use of the term 'mental health' rather than 'mental illness'? The government has stressed repeatedly in the National Health Service Next Stage Review that maintenance of health and well-being is its job just as much as treatment of illness. Performance management, outcome measures and payment by results drive vague 'support' out of the system, promoting more structured, evidence-based care delivery.

The Future Vision Coalition, comprising leading mental health charities, directors of social services, the Mental Health Foundation and, crucially, the network of our employer trusts, has just published *A New Vision for Mental Health*,[3] bringing health and social models together, focusing more on health promotion and on quality of life rather than illness, and redefining relationships between services and users. If the psychiatric profession endorses Craddock *et al*'s vision instead, who is likely to end up out of step and disregarded?

The current investment in improving access to psychological therapies demonstrates how those evidence-based services have not been over-provided or over-used to date, whereas 93% of patients have been prescribed medication. The National Institute for Health and Clinical Excellence[4] stresses the efficacy of both psychological and psychosocial interventions. The relevant expert should lead discussions where biomedical approaches are key, but where that is not the case or the whole story, which is often, the other experts are similarly important. 'Jollying along' was seen when other professions were the handmaidens of psychiatrists, only trusted to give 'support'; now they may be prescribing as well as delivering other therapeutic interventions.

Politically correct terms like 'service user' have arisen because of stigma, which psychiatrists have played their part in perpetuating, being accused of low expectations, making assumptions about behaviour based on diagnostic labels, patronising or unhelpful letters, using patients as 'cases' for training, and promoting the 'medical' model while dismissing side-effects as 'psychological'.

Our answer to their 'thought experiment' question – would you opt for a distributed responsibility model if a member of your family was the patient – is a resounding 'yes please'. Going back to a psychiatrist with a case-load of hundreds, or awaiting the arrival of yet another locum for a decision, is neither safe nor satisfactory. Lord Darzi[5] heralds a 'new professionalism' based on teamwork; teams can only be efficient and effective if members are appropriately skilled, competent and take responsibility for what they do.

We agree with Craddock *et al* that psychiatry can have a great future, but only by embracing teamwork, abandoning hegemony and accepting the importance of social and psychological as well as biological determinants of mental ill health, rather than harking back to a past which was actually far from ideal.


1 Hawkes N. Mentally ill are 'jollied along' rather than treated by psychiatrists. *The Times* 2008; 27 June.

2 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyebode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

3 Future Vision Coalition. *A New Vision for Mental Health*. The Future Vision Coalition, 2008.

4 National Institute for Clinical Excellence. *Depression: Management of Depression in Primary and Secondary Care*. British Psychological Society & Gaskell, 2004.

5 Department of Health. *High Quality Care for All: NHS Next Stage Review Final Report by Lord Darzi*. TSO (The Stationery Office), 2008.



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Craddock *et al*[1] present a compelling argument for retaining the biomedical model of psychiatric illness, while acknowledging that evidence-based psychosocial interventions do have an important place in management and treatment.

It is their discussion about New Ways of Working that particularly struck a chord with me. As a third-year specialist registrar who will soon be looking for consultant jobs, I find myself in a dilemma: am I for New Ways of Working or against it?

Case-loads of 300 patients seen briefly in 15-min 'routine' out-patient clinics; one urgent appointment after another; the community team, day unit and GPs all wanting their patients to be seen only by the consultant;[2] shouldering responsibility for patients not seen or advised on by me; to me, all of this sounds like a certain recipe for early burnout. Is it any surprise that I do not want any of this?

On the other hand, my medical training has taught me to diagnose and treat appropriately and I do this well. When other members of the team ask me to see someone who they think may have depression, my training enables me to not only exclude depression but to pick up the drowsiness, slurred speech and small pupils of morphine addiction, and to then manage the patient appropriately. As Craddock *et al* point out, having a broad-based assessment by a doctor at the first point of contact is likely to ensure that the patient gets the most appropriate treatment.

Craddock *et al* think we should be arguing for better resources and increased workforce. This is very reasonable but is it realistic?

Is the choice, then, between one's personal well-being and that of one's patients? I have not found the answer to this dilemma yet. It is reassuring to see that experienced psychiatrists have strong views on both sides, illustrated by the heated debate over the past few months. Perhaps I should sit on the fence just a little while longer.[3]


1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyebode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

2 Hampson M. It just took a blank piece of paper: changing the job plan of an adult psychiatrist. *Psychiatr Bull* 2003; **27**: 309–11.

3 Vize C, Humphries S, Brandling J, Mistral W. New Ways of Working: time to get off the fence. *Psychiatr Bull* 2008; **32**: 44–5.



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We strongly support the views expressed by Craddock *et al*.[1] In our opinion, their perspective is shared by many NHS consultant colleagues and is not limited to academic psychiatry.

