2020

Training in addiction psychiatry: *current status and future prospects*

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

This report was commissioned and funded by HEE London. The project was hosted by the Royal College of Psychiatrists and overseen by a Steering Group consisting of;

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1. Introduction

This report reviews the current provision of training across the UK, reflects the current experience of trainees, considers the particular issues arising when services are delivered outside of the "NHS family", describes local solutions and attempts that have been made to work around the problems. It makes recommendations to ensure a sustainable supply of addiction psychiatrists to meet the needs of patients, service providers and other professionals. This report will demonstrate that the picture is not the same across the UK. The project which led to this report grew out of a particular concern about the situation in London.

All psychiatrists need a sound grounding in addiction psychiatry in order to respond to the needs of the populations they serve. People receiving treatment in specialist addiction services need specialist doctors to oversee and contribute to their care. Over the past decade a gradual reduction in the numbers of addiction psychiatry consultants has been accompanied by a reduction in the numbers of training places available. Thus a negative cycle is established whereby trainees cannot become specialist and in turn train the next generation. There is a risk that services and people receiving treatment will become used to doing without the specialist input leading to poorer outcomes and the collective memory of what good looks like will become lost.

Several recent documents have identified the importance of a skilled and qualified addiction and mental health workforce in order to provide the services which our patients should be able to expect. This report sets out the steps which will ensure this can be delivered.

2. Addiction Workforce Strategy

The current national drug strategies[1] recognise the need for a suitably skilled and qualified workforce in treatment services. HM Government Drug strategy of 2017 for England and Wales recognised that commissioned services should have a competent, motivated, well-led and supervised workforce and one that can be responsive to new challenges. It also states that **"It is important that services have the resources and capacity to train and develop their workforce, including new and existing clinicians"** It sets out the need to work **"with Health Education England, commissioners and providers to ensure the development and retention of the workforce, ensuring quality and safety of services and the outcomes"**

This strategic focus reflects that of the Five-Year Forward View for Mental Health[2] which recommends the **"development of an appropriately trained and competent workforce to meet the needs of people with co-occurring substance use disorders and mental health conditions."**

The NHS Long Term Plan[3] recognises the opportunity to respond more effectively to the many patients attending A&E as a result of alcohol dependence and

recommends the development of Alcohol Care Teams in those hospitals with the highest rate of alcohol dependence-related admissions. Delivery of these teams will require addiction psychiatrists to support the teams and / or to train liaison psychiatrists. The current shortage of addiction psychiatrists should not result in an omission of their role in the workforce planning to deliver Alcohol Care Teams.

A recent report by the Advisory Council on the Misuse of Drugs (ACMD)[4] sets out the rapidly changing profile of those in treatment for addictions, with the growth of a cohort over 40 years of age who have complex physical, emotional and social presentations. The report makes a specific recommendation about the need to ensure the required range and availability of skills, treatment and support and the availability and knowledge of staff to address complex physical and mental health needs of older drug users. It calls for a published review of the workforce.

HM Government published an open consultation; Advancing our health; prevention in the 2020s in July 2019[5]. This green paper recognises the on-going range of harms associated with drug use and dependency to the individual, family and society, notes the risk of an opioid epidemic and commits to developing a shared understanding with partners of the current challenges facing the addiction treatment and recovery workforce

Taken together these documents confirm the requirement for psychiatrists to be trained in addiction psychiatry and for a cadre of sufficient size to be trained in the sub-specialty.

Previous work on addiction psychiatry provision

Two key documents have addressed the roles of doctors in providing medical services to addiction services in recent years. “Delivering Quality Care for Drug and Alcohol Users: The Roles and Competencies of Doctors” (Royal College of Psychiatrists and Royal College of General Practitioners, 2012) and “The Role of Addiction Specialist Doctors in Recovery Oriented Systems” published by RCPsych / RCGP and endorsed by Public Health England (PHE) in 2015.

The report of 2015 defines three levels of competency that should be represented in all recovery-orientated systems: general, intermediate and specialist – with addiction specialist doctors having the competences required to diagnose and to treat the most severe and complex service users, and also adopt key roles in clinical leadership – comprising clinical governance and innovation, supervision, appraisal and training, and leading service development. It identifies that “addiction specialist doctors will either be consultant psychiatrists with formal recognition of specialist competence by the General Medical Council (GMC), or will be GPs who have achieved a wide recognition of their addiction specialist equivalence by undertaking additional training and developing suitably specialised experience.”

The report notes the reduction in numbers of addiction specialist doctors, affecting current service delivery and the ability to train future specialists. The report notes that “it will require the sector to move away from reliance on the NHS to develop and support the expertise of addiction specialist doctors. Increasingly, the capacity of non-NHS providers to support and train the next

generation of specialists will need to be developed if the skills of addiction specialist doctors are to be retained within the alcohol and drug treatment sector" and sets its recommendations in the context of the Francis Report whereby commissioners have a responsibility to commission and providers to provide safe services of good quality which "begins with frontline professionals working in services".

