A BETTER UNDERSTANDING
PSYCHIATRY’S SOCIAL CONTRACT
Psychiatry as a medical speciality has a major role to play in improving the mental health of the population as well as treating those who develop mental illness. Societies and cultures around the world decide how to fund health care and also determine how much of it is allocated to mental health services. Psychiatrists on the other hand respond to social factors and how societies dictate risk assessments and risk management. The social contract between the psychiatrists and the society has always been implicit and has often raised issues in ascertaining responsibilities and roles which are also defined and delineated by the profession.

Social changes occur locally where populations have raised expectations and patients expect to be equal partners in deciding which treatments to accept from all the options made available to them. Whereas society expects clinicians to be caring, humane and up-to-date in their knowledge, clinicians have certain professional obligations focusing on the greater good. Codes of professional conduct change in response to social expectations.

The contract between psychiatry and its practitioners follows on from the medieval times. Professional monopolies were allowed and the professional values and responsibilities included autonomy and resulting social status and rewards. In return the profession was expected to provide services in a competent manner with technical knowledge and high moral values of probity and integrity. In the past few decades there has been increased pressure on resources and the professions to deliver services which are expected and useful.

The Mental Health Foundation took the lead in exploring the Psychiatry’s Contract with society. We are grateful for the participants for expressing their views so openly and to the staff of the Foundation to deliver such a unique product. The aim of the report is to continue the debate as society and its expectations change.

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The Royal College of Psychiatrists explains the role of psychiatrists as follows:

**What is a psychiatrist?**

A psychiatrist is a medically-qualified practitioner who will have spent 5-6 years training as a doctor. He or she will then have worked as a doctor in general medicine and surgery for at least a year. He or she will then have had at least 6 years of further training in helping people with psychological problems.

**What are a psychiatrist’s special skills?**

All psychiatrists will learn how to:

- assess a person’s state of mind
- use the “biopsychosocial” model of understanding. This emphasises the importance of a person’s past experiences, family, culture, surroundings and work as well as any medical features.
- diagnose a mental illness
- use a range of psychological treatments
- use a range of medications
- help a person recover.

As well as these ‘core’ skills, a psychiatrist will specialise and develop skills in working with the particular problems that affect different groups of people. For example:

- a general adult psychiatrist needs to develop skills in talking with people who have disordered thinking and hallucinations. Behavioural problems etc in adulthood; and
- a child psychiatrist will usually develop skills in working with families and with the special needs of children and occasionally adolescents.

Spiritual, anthropological and sociological awareness and understanding can be extremely helpful in working with patients.

**Where do psychiatrists work?**

These days, NHS psychiatrists work across a whole range of places – from the street (literally) to specialist hospital units. However, most work in community mental health teams, out-patient departments and hospital wards. Some do sessions in general practices. Increasingly home treatment teams work with patients, their carers and families at their homes.

**How do they work?**

Psychiatrists sometimes see patients on their own in an out-patient clinic. More often, they work as part of a team with colleagues from other professions such as nursing, social work, psychology and occupational therapy. The team will ask the psychiatrist to see patients, either on their own or with another member of the team present. The psychiatrist will also work as a consultant to the team, discussing people’s individual mental health needs and working out how to best manage them. The psychiatrist will also review patients with other team members in their regular team review meetings.

**What might a psychiatrist recommend?**

- Psychological treatments
- Medications
- Practical ways of dealing with an illness
- Practical ways to stay well
- Ways to get active, see other people and get back to things you like doing.


Extract from Royal College of Psychiatrists website [http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/psychiatrists.aspx](http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/psychiatrists.aspx)

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This report looks at psychiatry’s “Contract with Society” across the UK. Two key questions are considered: what is the nature of the “contract” between psychiatry and society, and what responsibilities and expectations are there on both sides to enable high quality NHS psychiatric care to be provided across the UK?

The authors sought evidence from published literature on the issue; two online surveys; twelve interviews with senior figures in the field of mental health; and two focus groups involving service users and carers. The authors looked at psychiatry’s role, responsibilities and relationships with not only society as a whole – the general public across the UK – but also with specific interested parties, including other health and social care professionals; health service managers; service users, carers and families; commissioners of services; the media; and policy-makers and politicians.

Our hypothesis is there is an implicit “contract” or ‘understanding’ between psychiatry and society across the UK, based on reciprocity and mutual expectations. This involves on the one hand psychiatry and psychiatrists demonstrating the benefits they bring to wider society and individual service users; and on the other, stakeholders in society, such as the state, other health professionals, service users and the media, acknowledging their responsibilities to support psychiatry to enable it to do its job effectively.

The “contract”, however, is not well understood by all stakeholders, and only variably fulfilled on both sides thus a better understanding of the idea of the contract is required. This could bring a greater consistency among psychiatrists in practicing collaboratively with service users, health colleagues and others as part of a ‘new professionalism’. It would also help society to establish a climate in which psychiatry and other health disciplines to support mental health are valued and properly resourced, and the stigma of mental health problems is reduced as are the inequities related to a lack of social justice.

Key issues for psychiatry in fulfilling its side of the “contract” are:

- How to overcome challenges that include resource pressures; the stigma associated with mental health problems; a lack of public understanding about psychiatry’s role; mistrust of the profession linked to a perception that it is too focused on medication; and a sense of being de-professionalised and undervalued.
- How to educate all psychiatrists to work to a recovery-based, empowering and partnership model of care, offering and discussing a range of treatment options, and developing their interpersonal as well as clinical skills to ensure good relationships and communication with service users, carers, colleagues in health and other professions and wider society.
• How to encourage psychiatrists to be leaders in mental health, and wider healthcare; actively participating in research, national and local policy development; service planning and management; prevention and health promotion programmes; and contributing their expertise in primary care, community and acute settings.

• How to campaign to get their views across to a wide range of audiences, and fight for good mental health of both the population and service users; as well as fulfilling their educational role providing information to the general public, the media, healthcare professionals and other sectors and their staff. Being advocates for their patients is an important but often ignored role.

• How to demonstrate openness and honesty about what psychiatry can achieve, and what it can’t be expected to achieve. Psychiatry should explain better what it does, and the judgements psychiatrists make in applying its practices, such as the use of compulsion and psychiatric medication. The sometimes failure to do so is a stumbling-block to its credibility and a cause of much of the mistrust which it faces.

Key issues for Society in fulfilling its side of the “contract” include:

• Governments across the UK must ensure that psychiatric services and mental health research are adequately funded to meet assessed levels of need in their populations, and that the role of psychiatry in health care is recognised and accorded appropriate priority in health strategy and policy. Governments need to promote good mental health among their populations and contribute towards tackling the stigma that surrounds mental health problems.

• Governments across the UK need to tackle the social issues, such as poverty, unemployment, inequality and stigma that are very significant contributors to mental distress and causative factors in mental ill health. They need to ensure that policies and their proposed implementation methods are assessed for the risk they pose to the mental health and well-being of their populations. Social justice for the mentally ill is crucial in achieving equal status for the discipline and the patients.

• All health professionals working with psychiatric patients should respect and value each other’s expertise, and should be skilled, competent, professional and collaborative. Colleagues both inside and outside direct mental health care should be expected to be ‘psychologically-minded’, and have a basic understanding of mental health problems.

• In general, people using any health service are regarded by the NHS Constitution as having certain responsibilities. These include the responsibility to be open and honest about their symptoms, to treat health service staff with respect, to listen and take the expert advice offered. Patients themselves equally
should be treated with respect and listened to. It is for the benefit of all for the information shared to be clear and accurate. However, it is important to recognise that for people with mental health problems stigma, fear of compulsion or indeed their condition itself, may render these normal expectations difficult to deliver.

• Both sides need to work to build a good relationship and communication between psychiatrist and carer. Carers often perceive that they are excluded for reasons of “patient confidentiality”. Carers might be expected to raise concerns they have about the person they are caring for with psychiatric services or the nature of the support which is available and to make clear what they will need to support their loved ones on the journey to recovery in their daily lives.

• The media might be expected to report on mental health issues, including those involving psychiatric services, truthfully and accurately, and in an informed, responsible and balanced manner. Journalists who work on mental health stories should have at least a basic understanding of the role and responsibilities of psychiatric services, and mental health more broadly. They should be able to report psychiatric issues in a non-discriminating and objective way.
Early in 2014 the Mental Health Foundation was commissioned by the Institute of Psychiatry to produce a briefing paper outlining the key issues around psychiatry’s “Contract with Society”, with the aim of influencing the ongoing debate about psychiatrists’ role in the UK.

This follows on from the publication in 2013 of the Mental Health Foundation’s Inquiry Report on the Future of Mental Health Services in the UK, which included a number of messages for psychiatry around the need to maintain specialist skills while developing more collaborative and integrated models of working.

For the purpose of this report, the authors have tried to encapsulate psychiatry’s role, responsibilities and relationships with not only society as a whole – e.g. the general public across the UK – but also with specific interested parties from within society, including other health and social care professionals; health service managers; service users and their carers / families; commissioners of services; the media; and policymakers and politicians. The aim being to contribute further to the debate about psychiatry’s “Contract with Society”.