At the heart of the debate is the progressive downgrading of the role of the consultant psychiatrist in diagnosing and managing

severe mental illness as opposed to 'mental health problems'. The latter may not require specialist psychiatric input as medicalising problems of living is clearly undesirable.

The centrally driven 'one size fits all' approach to 'modern' service delivery has left many patients with serious psychiatric illness bereft of the clinical expertise and leadership to effectively manage their condition. Notions of complexity (undefined) and risk have superseded diagnostic context. The 'diffusion of responsibility' as conceptualised in New Ways of Working often leads to unfocused care plans and risk management assessments without the one element essential to modifying any risks – that is, effective psychiatric treatment based on a comprehensive diagnostic formulation and understanding of the nature of the illness. Accurate diagnosis not only allows appropriate treatments for individual patients but also prioritisation of resources in service delivery. Furthermore, a diagnostic threshold is an essential requirement of the Mental Capacity Act in the assessment of capacity of our most vulnerable patients.

Major changes in psychiatric management and service structure have been introduced that are mostly not evidence based and certainly not consequent upon real advances in treatment. The political dimension to this process makes constructive criticism difficult. The letter to *The Times* from Kinderman and members of the New Ways of Working Care Services Improvement Partnership and National Institute of Mental Health exemplifies this.[2] In response to the article by Craddock *et al* they refer disparagingly to the 'traditional medical model' in contrast to 'modern mental healthcare' which is a 'collaborative team effort' as if the medical model concerns itself only with medical matters in the most narrow sense. They also suggest that some psychiatrists are unable to 'cope with the loss of hegemony' and refer by implication to Craddock *et al* as demonstrating 'intellectual arrogance . . . and assumptions of superiority'. Their response to put it mildly offers little basis for constructive debate and has previously been described as 'messianic' in tone.[3]

Like many psychiatrists engaged in the treatment of serious mental illness and organic brain disease we look to our professional body the Royal College of Psychiatrists for a lead but find our views are not adequately represented.


1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyebode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

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I would like to provide a medical student's perspective on the paper by Craddock *et al*.[1] I am about to enter my 4th year of medicine (having just completed an intercalated BSc in psychology and medicine) and will soon have my first real exposure to clinical psychiatry. Although I am keen on psychiatry, the majority of my fellow students are happy to express disdain at the thought of a psychiatric career. It is obviously difficult to say why this might be the case but something is clearly amiss in the way that psychiatry is being presented to tomorrow's doctors.

During my BSc, it was interesting to gain insight into the opinion that psychologists have of psychiatry, which unfortunately was one of 'over-medicalisation' and neglect of psychosocial factors. For me, this reiterated the importance of early positive interaction between the two professions and a need for better understanding of each others' strengths. Perhaps this interaction is best initiated during undergraduate training?

More importantly, and from the angle of a card-carrying wannabe psychiatrist, this paper has confirmed that clinical psychiatry is attractive to me not because it is excessively reductionist but because it deals with the complex interplay between psychiatric (and non-psychiatric) illness and countless important psychosocial factors. Furthermore – and this may be the blind optimism of youth talking – I hope to become an excellent physician who is trusted and respected by her patients. Because of this, I am not discouraged by those who fail to consider psychiatrists as 'proper doctors', although it is clear to me that this negative view by other doctors acts as a deterrent for some of my colleagues who might have been interested in a psychiatric career.

Finally, on a more anecdotal note, I have the perspective of someone who has lost a relative because of failure in psychiatric and non-psychiatric care and social support. Had an appropriate (and properly functioning) multidisciplinary team been in place, both in assessment and management, I believe that the outcome would have been very different. So in response to the question 'if a member of your family were a patient, is a distributed responsibility model the one for which you would opt?' my answer would be an uncertain 'ummm, I think so', so long as this included the appropriate level of assessment and involvement of a senior psychiatrist alongside other professionals.


1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyebode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.



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Craddock *et al*[1] call for the restoration of the 'core values' of biomedicine – diagnosis, aetiology and prognosis – despite evidence that such concepts have delivered little more than stigma and helplessness.[2] A generation ago, Mosher demonstrated that contrary to received opinion, the recovery of people with schizophrenia could be enabled with no more than sophisticated psychosocial support.[3] Since then the role of personal, social and environmental factors in generating 'breakdowns' and 'fostering recovery' has become widely accepted. The 'mental well-being' train has left the station and in many places is close to its destination.

Craddock *et al* advocate a 'more positive and self-confident view of psychiatry', but complain that 'many people . . . have developed exaggerated and unrealistic expectations'. Clearly, psychiatry's reification of diagnosis, with the implication of effective treatment, fostered such expectations. The comparison of mood disorders with heart disease serves as an illustration. Much of the emergent distress within high-income nations has more to do with lifestyle, values and other psychosocial factors,