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Psychiatry in the future

The good, the bad and the boringly likely

As a general adult consultant psychiatrist who has worked full-time in the National Health Service (NHS) for 15 years, I have seen that things do change, but rarely in the ways expected or planned for. Having done the same job for six different reconfigurations of local services, I can confirm that reorganisation is largely irrelevant. However, new treatments (such as selective serotonin reuptake inhibitors and atypical antipsychotics) and new buildings, along with enthusiastic staff, can be seen as genuine advances. Changing social attitudes, in particular the rise of morbid individualism and an increasingly virulent, reactionary anti-science lobby, alongside sheer social overcrowding and pollution, do bring fears for the future. Community care has become a joke term rather than a watchword for acceptance of the stigmatised among 'normal' society. Three visions are possible: the dystopian, the normotopian and the utopian, looked at along the biopsychosocial spectrum.

Dystopia

From the biological perspective, our new drugs might prove disastrous, with severe forms of brain damage or metabolic side-effects worsening outcomes in schizophrenia. Likewise, the effects of HIV or variants thereof (to be expected, given its mutation potential), alongside (for example) the damage done by deranged genetically modified crops, organic pesticides or the pollutants of global warming, could lead to new forms of psychiatric disorder. Rising levels of stimulant, alcohol, sedative and appetitive (e.g. sugar, chocolate) substance misuse could generate chronic forms of uncontrolled anxiety and aggression, particularly in adolescents. Psychologically, the demands of the 'worried well' could lead to forms of 'speed therapy' (one instant session, no payment unless successful), or psychotherapy being available in supermarkets or even roadside beggars who will 'emote for food'. In social terms, mass unemployment, psychiatrists deployed only in jails, and the banning of coffee, alcohol, sugar and tobacco (enhancing the jail population to gulag-class proportions) will accompany the use of forced training camps for the obese or psychotic. Psychiatrists will have as much status as garage owners, community mental health teams will be managed by the police and paperwork will be ubiquitous.

Normotopia

This future would see little change from now. Perhaps drinkable coffee in NHS hospitals, clean carpets and non-malfunctioning information technology systems might emerge. Current medications would be used as now, but more judiciously, with better understanding of combinations and side-effects. We might have been enabled to identify anxious somatisers before they swamp general medicine clinics. This will depend on whether the Royal College of Physicians makes its trainees do some formal postgraduate psychiatry. From the organisational point of view, there might even be a professor of obesity psychology. General psychiatrists will continue to be seen as the displacement resource for patients unwanted by other psychiatric specialties, but they might be paid a bit more money because of this. The National Institute for Clinical Excellence guidelines will have long since rotted away.

In social terms, normotopia would view football stadia as potential bases for community mental health teams, which would still be seen as relatively useful. More likely than not, these would have reabsorbed the assertive outreach, early intervention and crisis intervention teams, their demise due to the classic combination of boredom and burnout. Psychiatry will still have a street-cleaning function, but with better machines. The sensible reintroduction of benzodiazepines and tricyclic antidepressants, intelligently used, would have been accompanied by their re-patenting, thanks to new laws generated by the psychopharmaceutical companies.

Utopia

From the biological treatment point of view, there will be defined biochemical (and/or radiological, using new-wave magnetic resonance imaging scanners) tests for schizophrenia, bipolar disorder and panic disorder. These might include some heroic dynamic testing (as one does with

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insulin stress testing in endocrinology), giving trainee psychiatrists some edge. There would be an anti-heart-sink pill, effective against the panicking health-anxious somatiser, given in combination with a highly-specific form of cognitive therapy that only psychiatrists could deliver thanks to their training, making psychiatrists the highest paid of all NHS consultants. A polypill, able to treat the combination of psychosis, substance misuse and personality disorder, with an add-on for those with learning disabilities, would routinely be in use. Laser-based implants, entirely safe but maintaining appropriate levels for at least a year, would overcome the problems of compliance.

In psychological terms, counsellors would retrain as friendship developers, and be able to make friends and maintain friendships with their patients. Self-therapy practices would be developed, and brief courses of intensive insight awareness, using computer technology, would reinforce this. Brief therapy training would be routine for all nurses, on wards and community teams, and even in primary care.

All Arts Council projects would have to have a patient with bipolar disorder attached, to ensure sufficient creativity. Hospitals would be like smart hotels, with convalescent units enabling a graded and humane return to living at home. Psychiatry, along with common medical topics, will be taught routinely in schools, with the near-elimination of stigma, and psychiatric nursing will have become a sought-after and well-paid career. The legalisation of illicit drugs would enable custodial funding to be switched to therapy-based programmes, with major benefits, and a new Mental Health Act will have ensured patient rights alongside empowered relapse prevention.

Conclusions

No one ever gets the future right, and if someone did people would resent it. What is sure is that something entirely unpredictable will happen, leading to profound effects in the system. For example, tuberculosis hospitals melted away in the 1950s because of public health incentives and antibiotics, and one effective anxiolytic could lead to the demise of brief interpersonal therapies. The decline of psychoanalysis (very much a 20th century construct, like phrenology in the 19th century), the likely return of the asylum in various disguised forms and major advances in information technology will all have an impact. However, overall, I expect I shall be talking to patients, in an office, somewhere in London, in something like my tenth reorganisation (judging by past ones), generally being of some help. The real question is, will I have had any time off from clinical practice and paperwork to effect any pro-utopian changes?

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