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Higher specialist training in child and adolescent psychiatry: a survey of academic programmes[†]

AIMS AND METHOD

Academic programmes are mandatory in child psychiatry specialist registrar training. A postal questionnaire survey was undertaken to explore the views of specialist registrars and academic programme coordinators identified nationally with regard to their local academic programme.

RESULTS

Sixty per cent of specialist registrars (152 out of 253) and 90% of co-ordinators (17 out of 19) responded. All schemes offered an academic programme with protected time. Teaching methods were diverse, and satisfaction varied within and between schemes, with trainees reporting greater satisfaction

associated with active involvement of coordinators.

CLINICAL IMPLICATIONS

The authors provide recommendations for local planning of academic programmes. The authors request the assistance of CAPSAC in standardising the appointment and training of coordinators and facilitating their release from clinical commitments.

The Royal College of Psychiatrists' Child and Adolescent Psychiatry Specialty Advisory Committee (CAPSAC) specifies that all child psychiatry specialist registrar training schemes must have a formal academic programme (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). Training in child and adolescent psychiatry has been examined periodically (Garralda et al, 1983; Bools & Cottrell, 1990; Smart & Cottrell, 2000), but no previous comprehensive survey of academic programmes in terms of content and delivery has been published to date.

Academic programmes are usually organised by a local coordinator and are supposed to 'encourage self-directed learning as preparation for lifelong learning' and 'support the practical clinical training' (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). It is recommended that 'the academic programme is formally evaluated' and that 'the results of such evaluation should be used to inform the future development of the programme' (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). As there is currently no formal national curriculum, there exists the potential for broad variations in academic training, and we therefore sought to obtain a national picture of academic programmes from the perspective of both trainees and coordinators.

Method

Two similar questionnaires for trainees and coordinators were designed by consulting the CAPSAC advisory papers and the *Higher Specialist Training Handbook*, which refer to skill acquisition as well as theoretical knowledge (Royal College of Psychiatrists, 1998; Royal College of Psychiatrists Higher Specialist Training Committee, 1999). Advice regarding the structure of the questionnaires was sought from the local research and development department and the local research ethics committee was approached. The questionnaires were piloted on a small sample of specialist registrars and modified following feedback. Questionnaires were confidential but not anonymous.

Both questionnaires covered demographics and programme arrangement, organisation, structure and content, as well as views on quality and satisfaction. Questions took the form of yes/no responses, questions with comment boxes, and five-point Likert scales rating strength of agreement to a range of statements. In the questionnaire we acknowledged that there is no expectation for the programme to comprehensively cover all areas of training. However, we were interested to explore trainees' views of how their academic programme contributed to the various learning objectives listed. The coordinators' questionnaire also sought information on the content of the local programme.

Liaison and discussion between the authors and CAPSAC took place throughout the design process in order to meet the College requirements for release of its list of specialist registrars and training programme directors in the UK and Ireland. However, this survey is independent of CAPSAC and the methodology and opinions are those of the authors. Given the high turnover of specialist registrars and the option of anonymity in the College records, the authors did not assume that the College list was comprehensive. It was also clear, from the authors' local knowledge, that the list was inaccurate. Therefore, all training programme directors were contacted in order to obtain a list of specialist registrars currently on each scheme and to identify the local academic programme coordinator.

The questionnaires were sent to a total of 253 specialist registrars and 19 academic programme coordinators in child and adolescent psychiatry in August 2003. A targeted second mailing was carried out 6 weeks later. The results were analysed using descriptive statistics.

Results

There were 152 trainee respondents, giving a response rate of 60%. Of these respondents, 72% were female and 34% were flexible trainees. Seventeen coordinators

[†]See pp. 23–24, this issue.

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(90%) responded. Qualitative and quantitative data were generated. Quantitative results are summarised in Tables 1 and 2. To simplify the analysis, results from the Likert scales were amalgamated into three groups: agreement, disagreement and neither.