The authors sought evidence from published literature on the issue, our own online surveys, one-to-one interviews and focus groups. The full methodology is set out in Annex A.
Much of the information in this section is derived from chapters by various authors in Psychiatry’s Contract with Society (ed. Bhugra, Malik and Ikkos, 2011) (PWCS). The authors have referenced these as coming from PCWS, with the page on which the chapter commences. To supplement this, and bring the evidence up to date, we undertook a further search on the subject taking in selected recent literature on the issue (primarily 2011-2014). In this, 33 peer-reviewed journal articles were included, which were relevant to aspects of the interaction between psychiatry and wider society. A thematic analysis of the literature was carried out to identify key messages which shed light on the issue of psychiatry’s implicit “Contract with Society”, under the following headings:

- The current “contract” between psychiatry and society
- The challenges facing psychiatry in the current climate
- Expectations of psychiatry and psychiatrists from themselves and society
- ‘New professionalism’
- What is expected of society in the “contract”?  
- Clarifying the “contract”

The current “contract” between psychiatry and society

Authors have written about the “contract” that exists in health care provision as a whole, although not always using that term. Rosen and Dewar (2004) proposed a ‘compact’ involving three interlocking societal components – patients, patients’ groups and the public; health care managers, the state and government departments; the medical profession and its professional bodies. Each group has reciprocal relationships with the other two. Each relationship is mediated by the media, the legal system and the regulatory framework.

Bhugra (PCWS, p.1) points to an implicit “contract” between the society and medicine as a profession of which psychiatry is one component. The rights and duties of the state and its citizens are reciprocal, and this reciprocity (and its recognition by both sides) constitutes a relationship which by analogy can be called a “social contract”. The psychiatrist has under this “contract” multiple levels of responsibility – from personal to the patient; professional to the profession to which he or she belongs; and to society. The “contract” keeps evolving as a result of changes in social expectations, health care systems and their funding and factors such as the development of new therapeutic interventions and specialisms within professions.

For Creuss and Creuss (PCWS, p.123) society, acting through its governing structures, cedes authority to the medical community in return for expected benefits to its citizenry. They argue that under a ‘new
professionalism’ there is increased professional responsibility to society, with more accountability and more transparency. This type of “social contract” better meets contemporary societal expectations.

In another contribution, psychiatric care is seen as a reciprocal, two-way process which involves mutual expectations and input from both patient and the psychiatrist (Pettersen and Hem, 2011).

The challenges facing psychiatry

In many respects the challenges faced by psychiatry today are challenges for all medical professions. Downie (PCWS, p.23) points to the threats that all professions can feel under. He notes that the general public is no longer willing to tolerate poor service and this public distrust has been picked up by governments of all political persuasions, who have restricted professions’ independence and have tried to control them.

Some authors suggest that there are particular considerations that apply to psychiatry. Adebowale (PCWS, p.35) suggests that psychiatrists work in an area that is intellectually difficult and complex and of which few members of the public have any understanding. Coupled with this is a failure to articulate this sphere adequately to patients, their carers or the wider public. A lack of public understanding of psychiatry, and what psychiatrists do, pervades the literature. In addition, psychiatrists can still appear paternalistic in their dealings with patients, carers and colleagues. Pelto-Piri et al (2013) report Swedish psychiatrists’ self-reported low levels of reciprocity in their professional interactions. Paternalistic perspectives were the dominant approach among psychiatrists, prompting suggesting for changes to training programmes.

A number of authors refer to the adverse impact of resource constraints on psychiatry (including Yager, 2011; Beresin et al, 2014). Lydell and Malik (PCWS, p.73) refer to the pressures on psychiatrists, and consequent risks to quality of care, due to reductions in working hours, and the loss of protected supernumerary and lack of research investment. More generally, the underfunding of mental health services relative to the prevalence, chronicity and disability associated with mental illness, impacts not just on public health but also on services, training and recruitment. Michels (2012) observes that the economic and organisational demands on psychiatry are often greater than the demands placed on the profession by patients and/or members of the public. This has the effect of skewing institutional emphases towards economic considerations above patient concerns.

Bouras and Ikkos (2013) suggest that demands on psychiatry have increased, partly through increases in addiction problems, the breakdown of social capital and influxes in migration, with its cultural and communication challenges, without accompanying rises in resource allocation and the status of psychiatry within society. Freddolino and Knapp (PCWS, p.43) refer to the fragmented nature of mental health systems (in the UK), with multiple sources of funding and multiple service delivery and damaged support mechanisms for individuals who are unwell, from health, social care, housing, criminal justice agencies and
others, within which psychiatrists (and indeed other professionals) are expected to operate to the highest of standards and achieve consistent outcomes.

It is also argued that psychiatry is being ‘deprofessionalised’ across the UK for a number of reasons. Health employers are devaluing the end point of specialty training, with the affordability of consultant psychiatrists being questioned, and patients becoming less concerned about being treated by a highly trained doctor than with having ‘experienced, qualified’ people treating them. A better informed public, including service users accessing information through the internet, are demanding a greater say in their care and questioning traditional psychiatric thinking. Some of psychiatrists’ statutory powers under mental health legislation may now be undertaken by other professions. Bhugra (2013) suggests a lack of preparedness for societal demands has caused widespread demoralisation within psychiatry and highlights a need for updated training models to enable psychiatrists to receive training appropriate to the changing expectations of society. In addition, a further challenge for psychiatry is not to raise unrealistic expectations, and to establish an understanding that there are limits to what psychiatry can achieve (Bhugra and Malhi, 2013).

Psychiatry’s relationship with pharmaceutical companies has also been challenged. For example, Mitchell and Read (2011) found that in relation to Attention-Deficit Hyperactivity Disorder, drug-company funded websites were significantly more likely than non-drug-company funded websites to recommend medication rather than psycho-social treatments. Appelbaum and colleagues (2013) put forward suggestions for a better working relationship between psychiatry and the pharmaceutical industry, following indications that psychiatric practice has been negatively impacted through an imbalanced relationship between the profession and the industry for example by pharmaceutical marketing preferences resulting in misleading or incomplete information being relied upon by psychiatrists in making treatment decisions.

Misrepresentations of psychiatry within the popular media also create a challenge, as they affect public perceptions of psychiatric treatments. Popular media have a particular tendency to hype positive outcomes without due consideration given to risk factors and ethical issues which psychiatrists must necessarily account for in making treatment decisions. This can cause conflicts between service users’ perceptions or expectations and psychiatrists’ ability to fulfil those expectations. Gilbert and Ovadia (2011) call on the psychiatric profession to act as ‘watchdogs of science’. Good partnerships between the media and psychiatry can have substantially beneficial effects on public health education and reduce the stigma associated with psychiatric treatments.

Technological information developments and the rise of social media means boundaries between doctor and service users can become blurred and the power relationship is changing. Service users’ posts on social networking sites (e.g. Facebook) can be accessed by psychiatrists while there are no standardised guidelines for maintaining boundaries online, and service users can similarly conduct searches of their psychiatrist on sites (Frankish et al, 2012). However, social networking has also allowed psychiatrists to rapidly share clinical information and professional advice
as well as offer online treatment methods. Gabbard et al (2011) suggest that early introduction of social networking ethics can be applied to psychiatric training to minimise risks to service users’ and psychiatrists’ privacy. Yager (2011) argues that increased use of computerised tools to monitor service users’ status and shifts towards home-based online psychiatric care indicate a need for technologically relevant training for psychiatrists.

Finally, recruitment and retention of psychiatrists has been repeatedly cited as a difficulty within the profession (e.g. Steele and Beattie, 2013). Barras and Harris (2012) found that 30% of psychiatry trainees did not intend to remain within the field of psychiatry due to a number of perceived problems within the profession, including the amount of paperwork required and a lack of inpatient beds. The overriding factor was a perception that changes—real and expected—are superseding psychiatric expertise, causing psychiatry trainees’ dissatisfaction with their professional prospects. Overall, considerable stigma against mental health problems and a lack of acceptance of psychiatry by other professions and the general public appeared to have negative effects on retention rates.

**Expectations of psychiatry and psychiatrists**

Psychiatrists are doctors first and foremost, and expectations of psychiatrists are not fundamentally different to expectations of any doctor. Coker (PCWS, p.195) quotes the General Medical Council’s Good Medical Practice (2006) which states that patients must be able to trust doctors with their lives and health. To justify that trust doctors must, among other things, make the care of the patient their first concern; protect and promote the health of patients and the public; provide a good standard of practice and care; treat patients as individuals and respect their dignity; work in partnership with patients; be honest and open and act with integrity.

Ikkos (PCWS, p.9) points to the Royal College of Psychiatrists’ own ‘core attributes’:

‘Good psychiatrists make the care of their patients their first concern: they are competent; keep their knowledge up to date; are willing and able to use new research and evidence to inform practice; establish and maintain good relationships with patients, carers, families and colleagues; are honest and trustworthy, and act with integrity. Good psychiatrists have good communication skills, respect for others and are sensitive to the views of patients, carers and families.’ (Royal College of Psychiatrists, 2009).