The report sets out recommendations (Appendix A). Our report includes evidence of some attempts to implement these recommendations. However, the continued reduction in training places underlines the need to re-energise the approach to the problem, to strengthen the recommendations and to identify accountability for their delivery.

Context

Addiction Psychiatry is a sub-specialty of General Adult Psychiatry. The route to being recognised as an Addiction Psychiatrist and development in the curriculum are set out in Appendix B.

Much of the service provision is currently by Third Sector organisations. Appendix C sets out the implications of this for training in Addiction Psychiatry and Appendices D, E and F describe initiatives which have been taken to ensure that training continues to be provided.

During this project we spoke with and received feedback from trainees in psychiatry about their experience of pursuing training in Addiction Psychiatry. This is reported in Appendix G.

3. RCPsych Workforce Data

The RCPsych collects data on the number of posts in psychiatry and its sub-specialities. Over the past decade the number of substantive whole-time equivalent consultant addiction psychiatry posts in the UK has fallen from a peak of 120 in 2007 to 81 in 2017, having recovered from a nadir of 51 in 2015 (Fig 1). There has been a related decline in the availability of addiction higher training places in England (Fig 2) and in the number of doctors UK-wide gaining a CCT in addiction psychiatry (Fig 3).

Figure 1[6]

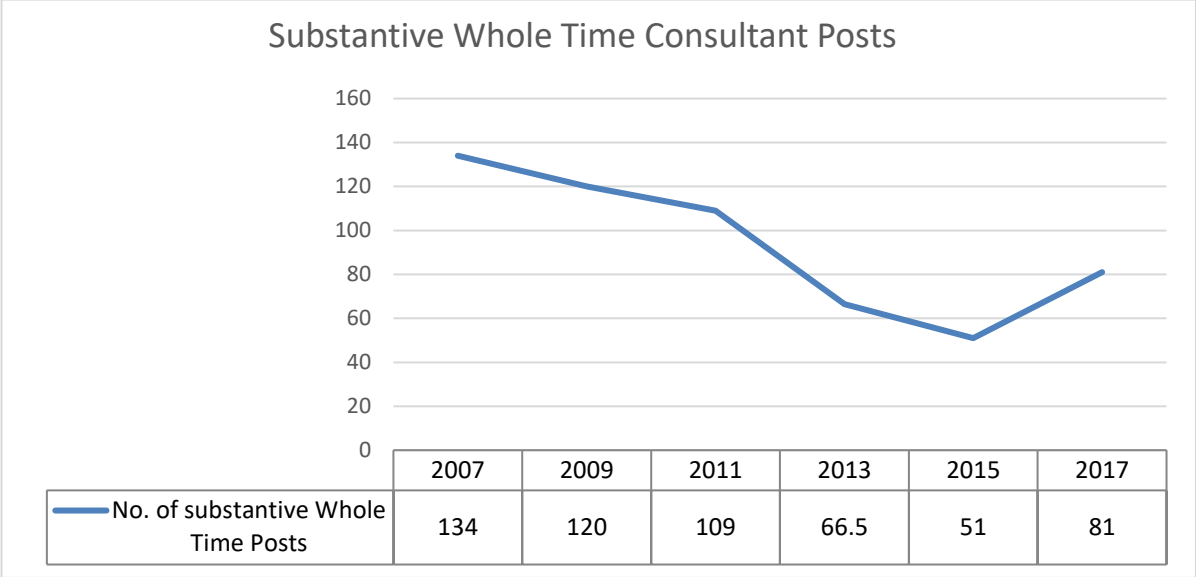


Figure 2[7]

