Committee (March 1988) and on a discussion at the 1988 Tutors' Conference in York.

In 1984 the Royal College Section for Social and Community Psychiatry set up a working party on education and training. Its report led to the publication in 1987 of recommendations both for SHO/registrar training and for higher training, specifying relevant areas of didactic teaching and clinical experience.[1,2]

The Group also took as its starting point the Report of the Collegiate Trainees' Committee Working Party established in September 1986 to study the Training Implications of the Shift to Community-Oriented Psychiatric Services.[3] This concluded that "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"; at the same time it drew attention to the several problems and disadvantages associated with such a development.

The present report will echo many of these themes, likewise welcoming the educational opportunities implicit in community work, while also exploring some possible solutions to the problems identified, and ways in which the overlapping training needs of various disciplines may be met by sharing joint facilities and teaching.

The evolution of a community oriented psychiatric service

In 1968 the Royal Commission on Medical Education[4] recommended that "every psychiatrist should be familiar with the conduct of community psychiatry". Freeman (1985)[5] viewed the training facilities as so restricted as to necessitate the secondment of trainees to those few centres practising in a community oriented way. In 1987 the CTC report expressed concern that "we still seem to be no nearer achieving this recommendation". Since then the movement towards a community oriented approach has gathered momentum, and major changes have been planned or effected. They encompass:

the move from large central psychiatric hospitals to smaller units situated near the population serviced (sited in DGHs or alone)
the setting up of peripheral day hospitals and day centres
the development of community mental health centres
the siting of out-patient clinics in general practitioner health centres or surgeries, and closer liaison with general practitioners
the deployment of more community psychiatric nurses and of community mental health care teams
the increased emphasis on domiciliary assessment and active outreach, on liaison with community residential and occupational facilities and with other professionals and voluntary agencies
the establishment of local planning and management bodies which are responsive to community needs.

The rapidity of these developments and the diversity in the pattern of psychiatric services which currently exist carry a number of broad educational implications:

(a) Over the next few years some psychiatrists in non-training grades will need special opportunities to expand their knowledge and expertise so as to take on new roles in a community oriented service.
(b) For trainee psychiatrists the educational specifications for community experience

should not be rigidly prescriptive at this stage; rather the emphasis should be on securing the optimal level of involvement in accessible community oriented developments while ensuring a balanced and comprehensive psychiatric training.

(c) While various patterns of service are evolving and in the absence of conclusive evidence for preferring one pattern to another, theoretical instruction should include principles and methods of evaluation, as well as current practice.

These developments offer exciting and welcome opportunities to widen the scope of psychiatric education, particularly with regard to its context and its interaction with other disciplines. Both trainers and trainees exposed to such opportunities have found them challenging and rewarding; the issue is currently not whether training in community settings has a viable place, but how this valuable and, indeed, essential experience may be made available to all trainees, how its benefits may be maximised, and how it may be integrated into a comprehensive training and the maintenance of a comprehensive clinical service.

The benefits are to be seen as supplementary to rather than alternative to the existing and carefully evolved system of training. Current skills and knowledge will not be superseded but will remain an essential basis. Specifically there will remain a need for in-patient facilities, for example for the most disturbed psychotic and handicapped patients, and most psychiatrists will need to maintain the competence to manage this clinical group.

The task to be addressed is therefore not one of supplanting this competence but of extending it in ways which will enrich our educational experience and the service we offer to patients.

Skills and knowledge required for community oriented clinical work

There is no generally accepted and comprehensive description of the types of expertise needed for community oriented work. The following list of required skills (abbreviated from Connolly & Marks[6]), while clearly not exhaustive, will serve to highlight some educational issues:

assess in a variety of situations a patient's psychiatric condition and formulate a treatment plan
discuss the implementation of this with patient and relations, etc
decide the best site and facilities for treatment (short and long-term)
identify and access the personnel available for the treatment, ensuring that specific roles and monitoring functions are allocated
review and monitor a case load
keep individual records and work statistics
liaise with other members of the community team, with the primary care team, other professionals and voluntary agency workers
apply the Mental Health Act appropriately
monitor community psychiatric morbidity and identify possible prophylactic interventions
promote local mental health support systems
educate other professionals and pursue health education
evaluate cost-effectiveness of the service
plan future development of services.