That, taken with the College’s statement of what you might expect from a psychiatrist set out at the start of this report (http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/psychiatrists.aspx), outlines much of psychiatry’s side of the “contract” with society, at least in respect of individual patient care, and relationships with carers and colleagues.
Bhugra and Malhi (2013) suggest that patients currently have differing expectations of what psychiatrists can do for them compared to previous decades. Patients are primarily focused on understanding the causes of their mental health problem and improving daily functioning (a ‘recovery’ approach) while traditional psychiatric models approach mental health problems in terms of diagnoses and treatment. Barber (2012) suggests greater adoption of recovery approaches within psychiatric treatment models as being particularly beneficial in promoting patients’ personal and clinical outcomes.

Other changes to societal expectations included the emergence of the competency movement, which entails a shift towards professionalism as an ongoing development aim and is achieved only through lifelong learning and demonstration of good practice (Beresin et al, 2014). In addition, the greater acknowledgement and better understanding of human rights within society has led to a pervasive mistrust and dissatisfaction with the psychiatric profession. Psychiatry needs to address service users’ personal, spiritual and cultural experiences, as well as clinical outcomes. Coker (PCWS, p.195) sets out the five principles of the ‘Human Rights Based Approach’ (HRBA) to health care delivery, and Jakovljevic (2012a) urges psychiatry to operate within a philosophical and political context in which human rights are upheld as central to professionalism. These may be placed in the context of social justice and outcomes based equity.

There is relatively little published literature setting out what service users want from psychiatry. What there is suggests that, for service users, expectations of psychiatrists fall into two broad headings – clinical skills, competence and knowledge, and empathy and communication (similarly to other kinds of healthcare one would suspect). As put by Lelliot (PCWS, p.147), “Quality at this level depends on the clinician possessing both technical proficiency, which requires knowledge and judgement, and the ability to manage interpersonal relationships”.

Clinical skills

Freddolino and Knapp (PCWS, p.43) refer to considerable anecdotal evidence that in times of someone’s crisis, service users and their families want to know from a trusted psychiatrist about one or two choices available to them, together with a professional recommendation as to which would be ‘best’ for them. The new right of patient choice in mental health services, which came into effect in April 2014, makes the commitment of the psychiatrist to offer this choice all the more imperative.

Mynors Wallis (PCWS, p.181) points to the importance of revalidation of clinical skills for all doctors, including psychiatrists, to ensure that they remain up to date and fit for practice. Continuing professional development (CPD) is an essential aspect of clinical care that psychiatrists must actively engage in. Yager (2011) predicts that, despite substantial changes to the nature of psychiatric practice, medical advances in medication-based treatments will ensure the place of psychiatrists in specialist mental health care.
Interpersonal skills

The literature on medical and psychiatric professionalism is threaded with references to empathy, communication and the need to take account of service users’ spiritual views.

Bhugra et al (PCWS, p. 59) recognise that patients expect doctors to be efficient, accessible, approachable and honest, and show empathy. This is seen as an integral part of their professionalism. They point to studies showing that giving clear explanations enhanced patient satisfaction. Borman (PCWS, p.209) refers to the importance of communication and the sharing of information, by the patient and psychiatrist alike. Adebowale (PCWS, p.35) argues that in terms of perception, some psychiatrists engage with patients and communities defensively and negatively, rather than as positively or constructively, as they could. Better, more open and constructive communication with patients would alleviate the perception of discrimination, bolster trust for psychiatrists, and allow for psychiatric skills to be widely recognised as essential tools. This partnership model requires improved, two-way communication, in which the patient’s wishes regarding their care are more fully acknowledged and the doctor is expected to provide guidance, rather than direction, through a range of treatment options.

Important benefits can be derived from appropriately accounting for service users’ personal, religious or spiritual beliefs during consultations. However UK psychiatrists in general, tend to place less importance on spirituality than service users and feel more reluctant to consider and discuss spirituality in the context of their professional practice. Migrant psychiatrists were more comfortable with responding to and even utilising patients’ religious or spiritual beliefs to enhance clinical efficacy and the therapeutic relationship (Dura-Vila et al, 2011; Cook, 2011; Ikkos et al, 2011).

Contribution to integrated working

Kaplan (PCWS, p.163) points out that doctors are not simply valued, or indeed paid, on the basis of medical skills alone. They are professionals who operate within teams and within organisations. They are increasingly needed to provide a source of expertise more widely, such as in courts and on commissioning bodies and policy bodies and strategic bodies such as Health and Wellbeing Boards. Psychiatrists should be helping to shape priorities, ensure that assessments of local needs include mental health needs, and sharing information appropriately across organisational and sector boundaries. Griffiths (PCWS, p.171) suggests that it is less a question of medical expertise, and more about the ways that doctors can contribute in a changing world.

Coker (PCWS, p.195) says leadership “is not about command and control over others, but working with others to achieve the best solution”. This means taking an interest in ‘whole system’ thinking. Downie (PCWS, p.23) adds that professional leaders have a moral duty to speak out on matters of public policy as it affects their patients and professions, though this may not always be welcomed.
Lelliot (PCWS, p.147) notes that a range of levers affect the quality of health care exist. These include not only policy guidance and directives but also processes such as standard setting; regulation of services; performance management; public reporting of performance of providers of services; peer review and accreditation. He argues that professions such as psychiatry can only achieve the broader aim of improving the quality of mental health care and of the outcomes for patients if they engage actively with these levers.

**Advocacy**

As mentioned above, advocating for patients is the duty of the psychiatrist. Robertson and Walter (PCWS, p.221) argue that advocacy is another responsibility that psychiatrists should undertake, addressing the patient's journey through various institutions, including health, housing, welfare and criminal justice systems. Bhugra et al (PCWS, p. 59) believe that health care employers expect psychiatrists to be advocates for patients, to enable them to gain and maintain employment, quality housing and at least some social activities. They also suggest that psychiatry has not only to engage patients, their carers and other colleagues, but also has to speak to society at large.

**‘New professionalism’**

Robertson and Walter (PCWS, p.221) state that

> “the ‘new professionalism’ refers to the evolution of medical ethics in light of a number of changes in health care, including the scale of health care, the rise of interdisciplinary health care and prominence of the biopsychosocial model in mental health, technical progress, increased literacy about health care in the community, public policy and expectations of third parties”

In return for demonstrating certain qualities (like specialised clinical skills and empathy) that benefit society, providing a public service and promoting the public good, professions are accorded rights and privileges, including autonomy and the capacity to self-regulate – this is, in effect, the “contract” between a profession and society (Michels, 2012; Bhugra and Malhi, 2013; Ikkos et al, 2011). However, mutual expectations have changed over time, along with changes to the dominant social values, beliefs and ideologies. These changes can be best responded to through the adoption of a ‘new professionalism’ which requires greater attention to collaborative working, understanding individuals’ ideologies and maintaining clinical and scientific credibility of the profession (Bouras and Ikkos, 2013).

One of the messages from the Mental Health Foundation’s Inquiry into the Future of Mental Health Services (Mental Health Foundation, 2013) was about greater collaborative working and integrated care. The report suggested the need

> “to maximise opportunities for both the current and future health and social care workforce to be better informed about the indivisibility of physical and mental health and the value of collaborative working"
and the skills that colleagues in other disciplines bring to patient care. These issues need to be a core element of early basic training of all health and social care staff.”

Coker (PCWS, p.195) suggests that clinicians will have to learn to embrace partnership and collaboration as a normal way of working in the future. They have to acknowledge the reality of working in a complex system such as the NHS. Creuss and Creuss (PCWS, p.103) believe that professionalism must be taught in an integrated fashion throughout the undergraduate and postgraduate curriculum.

The importance of advocacy and empowerment

The term ‘new professionalism’ is symbolised by the rise in advocacy and empowerment, as well as by the concept of recovery as a deeply personal process, rather than a destination or final outcome (Bouras and Ikkos, 2013). Borman (PCWS, p.209) suggests the medical profession needs to embrace the social changes that have come about through more empowered service users in order to achieve this ‘new professionalism’. Jakovljevic and Ostojic (2013) discuss the changes facing medical professionalism, suggesting we are starting to see a shift from paternalism towards partnership with service users. Specifically underlying psychiatric professionalism is a commitment to justice, education, research and human rights.

Training and recruitment of psychiatrists

With changing societal expectations of psychiatry and the encouragement of a ‘new professionalism’, it is argued in line with Creuss and Creuss (cited above) that there is no consistent method of conveying updated codes of professionalism within medical training (Jakovljevic and Ostojic, 2013). Jakovljevic (2012b) expresses concerns about stigmatisation observed within the psychiatric profession, which often draws a line between professional (us) and service users (them). Such an approach depicts service users as unreliable, unpredictable and unreasonable, while the psychiatric professional is the very arbiter of reason, reliability and prediction. The urgency of the need to combat this stigmatisation is self-evident.

To improve training, Widge et al (2014) report on a model which supports psychiatric trainees in developing the skills necessary for successful leadership, including assessment of their competencies in educating patients and families; active involvement in quality improvement; resource management; using structured procedures to enable patients to transition within or from psychiatric treatment. Steele and Beattie (2013) found that medical students who were exposed to psychiatry-based experience within the first year of their postgraduate work experience were over eight times more likely to specialise in psychiatry. This has been confirmed by Lydell et al (2013) in a 20 nation study. These authors reported that clinical experience along with charismatic teaching made a difference in getting the students to choose psychiatry. In addition, early professional development for students focused on good communication skills, respect for patient autonomy and commitment to addressing poor
practice - three professional attributes of the ‘new professionalism’; and peer and pastoral support was provided throughout the training for newly recruited psychiatrists. Yager (2011) calls for psychiatric professionalism to be explicitly linked to academic training in hospitals in order to prepare trainee psychiatrists for real-life practice, which is often characterised by resource constraints and ethical dilemmas.

