

Special article

Wake-up call for British psychiatry

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Summary

The recent drive within the UK National Health Service to improve psychosocial care for people with mental illness is both understandable and welcome: evidence-based psychological and social interventions are extremely important in managing psychiatric illness. Nevertheless, the accompanying downgrading of medical aspects of care has resulted in services that often are better suited to offering non-specific psychosocial support, rather than thorough, broad-based diagnostic assessment leading to specific treatments to optimise well-being and functioning. In part, these changes have been politically driven, but they could not have occurred without the collusion, or at least the acquiescence, of psychiatrists. This creeping devaluation of medicine disadvantages patients and is very

damaging to both the standing and the understanding of psychiatry in the minds of the public, fellow professionals and the medical students who will be responsible for the specialty's future. On the 200th birthday of psychiatry, it is fitting to reconsider the specialty's core values and renew efforts to use psychiatric skills for the maximum benefit of patients.

Declaration of interest

All authors are members or fellows of the Royal College of Psychiatrists and currently work within, or have recently worked within, the UK National Health Service. We hope that both of these organisations will be influenced by this paper.

British psychiatry faces an identity crisis. A major contributory factor has been the recent trend to downgrade the importance of the core aspects of medical care. In many instances, this has resulted in services that are better suited to delivering non-specific, psychosocial support rather than a process of thorough, broad-based diagnostic assessment with formulation of aetiology, diagnosis and prognosis followed by specific treatments aimed at recovery with maintenance of functioning. These changes have been driven in part by government, but there has been both active collusion and passive acquiescence by psychiatrists themselves. Our contention is that this creeping devaluation of medicine is damaging our ability to deliver excellent psychiatric care. It is imperative that we specify clearly the key role of psychiatrists in the management of people with mental illnesses.

Psychiatric illness and 'mental health'

How many of us have, in clinical discussions, been aware of uneasiness in colleagues in defending 'the medical model of care'¹ or been the only one using the word 'patient' when discussing service delivery or planning? However, despite the recent misguided tendency by many to caricature a medical psychiatric approach as being narrow, biological and reductionist, we are struck by how keen other members of staff are for themselves or their relatives to be seen by an experienced psychiatrist when mental illness affects them. Moreover, when patients were asked how they would prefer to be described by a psychiatrist, 67% preferred 'patient' and only 9% preferred 'service user'.² This disjunction cannot be a healthy state of affairs and aggravates public and health professionals' difficulties understanding psychiatric illness and the psychiatrist's role.

One key issue is that the concept of mental illness has broadened considerably since Reil first coined the term psychiatry 200 years ago.^{3,4} As a result, many people with mild psychiatric

symptoms have developed exaggerated and unrealistic expectations of psychiatry. Indeed, psychiatric services may not be best placed to manage the majority of individuals with such mild symptoms, who would be better served by other more general services. It is probably in the best interest of such individuals to avoid medicalising both the terminology and the type of help that they may require or want.

Certain circumstances do, however, require professionals with medical training to diagnose and treat underlying psychiatric or non-psychiatric physical disorders. Further, those with severe mental disorders can and do benefit from the process of a medical psychiatric assessment, diagnosis and treatment.^{5–7} For those with severe mental illness, to avoid medicalisation is at best confusing and at worst damaging or even life-threatening. These individuals, the very people for whom Reil argued that psychiatry was needed,^{3,4} are being let down by the current state of affairs. These considerations about the nature and breadth of psychiatry bear upon the fundamental issue as to where its appropriate boundaries lie, and whether practitioners can and should continue to try to span such a broad spectrum of skills, knowledge and interests.⁸

We have spoken naturally about psychiatrists treating mental illness: use of the term 'mental *health*' to describe services for those with mental *illness* risks undermining the real importance and impact of these conditions on patients. The recent renaming of one Welsh trust's psychiatric out-patient clinic to 'Mental Health Well-Being Clinic' takes this confusion one step further. Using such terminologies may in turn undermine the priority of psychiatric illness for health commissioners and politicians. Psychiatry is more or less alone among medical specialties in the extent to which it has adopted this approach that so distorts its original purpose.