From this it is evident, firstly, that the required expertise overlaps extensively with that needed for good hospital based practice; the essential differences lie in the variety of assessment settings, the more explicit liaison with other health care workers, and the consideration of some local issues regarding facilities and morbidity. Secondly, there is a graduation of tasks, increasing in complexity and in the level of knowledge demanded, so that the trainee may start with a circumscribed role at an early stage and gradually extend his involvement. Thirdly, many of these specified skills may be expected of other members of a multidisciplinary psychiatric team, so that consideration can be given to a multidisciplinary training programme available to various groups such as junior CPNs, ward based nurses engaging in some home visiting, social workers, clinical psychologists and occupational therapists as well as psychiatric trainees. Such programmes could usefully include interview training, psychiatric assessment, management planning and information about local facilities. Such shared training programmes may help to promote the cohesiveness of multidisciplinary teams.

At the same time, explicit attention will need to be given to the risk of eroding the specific role and skills which each profession can usefully bring to multidisciplinary management. In all psychiatric settings there will be a continued expectation that the psychiatrist has a particular contribution to make to the multidisciplinary team, and training must ensure that he can command a detailed knowledge of psychopathology (including psychodynamic aspects), of psychiatric diagnosis and prognosis, and of psychopharmacology; also a good grasp of medical and neurological diagnosis, a wide experience of varied approaches to psychiatric management, and psychotherapeutic expertise adequate for working in a variety of ways with patients and their families.

Training implications for consultants

Consultants who have had little opportunity to work in community settings and who may be called on to assume a new clinical role or to engage in planning community facilities should consider negotiating a period of additional training for themselves. This could usefully involve visits to a number of centres

with varied patterns of facilities, associated with reading and discussion with a wide range of professionals. Experience gained in this way may help to avoid costly mistakes at a time of rapid change.

It is also part of a consultant's role to ensure his continuing professional self-education. This is of importance when the clinical service is evolving, and when his changing role may demand new knowledge and expertise. Those concerned with specifying and reviewing a consultant's timetable should have in mind the need for sessional time devoted to such continuing education and possibly also for research into the need for, or implications of, a planned service development. In many cases two sessions per week would be required.

The supervision and teaching of junior medical staff, and of other professionals, are likely to demand considerable time and attention in relation to community work. In a dispersed service there may be less contact between trainer and trainee, and there will be fewer opportunities for the joint interviewing of patients. Standards of training will be jeopardised unless the consultant can set aside a minimum of one hour per week exclusively for trainee tuition; this is in line with General Medical Council recommendations.

In addition, a careful review of work patterns in a developing community-based service may reveal fresh ways of combining teaching with routine clinical work; an example would be the joint scrutiny by consultant and trainee of all referrals to the community team.

Management training should be available to all grades of staff, and there may be advantages in combining medical staff having varied levels of experience and other professionals. Such courses should include teaching on the roles of the different disciplines involved in community work, on the dynamics of team work and styles of leadership, and on methods of evaluation and data collection; sample planning and research exercises can be undertaken on a group basis.

More advanced courses should cover management arrangements for the NHS and Social Services, planning and development of services, funding and budget management, team management, case-load management and time management.

Few management courses of this type are currently available, and time, personnel and funding will need to be allocated in order to establish them, as specified by the NHS Training Authority[7].

Training implications for associate specialists, staff doctors and clinical assistants

Psychiatrists in non-training grades need to engage in a continuing programme of education as part of their regular work if they are not to lose touch with developing patterns of care. This is particularly important where they are dealing with out-patient follow-up work, day facilities, rehabilitation, mental handicap or the care of the elderly.

Consultants should ensure that staff in these grades have opportunities to engage in educational activities, make appropriate use of study leave to familiarise themselves with community oriented developments, are involved in the planning process, and can attend management courses where appropriate.

Entitlement to educational time and study leave may need to be clarified or negotiated with employing authorities.