Another psychiatry training project, piloted in Malaysia, required psychiatry trainees to promote awareness of mental health to the general public with the aim of developing communication skills and reflective professionalism from an early stage in their psychiatric training. Trainees reported its efficacy in building team working skills and providing a valuable basis for leadership training (Bahari & Alwi, 2012). Barras and Harris (2012) report on psychiatry trainees’ suggestions to improve perceptions of psychiatry through increasing the level of integration, geographically and philosophically, with other specialties. Jain et al (2011) highlight the usefulness of web-based technologies to provide ethics and professionalism training, as students perceived these methods as highly relevant to their clinical practice. There is no doubt that the younger generations have different ways of learning and retaining information (Bernstein and Bhugra 2011).

What is expected of society in the “contract”? 

The bulk of the literature reviewed for this report focused on expectations of psychiatry and psychiatrists in the implicit “contract” that they have with society. However a contract is generally a two-way agreement. What does the literature say about society’s side of the bargain? What we found can broadly be divided into views of the role of the state (including politicians and policy-makers), other health professionals (including managers of services), service users and the general public. Much of what has been found though this research has more widespread applicability to the medical profession as a whole, rather than just psychiatry.

The State

Bhugra (2008) asked members of the profession about challenges affecting the profession and role of politicians and resulting interference was one of the commonest complaints.

Creuss and Creuss (PCWS, p.134) suggest that the medical profession’s expectations of government include autonomy sufficient to exercise judgement; self-regulation; a health care system that is value-laden, equitable, adequately funded and staffed; a role in developing health policy; monopoly through licensing laws; and rewards, both non-financial (respect and status) and financial.

The role of politicians and policy-makers is highlighted by Ikkos (PCWS, p.9). Politicians have an important role in negotiating and supporting professionalism and a determining role in the failure as well as the success of psychiatry through their social and healthcare decisions, such as the deliberate move across the UK towards deinstitutionalisation and care in the community from the 1960s. Lelliot (PCWS, p.147) points to the impact on mental health care of such factors as levels of social deprivation.
and the ethnic composition of the local population, and the political and societal forces that influence attitudes to mental health problems and resulting stigma and discrimination. Social determinants of mental health although noted, have not received the attention they deserve.

A number of authors refer to the need for mental health services to be properly resourced. Freddolino and Knapp (PCWS, p.43) suggest that the ethical obligation for health professionals to use evidence-based ‘best’ medical practice is limited at a collective societal level by what health care resources are available.

Other professionals
Psychiatrists across the UK need to collaborate with professionals outside their own discipline. Lelliot (PCWS, p.147) cites the importance to psychiatry of workers from other disciplines, including administration, information, communication and many different elements of services and support.

Service users
If doctors are to work in partnership with service users, as part of the ‘new professionalism’, then this needs an understanding from service users of their own collaborative role.

In general, people using any health service are regarded by the NHS Constitution as having certain responsibilities. These include the responsibility to be open and honest about their symptoms, to treat health service staff with respect, to listen and take the expert advice offered. Patients themselves equally should be treated with respect and listened to. It is for the benefit of all for the information shared to be clear and accurate. However, it is important to recognise that for people with mental health problems stigma, fear of compulsion or indeed their conditions, may render these expectations difficult to deliver.

The literature we found contained very little about service user’s obligations under the “contract”, and very little written by service users themselves. One example from Canada (Selkirk Mental Health Centre, 2014) sets out a list (not legally binding) of service user responsibilities, including

- respecting the rights and property of other service users, staff, and the Centre;
- participating as much as they can with the staff in their treatment;
- being responsible for their actions and the outcomes arising from those actions; taking good care of their own physical needs

However, it would be legitimate to ask whether people who are unwell should be held to be responsible for their actions and to take care of their physical health needs if they are clinically depressed, highly anxious, in a crisis, hearing voices, having delusions or potentially lacking capacity.
A number of authors cite patient empowerment (e.g. McQueen et al, PCWS, p89). Borman (PCWS, p.209) and suggest that this ‘mutualism of empowerment’ could form the basis for a new social “contract” between psychiatrists and society. However, while some service users may feel confident and able to raise their voice and join in decision-making processes, others might not feel empowered by their interactions with health professionals; they may go with their psychiatrist’s recommendation, or feel so unwell that they do not wish to engage in the process.

The Mental Health Act and the powers to section people against their will makes notions of empowerment very difficult and complex because, in this context, the professional does have the power.

The public

Bhugra et al (PCWS, P.59) point out that public attitudes and beliefs around mental distress could be better informed to support the notion of responsibility. There needs to be investment in public education concerning the factors that impact on mental distress, if there is to be any sort of debate about an explicit “contract” of patient personal responsibility.

The public is a key stakeholder in identifying needs related to mental distress and must be a partner in dialogue about what constitutes truly accessible services. An improved public understanding of psychiatry is not solely the responsibility of psychiatry.

Clarifying the “contract”

The literature acknowledges and tries to define the implicit “contract” between psychiatry and society. In this psychiatry is not unique as such a “contract” may be said to exist between any medical specialty and society. It proposes that there is a need for a better understanding of what the “contract” means, and the roles and responsibilities of all those who are part of the “contract”. All stakeholders should have an interest in improving this understanding.

None of the literature we looked at suggests that a more formal, possibly even written, contract is the way forward. Written statements made by the Royal College of Psychiatrists already set out with some clarity the expectations that we should have of psychiatrists. In view of this, Ikkos et al (2011) suggest that psychiatrists need to be more active in discussing with and informing society about psychiatric problems, stigma and risk management, ensuring that those with decision-making powers understand the full complexity of providing person-centred psychiatric care. They need to engage collaboratively within wider health teams and help to manage health systems, whatever part of the UK they work in.

At the same time society needs to engage in a wider debate about mental health, the social and economic steps that can be taken to improve mental health and recognition of the appropriate services to help people achieve recovery. The “contract” from society must have at its foundation parity of esteem for mental and physical health and recognition of the many specialisms, including psychiatry, that are making a contribution towards this.
The evidence set out in this section came from: two online surveys; twelve semi-structured interviews with senior figures from a range of professions working in the field of mental health; and two focus group sessions, one of service users and one of carers. A full methodology is set out in Annex A. To aid comparison with the evidence from the literature, we have set out the evidence collected under the same key thematic headings:

- The current “contract” between psychiatry and society
- The challenges facing psychiatry
- Expectations of psychiatry and psychiatrists
- ‘New professionalism’
- What is expected of society in the “contract”?
- Clarifying the “contract”

**The current “contract” between psychiatry and society**

The word “contract” meant little or nothing to most of the respondents, who rather referred to the benefits of a ‘conversation’ or ‘understanding’ between psychiatrists and service users (and others, such as health care colleagues) that should form the basis of psychiatric care. Setting aside this terminological issue, there was a general understanding that psychiatrists would do their best for service users within the resources they had available, while service users, carers and others should support psychiatrists in their job as best they could. Many responses showed that in some people’s personal experience, there was a gulf between the aspiration and the reality of psychiatric care today. Healthcare staff, including psychiatrists, generally accepted that changes in society needed to be reflected in changes to mental health care across the UK, involving a greater openness about what could be offered to service users, more effective collaborative working and the greater involvement of service users themselves in decisions about care and treatment, where possible. It was pointed out that this had been happening, to a greater or lesser extent, across UK mental health services for many years. However but the evidence included numerous examples where there was clearly still some progress to be made.

It was suggested that to fulfil its side of the “contract”, psychiatry needed to be three things. First, it had to be credible, which meant acknowledging some of the problems that have happened in the past, and not making exaggerated claims about what psychiatry could do, for example in terms of preventing homicides by people with a mental health problems or suicides. Second, it needed to be visible, and spoken about. Third, it had to be useful, which meant, in terms of health services, doing the right thing in the right places.
Challenges facing psychiatry

The main challenges facing psychiatry in fulfilling its side of the “contract” with society, as told to us, covered broadly the same areas as set out in the literature. These included:

Resources

Although there is a single Royal College representing psychiatrists across the UK, individual psychiatrists operated in increasingly complex health care systems, each differing in some way in the four parts of the UK (although all were under considerable resource pressures and facing increasing demands). While the NHS as a whole faces such pressures, respondents told us that scarcity of resources across mental health services was creating a culture in which professionalism has become more difficult to aspire to. There was an apparent sense of hopelessness in relation to the future of mental health services overall. In addition there is no single body speaking for psychiatry.

“Extremely pessimistic as the whole health care atmosphere is so oppressive especially towards ideas that do not conform to the latest fad or those sanctioned by the DH or the big-wigs in parent organisations.” (Mental Health Worker)

“I sense they are pressured to keep brief time slots and don’t have enough time to do their jobs to their potential.” (Service User)

Many respondents, including service users, acknowledged these pressures on psychiatry. Frequently, they reported a need for more funding to be allocated to psychiatric practice so that system wide improvements can be implemented. These responses called for more inpatient beds, more time with service users, more frequent consultation visits and greater availability of services, particularly in rural areas and/or during crisis periods.