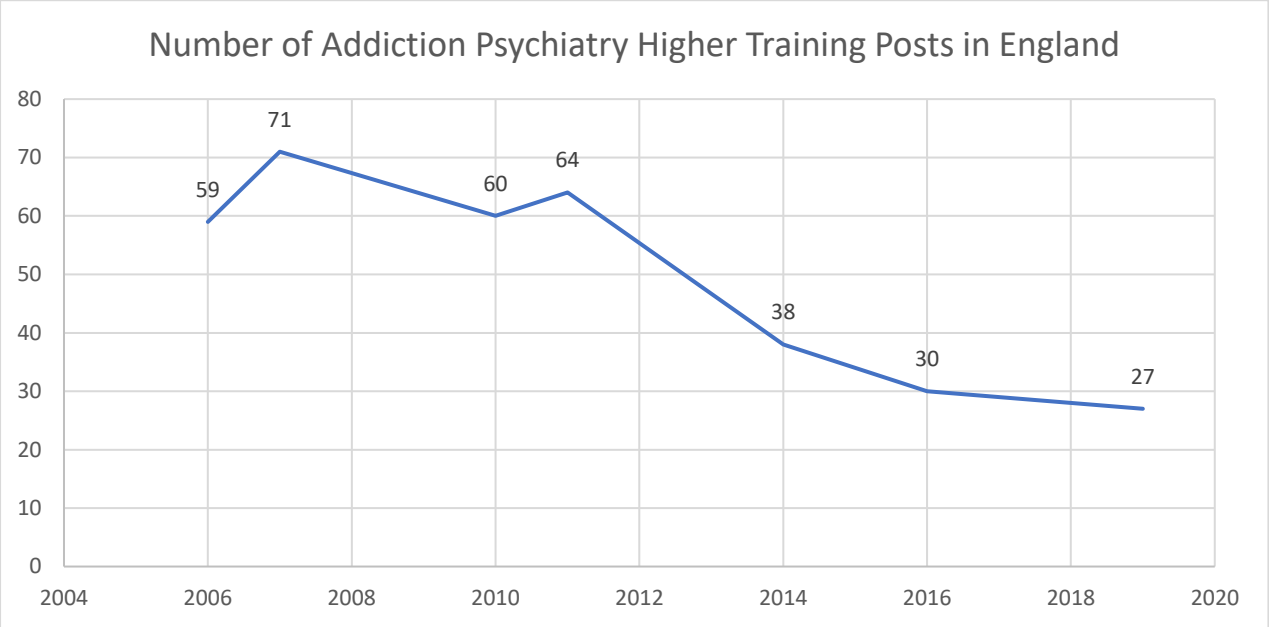
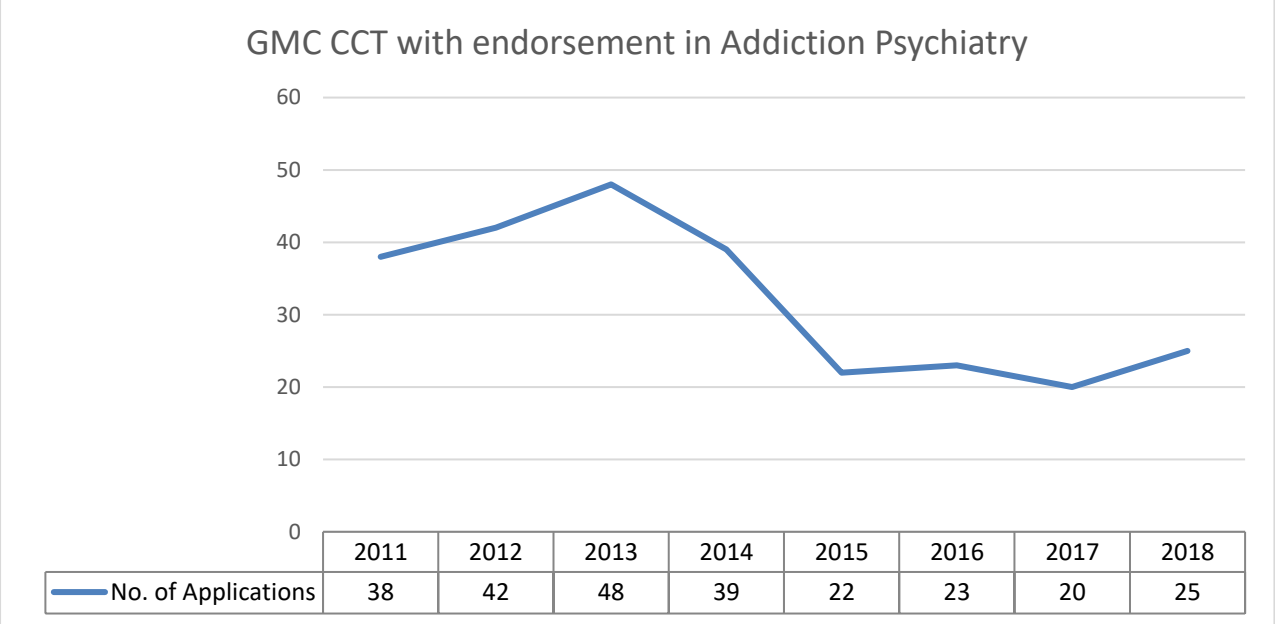


Figure 3[8]



Other psychiatric specialties have also experienced change over this period. Medical psychotherapy experienced a significant decrease in consultant numbers between 2007 and 2017. The numbers have been maintained at the current level for the past few years which ensures that there are consultants to provide training in medical psychotherapy. Such training and experience is required by the GMC for all those taking the MRCPsych examination. Whilst this supports the ongoing training and grounding in psychotherapy for all psychiatrists, it does mean that the majority of the consultants' work is taken up in training with little capacity for service delivery or service development. We think that medical psychotherapy is an important model to consider for addiction psychiatry. A requirement during the period of core training in psychiatry to have experience and summative assessment in managing addiction would be a powerful driver to ensure the experience of working in an addiction or other relevant setting supervised by a specialist was available to all.
By contrast liaison psychiatry, another sub-specialty of general adult psychiatry, has seen a significant increase since 2013. This reflects a key and explicit prioritisation of these services by NHSE as set out in the MH Five Year Forward View. The RCPsych and GMC responded to the requirement for a rapid increase in the numbers with specialty accreditation by developing a credentialing pilot which has developed in Peri-Natal Mental Health and could also be a model for addiction psychiatry.