Implications for higher psychiatric training

It is during the four years as a senior registrar that the young psychiatrist is likely to have his most important experience of community oriented treatment and in the majority of higher training posts this experience is already available in some measure. The Joint Committee on Higher Psychiatric Training (Handbook, 1990 Edition)[8] sets out training requirements which may be summarised as follows:

(a) General psychiatry: "General psychiatry is developing an increasing community emphasis and training in community psychiatry approaches should be obtained by all general psychiatrists during professional or higher training. Each approved training scheme should include an opportunity to train with a consultant who offers a service which is community orientated and based. The range of available supervised experience, although not necessarily within a single team, should include work in primary care and day settings, domiciliary assessment of acute patients and families, application of crisis intervention techniques, work in the community with members of other disciplines, provision of consultation to other statutory and voluntary agencies, and involvement in health service planning teams. Care must be taken to ensure that in each setting the work allocated to the senior registrar is appropriate to the higher training level of responsibility. Some trainees may wish to spend longer periods in such training to develop special competence."

(b) Trainees in child and adolescent psychiatry "must have the experience of working in a variety of settings and with the full range of related disciplines. These should include outpatient services, schools, social services and

https://doi.org/10.1192/pb.14.11.686 Published online by Cambridge University Press

Courts. It is important that a significant part of the trainee's experience is gained outside a hospital setting including visits to the homes of referred families."

(c) Trainees in mental handicap psychiatry "should have the experience of working in a variety of settings and with the full range of related disciplines. A balance must be struck between hospital and community work.... In the community this should include working within a multidisciplinary team, outpatient departments, education and social service establishments, the Courts and patients' own homes.... Trainees should provide a consultation service to other professionals and agencies caring for the handicapped. This experience could be provided by attachment to statutory and non-statutory day and residential services."

(d) Forensic psychiatry: "Community experience of managing offenders is important.... Experience should be obtained in the following settings: adult prisons and services managing juvenile offenders. Liaison with the probation service is important.... Trainees should make their assessments in as many different settings as possible."

(e) Old age psychiatry: psychogeriatric placements should allow involvement in "Ongoing planning and organisation of a service to the population; assessment, investigation, treatment and long-term support of patients at home, in rest homes and nursing homes. The use of in-patient, day hospital and/or out-patient facilities for assessment, investigation, treatment and long-term support, working as part of a multidisciplinary team both within the hospital and the community."

(f) Psychotherapy: "This should include experience with a wide variety of newly referred patients who are being assessed for their suitability for psychotherapy.... Consultation with other psychiatric services, such as general, child and adolescent and forensic psychiatry, crisis intervention and community services is desirable."

In addition to the senior registrar's supervised clinical experience he is likely to benefit from a management training course directed at community issues, and provision should be made for this.

Encouragement should also be given to the senior registrar to gain some experience in community oriented research. Such research projects may be more complex than those relating to hospital based patients and records so that more intensive expert supervision may be needed.

The development of training opportunities in an increasing range of community settings is likely to mean that the senior registrar will in future be unable to involve himself in all the activities of the clinical firm to which he is attached. Trainers will need to exercise care in drawing up a realistically circumscribed programme to meet the individual trainee's needs.

Concern has been expressed that the senior registrar may be called upon to act down inappropriately in the context of community work. In the event this has proved not to be a problem, and the absence of a hierarchy of grade-specific tasks is seen mostly as a welcome stimulus to versatility and self-reliance.

More senior registrars, in common with other community workers, may spend a significant proportion of their time travelling between various community settings. Trainers should give attention to minimising this time by choice of an appropriate number and geographical location for these settings.

Training implications for SHOs and registrars

The revised Statement on Approval of Training Schemes for General Professional Training for the MRCPsych[9] specifies: "some supervised community experience is necessary, including accompanying on suitable domiciliary visits, home assessments with community nurses or social workers and attachments in general practice. Other experience could include work in a community mental health centre, crisis intervention service, treatment at home etc."

Tutors and trainers are likely to find themselves increasingly taxed by the task of balancing competing claims on a trainee's time during the three or four years of his general professional training. On the one hand it is important to introduce the trainee at an early formative stage to the concepts and practice of community oriented psychiatry, while on the other it must be acknowledged that hospital based clinical experience will allow trainees most securely to master the essential skills – meticulous history-taking and mental state examination, investigation and case presentation – and to familiarise themselves with the full range of abnormal mental phenomena. The following paragraphs will address this issue of balance, and of circumventing the problems which may accompany the introduction of community experience.