Medical model

Many respondents perceived psychiatry to be reliant on the medical model of treatment, involving medication as the first, or only, option offered. Some of the strongest criticism of psychiatrists in this respect came from other mental health workers, although they acknowledged the value of psychiatric expertise. Psychiatric medication is clearly deeply mistrusted by many service users.

Other evidence we received makes clear that in fact much of psychiatry has moved beyond this to a more holistic approach to care and treatment, with a range of options offered to service users. But it remains a core concern for many people, some of whom have had a poor personal experiences with psychiatrists. There was more than one call for the wholesale abolition of psychiatry. In addition several respondents reported difficulties with accessing physical and mental health care when both were needed simultaneously. Other respondents referred to the physical health of psychiatric service users being overlooked.
Access
Balanced against criticism of psychiatry, paradoxically there were many calls for greater access to the skills and expertise that psychiatrists were felt to have, through embedding psychiatry further into mainstream services (for example in primary care and A and E). Indeed, lack of access to psychiatrists was cited as a concern throughout the evidence, as was a lack of continuity of care by the same psychiatrist.

“In my CMHT you’ve more chance of seeing a shooting star at noon than see a psychiatrist within a SIX MONTH waiting list.” (Service User)

“My consultant, who I had known for many years, was moved to a different area without a permanent consultant being in place. Consequently, I received inconsistent care as each time I saw a consultant I saw a different one for many months. Psychiatric conditions require continuity of care which this service did not provide.” (Service User)

“The doctors move continuously, that’s the main problem because my husband sees different people. He doesn’t like seeing different doctors.” (Focus group)

Stigma
A number of respondents pointed to the challenge posed by the stigma attached to mental ill-health, with the resulting low status accorded to psychiatry within the medical profession.

“You can’t diss a profession for years on end and then expect young people to go into it. It’s respect isn’t it, and internal rewards – which have been lost because they are getting constantly criticised, constantly demoralised, constant smears about how bad people are.” (Interview)

Attitude
The evidence also highlighted continuing concerns about psychiatrists working in silos rather than in collaborative teams, as a result of “the way people see themselves, as an expert that is somewhat untouchable” (Interview). As one health professional put it,

“I worked in lots of different teams, in-patient and community, and the summation of my experience of everyday clinical work with psychiatrists was a negative experience. I didn’t feel like an equal, I didn’t feel we were having conversations. I felt it was like being in a room with a headmaster or a headmistress. They weren’t really interested in the wider team, or approaches that were not medical…. they were domineering, they led, they were the boss, that was it. There were other psychiatrists who were different, they weren’t all like that.” (Interview)
An inexact science

Psychiatry was also challenged by the perception of diagnosis and treatment of mental distress being an ‘inexact science’, with calls for psychiatry to be more honest about its inability to resolve every problem.

“Most of them, if you look back through their notes, cycle through diagnoses every time they see a different psychiatrist, schizophrenia, schizoaffective disorder, bipolar, tralala, it’s an intellectual game, I don’t see the point.” (Interview)

“None of the psychiatrists who have seen my husband never been the same diagnosis for him, some people say mood disorder, some people say paranoid psychosis some people say chronic paranoid schizophrenia.’ They tried four or five medications, then finally settled on one.” (Focus group)

While the evidence suggested these views are widespread, it was also pointed out to us that psychiatry was not alone in being inexact in terms of accurate diagnosing and uncertainty over optimum treatment.

Low status

A number of responses referred to psychiatry’s low status among the medical profession.

“We are treated as second class citizens by other specialities/patients.” (Psychiatrist)

“I think the Royal College [of Psychiatrists] are viewed at the bottom of the pile in doctor world. That’s a tricky position for them. Medical students are told, if you want to get ahead as a doctor, don’t become a psychiatrist.” (Focus group)

For some psychiatrists, the perception of a devalued psychiatric profession was the result of a necessary progression into preventative and community-based care, delivered within an increasingly holistic, integrated and multi-disciplinary approach. Psychiatrists often viewed their specialist knowledge as having a necessary, but perhaps a more limited, place within generic health care services. One participant felt that a psychiatrist’s role was tricky to define as it straddled a number of areas:

“We are interested in disorders of the brain but we are not neurologists, we are interested in disorders of the mind, but we are not psychologists, we are interested in problems in society, but we are not sociologists. We are a bit of all three.” (Interview)
Societal problems
A number of responses, including from psychiatrists, referred to what was described by one respondent as an ‘inhumane society’ in the UK, which renders it difficult for many to stay mentally healthy, or results in people becoming unwell. Psychiatrists feel they are playing catch-up to repair the damage that an unwell society has inflicted upon the individuals that come into their care. There is a strong sense that psychiatrists perceive their remit as too limited to enable wider progressive developments, which are of paramount importance to addressing mental health inequalities.

“The fundamental question should be what sort of society would be conducive to the mental wellbeing of individuals and not how do we provide care for those who have understandably been scarred by an inhumane society.” (Psychiatrist)

“Psychiatry is intricately linked with the prevailing social condition of the country. In my opinion, no significant changes to service delivery can be made if this issue is not addressed.” (Psychiatrist)

Influence of pharmaceutical companies
A sense of frustration and mistrust with the psychiatric profession was evident in many responses, which seemed to be particularly centred on, but not exclusive to, issues with psychiatric medication. Some respondents challenged psychiatry about the influence of pharmaceutical companies on psychiatric treatment models. Several argued that this has caused reduced validity in psychiatric approaches to mental health problems and an entrenching of traditional models of care within psychiatry. The influence of the pharmaceutical companies have struck some as negatively impacting on the efficacy and trustworthiness of the psychiatric profession

“…. not driven by the agenda of pharmaceutical companies.” (Psychiatrist)

“…. not dominated by the huge financial interests of the pharmaceutical industry.” (Health worker)

However, it was pointed out that it could be argued that any doctor who prescribes drugs is influenced by the pharmaceutical companies. Psychiatrists and many service users alike accepted the benefits that medication could bring in enabling service users to recover and get on with their lives – as one service user put it, “some of the drugs really are life-saving.” (Interview)

Expectations of psychiatry and psychiatrists
“If we think about the function of a psychiatrist, we’re expecting them to have a significant technical capability, but in addition to that we’re also expecting them to have a particular compassion for social understanding, people’s social networks, and engagement of other components of the care continuum which aren’t simply about technical expertise.” (Interview)
The overall picture we heard was similar to that has already been reported in the literature: that the responsibilities of psychiatrists lie primarily in demonstrating appropriate clinical skills around assessment, diagnosis and treatment; allied to building a therapeutic, supportive relationship with service users. This requires strong interpersonal skills and an ethos of kindness and caring. There are also expectations that they will have a breadth of skill to look right across their physiological and psychological issues, create an assessment based on both of those, and provide appropriate treatment.

‘Good’ and ‘bad’ psychiatrists

What was interesting from the evidence was the number of times respondents divided the psychiatric profession into ‘good’ and ‘bad’ psychiatrists. The message appears to be that psychiatry’s side of the “contract” with society is being fulfilled only patchily across the UK at present.

“Some psychiatrists are absolutely sensational, and others are not.” (Interview)

“My personal expectation of psychiatrists is to stop being such arrogant bastards and to take a much more user/carer led view of when they work with service users. I think we are a very mixed bunch at the moment and some do this really, really well; and some are still living in the dark ages and hardly do it at all.” (Interview)

“There are four psychiatrists in my family, you know, so I am not anti-psychiatry by any means, but unfortunately the ones in my family are also extremely arrogant! There are really good ones [name given]. He’s brilliant, runs a great service. He’s got some humility.” (Focus group)

Honesty

Many respondents talked of the need for psychiatry in general, and individual psychiatrists, to be more open and honest about their limitations. Honesty and transparency from the profession about what psychiatry could realistically achieve would increase respect for the profession and help overcome current mistrust and scepticism. In particular, there were calls for greater honesty about psychiatric medication, particularly in the limitations of its effectiveness and the potential for serious consequences as a result of side effects, and the influence of the pharmaceutical industry on psychiatric care.

“I think the RCP are sheepish and cautious about their profession, such as on their website, how they describe themselves. They would do better to have a bit more honesty about what psychiatry can and can’t do.” (Interview)

Clinical skills

The clinical skills, qualifications, revalidation requirements and professional ethics expected of psychiatrists came high in people’s expectations, as
one would expect for any medical professional. Service users, carers and
other health professionals look to psychiatrists for particular expertise
around assessment, diagnosis and treatment of mental ill-health, which
should extend into having a holistic understanding of mental health and
wellbeing. Expert understanding would be indicated by providing accurate
diagnoses which account for the entirety of a person’s experiences and
difficulties, not just their symptoms. In particular, they are expected to be
up-to-date with psychiatric medication options, and expert in its complex
interaction with other medications and health problems.

