

Futures of psychiatrists 2020: external and internal challenges

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The longer you can look back the longer you can look forward. (Winston Churchill speaking at the Royal College of Physicians, London, 1944)

At the turn of a new decade how might the futures of psychiatrists look? Here we address issues of social inclusion and, also, the professional identity and relationships of psychiatrists.

Social inclusion

Wolves can dress in sheep's clothes (Ikkos, 2010). Mental asylums and care in the community have been conceived with genuinely good intentions and high aspirations, but both have been associated with great disappointments at times. With respect to asylums, the lowest point was reached in Nazi Germany in the 1940s. Following certification by psychiatrists as having 'lives unworthy of life', 100 000 people with a mental illness, intellectual disability or epilepsy were exterminated in gas chambers in six so-called 'mental hospitals'. This was in the interest of 'racial hygiene', that is, in the interest of public mental health as conceived by the Nazis, including Nazi psychiatrists.

Extremes of libertarianism as well as authoritarianism can have negative consequences for people who have a mental illness. With respect to community psychiatry, the closure of asylums has been associated at times with reduced symptom control, the incarceration of those who are mentally ill in prisons instead of hospitalisation and increased suicide rates. Today in the UK, and perhaps especially in London, services sometimes maintain patients in the community in conditions that would have been severely criticised had they been found in asylums 30 years earlier. Increasing inequalities in the context of globalisation, resource constraints secondary to the 'credit crunch', competition for resources from other medical specialties and environmental pollution place our patients at risk in the next decade. The successful social inclusion of people with a mental illness will remain a key external challenge for the profession (Boardman *et al*, 2010).

Identity

Is psychiatry an endangered species (Katschnig, 2010)? Craddock & Craddock (2010) answer that 'patients must be able to derive maximum benefit from a psychiatrist's medical skills and broad training'. They decry 'often nebulous

and frequently indiscriminate implementation of the dictum that psychiatrists must embrace biological, psychological and social approaches'. They emphasise the training of psychiatrists in the biomedical sciences and their unique diagnostic skills among the mental health professions. These, together with training in 'psychological and social issues', contribute to psychiatrists being 'uniquely placed' to see the 'big picture'. Future advances in molecular genetics and brain imaging will bring further strengths.

If remedying the disorders of the nervous system requires the training and skills of the neurologist, what is the field that requires the training and skills of the psychiatrist? Panksepp (2009) proposes 'affect'. Affect refers to emotion and its manifestation in thought, impulses, behaviour and relationships in family and society. It is disturbance of affect (i.e. subjective distress or disturbed behaviour or disturbed relationships) that brings patients, voluntarily or not, to psychiatrists (Ikkos *et al*, 2010). Affect is rooted in biology and evolution but influenced by upbringing, relationships and culture. Kagan (2009, p. 81) remarks:

The influence of biology on human psychological functions is extensive, but not unlimited. Evolutionary psychologists like to write that genes keep cultures 'on a leash'. However, culture, like a large powerful dog, can pull the person holding the leash in new, unplanned directions.

Recent research suggests that psychological trauma to a mother affects development of the foetus and child. Trauma and abuse in childhood affect neurodevelopment and function in adulthood. Abuse in childhood increases the risk of psychosis in adulthood and high expressed emotion increases the risk of relapse in schizophrenia. Psychological interventions reduce relapse rates in affective, anxiety and eating disorders. In addictions, Stephens & Graham (2009) suggest, it is not the disturbance of biological function that is the problem but the hijacking of normal biological functions for pleasurable, i.e. psychosocial, ends. Finally, attendance to affect highlights the importance of continuity for the many patients who benefit significantly from longer-term care.

Psychiatrists will need to enhance their biomedical skills, and also their psychosocial skills, if patients are to benefit most from the forthcoming advances in molecular genetics and neuroscience. The future of psychiatry will be safeguarded by the successful management, not the elimination, of the tension between biomedical and biopsychosocial approaches. This will remain a key internal challenge for the profession.

Relationships

Identity and context define our relationships. Not all disturbances of affect require the skills of doctors. Most disturbances are taken care of by people themselves and their families and friends. Medical expertise in the management of disturbances of affect will be relevant when harmful departure from species-typical functioning (i.e. dysfunction) leads to medical necessity (Daniels, 2008). Debate will continue as to where the boundaries are.

Not all medically necessary interventions require the skills of psychiatrists. There is convincing evidence that much psychiatric morbidity may be managed in primary care. Well-informed primary care physicians and other health professionals will know when they have reached their limits. Ease of referral from colleagues to psychiatrists and availability of referral to a psychiatrist when patients have the need and choose that option merit advocacy from the whole medical community, not just psychiatrists.

Following referral to specialist mental health services, of fundamental importance are the quality of assessment, the process of care and the outcome. It may not be possible for every referred patient to be seen by a psychiatrist and, indeed, other professionals may have greater expertise in managing specific aspects of disturbed affect; related disciplines will be better equipped to deliver some interventions. However, psychiatrists do have unique training and skills to see the 'big picture', especially in complex cases (Craddock & Craddock, 2010). Ease of referral to a psychiatrist is likely to be essential when a colleague on the multidisciplinary team is uncertain in an assessment or about a patient's progress with treatment. Psychiatrists will need to play leading roles in developing teams and treatment pathways and in ensuring that there is easy access to their skills when necessary. A particular challenge will be to develop flexible and effective protocol-based approaches that take full account of comorbidity.