2019 Training Survey

We established the current number of addiction psychiatry training places across the UK by sending a training post survey to the Head of School in each of the HEE training regions, the Wales Deanery, Northern Ireland (NIMDTA) and Scottish training regions of NHS Education for Scotland (NES). We also sought to gain an estimate of the current fill rates of identified addiction psychiatry training places. (Table 1).

We asked about the experiences of respondents in trying to set up or protect addiction psychiatry training posts. We sought examples where this has successfully been achieved and evidence of where barriers had been insurmountable. We asked about the financial and quality assurance arrangements for any newly created post. We aimed to understand the conditions in which training posts are protected and new ones are created, aiming to share good practice about what works.

We discussed the survey responses at the RCPsych Heads of Schools' meeting in July 2019.

Table 1

Region	**Reported Post Numbers**		**No. Filled Aug 19**	
	Core	**Higher**	**Core**	**Higher**
England				
East Midlands	3	3	3	2
East of England	0	3		2
KSS	1	0	1	
London North Central	3.5	1		
London North West	1	3	1	1.5
London North East	0	2		0
London South East	2	4	2	4
London South West	1	0	1	
North East	1	2	1	2
North West	3	1	3	1
Severn	2	3	1	0
South West Peninsula	0	0		
Thames Valley	0	0		
Wessex	1	0	1	
West Midlands	2	3	1	2
Yorkshire and Humber	2	2	2	2
Scotland				
North Scotland	1	1	0	1.5
South East Scotland	1	3	1	1
West Scotland	15	8	2	3
Northern Ireland	4	2	4	2
Wales	7	6	7	2
Totals	**50.5**	**47.0**	**31.0**	**26.0**

While the overall numbers are low and, at least in England, on a reducing trajectory, the picture of the paucity of training is masked by regional variation. The data indicates that the reduction in training places is an English issue. 28 out of 50.5 core posts are outside England and 20 out of 47 higher posts are outside England. Communications from Wales, Northern Ireland and Scotland reflect this data and Heads of Schools there report that they are not in the same situation as English training regions. These regions report both a demand for Addiction Psychiatry placements and the ability to accommodate this. However, the lack of pressure on places in Wales should be viewed in the context of generally low numbers of higher trainees there.

Four English regions have no core training post, leading to a missed opportunity for trainees to gain core competencies in a specialist setting and to explore their interest in a higher training post. Five English regions have no higher post, meaning that there is no opportunity for any trainee to gain an endorsement in addiction psychiatry and no pipeline for service providers to recruit a specialist from. Two English regions have neither.

The fill rate data should be treated with caution as placements can change even close to the rotation date when we requested the information but indicate that the actual numbers of trainees accessing training is even lower than the theoretical availability. The reports from Northern Ireland, Wales and Scotland indicate the disparity reflects excess capacity which is able to respond to trainee need, but the situation in England indicates that even some of the highly sought after posts are not filled; we heard that in at least one case this was due to service financial pressures. In one case we heard that the training post is in theory still available but that presently there is no trainer available.

4. Commissioning and funding of addiction services and training provision

Commissioned services are contractually required to provide interventions for people with drug and alcohol use disorders which require the clinical competencies of consultant addiction psychiatrists. However, the commissioning process does not explicitly protect training capacity and capability within services. The funding available to adult addiction services in England has reduced in real terms by 28% between 2013/14 and 2017/18.[9] Therefore, as contracts for services have been re-let every few years, each has reflected this reduction in budget available. This has in turn put pressure on monies available for medical posts including training posts. This pressure is reflected in the service structure and staffing of all service providers; both those in the third sector and those in the NHS. Where the service element of budget is no longer available, the post is at risk.