“The primary role of psychiatry is to deliver a professionally based
approach to the treatment of people who experience poor mental
health, and to deliver it in a positive and recovery-orientated sort of
way.” (Interview)

“I look to psychiatrists to provide an accurate and helpful diagnosis
in order to guide treatment by myself and by other professionals and
also to have an expertise in mental illness but also in the prescribing,
monitoring and adjusting of appropriate medication, pharmacological
therapy.” (Interview)

A significant number of respondents s claimed that psychiatrists were
much less expert in knowing about alternatives to medication, and that
this was a major gap in their knowledge and skill base. Expertise would
be signified by having a well-rounded knowledge of existing treatment
options, including routes to referrals for further support, whether from
other health professionals or from community-based programmes.

“Less on doling out the same old rubbish psychiatric drugs, and
more on therapy and developing proper treatments that work without
making you ill or fat or live like a zombie.” (Service User)

“All my experience tells me that people become mad because of
the context has become intolerable in one way or another. I’ve
had people who were declared to be severely schizophrenic who,
when they got out of an abusive relationship, were actually fine. All
psychiatrists should understand the social context, and be interested
in it, and curious about it, and willing to engage with it.” (Interview)

In addition to the skills that would allow a psychiatrist to fulfil all the
expectations set out here, a number of responses referred to the need for
psychiatrists to play an increasingly active role in the prevention agenda.
This would require skills in understanding how to help communities and
individuals develop resilience to mental health problems in the first place,
and prevent them reoccurring when they happen.

Interpersonal skills

The expectation that psychiatrists would have significant interpersonal
skills pervaded responses. These include the ability to feel and
demonstrate empathy with service users; be good at listening and
valuing others’ input; engage in informed discussions with service users
as equals; show respect to service users, carers and professional health
colleagues; and work well with colleagues in teams. Respondents
highlighted the increased importance of such qualities when interacting
with people who are often at their lowest, most vulnerable and even in a crisis. Service users seemed to place greater focus on interpersonal skills and qualities over other aspects of psychiatric professionalism. While service users’ feelings towards psychiatry were mixed, a significant majority cited dissatisfaction with psychiatrists’ interpersonal skills.

“In 20 years’ experience of the mental health system, I haven’t met a psychiatrist who understands my needs or shows any empathy for my problems.” (Service User and carer)

“I have found psychiatrists quite remote on the whole. I have often felt that my case and both my son’s and daughter’s cases are regarded as academic exercises so an improvement in ‘bedside’ and communication skills would be appreciated.” (Carer)

“Psychiatrists need to listen more! I have encountered more than one who have been very dismissive of my input, which is something that induces great anxiety.” (Service User)

“They are reconfiguring a service, they don’t even tell you about it even though they have a legal duty to do so. He said ‘We would have told you but you wouldn’t have understood it’. I mean, the level of arrogance of these people!” (Interview)

“My experience is that many psychiatrists (not all - I have some very positive experiences too) are reluctant to respect patients as equals or to engage in discussion about treatment options, and to keep patients fully informed.” (Service User)

Many of the responses, which indicated a need for more empathic psychiatric care related to the amount and quality of time that psychiatrists spend with service users. Most respondents who referred to psychiatrists’ personal qualities as needing improvement were focused on the depth of information gathered in consultations and genuinely listening to service users, which might not always be possible in very short spaces of time. In addition, many called for all health professionals, not just psychiatrists, to show more humility and honesty in their conversations with service users.

Leadership

It was clear from the evidence from psychiatrists that they see themselves as having a leadership role.

“Need psychiatrists to be the leaders.” (Psychiatrist)

“Recruitment into psychiatry is likely to worsen unless psychiatrists are back in the driving seat of assessment and care for more severe mental illness.” (Psychiatrist)

However, there was a distinction made between leadership in which psychiatrists take decisions unilaterally (whether as a profession or as individuals within the health care systems they are working in) and leadership, which is accepted by all as a natural and necessary role for psychiatrists as experts in their field (but offered as equal partners with colleagues). The latter was strongly encouraged in the responses we received, and would apply to issues beyond treatment and care such as service design and management, resource allocation, policy development
Several respondents referred to the role of psychiatry in advising and supervising mental health care teams, and helping to coordinate mental health and other health care teams.

“What I need from a psychiatrist at the moment is leadership around changing and transforming models of service delivery, and also leading in what I think of as the changing “contract” between citizens and professionals.” (Interview)

“There’s leadership and leadership. You can either pretend you are a general on the battlefield, but that doesn’t normally work, and telling people what to do, or you can have leadership through example and personality, experience, etcetera - that kind of ‘softer’ leadership.” (Interview)

“Psychiatry, or the medicalization of mental ‘health’, should really not preside so dominantly over matters …. like any other profession it is not the be all and end all.” (Carer and health care worker)

“I’ve never felt the psychiatrists should necessarily be the leader of a multi-professional team. They could be, but they shouldn’t necessarily be. Part of their role should be clinical leadership but they absolutely shouldn’t be the only profession that has that clinical leadership role.” (Interview)

Public education

A number of respondents referred to the role of psychiatry and psychiatrists in educating the public about mental health and mental illness, and raising understanding of the place of psychiatry in society. This could help address myths, improve credibility and status, tackle stigma and assist collaborative practice. It would also help society fulfil its side of the “contract” by reducing uncertainty about psychiatry and fears about mental ill-health; and clarifying the benefits of resourcing psychiatry and other associated mental health professions properly. One view was that it was essential for psychiatrists to better educate health and other professionals about their role and responsibilities, and what they can offer within the overall health care system. This was particularly important with respect to the high levels of comorbidity among people with mental health problems. If public understanding of mental health was generally not good, many professionals, in health and other systems, like housing, criminal justice and welfare, were also uncertain about important aspects of psychiatric needs, care and treatment.

“It’s a bit like, you know, you stand on your soapbox and nobody listens to you for about 5 minutes, but…. by the end of the evening, if they’ve got any communication skills at all, there is a different understanding of the breadth and depth of what a psychiatrist does. We need to go into schools, libraries, public places, working with local government.”

“We need to ensure not just that mental health services are looking after the physical health of their patients, but the acute sector, and indeed primary care are really tuned into thinking about the mental
health of their patients. We also know that the most effective way to deliver that attitudinal change is a peer to peer model."

"I’m sure psychiatrists are seen as “there’s somebody who treats somebody who’s mad and bad” and I still think that those myths exist. But the profession itself has to take responsibility for that. We need to be campaigning, lobbying politicians and civil servants."

There was a sense that psychiatry is in a good position to engage a range of stakeholders, including the media and the general public. However, this would require a concerted effort at national, regional and local levels across the UK, and the commitment of the Royal College of Psychiatrists, all its Faculties and individual psychiatrists to devote time and resources to getting accurate messages about psychiatry out. Professional communication skills would be needed to support this effort, and research and statistics that would attract media interest.

‘New professionalism’

One of the straplines set out on the homepage of the Royal College of Psychiatry’s website reads:

"Psychiatry is at the heart of medicine. Our goal, in collaboration with colleagues, patients and carers, is to relieve the suffering caused by mental disorders."

This view of psychiatrists as collaborators in care presents as clear a statement as could be hoped for about psychiatry’s adoption of the ‘new professionalism’ that is at the heart of its “contract” with society. It reflects many changes that have already taken place in mental health care over the past few years. These include an emphasis on multidisciplinary working and integrated care, and the strong call in the evidence for psychiatry to be embedded more in mainstream healthcare settings (particularly in primary care (general practice)surgeries, Accident and Emergency (A&E) departments and acute medical and surgical wards). Several responses referred to a need for improved communication between professionals in order to achieve good integrated care, particularly between physical and mental health care services. Carers highlighted psychiatrists’ role in enabling better collaborative working between primary and secondary care, especially in respect of discharges from hospital.

Many responses made clear the benefits, and desirability, of collaboration and partnership with other professionals through an understanding of how society, relationships and communities affect mental health and mental ill-health.

“If you have a psychosis diagnosis and you are living in your car and your wife has dumped you and you haven’t got a job, it’s no good just treating the psychosis diagnosis in isolation. You need to get them not living in their car, and hopefully in a better relationship, and perhaps back into work. So psychiatrists need a better understanding of all the other issues and help them out with those. It’s not a psychiatrist’s job to get people a better income and into a job; of course not. But they should be part of a team, whose job it is to support the person and to communicate with each other and with
the patient – a systemic understanding of the whole of a person’s life and the total impact on them.” (Focus group)

“You’d start talking [in the team meeting] about someone, and somebody would say “I think I’m seeing their husband” or “Don’t you remember what happened to their child?”. You’d get this very rich picture emerging. Psychiatrists were always really astounded by how much the combined team knew about their service users.” (Interview)

“Seek to be more inclusive in developing models of mental health care that involve psychiatry, psychology, nursing, social work, social care, and most important service users.” (Health care worker)

The benefits included not only sharing decisions about what care and treatment to offer, but also sharing responsibility.

A few participants expressed concerns that mainstreaming psychiatry within wider health and social care services has served to conflate and confuse the respective roles and responsibilities of psychiatry and other professions, and led to a devaluing of the role of psychiatry within mental health services.