The influences that encourage demedicalising the care of those with severe mental illness are legion and apply in part to other fields of medicine. They probably include political drives to cut

costs, interprofessional rivalries, the scepticism of some psychiatrists towards biomedical explanations of illness⁹ and service development predicated on the false assumption that severe psychiatric illness equates only to chronicity and poor treatment response.¹⁰ The net effect of these influences, however, is the same: to obstruct our primary medical duty towards patients with severe psychiatric disorders. Hence, it is imperative that we take action to ensure that patients with mental illness are not disadvantaged compared with others within the National Health Service (NHS).

Patients have a right to expect more than non-specific psychosocial support

The drive within the NHS to improve psychosocial care for those with mental illness has been both understandable and welcome: evidence-based psychological and social interventions are extremely important in managing psychiatric illness. However, an unintended adverse effect is that there is an increasing tendency for many services to be based on non-specific psychosocial support with extremely limited therapeutic ambition.¹⁰ In order to follow clinical guidance (such as that provided by the National Institute for Health and Clinical Excellence (NICE))⁷ to develop excellent 'mental health' care (for those with mental illness), it is important to recognise that a biomedical component, with access to appropriate facilities and appropriate service pathways, is usually crucial. Many recent NHS changes, including, for example, those outlined within the National Service Framework for Mental Health,¹¹ have provided an extensive discussion of important generic issues, including social inclusiveness, stigma and access. What they have not done, however, is to place sufficient weight on medical fundamentals such as the need to distinguish the major forms of mental disorder, the implementation of appropriate evidence-based treatments, the subsequent monitoring of mental state for optimal outcome and the importance of addressing the physical morbidity and mortality associated with almost all types of psychiatric illness.

For example, in some crisis intervention teams, the focus on the general practicalities of a crisis can lead to patients not receiving the benefit of a thorough diagnostic assessment at the time of acute illness. The effect of this may be to have a negative impact on the outcome of the acute episode. Even if the episode resolves, lack of a thorough diagnostic assessment, including physical examination and investigations, may result in inappropriate, suboptimal or ineffective management between episodes and a failure of relapse prevention. Such a scenario could have major consequences for the life experiences of the patient as well as implications for 'service costs'.

One of the great strengths of medicine, when practised well, is its focus on making a demonstrable difference for the patient and its willingness to be pragmatic in using whatever approaches are shown to be effective. We should seek to minimise the unhelpful influences of political idealism or rigid adherence to particular schools of practice or thought and must strive to ensure that the effectiveness of all therapeutic modalities is judged using similar standards of evidence.¹² We must face up to our professional responsibilities to ensure that *all* aspects of management are as good as possible. This includes advocating the maintenance of the skills, facilities and resources to provide excellence in biomedical care for patients with psychiatric illness. Given our training and our statutory position as prescribers of medication, psychiatrists have a particular responsibility to ensure that pharmacological interventions as well as other interventions are used appropriately and according to the best available evidence. We must not

contribute to stigmatising and disadvantaging psychiatric patients by denying them access to treatments that work.

Patients referred by their general practitioner should be assessed by a named psychiatrist rather than an anonymous team

Psychiatry is a medical specialty. We believe that psychiatry should behave like other medical specialties. When a general practitioner is confident that a psychiatric assessment is *not* needed, it should be possible for a referral to be made directly to a relevant non-psychiatric professional. However, where the general practitioner is unclear about diagnosis or treatment, the patient should be assessed by the most appropriately skilled and experienced professional on the team, the psychiatrist. This is analogous to managing back pain, where in many instances a general practitioner is confident that a medical orthopaedic opinion is not needed and will refer directly to a physiotherapist or an alternative therapist such as an osteopath or chiropractor. However, in severe, persistent or otherwise complex cases an orthopaedic referral should be made, because an assessment by an orthopaedic surgeon is required to ensure accurate diagnosis and exclude or treat causes that are remediable, thereby improving the patient's quality of life and minimising the risk of complications such as paralysis.

