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Ψ2K: What sort of psychiatrist will be required this millennium?

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Initially, psychiatrists in this millennium will be remarkably similar to those available at the end of the last. But then they will change quite rapidly. Generalists will require a wider range of skills, and specialists will need more in-depth and evidence-based knowledge. The twin bases to knowledge of psychiatry during training remain phenomenological psychopathology and psychiatric epidemiology. There will also be a continuing need for training in the sciences basic to psychiatry and in psychology, sociology, and so on. More knowledge will be required regarding running services and assessing one's own and others' performance to meet standards. All psychiatrists should have an excellent facility with psychopharmacology, and expertise in at least one style of psychotherapy with knowledge of when others should be used. Practitioners will be required to collaborate with other mental health professionals, with primary care and with social services. Attitudinal change should result in greater readiness to listen to user and carer opinion, without impairing the practitioner's clinical judgement.

This is all somewhat daunting. However, after we gave a lead in taking continuing professional development seriously, the Government and the National Health Service (NHS) Executive are now catching up and realising that what is called 'lifelong learning' is essential to improve quality of care.

In October last year, the NHS produced its *National Service Framework for Mental Health* (NHS Executuive, 1999). This will, undoubtedly, mould the working practice of psychiatrists over the next few years in the UK. It lists national standards and service models in five different areas:

- Standard 1: mental health promotion
- Standards 2 and 3: primary care and access to services
- Standards 4 and 5: effective services for people with severe mental illness
- Standard 6: caring about carers
- Standard 7: preventing suicide

At the moment, the standards set are disappointingly bland, but perhaps quantification will give them more substance. *Advances in Psychiatric Treatment*, in subsequent issues, will offer advice on ways to achieve the standards, addressed to psychiatrists.

The advantage of setting standards is that people start working hard to achieve them – especially if there are incentives for so doing. One of the disadvantages is that they may stop trying to achieve other important objectives that have not been set as standards.

We will take standard 5, in-patient provision, as an example, because the lead organisation is the NHS trust and lead officer its Chief Executive:

> "Each service user who is assessed as requiring a period of care away from their home should have:
> - Timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public and as close to home as possible.
> - A copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis" (NHS Executive, 1999).

The two goals are obviously valuable and attaining them (access and a discharge care plan) nationally will certainly improve quality of care. However, it is important that psychiatrists make sure that other necessary aspects of care are maintained – a safe environment for different types of patient, competence and availability of essential clinical staff, a range of accommodation suitable for different types of patient, and so on. Perverse incentives can be introduced only too easily by accident.

All the standards are very general and require refining and making more precise. The rationale is

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that if a satisfactory structure is in place, then the quality of care given and the nature of the human interactions between individuals involved are more likely to be beneficial and therapeutic. Establishing standards is a commitment to improving the facilities for their achievement; it is acknowledged that this cannot be done without additional resources.

It is to be hoped that structures to measure and achieve the standards will be set to promote health and to prevent mental illness. However, this is not enough, and this is where we return to the first paragraph. It is essential that the psychiatrist of the present and the future is well-trained, well-motivated and continues to put the needs of individual people, patients, their relatives and friends first. Use of the *National Service Framework for Mental Health* with improved training for all future psychiatrists, better working conditions including an increased ratio of psychiatrists relative to the local population, and continuing professional development directed to the needs of the individual psychiatrist should undoubtedly produce improvements in the service, both nationally and locally.

References

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