Considering the ensemble of a trainee's placements in the first three or four years of psychiatry, it would be unusual for this not to include attachments in the psychiatry of old age, child and adolescent psychiatry and the psychiatry of mental handicap. In these subspecialties there is already a marked community orientation, so that general adult placements do not necessarily have to bear the major responsibility for initiating the trainee into community work.

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Trainees entering psychiatry after a general practitioner training may have already the advantage of a community orientation which will influence their psychiatric experience. There would be similar advantages in tutors securing arrangements for some other trainees to have full time attachments to general practitioners. These should be for six months and should occur as early as possible in basic training. Alternatively it may be possible for junior trainees to have sessional attachments to GPs with the role of observer. The choice of GP trainer is crucial to the success of these attachments; a particular interest in community psychiatry is essential.

Overall a trainee should have a minimum total of 12 months' experience of community oriented psychiatry. Not more than six months should be spent attached to a service working exclusively outside hospital.

On the whole it is advisable for trainees to spend the first year of basic training in predominantly hospital based work so as to build a solid basis of assessment skills. They may usefully accompany senior staff or CPNs on domiciliary visits or visits to facilities in the community. If they are to take responsibility themselves for assessing and treating patients in community settings during this first year, then the trainer should pay special attention to ensuring a high level of supervision.

Where posts entail a mixture of work with in-patients and work in the community careful attention should be given to the mix. In general up to three or four sessions should be given to community work, this upper limit being particularly relevant if the latter service is slanted towards patients with the milder neurotic and adjustment problems.

The trainer should acknowledge that psychiatric trainees need tuition and supervision in relation to community work additional to that which is appropriate for the community team as a whole. The aim should be to develop those skills which a team may ultimately look to its psychiatrist member to contribute, and to set high standards of case presentation (which may be given a lower priority by a team). This will also provide a forum for discussing interprofessional issues, in particular the role of the psychiatrist in a multidisciplinary team – a probably source of some discomfort for the inexperienced trainee.

There is concern that the standard of care given to in-patients might suffer if trainees devote more time to work outside the hospital. This is allied to the problem of ensuring uninterrupted medical staff cover for in-patient units. These problems are ideally solved by having a pair of trainees providing cover for one another and being sufficiently familiar with the other's patients to provide effective continuity. The arrangement whereby cover is provided by a doctor not familiar with the unit or a clinical assistant whose usual work may be different is clearly less satisfactory clinically and educationally. Additionally the detailed assessment and monitoring of in-patients may be the dual responsibility of the trainee and another member of staff, for example a qualified nurse taking on the role of "key worker"; this arrangement acknowledges the growing expertise of nurses and other staff and the welcome wide dissemination of skills both for hospital and community based work.

As work patterns become more complex so there will be a need to clarify the extent of the trainee's duties in relation to demands from the locality served (for example, out-of-hours emergency assessments). One aim must be to facilitate his allocation of time to the various elements in his comprehensive training, and to safeguard key times of educational activity. Responsibility for this is shared between the consultant and the tutor.

A trainee working predominantly in the community may need to set aside three sessions from his main attachment for other training purposes. This time will be required for attendance at centrally organised day release courses, journal clubs, seminars, case conferences and interview training as well as psychotherapy practice and supervision. The latter should be seen as both an educational and a clinical activity.

The widespread move towards community oriented treatment has already resulted in the fragmentation of some of the larger rotational training schemes as central psychiatric hospitals close and smaller units are established in districts which now aim to be self-sufficient providers of psychiatric care. To an extent this conflicts with College policy hitherto, which has been to encourage the bringing together of training posts into schemes which are large enough to provide a wide variety of training experience and to facilitate group learning, for example in seminars. The problems accompanying the fragmentation into smaller schemes are compounded by the greater deployment of staff outside hospital. The results are a diminution of cohesiveness in training schemes and of companionship and mutual support among trainees. Tutors, trainers and managers will need to work with trainees to minimise the effects of professional isolation by giving importance to communal training and social activities.

The problem is likely to be further compounded by the effects of manpower changes brought in by *Achieving a Balance: Plan for Action*.[10] The reduction in UK graduate registrar numbers will in some areas retard the growth of community oriented care, daytime cover for in-patient units may be difficult to secure, and visiting registrars unfamiliar with cultural patterns in the UK will need a settling in period of three to six months before undertaking some types

of work in the community. These factors will need careful consideration by clinicians and managers planning to undertake new commitments at this stage.

