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ANDREW F. TARBUCK, DAPHNE RUMBALL AND STEPHEN M. JONES

Additional clinical experience (ACE) modules in psychiatric specialities for general practice registrars

As part of training for general practice, approximately 40% of junior doctors will undertake a senior house officer (SHO) post in psychiatry (Ratcliffe *et al*, 1999). The majority of such posts will be within general adult psychiatry. As a result of this general practitioner (GP) trainees often receive little exposure to old age psychiatry or child and adolescent psychiatry. Similarly, although trainees will inevitably gain some experience of substance misuse associated with mental illness, there is little opportunity to develop skills in addressing primary substance misuse disorders and there is a clear need to develop better skills in the recognition and management of psychiatric comorbidity (Commander *et al*, 1999).

There is evidence that GPs feel they do not receive adequate teaching in the diagnosis and management of some mental health problems during their training (Williams, 1998). This has been demonstrated most clearly in the area of alcohol (McAvoy, 1997) and drug problems (Abed & Nierra-Munoz, 1990). There are similar findings in the fields of child and adolescent psychiatry (Orr *et al*, 1987) and old age psychiatry (Tinsley *et al*, 1998).

There is evidence that appropriate educational interventions can have a beneficial effect on GPs' ability to manage psychological problems such as drug misuse (King *et al*, 1998).

The aim of vocational training for general practice is to provide a broad base of clinical experience in areas relevant to primary care. The Royal College of General Practitioners encourages the development and evaluation of novel teaching programmes, including, for example, short-term supervised out-patient attachments (Royal College of General Practitioners, 1994). However, a balance has to be struck between providing a broad spread of educational opportunities and ensuring that trainees obtain sufficient hands-on clinical experience in order to consolidate their knowledge. The trainee's contribution to service delivery also has to be considered.

Additional clinical experience (ACE) modules have previously been used in paediatrics to enable specialist registrars to gain extra training in particular areas of paediatric medicine and surgery. One of the authors (S.M.J) initially adapted this idea to the training of GP registrars in child and adolescent psychiatry. Subsequently we have developed modules to provide GP registrars with additional educational opportunities in old age psychiatry and substance misuse.

General structure of modules

The content of each ACE module is flexible and can be tailored to the needs of individual GP registrars. Training requirements are discussed at an initial meeting between GP registrar and consultant, and a suitable educational programme is developed. All three modules have the same basic structure. For each module, over a period of up to 12 weeks trainees are offered a minimum of 6 sessions with different members of the multi-disciplinary team. The supervising consultant provides two or three tutorials and suggestions are provided for further reading. Trainees are given the option of preparing a small project, usually a case report including a critical discussion of some aspect of management with reference to the relevant research literature. The specific learning objectives and structure of each module is given in Box 1.

The aim is to provide basic skills and knowledge relevant to primary care. This includes the presentation and assessment of conditions that are commonly encountered in general practice, knowledge of effective interventions, information regarding referral criteria and the role of the different members within the multi-disciplinary team.

The long-term goal is to improve the knowledge and skills of GPs in the recognition and management of mental health problems occurring across the life span. One of the core aims is to encourage the development of a positive attitude to patient groups that have often been seen as 'difficult' or 'unpopular'. Many GP registrars become principals in the locality in which they have trained and it is hoped that this additional education will have a positive future influence in areas such as referral patterns and commissioning (via primary care trusts).

Findings

The rate of uptake of these placements is high, and trainees have been very positive in their comments. Several

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Box 1. Contents of additional clinical experience (ACE) modules for general practitioner trainees in old age psychiatry, child and adolescent psychiatry and substance misuse psychiatry

