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Trainees' forum

Training to stay ahead

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Communities and psychiatrists differ with regard to how they have been 'conditioned' to accept responsibility for caring for the mentally ill. Some are reluctant to change the style of care they have become accustomed to (*Lancet*, 1985). The White Paper (*Community Care in the Next Decade and Beyond*) has emphasised the added 'where/how/who' meaning of psychiatric care: from treatment to prevention, clinical to management skill, and from a position of superiority to one of equality. Some psychiatrists feel threatened by the possibility of a 'non-medical takeover'. Mental health care is not a social service priority and future consultants should equip themselves to take an effective lead in ensuring that adequate resources are made available (Freeman, 1985). Appropriate training opportunities are scarce (Scott, 1988) and we have only two years grace.

I was a full-time community registrar, based in Hartfield Clinic, the mental health centre in Dumbarton, for 15 months. The post offered a wide range of clinical and liaison experience (see Naismith, 1989), but more importantly, experience in what hospital-based training programmes fail to emphasise – the planning, management, co-ordination and utilisation of community mental health care resources.

The football team model of comprehensive community care

The concept of community care is the antithesis of traditional hospital-based psychiatry, where the highest status is accorded to those with medical skills and where attitudes are geared to specialised in-patient treatment. Existing models of community psychiatry emphasise the structure of the specialist psychiatric service which is only one of many appropriate alternatives. The optimal method, intensity and duration of intervention depends on individual need. Services are becoming more autonomous and psychiatrists must learn to share responsibility with others who have traditionally been beneath them in the professional hierarchy. Responsible people with no specialist psychiatric training can cope with quite severe illness, given education, reassurance, and trust in the prompt response of specialised care givers. What matters is that a comprehensive, efficient and effective service is available (Consensus Statement: A Carer's Perspective, 1987).

Teamwork

My model of community mental health care is that of football, where the field extends into the homes of the mentally unwell, and the players are the families and different services and organisations caring, as equal partners, for society's vulnerable members. World-class football matches are won by teamwork, not on the skills of one or two outstanding players.

No single model of mental illness can account for all the inter-related variables which contribute to a complex problem, and no isolated team player has sufficient expertise to solve the problem. Team tactics are good communication, responsiveness and flexibility (Consensus Statement, 1987). Every player needs the respect, support and skill of others.

Learning where/how/who community skills

Some trainees fear insufficient supervision and peer contact in community posts (Scott, 1988). My basic training skills were adequate to deal with problems which required the familiar 'medical model' approach, but, like most, I had only token social work skills, minimal administrative experience, and was unaccustomed to making my own decisions. Working in the community made me acutely aware of these training deficiencies.

What I learnt most from my consultant was how to go about planning, co-ordinating and managing the specialist service, and how to initiate ventures with the local authority and other organisations. What I learnt from other team players more than compensated for lack of peers. The Hartfield team was compact, cohesive, mobile, and supportive. I was

often able to consult problem cases with non-medical colleagues. This was a more useful learning experience than posting a referral letter, and I gained a greater understanding of how the training of allied professionals influences their overall approach.

Discussion

I am optimistic that community mental health care will be effective, but I cannot predict how communities will take to the idea of paying for their mental health care or whether appropriate care will be purchased responsibly. Without adequate resources for all levels of care it is certain that the most vulnerable will suffer unnecessary deprivation.

I am concerned that teaching programmes still stress the acquisition of clinical knowledge and skills at the expense of reinforcing the attitudes of hospital psychiatry, and that even higher trainees have difficulty receiving adequate management training within 'clinical' working hours.

It is worth emphasising that it is not the structure of a community service that matters for training purposes, but the fact that it functions, and provides the required experience.

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Audit in practice

Prescribing patterns in a psychiatric follow-up clinic

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There have been several surveys of prescribing for psychiatric patients (Muijen & Silverstone, 1987; Johnson & Wright, 1990) indicating inappropriate prescribing and a tendency towards polypharmacy. Most studies have looked at prescriptions for psychiatric patients in all settings (out-patients, day-patients and in-patients) in conglomeration rather than just out-patients. Out-patients experience a comparatively lesser degree of supervision (hence a greater risk of non-compliance) and have other opportunities to acquire prescriptions (e.g. through general practice). With this in view a pilot study to observe prescribing pattern in a follow-up clinic was performed.

The study

Methodology for this study has been described in detail elsewhere (Shah & Lynch, 1990) and is briefly summarised here. A pilot study was performed prospectively for two months (November and December 1988) in a registrars' follow-up clinic at a London teaching hospital.

All patients booked to attend the out-patient clinic were included. An itemised questionnaire of the various characteristics of the patients was completed with the aid of the case-notes, interview with the patients, and previous personal knowledge of the patients. The questionnaire included detailed items on current drug prescriptions.

Fisher's exact probability test and the χ^2 test were used to analyse the data.

Findings

The characteristics of all the out-patients and the differences between attenders and non-attenders in