Arrangement of the programme

All training schemes offer an academic programme, which varies from weekly in some schemes to monthly in others. There was a notable difference in coordinator involvement, with some coordinators meeting trainees occasionally for planning and others carrying out direct teaching of trainees on a weekly or fortnightly basis. Trainees reported greater satisfaction with active involvement of coordinators who collaborate with trainees to give a sense of joint ownership of the programme. All coordinators were of the opinion that they offered a 3-year rolling programme; however, only 60% of trainees received a copy of this programme when they joined the scheme. Those who did not receive a copy expressed dissatisfaction and a need for clearer organisation, more structure and planning.

A quarter of trainees contributed to the cost of the programme. Some trainees suggested increased funding would improve the quality of the programme by attracting a greater number of expert speakers; however, others resented having to pay for a compulsory programme from an already limited study leave budget. Eight schemes received no funding, and one of these was in serious arrears.

Three of the schemes covered particularly large geographical areas, resulting in considerable distances to be travelled. Lengthy travel time adversely affected satisfaction, particularly for flexible trainees. The option of variable venues within the more spread-out schemes did not appear to solve the problem, with attendance falling off once the teaching site was moved.

Coordinator training

Regarding the appointment of academic programme coordinators, most were nominated, recommended or invited, some were under contractual obligation and others volunteered. Only 29% had received training or guidance in organising the programmes. When training had occurred, it involved either a hand-over from the previous coordinator, meetings with other coordinators or guidance from an academic programme committee. Over two-thirds (71%) of coordinators use the *Higher Specialist Training Handbook* and the CAPSAC advisory papers to design the programme, with half of those who do so following them closely. A similar number (71%) felt that it would be useful to have a College curriculum to guide design of the programme, although there were reservations that such guidelines might become prescriptive or mandatory.

Organisation and preparation of the programme

The mean number of protected coordinator sessions per week for the preparation of the programme was 0.8 (range 0–2). Trainees and coordinators contributed to the organisation of the programme either jointly or independently. Smaller schemes created a greater burden on the trainees with respect to preparation. Trainees from these schemes expressed the view that at times the academic programme seemed untenable. Inadequate notice for preparing material was reflected in reduced satisfaction and the feeling that the level of preparation expected was too onerous. A lack of administrative support for coordinators was felt to be responsible for inadequate notice in certain schemes. Only 65% of trainees reported that they were given adequate advance warning. In contrast, the coordinators believed that reading material was circulated between 7 days and 30 days in advance, seemingly unaware of trainee dissatisfaction.

Feedback

All coordinators said feedback was invited, compared with 85% of trainees, two-thirds in each case being by means of an evaluation form. Over two-thirds of coordinators described the feedback they received as positive, and commented that it was used to inform the development of the programme.

Content of academic programme

Table 2 details the training opportunities and teaching styles provided by the academic programme. The disparity between the views of the coordinators and the trainees concerning the training provided was striking. When trainees were asked how the content of the programme could be improved, suggestions were made for more case presentations, greater clinical relevance, and skills-based or problem-based learning rather than didactic teaching. The trainee group showed ambivalence towards journal appraisal and trainee-led teaching. The coordinators' suggestions for improving the content of the programme included increased funding, protected time for coordinator-related work and more trainee participation. Research methodology appeared to be covered particularly well by schemes with active local academic departments. Most schemes offered some training in management and medico-legal aspects of practice. Local resources (e.g. mini-pupillages, adolescent forensic teams and youth offending teams) facilitated incorporation of these training components, but external courses were also encouraged.

Discussion

Our study required detailed planning in order to meet the criteria for the release of the College membership list. Once released, it was clear from the authors' local knowledge that the list was inaccurate. Direct queries to