Each training post is funded through a combination of monies which flow from HEE, Wales Deanery, NHS Education for Scotland (NES) and the Northern Ireland

Medical and Dental Training Agency to NHS trusts which includes a contribution to the trainee's salary and an educational training placement fee. The host organisation is responsible for the remainder of the salary including any payments for out of hours work. The precise figures for each post can vary depending on local arrangements. A typical arrangement in England would see HEE contribute approximately 50% of the trainee basic salary, plus an educational training placement fee of £13 – 15k. Costs to the service provider would include the remainder of the basic salary, on-call payments and on-costs. Due to the educational requirement for trainees and their on-call commitments their clinical contribution to the service provider is less than full time. The monies for the remaining, service provider, element of the trainee costs flows from commissioners to the provider. For most medical specialities this financial management is managed in England through Trust contracts with the local CCGs.

However, there is an exception to this mechanism in England in the funding of training in Public Health. Registrars in Public Health are employed by Lead Employers funded wholly by HEE and they carry out training posts in organisations including local authorities and PHE, who contribute supervision from a consultant in Public Health / Director of Public Health or deputy, office space and equipment but do not contribute to their salary and other costs. (personal communication for this project)

5. Conclusions and recommendations

1. Addiction psychiatry has fewer structural safeguards to maintain trainee numbers than in the case for other specialties.

Establish a requirement set out in the UK curriculum for psychiatry that all trainees progressing from core training need to complete two Workplace Based Assessments (WBA) for the assessment and the longitudinal follow up and management of patients with Addiction Disorders. The WBAs must be supervised by an addictions specialist and patients must be seen in appropriate settings, as described by the Addictions faculty, i.e. addictions services (NHS or third sector), acute hospital, prison services.

2. The situation over the past decade has resulted in a "lost generation" of addiction psychiatrists and risks an unrecoverable decline as current older addiction psychiatrists retire.

Provide a training course to meet the needs of higher trainees, consultants with no experience during training and experiences SAS doctors.

Support SAS doctors in addictions settings to gain entry onto the specialist register via the Certificate of Eligibility for Specialist Registration (CESR).

Support GMC-credentialing in Addiction Psychiatry.

3. The disconnect between third sector providers and HEE has created barriers to providing training in addiction psychiatry. The perceived governance barriers have been overcome and the fundamental issue facing both NHS and non-NHS providers is the funding within service specifications to support specialist medical roles and training posts. Local commissioning by local authorities with reduced budgets means this is unlikely to be addressed without central support

Provide centralised funding to support addiction psychiatry training posts in all regions.

Consider using financial models of training in public health, general practice and other specialities whose trainees are not principally employed by NHS trusts.

6. Other supporting actions

A network of addiction training leads will be identified from the members of the Faculty executive committee to support educational programme delivery via HEE schools of psychiatry. This network will be tasked with building on the work done to produce this report to;

- Establish and manage a trainee hub with information about available posts and solutions where there is a temporary absence.
- Help organisations implement good practice
- Monitor the availability and fill rate of addiction psychiatry posts
- Establish a register of posts at risk

7. Final comments

The overarching aims of our recommendations are to;

- Protect current posts and support the creation of new posts
- Support current trainees in developing an interest in addiction psychiatry
- Support current trainees to access existing posts
- Ensure all psychiatrists have the necessary addictions competencies
- Ensure a minimum is set and maintained on all training schemes

Psychiatrists trained in addiction psychiatry play an important role in providing services to people receiving treatment from specialist addiction services and to those in other services who have co-morbid conditions. In Northern Ireland, Scotland and Wales there is, by and large, the ability to train psychiatrists to carry out these roles. However, in England there is an overall shortfall with significant gaps in the ability to train. Even in London, traditionally a region that has produced many addiction psychiatrists, the provision of training cannot be taken

for granted. The testimony from current trainees we heard from in the course of this project bears witness to the frustration, disappointment and lack of opportunity the situation is causing. There are a number of steps, contained within our recommendations, that can be taken to ensure good information sharing about where trainees can still get training, about how posts can be created in non-NHS settings, about how joint posts can provide experience and about how knowledge can be provided for those who have current CPD needs. However, we also call for action to be taken so that training posts are funded, either on a central basis, or by ensuring commissioning service specifications support them, and action to consider and review the regulatory basis on which addiction sits within training and specialist endorsement in psychiatry.
Our ultimate measure of success should be a normal level of access for patients with addiction problems to doctors trained in the diagnosis and management of them - as we would expect in any branch of medicine.