“The mental health services getting integrated with the social care has diluted the real/core functions of the mental health services. The danger is that, if it continues, that social care will become the major part of psychiatry.” (Psychiatrist)

Training and education

In terms of training and educating psychiatrists to fulfil their side of the “contract” with society better, responses suggested a number of improvements were required, which might be summed up as calling for a ‘more rounded’ education. There was a strong sense that this had to start from day one in medical school; and to involve all medical students, regardless of what specialty they might choose to focus on later. More specifically, this involved ensuring that all doctors were trained to be ‘psychologically minded’; and learnt the skills necessary to work collaboratively across professional boundaries, create positive relationships with service users and carers, based on equality and respect and developing humanistic personal qualities. For trainee psychiatrists in particular, there was a need to instil the values of ‘therapeutic optimism’ that is the ability of people to recover from mental ill-health; for service users to be involved more in the training process; and for trainees to spend more time in the community.

“I’m obsessed with having all medics more psychologically minded, then the whole thing would infiltrate the whole system.” (Interview)

“I think we all, across mental health, need a more common core basic training. It makes no sense to me we don’t get this. I mean, once you know you are going to be a psychiatrist, or a mental health nurse, or an OT working in mental health, then what I would like to see is common core training. With the emphasis on how to work together, right in at the beginning.” (Interview)
“There’s still a lot of work to be done not just around psychiatry but about how professionals work together, but also about how professionals understand and recognise the roles and responsibilities of each other’s work and where the boundaries are and where the expectations are. I think it needs to go right back to the embryonic stages of people’s professions and start with students really, and how we prepare students in their roles and responsibilities.” (Interview)

In addition, there were calls for psychiatrists to be more fully trained in psychosocial interventions and physical health care, and less focused on medication; and in coaching people in terms of taking responsibility for their own health. There was a sense of loss in regards to the trust placed in psychiatry by the general public.

“What is expected of society in the “contract”?"

Overall, what people told us reflected widespread agreement that psychiatry, just like any health profession needed to be properly supported to enable it to provide the expected benefits to society. Not unlike the evidence we found in the literature, this can broadly be divided into views of the role of the State (including politicians and policy-makers), other health professionals (including managers of services), service users, carers, the media and the general public.

The State

The evidence we received indicated that the State saw itself having two main responsibilities towards psychiatry. The first was to ensure that it received adequate funding and resources to fulfil its role and responsibilities properly. The challenging work environment within psychiatric services was apparent in responses that cited: a lack of resources leading to difficulty with accessing specialist psychiatric expertise; under-trained and unsupported health care staff dealing with psychiatric emergencies; and underfunded psychiatric research programmes. Government investment was called for to help tackle the stigma associated with mental ill health.

“I think psychiatrists need more time to diagnose and the Government needs to protect the funding to the mental health teams to make sure that they can continue their good work.” (Service User)

“There does seem to be a particular issue around bed availability in mental health. If you take that as emblematic of pressures the service is under, it may be that society, if there is a “contract”,...
through government, isn’t perhaps holding its side of that bargain.” (Interview)

Ministers and other politicians across the UK have a major say in how much money the NHS gets. Yet the actual commissioning arrangements for most psychiatric services across the four parts of the UK vary. This has already started to create an inequity between various geographical regions. Whatever the arrangements are, there was a strong call for commissioners of services to be fully knowledgeable about the levels of psychiatric need in their communities and the health, social and economic benefits of providing adequate resources for psychiatric services; and to engage with psychiatrists in designing local services.

“In relation to commissioners of services, they should expect to be working in, and with, the proper facilities and equipment that they need to perform their function in the way that their patients might expect of them.” (Service User)

The second main responsibility for the State is that it should ensure mental health was recognised to be a major health issue for all Governments across the UK; and should be accorded appropriate attention. It was argued that psychiatry will continue to face the challenge of working within a stigmatised context until mental health problems become widely recognised in society as being on par, in importance and effect, with other health problems. The ‘parity of esteem’ that underpins current mental health policy in England was cited as a positive development.

There was a strong sense of frustration among psychiatrists at the ‘inhumane society’ that is felt to be behind much mental distress across the UK. A number of responses referred to the State’s responsibility to tackle the social problems that are widely accepted to be at the root of many people’s mental health problems for example the increase in personal debt and financial concerns.

“We also need to remind people, you know, that the prevention of suicide and homicide, well, it’s a small part of what we do and much of it isn’t up to us. Most of it is due to the Chancellor of the Exchequer – if you f**k up the economy you get a rise in suicides, why should we get the blame for that? If you withdraw people’s benefits and put them on the street, why is that my fault?” (Interview)

“Most of the psychiatrists I speak to wish the State would do its job properly so that they could get on with actually working with people who had serious mental health problems that weren’t ‘state-produced’.” (Interview)

Stigma was clearly a significant issue for many respondents, and politicians and policy-makers were clearly considered to have a role in tackling this, through general public education campaigns as well as through specific policies and funding. Several respondents suggested that children should receive education in mental health at school in order to reduce stigma and facilitate informed discussion in future.
Other health professionals

To the question of what psychiatrists/psychiatry should expect from other mental health and health care colleagues, most responses referred to developing a collaborative relationship and working in a team towards common aims, with realistic expectations. A core aspect of building collaborative working relationships was mutual respect for each team members’ professional perspective and experience. Within that framework, it should be possible for other health professionals to challenge psychiatrists’ decision-making in the light of their own particular expertise.

“Inclusivity and open dialogue with a desire to share best practice rather than a defensive bunker culture which has been developed to preserve importance, prestige and superiority.” (Service User)

“It’s a two-way street, any successful relationship would be reciprocal and what we would expect is no more than what they should expect from the nurses they work with really – a relationship of mutual respect, predicated on appropriate respectful behaviours, a commitment to working cooperatively between the two disciplines, being respectful of each others’ specific knowledge.” (Interview)

“There should be a reasonable level of expectation from psychiatrists that their health professional colleagues have at the very least a kind of basic but reasonable understanding of mental health issues and the impact that that can have on people’s lives.” (Interview)

Some responses referred to the need to ensure that where good collaborative working across professional boundaries took place, there was also an understanding and agreement among all staff involved that responsibility was shared.

“If we want power sharing we must have responsibility sharing – doctors, me, patients – it’s not fair to the psychiatrist to share the power but leave them with a feeling them are being dumped on.” (Interview)

Service users

To the question of what psychiatry might expect of service users, responses were broadly divided into three groups: those who felt psychiatrists should not expect anything from service users; those who reported personal qualities that psychiatrists should expect; and those who indicated practical actions or behaviours, which psychiatrists should expect. A key issue was that some service users, as a result of their illness, or a crisis, could at times be unpredictable and lose the capacity to make decisions for themselves.

Several respondents indicated that psychiatrists should expect little or nothing from service users as each consultation will take place on the basis that the service user is experiencing difficulties in recovering from, or coping with, their mental ill health. This is especially true for people who are seeing psychiatrists that is those with more severe mental health problems. It was widely understood that the nature of mental ill health renders it difficult, or even impossible, to adhere to psychiatrists’
expectations. Some respondents suggested that the word ‘expectation’ was the wrong one to use and that the threat of compulsory treatment within the mental health system could be an understandable factor in people’s reluctance to be honest.

“Are you going to say ‘I should expect my patients always tell me the truth’, and all that kind of stuff? If I did expect compliance, I’d be a very unhappy person. 50% of all medication is not taken, and that’s not psychiatry. Do we expect people to be truthful, honest and academic observers of their own condition? Of course we don’t.” (Interview)

“Even when engaging with services and co-operating with treatment to the best of their ability they will often miss appointments, be unappreciative of the help they are offered and have unrealistic expectations due to the nature of their illness.” (Member of the general public)

“I think expectation is the wrong word. I think we should do everything we can to: support people in managing their condition effectively, to encourage them to stay well, to equip them with the information and the resources they need to stay well But I would steer clear of that expectation word.” (Interview)

Additionally the threat of compulsory treatment within the mental health system could be an understandable factor in service users’ reluctance to be honest about their ill-health.

“These people with long term conditions are very aware that what they say is filtered and screened through a value system that contains compulsion within it…. patients won’t disclose issues because of fear of detention and compulsory treatment. And I can completely understand that. I’m not critical of that at all. Why would you disclose a deterioration if you think you are going to be detained? You live in Birmingham, you are going to be sent to a bed in Cornwall, why would you say?” (Interview)

In terms of service users’ behaviour, a number of respondents suggested that there should in fact be expectations, with the very major caveat that their ill-health allows this. Practical actions were mostly related to keeping appointments, being on time and following the advice given by the psychiatrist. Compliance with agreed treatment plans and calm behaviour (including an expectation from psychiatrists that they will not be assaulted or insulted, as any other doctor or health care worker would expect) were also highlighted as important behaviours that psychiatrists should at least hope for, if not necessarily expect, from their service users.

“To engage as much as you are able to. And be honest about your feelings, your behaviour. Be open and honest. Yes, there should be obligations on us to follow treatment regimes, of course at least to the extent that they are able to.” (Focus group)

“If one works on the assumption that the nature of that relationship is a co-produced, co-designed shared relationship, there is a mutual requirement for both parties to do as they say.” (Interview)
This latter comment would only apply to a model of psychiatry based on co-production. This is a difficult model to achieve when the professional in the relationship has the ability to order the detention of the other person against their will.