In psychiatry, it is psychiatrists, who are trained in diagnosing physical and mental illness, who are competent to formulate diagnoses that incorporate physical, mental and social factors and, where appropriate, recommend initiation of one or more of a range of possible medical treatments. As in other medical specialties, initial assessment may also involve important contributions from other non-medical members of the team, and may include relevant medical investigations such as blood tests or imaging investigations. Assessment, in many cases, may lead the psychiatrist, as a leader in the clinical team, to conclude that the most suitable treatment is a psychological or social intervention delivered by the member of the team with the most appropriate skills. This approach allows the patient the benefit of a thorough, broad-based assessment by a highly trained professional in order that the most appropriate management is implemented at the earliest opportunity.

This approach contrasts in important ways with an alternative model advocated in the move to New Ways of Working.¹³ This is an initiative developed jointly by the UK government's National Institute for Mental Health in England and the Royal College of Psychiatrists. The report *New Ways of Working for Psychiatrists: Enhancing Effective, Person-centred Services through New Ways of Working in Multidisciplinary and Multi-agency Contexts* claims to be 'about a big culture change; it is not just tinkering at the edges of service improvement'. Within the New Ways of Working model of distributed responsibility and leadership, a secondary care patient may never see a psychiatrist or may see one only when problems are identified by other team members. This means that many patients will not benefit from a thorough psychiatric diagnostic assessment before starting treatment. Given the complex relationship between psychiatric and non-psychiatric disorders,¹⁴ and their common co-occurrence,¹⁵ providing sub-optimal or inappropriate treatment may have detrimental consequences for patients. For example, a patient may receive psychological therapy for symptoms best treated pharmacologically, or caused by an unrecognised treatable organic condition; or, potentially just as damaging, a patient may continue on inappropriate medication when, with correct assessment, a psychological or social intervention would have been indicated.

It is easy to understand how we have arrived at the model of distributed responsibility and leadership as a pragmatic, short-term response to recent crises in staffing and morale in general psychiatry.^{16–19} However, we should not assume that this pragmatic emergency ‘solution’ is an ideal, or even desirable, state of affairs.²⁰ Although distributed responsibility may make life easier for psychiatrists and appears to be the cheaper option, it does not follow that this is in the best interests of patients. Should we not be arguing for better evidence-based services and the resources and workforce to deliver these services?

We suggest a useful thought experiment: if a member of your family were a patient, is a distributed responsibility model the one for which you would opt?

Recruitment into psychiatry

One of the major problems confronting contemporary British psychiatry is difficulty with recruitment into, and retention within, the specialty.^{21–24} Reil argued that only the best doctors should become psychiatrists. We would assume that the most able, broad-minded and enthusiastic students, who may become the best doctors, would be attracted to specialties in which it is clear that they are able to make best use of their skills and knowledge within a service that values their extensive broad-based training. Would such individuals be attracted to a specialty in which skills that have been acquired over a long period of training are at a high risk of early disuse atrophy? In this context of a devaluation of specialist medical skills, it is commonplace in the UK to hear non-psychiatrists – and frequently psychiatrists themselves – referring to psychiatrists as not being ‘proper doctors’. This lack of professional confidence and self-confidence contributes to the retention problems in psychiatry.^{25,26}

In contrast to this negative view, it is much more accurate, and fully consistent with Reil’s original suggestions, to think of psychiatry as being the only specialty in which its practitioners are fully trained doctors, incorporating psychology and social-based knowledge and skills as major components of training. The absence of such skills in other medical specialties is a common cause of patient dissatisfaction. It is interesting to note that the distinguished neurologist Henry Miller said: ‘the psychiatrist must be first and foremost and all the time a physician . . . In fact, psychiatry is neurology without physical signs, and calls for diagnostic virtuosity of the highest order . . . The simple fact (is) that a psychiatrist is a physician who takes a proper history at the first consultation.’²⁷ Indeed, Henry Miller went one step further in emphasising this polymath function: ‘the psychiatrist should not only first be a physician but ideally a superlative physician.’²⁸