Dr Louise Sell MRCP(UK) FRCPsych for the Faculty of Addiction, RCPsych, January 2020

Appendix A: Recommendations from *The Role of Addiction Specialist Doctors in Recovery Oriented Systems*, RCPsych/RCGP, endorsed by Public Health England (PHE)[10]

- Commissioners and providers work collaboratively to ensure ongoing of specialist training posts in addiction services are available. This will involve engaging with the appropriate deanery (responsible for managing and delivering postgraduate medical education and supporting the continuing professional development of all doctors), which in most cases would be the role of the provider. The Royal Colleges of Psychiatrists and GPs may be able to help with this
- Commissioners and providers may want to be aware of the increased risk to existing posts when contracts pass from one provider to another, and consider making provision to mitigate these risks in tendering processes
- Commissioners and providers may want to make provision for trainee posts when developing service specifications (acknowledging the resource implications as well as the resource benefits of such posts)
- Commissioners and providers to consider working across localities to maximise opportunities for establishing training posts across deanery areas
- Providers to work collaboratively with the royal colleges to promote specialising in addiction as an attractive career option for trainee doctors

Appendix B: Addiction psychiatry within psychiatry

On completion of their training as a psychiatrist, a doctor obtains a Certificate of Completion of Training (CCT) and enters the General Medical Council (GMC) Specialist Register. There are six CCTs in psychiatry recognised by the GMC;

- Old Age Psychiatry
- Child and Adolescent Psychiatry
- Forensic Psychiatry
- Learning Disability Psychiatry
- Medical Psychotherapy
- General Adult Psychiatry, with three possible sub-speciality endorsements in;
    - Liaison Psychiatry
    - Rehabilitation Psychiatry
    - Addiction Psychiatry

Endorsement in the subspecialty is approved at the point of gaining a CCT and requires a full year of training in a GMC approved addictions sub-specialty post and completion of the mandated Intended Learning Outcomes (ILO). An alternative route to joining the GMC Specialist Register is available through the Certificate of Eligibility for Specialist Registration (CESR) in which doctors provide a comprehensive portfolio demonstrating their competency and experience which is assessed by a representative of the Royal College of Psychiatrists (RCPsych). At present this only offers the opportunity to include a sub-specialty endorsement to those whose primary qualification is from outside the UK. Addressing this inequity would provide a more flexible route for those who have missed out on addiction psychiatry training during the current drought to gain competence and an endorsement. Addressing the educational needs of SAS

doctors in addiction psychiatry and supporting their progress through the CESR process would increase the numbers of addiction psychiatrists.

The requirement for all psychiatrists to have competencies in Addiction Psychiatry is reflected in the curricula. However, the extent to which this is detailed and considered in each curriculum in a way that makes it clear how and where a trainee would gain these competencies varies between psychiatric specialties, with the Child and Adolescent curriculum having the clearest description.

The RCPsych is currently conducting a revision of all psychiatric training curricula, to be completed by the end of 2020 and implemented in August 2021. The new curricula will meet the new standards set by the GMC[11], and make sure the training programme is in line with the principles of the Shape of Training review[12] to foster flexibility and adaptability across higher medical training. The new requirements signal a departure from providing lists of granular competencies towards areas of capability, with emphasis on the knowledge, skills and attitudes that can be applied to a wide range of circumstances. Dedicated working groups for each psychiatric speciality and sub-speciality are currently working on the individual projects governed by the Curricula Revision Working Group and Associate Dean for Curricula.

The focus of addiction psychiatry has evolved as strategies have moved through harm reduction, criminal justice policy, recovery-oriented systems and now an increasing focus on managing problems which manifest in acute hospital resource usage, novel psychoactive substances, behavioural addictions and the needs of older people with substance use disorders. The curriculum review offers an opportunity to ensure that the standards set for training in addiction psychiatry remain fit for purpose. It presents the opportunity to clearly define the settings in which addiction competencies for all psychiatrists can be learnt. The addiction faculty should contribute to this by reviewing the curricula of other specialities to ensure addiction components are sufficiently represented.

A key role for addiction psychiatrists is in the supporting the management of those with co-morbidity. Many of these people are primarily managed in non-addiction specialist mental health teams. As a result, there are many opportunities for trainees to achieve competencies through activity undertaken in a range of services, including peri-natal mental health liaison, liaison, home treatment, public health teams, and primary care networks. These opportunities can support both the development of competencies required by all psychiatrists in their training, and more substantive placements which could contribute to an endorsement in addiction psychiatry.

Appendix C: Finding – The role of the third sector

The decline in the availability of addiction psychiatry training placements has coincided with an increase in the number of services being provided by organisations that are not part of the NHS family, but companies and charities who provide clinical services. Services are awarded to NHS or third sector providers through competitive tendering, for which local authorities are the lead commissioning agency.

Psychiatry training schemes, as with other speciality training schemes, are commissioned and monitored by Health Education England, Wales Deanery, NHS Education for Scotland (NES) and the Northern Ireland Medical and Dental Training Agency respectively, who enter into contracts with NHS trusts as Local Education Providers, to provide training posts within their services as part of a local and regional scheme which is overseen by the Head of School of Psychiatry in each region. Where services (in England) are provided by third sector providers, this established link between educational commissioning and service posts has broken down. Training posts have been lost entirely and, in some cases, moved to other sub-specialities. The identified drivers of the non-provision of posts in the third sector have been concerns about quality governance, financial resource and instability as services move from one provider to another every few years.