Whatever the pattern of psychiatric services it is certain that trainees benefit from visiting and familiarising themselves wth community facilities. One way of facilitating this is for each trainee to maintain a logbook which contains for each post a list of relevant facilities to be visited and a record of actual visits. This can then be reviewed by his trainer and tutor. It may be appropriate to combine this with an intensive one week induction course for trainees about to embark on a community oriented attachment.

The increasing enthusiasm for community work has engendered a fear that general psychiatrists will lose interest in the treatment of chronically psychotic patients. The risk of this will be less if the trainee has his interest aroused at an early stage, and this may be fostered by arranging for him to follow such a patient in the community for 12–18 months (that is spanning two or more attachments; there is a precedent for this in relation to psychotherapy cases).

Issues concerning travel and research apply to junior trainees as to senior registrars. It is possible to envisage that travel time could be profitably and even enjoyably spent if a range of educational audio tapes were available for use during car journeys. Only sporadic examples of such material exist at present in the UK. In the USA such material is widely available.

Research may fail to flourish in a more dispersed setting unless trainees are offered readily accessible encouragement and supervision. It may be helpful for a consultant to be nominated to act as research broker and facilitator for a training scheme or district.

The need for well developed psychotherapeutic skills is evident when working in community settings, and the trained psychiatrist should be expected to have acquired wide experience and knowledge of psychological interventions. The College Guidelines for the Training of General Psychiatrists in Psychotherapy[11] indicate ways of meeting that need, but in reality most trainees' actual experience falls short of what is recommended. To remedy this shortfall will require careful review and monitoring by trainers and tutors of each trainee's tuition in psychotherapy, together with a review of consultant establishments to ensure that psychotherapist trainers are available in each area.

Training facilities

When planning the construction or acquisition of a building for clinical purposes in a community setting consideration must be given to the need for access to a room that would serve for team meetings and also for seminars (seating about 12), a small lecture theatre (for about 50) with audio-visual equipment, and a video studio with equipment. It may be possible to use a postgraduate education centre, or to share facilities with a GP practice or with social services; a shared arrangement could give impetus to the planning of joint training programmes. Existing facilities should not be surrendered unless a satisfactory alternative is available.

Peripatetic patterns of teaching have developed in recent years and will doubtless expand further. Psychotherapists visit peripheral clinics and GP surgeries to teach and conduct Balint-style groups; clinical psychologists have experimented in siting training courses on anxiety management in health centres.

Such arrangements are, however, expensive and in the longer term it is to be hoped that distance learning technology will become more accessible and cheaper. Well developed videotape libraries, videodiscs, computer-based learning programmes, telephone conferencing and closed circuit television may ultimately service the training needs of several disciplines.

The decentralisation of treatment facilities poses problems also for the provision of an adequate library service. Currently a central district psychiatric library with a full-time librarian may supply loans and photocopies to peripheral units while the latter may have their own small bench collection. The limits of this system are quickly reached by those working predominantly in community settings. In time, and at considerable expense, fax machines and computer-based data storage and retrieval systems may offer ways of overcoming current limitations.

For the tutor responsible for training programmes time may be the most crucial facility. The organisation of training in the context of a dispersed service operating in a variety of community settings will be more demanding and more time-consuming. This may necessitate formal arrangements for relieving the tutor of some clinical sessional commitments for the duration of his tutorship. Two sessions might be required for the average sized training scheme.

Managers will need to give careful attention to travel arrangements for trainees of all disciplines, having in mind that not every trainee holds a driving licence and owns a car. There is also a need to eliminate ambiguity and idiosyncrasy from arrangements for the reimbursement of travel expenses.

Recommendations

The move towards community oriented treatment should be seen as offering exciting and welcome

https://doi.org/10.1192/pb.14.11.686 Published online by Cambridge University Press

opportunities for the development of psychiatric education. The issues raised will need wide and careful debate over the next few years and will need to feature regularly on the agenda of those concerned with planning clinical services and with staff training.

Community psychiatry should be viewed not as a specialty but as a way of working with patients which in the future will demand an extended range of expertise from all psychiatrists. The requisite training is to be seen as supplementary to (rather than as an alternative to) established hospital-based training.

