Community Psychiatry

Resident Training in Community Psychiatry

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Abstract: Community psychiatry is becoming a more common component of psychiatric training programs, with most Canadian residents reporting that they had received some training in the field. Yet, to date, there are no clear standards for training that have been accepted across the country, nor is there even an accepted definition of the term. In this paper, I offer a framework for training residents in community psychiatry that may respond to the areas previously identified as problematic. I hope this will begin the process that leads to national standards for the training and practice of community psychiatry.

Résumé : Formation de résidence en psychiatrie communautaire
La psychiatrie communautaire devient une composante plus fréquente des programmes de formation en psychiatrie; en effet, la plupart des résidents canadiens déclarent avoir reçu une certaine formation en la matière. Pourtant, à ce jour, aucune norme de formation définie n'a été acceptée dans tout le pays, pas plus qu'il n'y a une définition reconnue du terme. Dans cet article, je propose une structure à la formation des résidents en psychiatrie communautaire qui peut répondre aux régions déjà désignées problématiques. J'espère que cela entamera le processus qui mènera à des normes nationales pour la formation et la pratique de la psychiatrie communautaire.

Key Words: community psychiatry, education, program development, psychiatry resident

Over the past decade, the field of community psychiatry has become an accepted and respected part of the curriculum of many Canadian psychiatric training programs. However ubiquitous it may now be, the formal process of such training is hampered by the lack of a clear and concise definition of community psychiatry and by the lack of nationally accepted training guidelines in the field. Although the Royal College of Physicians and Surgeons of Canada is gradually accepting the idea of subspecialization for psychiatry, we community psychiatrists have not yet developed standard training and practice guidelines.

At the 2001 Annual Meeting of the Canadian Psychiatric Association (CPA), I chaired a symposium on issues in training residents to become community psychiatrists (1). It became clear in discussion with the audience that, while a lack of formal guidelines fosters creativity on the part of program directors, it also has an adverse effect on the quality of the training experience. In 1993, Goldman and others surveyed all major American training programs and found that training in community psychiatry was a highly variable experience (2). Of residents who responded to the survey, 61 per cent reported being trained in community psychiatry, whereas only 40 per cent of these programs offered formal training. Understandably, there was a wide discrepancy in their conception of such basics as the definition of community psychiatry. Residents identified that having experienced and positive role models as supervisors and having well-organized training experiences were important qualities for successful training. More recently, Freeland and others surveyed Ontario training programs to understand resident perspectives on training in community psychiatry (3). They found that 39 per cent of residents reported that their programs had a required rotation in community psychiatry, and 96 per cent were offered an elective rotation. Didactic teaching was offered to 78 per cent of resident respondents. To improve training in the field, residents suggested promoting training opportunities, improving the quality of supervision in community settings and providing more didactic teaching. Residents were also more likely to define community psychiatry in practical rather than in conceptual terms, (that is, home visits rather than advocacy), which reflects a narrow misrepresentation of the reality of community psychiatry.

In this paper, I propose training guidelines for Canadian residents who study community psychiatry. Although the CPA community psychiatry section has not formally adopted these guidelines, they have been and will continue to be discussed and debated. We hope that they will serve as a point of further discussion among training

directors and that they will assist in developing more coherent and comprehensive training experiences.

Definition of Community Psychiatry

No standard definition of community psychiatry exists; however, such a definition must encompass conceptual issues, such as philosophy of care, and more practical issues, such as service delivery. The community psychiatrist is much more than a psychiatrist who makes house calls. In 1993, the American Association of Community Psychiatry provided the following definition: "a branch of psychiatry which emphasizes the integration of social and environmental factors with the biological and psychological components of mental health and mental illness" (4). It proposed that community psychiatry be understood as having four components: clinical, consultative, administrative and academic.

The clinical component stresses the understanding of patients within their sociocultural context and strives for optimal enhancement of functioning and recovery, using interventions and resources within the patient's social environment. Practice is ideally situated in a well-organized and easily accessible setting, either urban or rural, wherein multidisciplinary care is available and encouraged.

The consultative component places the community psychiatrist in the role of direct and indirect provider of psychiatric expertise to colleagues, multidisciplinary health care providers, community resources, patients and families. An underrecognized role is that of public educator and consultant to public agencies involved in the development of services, systems and public mental health strategies.