To embrace this more positive and self-confident view of psychiatry would, of course, require a commitment by psychiatrists to aim for excellence in the core medical aspects of their role. This would include excellence in the prescribing of psychotropic medications as well as maintaining and developing expertise in the relevant aspects of assessment and management of the non-psychiatric illnesses that so commonly co-occur with psychiatric disorder and which are associated with decreased life expectancy of psychiatric patients.^{14,29} Although this may not appeal to some practising psychiatrists, it is interesting to note that consultants are much more likely to believe that recruitment problems arise because our specialty is ‘too psychosocial’ rather than ‘too biological.’²⁶ Whatever the personal preferences of some current psychiatrists, for the sake of the health of our patients²⁹ and our specialty we need to ensure that these skills are expected of future psychiatrists.

All too often in British psychiatry, thinking is dominated by the need to respond to the short-term practical constraints of whatever initiative is current at the time. However, as a profession we should be thinking with a longer-term vision of the needs of patients with psychiatric illness and how those can best be delivered now and over the coming years. Such strategic thinking should inform the profession’s advice to the health service and government as well as shaping training and recruitment initiatives for the specialty.

The future

It is hard to imagine that psychiatry will not assume increasing importance over the coming decades. Mental illnesses are, and will continue to be, major causes of human suffering and mortality. Mood disorders on their own are predicted to be second only to ischaemic heart disease as a cause of disability across the globe by 2020.³⁰ Major advances in molecular biology and neuroscience over recent years have provided psychiatry with powerful tools that help to delineate the biological systems involved in psychopathology and impairments suffered by patients.³¹ We can be optimistic that over the coming years these advances will facilitate the development of diagnostic approaches with improved biological validity and enhanced clinical utility in terms of predicting treatment response. We can expect that completely novel treatments will be developed based on detailed understanding of pathogenesis.³¹

With this, we need to have appropriately skilled and knowledgeable psychiatrists working within services that can accommodate the processes of diagnosis and management involved. Patients should expect prompt and accurate diagnosis followed by implementation of appropriate evidence-based treatment – much as is expected by the cardiology patients of today. We can anticipate that this will involve biological and psychological tests and neuroimaging as well as detailed clinical assessment (analogous to the enzyme tests, exercise electrocardiograms and cardiac perfusion studies that currently constitute assessment of cardiac patients). Psychological and social interventions will, of course, continue to be crucially important in managing psychiatric illness (as they are also in non-psychiatric disorders). However, in addition, patients have the right to expect that biological factors are fully considered and, where appropriate, evidence-based interventions delivered.

Conclusion

A great deal has changed in the 200 years since Reil introduced the term ‘psychiatry’ into medicine. It is a welcome advance that current management of psychiatric illness seeks to take a broad approach to care, embrace the benefits of multidisciplinary working and make optimal use of the skills of our colleagues trained in other disciplines. However, in recent years changes in psychiatric practice and thinking within the UK NHS are in danger of throwing the baby out with the bathwater. This is now to the potential disadvantage of many of our patients. Unless steps are taken to redress this balance we believe it will not be possible to translate the improving scientific understanding of psychiatric illness into clinical benefits for patients. There is a very real risk that as the understanding of complex human diseases steadily increases, recent moves away from biomedical approaches to psychiatric illness will further marginalise patients in comparison with those suffering from physical illness.

We believe it is fitting that, on the 200th birthday of our specialty, we should reconsider our core values and renew our

efforts to use our psychiatric skills to the maximum benefit of our patients. Psychiatric patients deserve nothing less.

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