A major effort should be made to ensure that all trainees have properly supervised community experience, as specified by the Joint Committee for Higher Psychiatric Training and by the revised Statement on Approval of Training Schemes for the MRCPsych.

In addition some consultants, associate specialists and staff psychiatrists will need to extend their experience and skills to encompass new patterns of working in community settings; study sessions and study leave should be made available for this purpose.

Encouragement should be given to the development of multidisciplinary training programmes covering skills and knowledge which are needed by psychiatrists and other professionals alike (a proposed multidisciplinary training programme in community care is to be piloted at the Institute of Psychiatry).

At the same time it must be accepted that the development of skills specific to a psychiatrist in a multidisciplinary team will demand additional supervisory time from the consultant trainer.

Management training related to community oriented work should be available to all staff. This will make demands on time, personnel and funding.

Community oriented research should be fostered, particularly among those in higher training. Greater attention should be given to the encouragement and supervision of trainees' research.

Community attachments need to be carefully planned so as to make efficient use of trainees' time.

Attention must be given during general professional training to maintaining a balanced and comprehensive experience introducing community based work at the appropriate stage, and avoiding professional isolation.

SHO/registrars should expect to devote three sessions to educational activities while in a community based attachment.

Adequate psychotherapy training is essential, and resources for this will need reviewing.

The task of the tutor with a widely dispersed training scheme will be more time consuming; a minimum allocation of two sessions should be made.

Managers of mental health services will need to attend to staffing levels (in relation to supervisory time, and the implications of *Achieving a Balance: Plan for Action*), community based premises, teaching facilities, library facilities, travel arrangements and management training.

The College may wish to consider what measures could usefully heighten its members' awareness of the training issues touched on in this Report. These might include:

a greater emphasis by Approval and JCHPT accreditation teams on the use made locally of community training possibilities

the inclusion in College Quarterly Meetings and other educational programmes of more contributions from a social and community perspective

encouragement to course organisers to include more community oriented induction courses and teaching in day release programmes (an example is given in Appendix I).

Approved by Council
June 1990

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Appendix I

Introductory Course on Community Psychiatry

Such a course could aim to cover three principal areas:

(a) a review and comparison of different management arrangements in inner cities, suburbs and rural areas, with a discussion of how to tailor services to suit local problems and resources

(b) the methodology of evaluating community services

(c) opportunities for the trainees to familiarise themselves with key local facilities and key professionals, including visits to day centres, residential facilities, mental health centres, courts and prisons, and sessions accompanying a community psychiatric nurse, a social worker and a member of a community mental health team.

Sample programme

The following programme of seminars on rehabilitation and community psychiatry is taken from the second term of the day release course for the South West Thames Region:

REHABILITATION AND COMMUNITY CARE

Wednesday 18 January 1989		
9.30–10.30	The role of the psychiatrist. Medication and compliance issues	To be announced
10.45–11.45	The range of accommodation options	Dr P. Fitton
11.50–12.50	Sheltered employment	Dr L. Rowlands
Wednesday 25 January 1989		
9.30–10.30	Models of work with the long term mentally ill	Dr R. Perkins
10.45–11.45	The range of accommodation options	Dr R. Perkins
Wednesday 1 February 1989		
9.30–10.30	Acute provision for LTMI	Dr T. Burns
10.45–11.45	Assessing needs of patients and carers	Dr C. Brewin
11.50–12.50	Long term behaviourally disordered	Ms Isobel Harris
Wednesday 8 February 1989		
LOCAL SERVICE ORGANISATION		
9.30–10.15	Wandsworth	Dr J. Bolton
10.15–11.00	Merton	Dr J. Hollyman
11.15–12.00	Netherne	Dr M. Ekdawi
12.00–1.00	Discussion of tailoring resources. Setting priorities	Above speakers
Wednesday 15 February 1989		
9.30–10.30	SS provision for LTMI. Income practicalities	Mr P. Roys
10.45–11.45	SS provision for LTMI. Case work	Ms H. Dobson
11.50–12.50	Day care provision	Dr F. Holloway
Wednesday 22 February 1989		
9.30–10.30	Case discussion	Dr J. Hollyman
10.45–11.45	Social management of schizophrenia	Dr L. Kuipers