Societies vary in how they invest in health. All health systems have to be tested against criteria of effectiveness, efficiency, fairness and choice. Carbon costs will also inform service funding in the future! The reality of wide variations in practice and the lack of a close association between investment and outcomes will lead to increasing demands for quality assurance, improvement and accreditation (Lelliott, 2010). These are complex areas. A review by leaders in the field of professionally led accreditation indicated that 'there is generally a lack of good evidence either to show that accreditation is effective or that is it not' (Lelliott *et al*, 2009). Nevertheless, systemic factors will ensure that, if psychiatrists do not engage effectively in this area, others will, perhaps with demonstrably adverse effects. To function effectively in these areas, psychiatrists will require new skills, in addition to biomedical and psychosocial skills.

Professionalism and authority

Physical and mental health, an adequate standard of living, good education and opportunities for work, leisure and rest are universal human rights. The fundamental principles of professionalism in medicine centre on patient autonomy, welfare and social justice. Psychiatry's commitment to socially

excluded citizens makes psychiatrists' lives more difficult sometimes but also gives the profession special value within medicine and this should be advertised.

The fundamental characteristics of professionalism in psychiatry have been summarised (McQueen *et al*, 2010) as the 'seven Es':

- empowerment of the patient
- evidence-based practice
- ethical practice
- emotion and relationships
- expertise through synthesis and clinical practice
- engagement with service development and delivery
- education and research.

In changing and increasingly complex external environments, the security psychiatrists have in an evolving identity will empower them to enhance their confidence and authority.

Reference to authority may appear odd at a time when it seems fashionable to challenge it. On the other hand, frequent recent references to the need for leadership in medicine suggest that it may have a place. Authority here does not mean arbitrariness and coercion but the confidence and respect that arise out of knowledge and trusting relationships. It is these that will inspire patients and carers to consider psychiatrists and mental health services a natural choice at times of distress, rather than a last resort.

Ultimately, the future of any profession depends on the young graduates who join it. Katschnig (2010) highlights a crisis in recruitment in some countries. A number of reasons have been suggested for this, including stigma within the medical profession and beyond, lower rates of remuneration compared with other medical specialties and competition from other health professions. Perhaps the greatest reason, however, has been the loss of confidence within the profession and consequent loss of authority. Bright and idealistic young men and women, when choosing a career, want to see models that inspire them and this requires of their teachers a secure identity and confident relationships. In judging this, medical students do not ask for our opinion, nor do they take our proclamations at face value; rather they attend to how our patients, their carers and our colleagues judge us.

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THEMATIC PAPERS – INTRODUCTION

Alcohol misuse by the young: problems and solutions

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Back in April 2006 (vol. 3, no. 2) we published papers on the theme of misuse of alcohol by young people, 3 years after the UK government had introduced the option of 24-hour drinking. The British Medical Association (BMA) subsequently recommended that there should be a programme of research to examine the consequences of this change to our drinking culture. In 2008, it reported on current trends in alcohol misuse (BMA Board of Science, 2008). An appendix to that report summarises the different alcohol control strategies pursued by the governments of England, Wales, Scotland and Northern Ireland in the past few years. These are outlined in the document *Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy* (HM Government, 2007).

In England, there is an emphasis on controlling alcohol misuse by the young through 'sharpened criminal justice for drunken behaviour', which contrasts sharply with the equivalent, more education-oriented strategies pursued by other regions in the UK. The distinction raises important questions about the evidence base for the relative effectiveness of persuasion and punitive action to curb substance misuse.

The UK ranks among the heaviest alcohol-consuming countries in Europe. Overall, the majority of the UK adult population drinks alcohol, but the prevalence varies considerably by ethnic group. While just 9% of White British people abstain, the equivalent proportions are 48% of people of Black African origin and over 90% among those of Pakistani and Bangladeshi origin. Cultural differences in alcohol consumption among the young are reflected in our choice of papers for this issue's theme.

To start, we have a fascinating report by doctors in Pakistan who studied attitudes to alcohol among medical students in Lahore. Nazish Imran and colleagues observed that medical students the world over are notorious for their liberal consumption of alcohol, so they conducted a local survey, which had an excellent response rate. They found surprisingly liberal attitudes to alcohol consumption among Pakistani students, but because social attitudes to drinking are in general very

conservative, it was not possible to discover how many students themselves were users.

A second report on attitudes to alcohol among the young comes from Drs Nkire and Nwachukwu, in Ireland. They express concern that the average age of drink initiation in that country is just 13 years, and is falling. An amazing 25% of children claim to get drunk regularly. They discuss potential influences on this highly undesirable behaviour, and make some stark observations about the considerable gap between the aims of Irish government policy initiatives that are designed to curb alcohol misuse, and the vigour with which they have been implemented.

Finally, we have good news from Iceland. In the late 1990s there was a serious drink problem among adolescents in that country, a situation not dissimilar to the current experience of the UK. Inga Dora Sigfusdottir and colleagues outline the collaborative community-based approach that evolved to deal with the issue. We learn how 'joined up thinking' by governmental and non-governmental organisations allowed them to put in place novel strategies of primary prevention. Their approach was based upon published evidence and was underpinned by theories from social science. Key to the remarkable success of the programme was its broad-based community support, in particular the willingness of parents to take responsibility for, and to closely supervise, their children's social activities. Alcohol misuse among the young was halved in just 10 years. We should be listening.

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