Table 1. Summary of responses

	n	%	Mean	Range
Respondent details				
Coordinator returns	17	90		
Trainee returns	152	60		
Trainee age, years			35	28–49
Proportion of flexible trainees		34		
Trainees per scheme			11	4–21
Current attenders		72		
Coordinators on full-time contract	14	88		
Coordinator sessions per week dedicated to programme			0.8	0–2
Coordinator meetings with trainees per year			11	2–30
Arrangement of programme				
Sessions per year dedicated to programme			34	18–60
Trainees receiving copy of 3-year programme at start of rotation		60		
Fixed location of programme		76		
Teaching location away from clinical base		74		
Protected time for trainee attendance		100		
Trainees contributing to cost of programme		28		
Trainees travelling more than 3 h		10		
Trainees receiving recommended reading list		78		
Coordinator training				
Formal training received		29		
Consultation with other coordinators		71		
Feedback				
Feedback invited		85		
Feedback via evaluation forms		59		
'The trainees are enthusiastic' (coordinator view)		94		
'The trainees prepare adequately' (coordinator view)		82		
Coordinators reporting generally positive feedback		71		
Trainee satisfaction				
Location		76		
Travel time		87		
Funding		90		
Venue		93		
Amount of preparation 'excessive'		20		
Amount of preparation 'too little'		11		
Adequate advance warning of necessary preparation		65		
Trainees' overall impression of programme (scale 0–10)			6.4	0–9.5

all schemes through training programme directors resulted in a lengthy process that delayed data collection. Nevertheless, the receipt of responses from all schemes and the overall 60% response rate showed that this was a representative sample. Gender distribution resembled that of the study population.

The appointment of academic programme coordinators is unsystematic. Specialist registrars are often not involved in the appointment process. The authors were concerned that only 35% of coordinators reported closely following the *Higher Specialist Training Handbook* and CAPSAC advisory papers in the design of the programme. Moreover, only 29% of coordinators received formal training in coordinating academic programmes. Currently the most that is provided is a hand-over from the previous incumbent or guidance from a training committee. Occasionally coordinators seek out their counterparts on other schemes and compare notes. There remain coordinators who have no protected time to prepare the academic programme. The CAPSAC could take a more proactive stance by standardising the

arrangements for appointment, induction and training of coordinators, and specialist registrars could be involved in the process of appointment, perhaps as part of a training committee. Furthermore, CAPSAC could put pressure on trusts to release coordinators from clinical commitments in order to prepare.

Table 2 demonstrates a marked disparity between coordinators' perceptions and trainees' experience of academic programmes. The coordinators had a more positive view of the training provided. This difference in opinion is most noticeable in the area of appraisal and application of research. This is of concern, given the current climate of clinical governance. This may relate to the mixed response across schemes regarding the usefulness and clinical relevance of journal appraisal. Training committees could recommend clinically relevant, high-quality journal articles.

There was wide variation between schemes in both organisation and content. Schemes covering large geographical areas, with little academic support and few trainees, struggle to achieve the quality and trainee

**Table 2. Training, opportunities and teaching styles provided by the academic programme**

	Trainees %	APCs %
Trainees and coordinators who agreed that the following professional competencies were contributed to by the programme ¹		
Capacity for lifelong learning	66	94
Description and application of the main findings from research	66	100
Appraisal of research and awareness of process of research	54	88
Expertise in child development and developmental psychopathology	68	88
Ability to apply multiple perspectives to cases	80	88
Integration of clinical skills that enhances the management of complex cases	66	88
Introduction to basic psychotherapeutic theories	76	94
Containment and management of anxiety in colleagues	35	53
Provision of clinical leadership	28	59
Skills of an autonomous specialist	46	71
Ability to exercise managerial authority	22	41
Opportunities that trainees and coordinators agreed were provided by the programme ²		
Development of academic knowledge	90	94
Peer support	92	100
Networking with peers	96	94
Improvement of local knowledge	64	82
Development of presentation skills	72	88
Trainees and coordinators who agreed that the following teaching styles were used ²		
Lecture	84	82
Small group seminar	88	100
Problem-based learning	60	59
Journal appraisal	79	94
Case presentation	84	100
Trainee's topics of interest	67	88
Video consultation	20	53
Trainee-led teaching	72	94

APC, academic programme coordinator.
 1. Information obtained by 5-point Likert scale.
 2. Information obtained by yes/no questions.

satisfaction of those based in larger cities. This inequity is particularly noticeable in research and medico-legal practice where trainees depend on local resources. The variation in the contribution to individual professional competencies (22–80%, Table 2) reflects the heterogeneity of programmes. This is not surprising, given that there is no standardised curriculum. The authors suggested that CAPSAC could usefully facilitate liaison between coordinators in order to exchange ideas about good practice and local solutions, in the absence of an agreed national curriculum. A useful method might be an e-mail discussion forum.