	Old age psychiatry	Child and adolescent psychiatry	Substance misuse psychiatry
Experience provided	Community visits with: consultant/SpR (diagnosis and medical management) CPN (role of nurse) community OT (assessment of function) social worker (role of social services) psychologist (cognitive assessment and psychological treatments). Visit to day hospital.	Six or more sessions with different members of the MDT, including experience of the assessment process deliberate self-harm child protection developmental psychology/ psychopathology systemic family therapy hyperkinetic disorder. Non-clinical sessions: MDT assessment meeting psychology seminars open seminars.	Sessions with: consultant/SpR (dual diagnosis) shared-care (GP) specialist nurse (management in primary care) harm minimisation specialist nurse (general health, HIV, hepatitis C and B) criminal justice specialist nurse (social and crime-reduction aspects) clinical drug worker (home and hospital detoxification). Visit to a community-based agency for young people. Visit to a community-based residential rehabilitation facility.
Tutorials	Diagnosis and management of dementia and delirium, including: assessment of cognitive function importance of an informant history role of social services use of medication. Diagnosis and management of depression in the elderly. The referral process and the role of the old age psychiatry services.	Public health issues childhood depression ADHD youth offending. Role of the child and adolescent psychiatrist containment of anxiety diagnosis prescribing Mental Health Act. Models of working in primary health care settings; ideas, concerns and expectations. The referral process/prioritisation of referrals by CAMHS. Reading material supplied at beginning of module.	Engaging drug and alcohol misusers in treatment. Current approaches to management in primary care. Discussion of reading and other issues such as risk assessment and stigma.
Suggested learning objectives	Knowledge of presentation, diagnosis and management of common psychiatric disorders in the elderly. Mental state assessment (including cognitive examination) in the elderly. Understanding of the old age psychiatry service, including the role of the members of the MDT and appropriate referral criteria. Development of a positive attitude towards elderly people with mental health problems.	Knowledge of referral process and the role of the child and adolescent psychiatrist; awareness of how professionals work in CAMHS Tier 3 and of treatments available. Skills of engaging with children, adolescents and families and of writing referral letters. To develop a positive attitude towards learning about the needs of children and adolescents and development of mutual respect and trust between primary and secondary care.	Knowledge of effective interventions in primary and specialist care settings. Development of a positive attitude to the patient population. Basic skills of assessment and treatment.

SpR, specialist registrar; CPN, community psychiatric nurse; OT, occupational therapist; MDT, multi-disciplinary team; ADHD, attention-deficit hyperactivity disorder; CAMHS, child and adolescent mental health services; GP, general practitioner.

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trainees have undertaken two, or even all three, of the ACE modules within their 6-month psychiatry placement. The local general practice vocational training scheme organiser has also been very positive about these additional educational opportunities.

The major problem encountered so far is that of time pressures, both on the part of trainee psychiatrists (GP registrars) wishing to undertake these modules, and on the consultants and other multi-disciplinary team members offering such training. Overall, the educational supervisors in general adult psychiatry have been encouraging and have enabled trainees to be released from their normal duties to attend.

Conclusions

As the popularity of this training grows, we hope that other consultants within our departments will become involved, thus further broadening the educational experiences available. We would like to make structured assessments of those GP registrars undertaking these modules in order to formally assess and refine the effectiveness of this method of teaching. The Royal College of General Practitioners has suggested that vocational training could be augmented with a period of higher professional education during the early years as a GP principal. We believe that our model would offer a very suitable means of delivering such additional educational experience.

It is clear that GPs require and want additional training in psychiatric sub-specialities. We would suggest that the modules described above offer an acceptable and cost effective means of providing this, and could be organised relatively easily in most areas.

References

ABED, R.T. & NIERRA-MUNOZ, E. (1990) A survey of general practitioners' opinion and attitude to drug addicts and addiction. *British Journal of Addiction*, **85**, 131–136.

COMMANDER, M. J., ODELL, S. O., WILLIAMS, K. J., *et al* (1999) Pathways to care for alcohol use disorders. *Journal of Public Health & Medicine*, **21**, 65–69.

KING, M., HINDLER, C., NAZARETH, I., *et al* (1998) A controlled evaluation of small-group education of general practitioners in the management of drug users. *British Journal of General Practice*, **48**, 1159–1160.

McAVOY, B. R. (1997) Training general practitioners. *Alcohol and Alcoholism*, **32**, 9–12.

ORR, D. P., WEISER, S. P., DIAN, D. A., *et al* (1987) Adolescent health care: perceptions and needs of the practicing physician. *Journal of Adolescent Health Care*, **8**, 239–245.

RATCLIFFE, J., GASK, L., CREED, F., *et al* (1999) Psychiatric training for family doctors; what do GP registrars want and can a brief course provide this? *Medical Education*, **33**, 434–438.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1994) Education and training for general practice. *RCGP Policy Statement no. 3*. London: Royal College of General Practitioners.

TINSLEY, J. A., SHADID, G. E., LI, H., *et al* (1998) A survey of family physicians and psychiatrists. Psychotropic prescribing practices and educational needs. *General Hospital Psychiatry*, **20**, 360–367.

WILLIAMS, K. (1998) Self-assessment of clinical competence by general practitioner trainees before and after a six-month psychiatric placement. *British Journal of General Practice*, **48**, 1387–1390.

Andrew F. Tarbuck Consultant in Old Age Psychiatry and College Tutor, The Julian Hospital, Bowthorpe Road, Norwich NR2 3TD, **Daphne Rumball** Consultant Psychiatrist in Substance Misuse, The Bure Centre, 7 Unthank Road, Norwich NR2 2PA, **Stephen M. Jones** Consultant Child and Adolescent Psychiatrist, Bethel Child and Family Centre, Mary Chapman House, Hotblack Road, Norwich NR2 4HN

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