

‘Public psychiatry’: a challenge for the profession?

INVITED COMMENTARY ON... ‘PUBLIC PSYCHIATRY’

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Abstract Michael Smith’s article considering the present and future of ‘public psychiatry’ assumes the continued existence of psychiatry following a conversation with the public. But what if the public does not want psychiatry?

Michael Smith’s article on ‘public psychiatry’ states that few people save psychiatrists care about psychiatry (Smith, 2008, this issue). There has been an active anti-psychiatry movement since the 1960s and there are critical psychiatry and post-psychiatry movements today (Bracken & Thomas, 2005). It is important to recognise the conversation that these parties have had with psychiatry. They challenge traditional technological and psychological psychiatry. Smith recommends that a mix of public education and public engagement would constitute ‘public psychiatry’ and improve the health of patients and the standing of psychiatry. However, research in other domains of public understanding suggests that it is hard to generate a conversation with the public, let alone one that is that is sympathetic to the experts’ views (O’Neill, 2001). Such a conversation may ask psychiatry to reduce its role, power and status.

The ‘dialogue of equals’ recommended by Smith will only occur if the public can expect psychiatrists to respond to their active engagement. However, Smith’s article seems to expect the engagement to be mostly one-way, with psychiatry in the lead. He seems to assume certain things to be true:

- a conversation between public and psychiatry will benefit all
- psychiatrists need public respect
- psychiatrists are needed
- there is not a dialogue already.

These points also arise in the wider debate surrounding the role of the public in policy-making related to science and technology.

Public understanding in a wider context

Much of the first section of Smith’s article, about the public status of psychiatry, seems to be an articulation of the deficit model of science. This is characterised by an ignorant public and knowledgeable experts where there is a dichotomy of views and lamenting of the public misunderstanding of expert terms and agendas. If only the public had access to good accurate knowledge, all would be resolved (Miller, 2001). Smith’s assumption appears to be that better knowledge will lessen the gap between the public perception and the objective reality of psychiatry – a view which is typical of the deficit model of science (Frewer *et al*, 2003; Sturgis & Allum, 2004). Smith refers to this under the section ‘Psychiatry’s responsibility’, where there is an exhortation to maintain professional standards and to remain neutral and objective. Such calls are, unsurprisingly, similar to those made by scientists seeking to preserve their professional elite.

Smith correctly identifies that trust may be a significant factor in whether an agency is believed. Furthermore, he recognises the need for greater attention to be paid to the impact of other knowledge spheres on factual scientific knowledge to contextualise the public’s understanding (Sturgis & Allum, 2004). Just as in discussions of public understanding of science, Smith’s next step is to drop the deficit model in favour of an engagement model in which there is a discursive and open conversation with society. Engagement with the public in matters of political and moral concern is

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supported by government policy (Office of Science and Technology & Wellcome Trust, 2001: p. 315). Indeed participation in decision-making is now a commonly stated objective in a wide number of policy areas, including mental healthcare (Tutton, 2007). However, Smith does not appear to fully embrace a dialogue of equals, saying 'Such dialogue needs to be relevant to public interests, without being subservient to them.'

A dialogue of equals

A conversation between psychiatry and the public requires engagement. What does the term 'engagement' mean? For social analysts it implies 'a degree of active involvement in taking decisions' (Few *et al*, 2006: p. 4). Therefore, institutions are required to give up their power in order to permit active participation from outside the institution. The wider literature on public engagement suggests that few professionals are willing to do this and that may explain why psychiatrists are seen as part of the problem (Schulze, 2007).

There is an appetite to engage in a conversation from specific publics such as mental health special interest groups (including Mind, Rethink and Sane). A conversation between the public and psychiatry is well under way (Royal College of Psychiatrists *et al*, 2001; Mind, 2007; McRae, 2008). Service user groups have been making recommendations for a long time. For example, in a substantial survey of service users' views, Rogers *et al* (1993) suggested that a user-centred mental health policy would make the issue of housing, not illness, the priority. This social model would operate at the expense of psychiatry, potentially leading to a reduction in the numbers of trained psychiatrists.

How have psychiatrists acted in this dialogue? The Royal College of Psychiatrists set out an approach to changing the role of the psychiatrist in *New Ways of Working for Psychiatrists* (Care Services Improvement Partnership *et al*, 2005). This document recognised service users' messages (section 5.6.4) and acknowledged that psychiatry is unlikely to expand further owing to recruitment difficulties. It supported the transfer of traditional psychiatrist's roles to other professionals and primary care. This could be seen as a stepping back of psychiatry, at least in part as a response to active public engagement.

Apart from mental health professionals and special interest groups, who else is going to engage in this conversation? The literature on public engagement suggests a variety of problems that may limit public motivation to take part in engagement activities (Bloomfield *et al*, 2001). Even those involved rarely

have an equal capacity to voice their opinion because of the inequities of social power. Finally, studies tell us 'the notion that clear consensus positions will emerge on which to base decisions may be highly optimistic' (Few *et al*, 2006: p. 5). None of this suggests that public psychiatry will be beneficial to the psychiatric profession or deliver a respectful public to our clinics.

Smith rightly points out that psychiatrists need an awareness of other points of view and have a role in addressing stigma, discrimination and bias. However, this role is wider than just psychiatry. Public psychiatry as talked about by Smith seems inevitably to be about the professional views and interests of psychiatrists and not about the wider context of people's lives. There is nothing wrong with this. Psychiatrists may relish the chance to promote their profession. However, the message from the public understanding of science literature is that there will be limited public engagement with the promotion of psychiatry. Following the Royal College of Psychiatrists' anti-stigma campaign Changing Minds, there was a small decrease in negative public opinion about some mental conditions, notably depression (Crisp *et al*, 2005). People with mental health problems were seen as less different. Knowing someone with a mental health problem was linked to more positive views. This is encouraging. However, in our society that has actively engaged with differences of race, physical disability and sexuality, mental distress remains an area of distinct exclusion. Perkins (2008) has suggested that professionals such as psychiatrists perpetuate that exclusion by inhibiting individuals and communities that might otherwise generate solutions to the human problems that are classed as mental disorders.

Conclusions

Psychiatry, rather than being alone in finding itself shunned by the public, is in good company and the idea of public engagement is a well-accepted solution to this isolation. The next question is can public psychiatry achieve what Smith hopes for in his article? The message from other policy areas is that to avoid public disillusionment, psychiatry needs to be clear from the outset what the purpose, limits and expected outcomes of public psychiatry will be. Expert-led discussion is fine but the public needs to feel that it can propose actions that will be genuinely considered an alternative to the expert choice if engagement is truly to work. Public psychiatry may be far more of a challenge to psychiatrists than Smith expects.

Declaration of interest

None.

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