Similarly, the administrative component involves the community psychiatrist in developing, implementing and supporting a comprehensive and coordinated network of mental health services in a given community. Intrinsic to this is participation in needs assessments and decisions concerning allocation of resources, to ensure available and accessible psychiatric care for those in need.

Finally, academic community psychiatry is centred in an academic department and emphasizes competency in teaching, training and research in such diverse areas as health care systems, service delivery, barriers to treatment, special needs populations (for example, the homeless) and the social and environmental impact on illness and recovery. Academic initiatives should include collaboration with public and government agencies, community and family organizations and patients, who will be the ultimate beneficiaries of such work.

Structure of the Training Experience

In 1988, Factor and others described the key elements of a model community psychiatry curriculum (5). These include "1) specific learning goals, 2) working within an effective treatment system with high quality clinical rotations, 3) good role models, 4) high quality psychiatric supervision, 5) a well-grounded didactic program and 6) high quality clinical rotations." These elements are the foundation for a successful training program.

In addition, one specific requirement states that only faculty who are experienced and knowledgeable role models affiliated with the university should supervise trainees. Programs may rely on local staff for remote placements; however, there must be central supervision by psychiatric faculty. The clinical program should have a well-defined mandate and population served, and the clinical care should be delivered in collaboration with multidisciplinary staff, wherever possible. Finally, although much of the experience should involve direct patient care, trainees should also have significant exposure to indirect clinical or nonclinical aspects of community psychiatry. Time for such activity must often be carefully protected by program directors and respected by supervisors.

Further, Brown and others describe more specific objectives for training, subdivided into the familiar format of knowledge, skills and attitudes objectives (4). These have been reviewed and adapted to relate more directly to training based in Canada.

Knowledge Objectives

Didactic teaching should include the history of the development and current state of community mental health concepts, federal and provincial health legislation, and model systems of mental health care delivery. Faculty should teach the basic concepts and major research findings of psychiatric epidemiology and medical sociology, along with a general understanding of the health economics that pertain to psychiatric practice, including the use of epidemiological, clinical outcome and cost-effectiveness data in the design of mental health care delivery strategies.

Moreover, residents should develop a practical knowledge of differing attitudes, values and social norms prevalent among various economic, cultural and ethnic groups. In addition, they should develop a basic understanding of the impact of these upon illness and recovery. A working

understanding of the principles and processes of support systems and social network interventions should include practical knowledge about agencies in the community that provide financial, vocational, medical, legal, child care, housing and other supportive services. Finally, residents should understand the impact of severe and persistent mental illness upon those living in the community, including housing, vocational, comorbidity, safety and general health issues.

Skills Objectives

As community psychiatrists, residents must learn to work effectively in various roles. For example, at different times, the resident must function as physician, psychiatrist, consultant, educator, case manager and team leader. This entails clinical, as well as basic leadership skills; specifically, informal supervision of services provided by mental health clinicians from various disciplines. It involves working effectively with community-based primary health care providers in a shared care model. Residents must have the capability to work as part of a multidisciplinary team, ideally in a community-based program that serves psychiatric patients.

Specific clinical skills include the ability to assess patients within the context of community and environment issues that affect patients and their families (for example, housing needs, entitlements, income and availability of community resources) and to assess the impact of other social factors, such as stigma, education, poverty, the proximity of violence and drug use. Interventions should be developed within this context, with an emphasis on maintaining the least restrictive treatment approaches—ones that are closest to the patient's natural environment.

Attitudes Objectives

Residents must display appropriate respect for and sensitivity to ethnic and cultural values of patients, families and community members. Beyond that, they should appreciate the richness of the patient's life and community and express a willingness to learn from the encounter. Their behaviour should reflect concern for the well-being of patients, families and the community as a whole. Finally, residents must show respect for the opinions and attitudes of patients, families, advocates and all partners in care, including both professional and nonprofessional personnel. Frequently, residents must balance diverse points of view in a respectful and considerate manner.

Conclusion

The preceding does not describe any one specific training program, but it does attempt to build a framework for developing a community psychiatry training experience. I have attempted to respond to residents' concerns, expressed in the two reported surveys, wherein the need for such structure was described.

Community psychiatry is a broad and exciting field. With proper program development in which teaching standards and training objectives are clearly delineated in advance, the experience can be an enriching and inspiring opportunity for residents at any level of training.

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