Colleagues in HEE regions and in the third sector have communicated uncertainty regarding training approval of third sector posts. In terms of approval of training posts, the GMC holds a list of all approved programmes and posts. These lists contain individual Trusts, CCG's and associated sites in each region that are part of an approved programme of training. While the list is compiled by the GMC, the GMC relies on regional HEE offices to keep approved programme site lists up to date. Sites can be added to the programme list with relative ease; as long as a training site has gone through local Quality Assurance processes successfully, it can be added to the list of sites within a programme (upon completion and submission of a GMC form B). Once it is on the list, HEE may make a formal visit to ensure agreed standards are being met.

The medical leaders in the third sector are clear about the need to ensure the continued training and provision of addiction psychiatrists (personal communication for this project). They also provide training for other professionals including GP's, nursing preceptors, medical students, nursing and social work students, clinical attachments in psychology and apprenticeships. The aspiration to offer addiction psychiatry training and other training is an important part of their organisational culture and offering, blurring a traditional distinction with NHS services. Meetings with third sector organisations who want to recruit addiction psychiatrists as clinical leads communicated that they did not usually find this easy, a finding which is at odds with the advice given to trainees that there were no posts available.

The point at which a service passes from one provider to another is a key risk time for the protection of a training post. Several attempts have been made to establish addiction psychiatry training posts in third sector organisations. A successful case study is described in Appendix C. An alternative approach is to protect training posts by moving them to a neighbouring NHS Trust as described in Appendix D.

Medical leaders in the third sector have expressed a willingness to better protect posts at this critical phase. There are also examples where the training and education supervision has remained based in an NHS Trust and established post

but a joint post has been created whereby the trainees spends a proportion of the week in an addiction service setting (Appendix A).

Appendix D: Case Study: Setting up a post within third sector service providers

- **Third sector training post set up in 2017**

Turning Point approached HEE regarding setting up a training post to stop the existing NHS Addiction Psychiatry post being rebadged as a General Adult post, something they report has happened previously when they have tried to set up training posts elsewhere.

There was an existing training post within the Trust under the remit of a Consultant when addictions services were provided by the Trust. This consultant was TUPE'd to the newly commissioned organisation, so a new post had to be created and formally approved for training so it could replace the previous post. The consultant moving into the third sector organisation was also important in creating the post.

- **Collaboration between HEE, Trust and Turning Point and Trainee Lobbying**

An essential part of the creation of this post was the open collaboration between organisations following trainee demand. Turning Point noted the importance of trainee lobbying in making partners in HEE aware of the situation developing with the NHS commissioned addictions service and in securing the development of the training post within Turning Point.

- **Pre-approval quality visit by HEE to ensure GMC site approval, therefore training approval**

Training posts have to be approved for training by the GMC who rely wholly on local quality assurance processes to ensure the post is suitable and can meet educational needs. A timely and pre-approval quality visit by HEE provided the necessary assurance that the post met the criteria and quality thresholds and could provide curriculum competencies. The post then went through the usual local approval process; ratification through the STC and School Board. A 'Form B' (example below) was completed and sent to the GMC – at this point it is added to a list of approved placements (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/programme-and-site-approvals)

- **Trainee seconded from Trust to Turning Point**

A Secondment Agreement for Employing, Contracting and Training Placement of Specialist Registrar between Leicestershire Partnership (Employer) and

Turning Point (Host) was agreed. The agreement was signed by Trust Medical Director (Employer) and Senior HR Business Partner (Host)

During each twelve-month secondment the Host pays the employer 50% of the secondee salary, on costs and expenses paid by the Employer, which includes, but is not limited to: Tax, National Insurance and Pension contributions, overtime, leave, sickness, maternity/paternity. The Host refunds the secondee all reasonable travel and other approved expenses and this is also invoiced to the Host at the end of each month.

- **Further Collaboration: Dual responsibility for training**

Trainees get a Clinical Supervisor from Turning Point (the Consultant Addiction Psychiatrist who TUPE'd into the organisation) and an Educational Supervisor through the trust.

Trainees get in-patient and out-patient experience, a wide variety of cases and the post is very popular.

- **The Future of the Post**

Organisations, whether NHS or non-NHS, work very hard to collaborate to set up training posts within third sector organisations that have won tenders to provide services but the reality is that these services will be retendered every two to three years and there is substantial risk that the training post could be lost again in the change. In this case, Turning Point were optimistic that due to their relationships with other providers that they could ensure the post would continue during a retendering process, but HEE could also track this and ensure continuity.

Appendix E: Case Study: Tees, Esk and Wear Valleys NHS Foundation Trust – Losing a training contract and resurrecting training

- What Happened to the Addiction Psychiatry Posts?