A major cause of trainee dissatisfaction was the burden of preparation. This appears to pose particular problems in smaller schemes. Coordinators held the view that reading material is circulated well in advance; however, 35% of trainees felt that advance warning was inadequate and 31% that the amount of preparation was unsatisfactory. This suggests a failure of feedback and communication. It could be assisted by adequate administrative organisation and support. When trainees are expected to take a lead in teaching (e.g. journal appraisal), timetabled protected time as well as discussion in supervision could be provided in order to prepare. Through a channel such as a training committee, the

issues of adequate advance warning could be raised and mechanisms for circulation of papers could be agreed and implemented.

Trainees appeared to appreciate having some influence in the organisation of the programme, but highest satisfaction was associated with support from an interested and active coordinator who regularly consulted trainees. Trainees who were expected to do the bulk of the organisation themselves found this burdensome in the absence of coordinator input. The coordinators reported higher levels of satisfaction with enthusiastic and motivated trainees.

Although current methods are well intentioned, locally creative and energetic, they are random and lack central coordination. There is no real financial resource, little release from clinical workload and meagre administrative support. The authors recommend a more universal adoption of training committees to include representation from training programme directors, academic programme coordinators and trainees. The training committee would have specific roles regarding the academic programme, including an organisational and planning role. It would also ensure that feedback was directly used to inform the evolution of the programme. Most importantly, it would enable the creation of a

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culture of collaboration and joint ownership of the academic programme that would direct the current arrangements to produce a more coordinated, protected and rewarding training experience. The CAPSAC could facilitate exchange of good practice between schemes, standardise the appointment and training of coordinators, and place pressure on trusts to release coordinators from clinical commitments to allow them more time for the academic programme.

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Declaration of interest

None.

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SALLY E. BONNAR

Talking together. Commentary on . . . Higher specialist training in child and adolescent psychiatry[†]

It is very encouraging to see trainees who are so enthusiastic about training that they are prepared to persist despite considerable barriers to carry out this type of audit. Hawkins *et al* are to be congratulated for raising these issues, especially at a time when postgraduate medical education is undergoing a revolution, and it is essential that we consider all the evidence available in planning future higher training curricula. I am particularly pleased because the issues raised in this paper have been considered at some length in the course of various meetings of the Royal College of Psychiatrists' Child and Adolescent Psychiatry Specialist Advisory Committee (CAPSAC), with many of the same solutions proposed here put forward.

It seems that most of the issues raised within this paper could be subsumed under the broad heading of communication: between CAPSAC and programme organisers through the advisory papers; between programme organisers and trainees; and between CAPSAC and managers through the written reports generated by accreditation visits. As psychiatrists we rightly pride ourselves on our excellent communication with our patients. How then can we make sure that the same skills are used to talk to each other?

CAPSAC and programme organisers

The CAPSAC advisory papers are written to provide guidance to those involved in running higher training

programmes and to allow trainees to assess whether or not the training that they are being offered is consistent with what the College recognises as adequate experience for the training of future consultants in their specialty. They are deliberately written so as not to be prescriptive. The wide range of training schemes across the country precludes standardisation and CAPSAC has never believed that standardisation of training is necessarily a laudable goal. The richness delivered by our variety is one of the things that attract people to child and adolescent training despite the fact that it is somewhat at odds with the current dogma of centralisation and sameness.

The advisory papers written in 1999 (Royal College of Psychiatrists Higher Specialist Training Committee, 1999) are in need of updating, but a decision has been made not to undertake this challenging task until we have greater clarity about the shape of future run-through training. This does mean that advice about training has not moved on as quickly as the demands of organising a scheme. The advisory paper on academic programmes does not specify the content of such programmes in detail. With the knowledge base in child and adolescent psychiatry expanding so rapidly, it would be foolish to try to delineate this too clearly. The publication of the advisory papers on the College website is a start in the wider communication between the committee and the faculty, and CAPSAC has also investigated the possibility of publishing academic programmes from schemes across the country on the website to enable better information

[†]See pp. 19–23, this issue.