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Training matters

Training psychiatrists for work in the community

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Community psychiatry represents a major revision of psychiatric service provision, and although there is currently no consistent body of knowledge upon which training for community psychiatry can be based, in the near future most psychiatrists will be working to a greater extent in the community.

A locally-responsive community mental health service must offer a flexible approach to the traditional aims of managing mental disorder with rapid response, good diagnosis, treatment and follow-up, as well as adequate provision for 'asylum'. In addition the service should be able to deal with other needs of people with mental disorders – such as access to a satisfactory living environment (a home), opportunities to achieve realistic personal long-term goals, and help in obtaining financial benefits.

Psychiatrists need to refine skills of leadership, group management, and supervision of non-medical staff as well as to be able to consider explicitly the resource implications of clinical decision-making. While the multidisciplinary team will be the main means of coordinating care, this group should be flexible enough to include other professionals such as local authority care managers, residential support workers, and the voluntary services as appropriate.

Trainees' experience of community psychiatry

The variety of workplaces and the multidisciplinary nature of community psychiatry can be personally rewarding for junior staff, but training programmes need to take into account problems of isolation (including the difficulty of attending educational meetings) and of time management (especially setting priorities for tasks when time is limited).

Malcolm (1989) has highlighted the practical difficulties of organising further investigations from a base in the community, and noted that time-consuming referrals were made from within the multidisciplinary team when no changes in clinical management were necessary. Higher specialist training in community-based psychiatry at present neglects such issues.

Training schemes

Improvements in psychiatric rotational training schemes have played a part in maintaining recruitment in psychiatry.

A revision of psychiatric training to embrace a community orientation need not result in a break with hospital medicine, but should emphasise the role of the general hospital psychiatric unit and primary care settings as integral components of community-based mental health services.

Trainees need to meet with each other as part of their postgraduate training programme, and greater attention should be paid to consultant support of trainees.

Non-community psychiatry

At all stages, psychiatric training should incorporate work in a variety of community settings. Non-community based psychiatry is not a satisfactory induction to community psychiatry. It may prove to be the case that studying psychopathology with the patient 'in-situ' (in their community) provides the necessary grounding for training in good acute in-patient care.

What is a psychiatrist?

A psychiatrist should be a clinician, a manager, a supervisor, an auditor/researcher and a teacher, and all these skills should be demonstrated to trainees first-hand (Breakey, 1989).

A clinician

A psychiatrist is primarily a clinician. By dealing directly with patients, psychiatrists maintain and

develop their skills and provide a role model from which trainees learn.

Psychiatric assessment needs time if accurate diagnosis, effective treatment, correct prognosis and overall clinical efficiency are to be achieved. A trainee needs the confidence and experience to be able to efficiently apply these skills in many different environments: the patient's home, the GP's surgery, the police station, the day centre, the hospital setting, and even possibly at the patient's place of work or in the street.

A manager/supervisor

Trainees need to be able to take part in the evolution of the organisational structure of their own service as well as understanding those of other community agencies. They need experience in planning and developing a service where the local community's resources form part of the solution.

All multidisciplinary team members need to be aware of the various lines of clinical accountability and supervision. Currently this issue is solved differently by different teams. Local variability depends upon personal working preferences and available resources.

Business failure tends to be valued in financial terms. Failure in a clinical service would be most apparent in terms of human distress or disability.

An auditor/researcher

Medical audit may have the effect of enhancing the clinician's skills in research methods.

Psychiatrists and trainees based in community settings need to liaise regularly with other community-based colleagues to set, monitor and modify clinical standards. This requires a scientific and reasoned approach if the results of their activities are to be suitably reliable and valid.

Non-medical members of the team are often less used to formal presentation of their work and may find the concept of audit more immediately threatening than many medical staff.

Locally responsive services will need valid clinical and epidemiological data from both national and local sources. The development and use of case registers and performance indicators requires experience of the range of local needs as well as experience of the limitations and difficulties of different techniques of data collection. A district wide medico-social mental health information system will require a great deal of discussion and compromise.

Familiarity and access to modern techniques of information technology are increasingly important.

A teacher

Trainers need to ensure that trainees have experience in applying local knowledge, and become involved in all aspects of clinical care – not just in managing medication.

Trainees' early contacts with non-medical agencies – voluntary, statutory, and private – need to be supervised. A greater emphasis upon joint trainee-consultant work has already been stressed.

Formal links with other medical specialties through 'grand round' presentations will become an important peer interface for the medical arm of the community team.

Comment

Training in community-based psychiatry should be viewed as an integral part of all psychiatric practice.

Trainees should be introduced to supervised work with enthusiastic trainers in community-based mental health services from their first placement on a rotational training scheme.

In addition to clinical skills, trainee psychiatrists need to develop a range of skills in management, working with a multidisciplinary team, and in information technology.

Training programmes incorporating local community experience are urgently required.

References

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