The NHS service at this trust lost their contract to provide Addiction services to another provider outside the NHS

- **What were the consequences of this?**

There was an exodus of consultants from the Trust who could no longer work in the NHS addiction service. This had an instant knock on effect on trainees as there was no-one left to train them – there are no agreements between HEE and non-NHS providers with regards to training so if an NHS service is lost, training posts are instantly lost at the same time.

- **How was the training situation resolved?**

At the time, Northumberland, Tyne and Wear NHS Foundation Trust had one specialty trainee and had capacity for more. They also had an Addiction Service.

The local Training Programme Director was aware of the situation at TWV and approached the Clinical Director at NTW in the hope of setting up another training post there in place of the lost posts at TWV.
Another Consultant Psychiatrist at NTW applied to be a trainer so they could feasibly take on another specialty trainee. The training post was then developed by the consultant so that training was maintained within the region.

- **Who were the key people that facilitated this?**

Trainees within the region – There was pressure from trainees who saw the value of Addiction Psychiatry training who approached their TPD
The HEE Training Programme Director – Having a TPD who appreciates the value of addiction psychiatry training with the influence to approach the correct people in order to set up a new training post in another trust was essential.
Consultant Psychiatrists – Having psychiatrists that are willing to take up training positions to increase the number of trainees in an NHS service helped make the post viable.

Appendix F: Split core posts – models for future training

	Hosts	Specialty Split	Roles Split		Roles Split Percentage
1	Camden and Islington NHS Foundation Trust	Psychotherapy Addiction Psychiatry	4 sessions Alcohol/Drug Service 1 Session MRCPsych course 1 Session Academic Meeting	3 Sessions Psychotherapy 1 Session Long Case Supervision	60/40 based on sessions within separate institutions
2	Pavilions, Brighton Sussex Partnership NHS Foundation Trust	Addiction Psychiatry General Adult Psychiatry	4 Sessions Addiction Psychiatry	5 Sessions Ward Work and Recovery Review 1 Session including Consultant supervision, WPBAs, Report Writing, Discharge Summaries	60/40 based on sessions within separate institutions
3	Addaction, Truro Cornwall Partnership NHS Foundation Trust	Addiction Psychiatry Early Intervention in Psychosis	2 - 4 Sessions Addiction Psychiatry (during term time, MRCPsych course takes 2 sessions)	6 Sessions EIP including community work, in house teaching/training, Balint groups and Psychotherapy sessions	60/40 non term time 80/20 term time

Appendix G: Trainee Experience

We conducted a drop-in session for trainees and offered the opportunity to submit written comments and experiences about training in addiction psychiatry or trying to.

The patchy provision and low overall number of training placements has resulted in trainees having difficulty in securing appropriate training, and in some cases being put off seeking it. Trainees have described real difficulties in pursuing a career in addiction psychiatry and the adverse effect that not being able to access addiction psychiatry has had on their overall training. We heard that there is a high level of interest in addiction psychiatry specialty experience and a demand for training that is not being met by the number of addiction psychiatry posts.

We have heard from trainees who have not been able to experience addiction psychiatry in the earliest stage of their career in core training, both because a core post was not available at all and also that it was so competitive that they had not been able to access one despite requesting for many years as an Less Than Full-Time (LTFT) trainee. We heard from another trainee who had struggled unsuccessfully throughout their training to access addiction and was in a region where even special interest opportunities were hard to gain. We heard from trainees who reported that the local third sector organisation was not able to accept trainees and heard about the particular difficulty in accessing an addiction post when pursuing a CCT in forensic psychiatry.

We received two very positive and eloquent descriptions from trainees who described a rich and varied experience of training in addiction psychiatry, covering several different settings and different aspects of the curriculum and a supportive welcoming group of consultants in addiction psychiatry. Both of these reports were from Scotland. We also heard about a very positive experience of varied and high quality training in addiction from a trainee based in an academic addiction psychiatry setting.

Trainees described the adverse effects of a lack of training in addiction psychiatry on their overall competence to manage the complex patients who present to secondary mental health services. Several commented on the need to be well trained in addiction to work in other parts of psychiatry especially working age in-patient units, Accident and Emergency (A&E), and Community Mental Health Teams (CMHTs). We also heard a concern that the lack of widespread training in addiction psychiatry, particularly the neuroscience aspects of the field, contributes to stigma about addiction.

Perhaps most worryingly we heard from trainees that it is hard to prepare for the Clinical Assessment of Skills and Competencies (CASC) exam with no real-life experience in addiction – they felt they were too reliant on books and the mock CASC for an exam which tests their clinical competence. We were saddened to hear from a trainee who had a very positive experience of training at core level but was disheartened with the message they received about a lack of availability of addiction psychiatry posts, having enjoyed the core post and set their heart on

doing addiction psychiatry. Trainees also described receiving career advice not to pursue addiction as a career due to a lack of posts.

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