
Consensus statement - Psychiatric services focussed on a community: challenges for the training of future psychiatrists

(approved by the participants at the 4th Meeting of Leaders of European Psychiatry - Geneva, 14th April 2004)

Contextual issues

Throughout Europe, psychiatry in the community continues to evolve both conceptually and in practice, leading to considerable changes of emphasis:

- 1) A much greater emphasis is on providing services that respond to (and are organised around) the needs of service users and family and carers. (In contrast to their needs having to adapt to settings and frameworks dictated by services).
- 2) Services therefore need to be mobile and flexible.
- 3) Inpatient services or alternative residential treatment settings are part of and back up community services (rather than being at the centre).
- 4) Mental health services have become multi-disciplinary and multi-agency with several disciplines and agencies possessing specific skills and competencies.
- 5) Community based treatment services should cover the full spectrum of mental illnesses and disturbances.
- 6) Surveys have shown that patients do not always experience sufficient respect from psychiatrists and they tend to be more distant than other mental health professionals. Mental health professionals themselves (irrespective of discipline) show some features of stigma towards patients. These findings have considerable training implications and need to be acknowledged for both clinical purposes and for the favourable development of the identity of the profession.
- 7) Modern psychiatrists need to be highly trained in all three of the bio-psycho-social aspects of mental health and illness. Biological knowledge and physical treatments are one core component of the psychiatrist's skills. Knowledge of social determinants of illness is a second core component. The third is being able to maintain an ability to relate well to patients and carers and to be skilled and knowledgeable in a variety of psychotherapeutic techniques. (Basic science knowledge has increased considerably in recent years: however what follows will focus more on the context and psycho-social aspects of the identity and training).

The competencies of psychiatrists therefore come under a number of headings:

- A) Clinical treatments
- B) Clinical management
- C) Education and training
- D) Operational management
- E) Research and evidence based practice
- F) Joint working
- G) Leadership

Training implications

- 1) The emphasis of the training of the psychiatrist in the community will vary somewhat according to the resources of the country.
 - A) In low level resource countries, most mental health care should be provided in primary care with psychiatrists being used for training personnel in primary care as well as consultation. The psychiatrist will be more centrally involved in complex cases in the community as well as being trained in hospital or alternative residential care.
 - B) In medium resource countries or areas, this support and training for primary care workers remains important but mainstream mental health services also include outpatient clinics and community mental health centres and day care.
 - C) In high resource countries, additional community psychiatry resources will be added to A) and B). These will include specialist and differentiated mental health facilities focussing on specific problems such as eating disorders, addiction problems as well as early intervention services and assertive community treatments and a variety of vocational training programmes. There will be

more sophisticated alternatives to both acute hospital beds (crisis and home treatment teams) and to those needing long term care (hostels and residential homes).

- 2) Psychiatrists training needs to take place in a variety of community settings especially in primary care so that they will become confident at working flexibly in different environments with colleagues and with the patients and their families. Psychiatrists should be familiar with the legal aspects relevant to community work.
- 3) Psychiatrists need to be trained to acquire skills at multidisciplinary practice and in multidisciplinary team work and in working with other agencies. This involves understanding and being able to manage group dynamics and to know how to partake in shared non-hierarchical decision making.
- 4) Psychiatrists need to train so that they have good skills at negotiating with patients and be able to address and coordinate therapeutic responses to patients' needs and disabilities as well as symptoms.
- 5) Psychiatrists need to train so that they have good skills at engaging families and assessing their burdens and strengths.
- 6) Psychiatrists need a good training in the core psychotherapeutic skills that enable respect and accurate empathy for patients and their families. They should be familiar with and able to manage their own particular emotional reactions to a wide range of personalities, behaviours, feelings and other phenomena encountered in clinical work. Psychiatrists should ensure that psychological treatment skills are available and appropriately organised in the community to treat the whole range of mental disorders that benefit from such approaches.
- 7) Psychiatrists should engage with public groups in discussions that inform them on how their attitudes to patients and families are perceived. Psychiatrists need to be aware of any tendencies in themselves and colleagues to stigmatise patients. Surveys and audit by patients and families and other professionals may be valuable tools at ongoing assessment.
- 8) Psychiatrists should be good at teaching persons from other disciplines and the public.
- 9) Psychiatrists should be able to know how to contribute on the one hand to assessing the mental health needs of a particular population and on the other be familiar with issues connected with globalisation.
- 10) Psychiatrists should be good negotiators of resources for mental health services. The percentage of DALYS (disability adjusted life years) due to neuro-psychiatric disorders is on average 20% worldwide and will rise considerably in the next decade. The percentage of health budgets for these disorders is far less.
- 11) Psychiatrists need to be well trained in evaluating service provision from two domains - that of evidence based medicine and that of the views of users and carers.
- 12) Psychiatrists should participate in life long learning and develop CME training plans that cover the full range of their roles.
- 13) There is a danger that working in some communities in mental health teams could lead to the professional isolation of psychiatrists. Programmes will need to attend to this without encouraging defensive retreat into hospital settings.
- 14) Working in the community must not lead to loss of skills of psychiatrists in contributing to effective and therapeutic wards, residential settings and other alternatives to hospital nor lead to a restriction of the scope of psychiatry as a discipline and a profession (e.g., an exclusive focus on psychotic disorders).
- 15) The community psychiatrist needs skills at working with patients with psychosomatic problems and with colleagues to whom they may present as well as psychiatric complications of medical disorders.
- 16) The organisation and definition of subspecialties within psychiatry will vary from country to country as will the organisation of services according to different age groups of patients.

(We are greatly indebted to Professors Thornicroft and Roessler for presentations that set the scene for our discussions and helped crystallise many of the ideas expressed).