

Adolescent Forensic Psychiatry Special Interest Group (AFPSIG)
Royal College of Psychiatrists

POSITION PAPER ON DUAL TRAINING

October 2011

Introduction

The AFPSIG is concerned about the reduction in dual training opportunities in child & adolescent and forensic psychiatry over the past 5 years. This paper aims to outline the ongoing need for such training and for this to be actively supported by the College and Deaneries.

Background

The changes to postgraduate training introduced via Modernising Medical Careers (MMC) are relevant in understanding the recent lack of dual training in child & adolescent and forensic psychiatry. The following are of particular relevance:

- The change in training structure, particularly the introduction of run-through training (now redundant for psychiatry) and the indicative term of six years from undertaking post foundation training to achieving a CCT.
- The change in emphasis from duration spent in training to the achievement of competencies (i.e. the introduction of competency based training).

Despite the above potential barriers, there continues to be scope to provide dual training under the MMC framework, as outlined particularly in paragraph 6.32 of the Gold Guide:

'6.32 Where trainees are competitively appointed to a training programme leading to dual certification (e.g. neurology and clinical neurophysiology), trainees are expected to complete the programmes in full and obtain the competences set out in both curricula. Application to GMC for a CCT should only take place when both programmes are complete. The two CCTs should be applied for and awarded on the same date and the expected end of training date for both CCTs therefore becomes the same date.'

The Royal College of Psychiatrists' current position regarding dual training is outlined in a statement dated 2 February 2009 (www.rcpsych.ac.uk/pdf/Dual_training_in_psychiatry.pdf – see appendix). This statement includes the following:

'The College supports the provision of dual training for all trainees who:

- (i) Have chosen to specialise in an area of practice within which the knowledge and competencies associated with acquisition of a CCT in more than one recognised speciality would be essential. Among good examples of this would be consultant posts in Forensic Psychotherapy or Child and Adolescent Forensic Psychiatry.
- (ii) Have indicated to their training deanery at an early stage in their higher training (within 18 months of entering ST4) that they are seeking dual training.
- (iii) Can realistically access the training that would be involved in the acquisition of a chosen dual CCT within their deanery.'

It is unclear why deaneries have not continued to provide dual training schemes in child and adolescent and forensic psychiatry since the introduction of MMC. This is in contrast to many other medical specialities (most notably medicine) where dual training is common.

The case for child & adolescent and forensic dual training

a) Service need and workforce planning

The need for forensic child and adolescent mental health services (FCAMHS) has become increasingly recognised. In recent years there has been an increase in the provision of in-patient forensic adolescent services, both within the nationally commissioned medium secure adolescent in-patient network and within the independent sector. In addition, there has recently been an expansion in community FCAMHS. However, despite the increasing acknowledgment of the benefit of specialised community FCAMHS teams, the majority of UK regions do not have a dedicated service. There is therefore significant scope for further expansion of FCAMHS over forthcoming years and this is being actively considered at a national policy level.

b) Contribution of psychiatrists to forensic child and adolescent mental health services

i) Clinical competence and expertise. The aim of dual training is to provide highly qualified, confident specialist psychiatrists who can negotiate complexity and provide meaningful advice, support, assessment and intervention to young people, their families and clinical colleagues. It is widely accepted that there is a clear need for specialist training in child & adolescent psychiatry and, in adult mental health, in forensic psychiatry. The core competencies for a child and adolescent psychiatrist include some reference to knowledge of criminal justice, risk and the legal system pertaining to young people. However, the complexity of clinical presentations coupled with the multifaceted systems around young people who present with high-risk behaviours or with mental health problems in contact with the criminal justice system, requires specific expertise and knowledge. Such expertise draws on competencies that can best be derived from the in-depth teaching available in both the child and adolescent and forensic curricula. Traditionally a specific five year combined dual training programme (two years child and adolescent, two years forensic and one hybrid year) has been adopted and the AFPSIG regards this as preferable to 'double training' (3 years of each specialism) which takes longer and not benefit from the integrative design of the dual training model.

ii) Clinical leadership. The extensive and varied training required to become a dual qualified child and adolescent forensic consultant psychiatrist provides excellent preparation for the responsibilities of medical and, if required, clinical leadership within an FCAMHS multidisciplinary team. Clear and consistent clinical leadership is particularly important when working with a complex, vulnerable and high-risk patient group.

Recommendations

1. The Child and Adolescent and Forensic Faculty Education and Curriculum Committees should consider the ongoing need for dual trained psychiatrists in forensic child and adolescent mental health services, and work together to promote dual training within the two specialities in order to ensure the ongoing provision of suitably qualified psychiatrists.
2. The Royal College of Psychiatrists should work closely with deaneries to highlight the ongoing need for dual training in child & adolescent and forensic psychiatry. Specific deaneries that have the provision to offer dual training should be identified.

Dr Oliver White, Senior Trainee Representative, AFPSIG

Dr Nick Hindley, Chair, AFPSIG



DUAL TRAINING IN PSYCHIATRY

Although the concept of dual training (within which an ST4-6 trainee is provided with training to acquire the CCT knowledge and competencies involved in two recognised psychiatric specialties) is supported within the Gold Guide, the general tide of change associated with the introduction of run through, fixed length, specialist training has seen a reduction in the availability of opportunities to follow this route.

The College supports the provision of dual training for all trainees who:

- (i) Have chosen to specialise in an area of practice within which the knowledge and competencies associated with acquisition of a CCT in more than one recognized speciality would be essential. Among good examples of this would be consultant posts in Forensic Psychotherapy or Child and Adolescent Forensic Psychiatry.
- (ii) Have indicated to their training deanery at an early stage in their higher training (within 18 months of entering ST4) that they are seeking dual training.
- (iii) Can realistically access the training that would be involved in the acquisition of a chosen dual CCT within their deanery.

The College would not support the provision of dual training to trainees on the basis of their having not decided by ST4 or later which specialty they wish to make their career choice. In the past, for example, a number of trainees followed dual training in Old Age and General Adult Psychiatry largely for this reason.

The College would also not support the provision of dual training as a means of delaying acquisition of a CCT for a trainee who was concerned that they were "not ready" for a consultant post or anxious that no suitable consultant posts were likely to be immediately advertised within their preferred geographical working area.

The College would want to support deaneries in the design of dual training programmes for individual trainees and particular combinations of recognised specialties, the length and content of which would be determined by measured acquisition of relevant competencies and knowledge, rather than by absolute length of training. Thus, it should be possible for trainees to acquire dual CCT competencies and knowledge in less than five years of higher (post ST3) training.

Professor Robert Howard
Dean
Royal College of Psychiatrists

2nd February 2009