

## Editorial

# Danger ahead: challenges in undergraduate psychiatry teaching and implications for community psychiatry

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## Summary

This editorial discusses current challenges faced by educators in undergraduate psychiatry in a community setting. It explores day-to-day difficulties faced by clinical educators and also considers the changing landscape of community services and how this might have an impact on

learning opportunities. We call for efforts to improve undergraduate teaching in community psychiatry.

## Declaration of interest

None.

Reem Abed (pictured) is a general adult community consultant psychiatrist at Northumberland, Tyne and Wear NHS Foundation Trust. She is currently pursuing a Masters in Medical Education at Cardiff University focusing on ways of improving community psychiatry experience for psychiatrists. Andrew Teodorczuk is Course Director for the Mental Health Rotations at the Medical School, Newcastle University. He is also a consultant old age psychiatrist working at the Campus for Ageing and Vitality, Northumberland Tyne and Wear NHS Foundation Trust and an Honorary Senior Lecturer at the School of Medical Education at Newcastle University.

## Background

In theory, community psychiatry experience is an essential component of undergraduate psychiatry placements, the benefits of which include an increased breadth of exposure and an improved understanding of the patient's experience.<sup>1</sup> Furthermore, it provides students with the opportunity to encounter less challenging degrees of mental illness in comparison with the in-patient setting. This is particularly important because some argue that undergraduate mental health teaching should focus on less complex problems in preparation for clinical work as junior doctors and generalists.<sup>2–5</sup> This argument is underpinned by evidence demonstrating that newly qualified doctors lack confidence in assessing and managing common mental health problems.<sup>6</sup>

However, faced with the difficulty of identifying out-patients for clinical encounters, the reality of teacher practice is that we are increasingly reliant upon patients from busy in-patient settings for students' clinical experience. This presents further problems because such patients are likely to have the most severe and complex difficulties, increasing the likelihood of patient fatigue and an unsatisfactory student experience. A secondary default situation is that the occasional teacher may turn patient encounters into a passive experience for students. Many senior clinicians complain they are too busy to teach and it is hardly surprising therefore that students may turn away from careers in psychiatry.

## The impact of newer ways of working on teaching opportunities

To add to the difficulties psychiatry teachers face, significant developments are taking place in mental health services driven by the need to reduce costs but at the same time maintain the quality of patient care. These changes involve ward closures and significant restructuring of community mental health services.

New ways of working have been replaced by even newer ways of working. Community staff now engage in mobile working, which means that they are spending less and less time at the community base and more and more time on mobile solutions (laptop computers).

One of the strengths of psychiatry teaching is to act as a window into the good collaborative practice that is essential in the management of chronic diseases. This is particularly pertinent given the importance of medical students learning about working within a multidisciplinary team that is highlighted repeatedly in *Tomorrow's Doctors*<sup>7</sup> and is emphasised in the Royal College of Psychiatrists' core undergraduate psychiatry curriculum.<sup>8</sup> However, with 'newer' ways of working, the concept of interprofessional working is being eroded in favour of the notion of individuals working in isolation and on the move. These changes are likely to have an impact on the ability of the workforce to accommodate medical students and may lead to a reduction in the meaningful learning opportunities available to medical students which is particularly concerning. With these structural changes to community services also comes uncertainty within the organisation about what services will look like and what exactly the consultant psychiatrist's role will be. This uncertainty is likely to have an impact on medical students' attitudes towards psychiatry as increasingly they struggle to understand what a psychiatrist does.<sup>9,10</sup>

Furthermore, there is an even more pressing need to improve undergraduate community psychiatry experience in light of new Health Education England guidance indicating that by 2017 all foundation year doctors will be required to undertake a placement based in a community setting.<sup>11</sup> Hence it is essential to know how to educate medical students in the community in order to develop foundation year doctors who can operate in the community. Notably training is no longer being shaped by the outdated models of hospital service provision.

## A way forward

In light of the new educational and clinical landscape, we propose that there is an urgent requirement to identify innovative ways of enhancing psychiatry teaching. Mechanisms to improve community psychiatry learning experiences for undergraduates would be a good starting point. Crucially, efforts must be made to ensure that although changes to community mental health services are necessary and inevitable, teaching and learning in these contexts is not forgotten.

Put another way, medical education must adapt to the changing nature of mental health services in order to accommodate the learning needs of medical students. This can only happen if funding for teaching and education is made more transparent and education is resourced appropriately in terms of administrative support and supported time in job plans to allow innovation and high-quality teaching to flourish. Furthermore, close relationships between universities and trust providers must be maintained carefully to keep two separate systems operating together for the sake of the students. Appropriate leverage from local education and training boards (driven by university data of student experience) at board level to increasingly expanding trusts may provide the means to allow this to happen.

We conclude that with challenges there come opportunities and as psychiatric educators it is up to us to respond to them creatively. Teachers must move away from *ad hoc* approaches to teaching psychiatry in the community and out-patient clinics. Rather, students should be exposed to a different educational approach that is planned, structured within systems in the clinical environment, and innovative, enabling students to feel more involved and part of the multi-disciplinary team. Despite organisational changes we cannot afford to sideline medical education; if anything, teaching psychiatry to medical students needs to be prioritised. To do otherwise would be myopic and, in terms of the psychiatrists of the future, could lead to even greater dangers ahead for psychiatry in general.

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