News and notes

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Identity of the European psychiatrist

Since 2001 there have been annual meetings between leaders of European national psychiatric organisations and leaders of the European-wide psychiatric organisations – the World Psychiatric Association (WPA) in Europe, the Association of European Psychiatrists (AEP) and the Union of European Medical Specialists (UEMS) Section and Board of Psychiatry, together with the World Health Organization's European Regional Adviser for Mental Health. In these meetings, nearly all psychiatric leaders have spoken of various difficulties and perhaps threats to the identity of the psychiatrist in contemporary Europe.

Current difficulties connected with the professional identity of psychiatrists stem, on the one hand, from anxieties resulting from the growth, organisation and practice of different modalities of psychotherapy by practitioners who are not psychiatrists and, on the other hand, by reports that the treatment repertoire of other disciplines in the mental health field could include freedom to prescribe certain medications.

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An important meeting of leaders took place in Geneva in May 2004. There was an assumption that the community will be the central focus for mental health services. The meeting directly addressed the changes in approaches and training needed to equip psychiatrists in their role as key members of mental health teams and their development.

A consensus statement was reached as a result of the meeting and subsequent exchanges. It is hoped that the statement will be of assistance:

- in furthering the status and core identity of psychiatry in European countries
- in developing training to provide the necessary skills as psychiatrists carry out their roles with renewed pride, satisfaction and confidence.

The statement, reproduced below, should also assist in developing the contents of programmes of continuing medical education (CME) and lifelong learning, and the development of all psychiatrists.

Consensus statement. Psychiatric services focused on a community: challenges for the training of future psychiatrists

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) In-patient 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 multidisciplinary 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 receive sufficient respect from psychiatrists, who 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 and neuropsychiatry will inform important aspects of all psychiatric practice; however, what follows will focus more on the context and psychosocial aspects of the identity and training.)

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

- Clinical treatments
- Clinical management
- Education and training
- Operational management
- Research and evidence-based practice
- Joint working
- 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:

- In countries with the least resources, most mental healthcare should be provided in primary care, and psychiatrists should train personnel in primary care as well as providing 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.
- In countries with more resources the support and training of primary care workers remain important, but mainstream

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mental health services should include out-patient clinics and community mental health centres and day care.

- In countries with the most resources, additional community psychiatry resources will be added to the above. These will include specialist and differentiated mental health facilities focusing on specific problems, such as eating disorders and 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 acute hospital beds (crisis and home treatment teams) and for 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 of community work.

(3) Psychiatrists need to be trained to acquire skills at multidisciplinary practice and in multidisciplinary teamwork 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 are 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 of 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 for ongoing assessment.

(8) Psychiatrists should be good at teaching individuals from other disciplines and the public.

(9) Psychiatrists should on the one hand know how to contribute 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 proportion of disability-adjusted life years (DALYS) that are due to neuropsychiatric disorders is on average 20% worldwide, but this is expected to rise considerably in the next decade. The proportion of health budgets allocated 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 lifelong 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) Community psychiatrists need the skills to work well with patients with psychosomatic problems and with colleagues to whom such patients may present, as well as with the psychiatric complications of medical disorders.

(16) The organisation and definition of sub-specialties within psychiatry will vary from country to country, as will the organisation of services according to different age groups of patients.

Brian Martindale

(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.)

Island of Kos Declaration (on Iraq)

The participants of the Panhellenic Congress of Psychiatry meeting on 14–18 May 2004, on the Hippocratic Island of Kos,

In the company of leaders of the World Psychiatric Association, of the American Psychiatric Association, and of over 20 other national psychiatric societies from Eastern Europe, the Balkans and beyond,

Upon receiving a report presented by the president and the secretary general of the Iraqi Society of Psychiatrists expanding on international media reports,

And in line with our professional and ethical responsibilities to protect and promote mental health across the world,

(1) Express concern about the recently documented abuse of detainees at Iraqi prisons, involving deeply humiliating and culturally degrading interrogation and mistreatment practices. There is well-established evidence of the long-standing harm of such practices to the mental health of victims and perpetrators and their families and communities;

(2) Also express concern about the amply documented loss of life and threat to general and mental health of the Iraqi population;

(3) Express solidarity with our colleagues of the Iraqi Society of Psychiatrists, who have reported the deeply disturbing conditions of insecurity and deprivation of professional means, including basic medicines, currently prevalent in Iraq, which are impeding their minimally meeting professional obligations with the population at large;

(4) Call on all governments involved to act urgently to stop the degrading practices at the Iraqi prisons, and the World Health Organization, World Psychiatric Association Member Societies, and other pertinent mental health organisations to assist our Iraqi colleagues with the basic professional means they require for the fulfilment of their fundamental responsibilities.

The College has given its full support for the Island of Kos Declaration.

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