Carers

The role of carers in psychiatry’s "contract" with society was hardly mentioned in the literature we looked at. However, a number of responses touched on the role of carers in supporting the service user with their treatment plan and in their everyday life; and how a good and effective dialogue with the psychiatrist can assist the clinician to build a relationship with the service user. It was clear that carers could only fulfil this role if they were informed and involved in decisions about the person they are caring for. Many responses referred to the unique perspective that carers often have which can be highly beneficial to supporting the service user’s recovery.

“Support to treat the patient, for example encouraging compliance with medication and keeping appointments; honest reporting of patient’s condition and behaviour to psychiatric team.” (Service User)

“A willingness to inform the psychiatrist of how things are going, and a constructive engagement when things aren’t going well.” (Psychiatrist)

“Why does the psychiatrist need to listen to the carer? Because the mental health patient does not tell the truth all the time. He will do one thing at home, then he will be a good boy in front of the psychiatrist.” (Focus group)

A common thread throughout almost all of these responses was a positive recognition of carers’ roles in providing support to better enable someone’s recovery. Mental health workers evidently perceived carers as a key resource in engaging with service users and in providing personalised care and support. However, it was clear that carers themselves faced many pressures. Of the four carers who took part in a focus group on the issue, three indicated that they themselves had mental health problems.

“That they are usually shouldering the burden of their family members’ problems. That their resources are limited.” (Member of the general public)

The issue of confidentiality was discussed in responses. Some carers clearly felt that there should be a free and full exchange of information to help them support the person they are caring for.

“We should have a right, if you don’t know about medication or something, we should have a right to know everything. I think the family should be informed, the closer people, properly with the psychiatrist, so the psychiatrist can explain about the medication and with the social worker.” (Focus group)
A number of health professionals pointed out that they were bound by professional guidelines on respecting confidentiality. Several responses advised caution in involving carers, not least because family/carer issues may be at the root of a person’s mental ill-health. One service user indicated that carers should only ever be informed or involved where the patient has expressly requested it.

“Often carers, family and friends are co-creators of the illnesses due to sick family dynamics, they must not be allowed to influence patient care or decisions about hospital or medications use.” (Service User)

“You would again be not really fit to be a doctor if you did not understand that carers may put a different view on things because of a million reasons – because they want to keep their loved one with them, or they don’t want to keep their loved on with them. They had enough or they haven’t had enough. Because they trust or they don’t trust the local services, who knows?” (Interview)

The media

It was commonly considered in the responses we received that media coverage of mental ill health, (in the press, on TV or the radio, or via the internet) was poor and unbalanced; and that this caused significant problems in terms of negative public perceptions of predominately people with mental health problems but also psychiatry itself. Stigmatising portrayals of service users did little to foster mutual respect and understanding between wider society and psychiatry. Respondents indicated that the media could go a long way to promoting improved understanding of mental ill health and the role of psychiatric services in providing mental health care, and public attitudes towards people with mental health problems.

We were told that psychiatrists should be able to expect society to bring about a significant attitude shift in how psychiatry and mental health are perceived. Media portrayal was a significant theme in these responses as it impacted on the general public, politicians and health care workers’ perceptions of psychiatry. The media was accused of “scaremongering” (Service User) and portraying a “prejudiced and stigmatising” (Service User) image. The view was expressed that it should use its range and power to educate the public responsibly about the reality of mental illness and the role of psychiatry.

“From the media they should expect accurate representation and not scare mongering or stigmatising. Psychiatrists already have a bad image, without negative press... The general public should be informed and educated so as not to gain the wrong impression of the profession.” (Service User)

“Television programmes and documentaries could also be used to educate and clarify requirements to the public.” (Service User)

“I think television is better, radio is variable. I just don’t want to hear any more neuroscience on Radio 4 in the morning talking about things that are never going to happen. I just wish they’d get some social science out there.” (Interview)
There was agreement that journalists reporting on mental health issues should be knowledgeable and informed about the issues, and not scaremonger. As a number of respondents pointed out that it was unrealistic to expect the media to bend to the ideal expectations and that it was the responsibility of mental health professionals to engage with media more on its own terms.

“It’s so easy to moan about the media. We can all say it’s absolutely shocking the way they report these things. But that’s like King Canute, it really is. It’s impossibly naïve to blame the media. You get the media you deserve. The best you can do with the media is understand them as far as you can and work with them the best you can to achieve your own agendas.” (Interview)

“I think the 1990s were very traumatic…. that relentless drip, drip, drip of what the media calls care in the community homicides. I think that was a terribly traumatic time for psychiatry and it didn’t respond well. I think they weren’t able as a profession to explain in an accessible way the complexities of the job and the balance of risk. Had they been able to do that better, I think the profession would be in a better place now.” (Interview)

The general public

There was widespread agreement in the evidence we received that the general public across the UK was often ill-informed and ignorant about mental ill health and the role of psychiatry. There was an evident sense of frustration that psychiatry was perceived by the general public in negative terms.

“Society is interested in ‘safety’. Its images and understanding is still clouded with concepts like the ‘Mad Axe man’.” (Patient)

This engendered calls on the public across the UK to involve itself in self-educating and fostering an understanding of mental ill health. Expectations went beyond just a better understanding. While there was a key role for governments, psychiatrists, service users and others to assist in educating the public, members of the public themselves should have a responsibility to become actively engaged with promoting awareness and understanding of mental health problems and combating stigma. This included an understanding of the nature of mental ill health and its treatment, the reality and limitations of what psychiatry can achieve, and a reduction in the culture of blame toward psychiatrists for patient behaviour.

Clarifying the “contract”

We specifically asked questions around what might be done to clarify the “contract” between psychiatry and society, and whether there need to be a more formal or explicit “contract”. Two issues quickly became clear. First, there was some unease with the terminology of the term “contract”; second, there needed to be a discussion that distinguished between a national “contract” involving psychiatry and society (however described) and a local “contract” between individual psychiatrists and those they worked with, including service users, carers and health care colleagues.
Terminology

The term “contract” caused some problems. While more academically-minded health staff were comfortable in understanding what was intended in terms of reciprocal rights and responsibilities between psychiatry and society, many respondents linked the term with some kind of financial arrangement. Outside the specific contractual employment arrangement between NHS employers and health care staff, this is misleading in NHS terms where care is largely provided free at the point of delivery. Some also thought that a “contract” implied a legal obligation, or sanctions for non-compliance.

“contract” is the wrong word. It implies some sort of financial payment to people.” (Interview)

“Charter’s a good word…. something that makes clear to the patient, service users, that there are expectations on them. Every citizen in health or ill health, has certain responsibilities.” (Interview)

There was general agreement that some sort of understanding about the reciprocity involved in providing psychiatric services did exist at both national and local, individual level.

“I suspect people don’t normally enter into any relationship with their health clinician with some kind of contractual concept in kind. I think the nature of our engagement with the NHS as the provider, and doctors as professional providers, is that we are going in expecting to receive a service and mainly going into that service willingly engaging with it because we normally want to get better.” (Interview)

A more explicit “contract”?

The general sense of responses was that it would be helpful if the “contract” (if it is called that) was better understood on both sides. This would act to encourage psychiatry to embrace the ‘new professionalism’ in a consistent and wholehearted way, while at the same time making it clearer to other stakeholders in the psychiatric care system what their own responsibilities were. Even if this only had a ‘nudge’ effect, it was felt it would be helpful in: supporting psychiatry to do a difficult job, improve understanding of mental health problems, reduce unrealistic expectations and help tackle stigma.

The issue of whether there should be a more explicit, formal “contract”, which was generally taken to involve something in writing, divided opinion. The majority strongly opposed the idea of a written “contract”, whatever form it might take; even suggesting that psychiatry must be in some form of crisis if it felt such a document was necessary. It was in this discussion that the distinction arose between a national and a local “contract”.

National “contract”

There were suggestions about exploring other forms of “contract” which might provide a model. Examples cited were the Citizen's Charter, the NHS Constitution and the Military Covenant. In particular, we noted that the NHS Constitution in England (Department of Health, updated 2014).
already has a section referring to responsibilities of service users and the public, including:

- Please recognise that you can make a significant contribution to your own, and your family’s good health and wellbeing, and take personal responsibility for it
- Please treat NHS staff and other service users with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution
- Please provide accurate information about your health, condition and status
- Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

These responsibilities are clearly meant to apply to mental health service users as to any other service user, but there was general agreement that none of these initiatives were widely known about; and public knowledge and understanding of the reciprocal rights and responsibilities in them had been, and remained, low.

It was pointed out that one side of the “contract” - the role and responsibilities of psychiatry, and individual psychiatrists - is in fact already quite explicit. Expectations of psychiatrists (as set out at the beginning of this report) are freely available to anyone via the Royal College of Psychiatrists’ website, which also contains a wealth of information about types of mental disorder and options for treatment. Psychiatrists themselves appear clear about their role and responsibilities, even if there may be some variation in actual practice.

“I don’t think there is a need for a “Contract with Society”. All doctors, if you want to put it that way, have a “contract” in the sense that they have to fulfill the legal requirements imposed on them by the State; they have to fulfill the professional requirements imposed on them by being doctors and then they have to fill the expectations that come from the area within the whole of the medical framework where they are situated – and for us we deal with, loosely, mental illness.”

(Interview)

Local “contract”
A small number of respondents felt that a formal local “contract”, between individual psychiatrists and others (particularly service users) might possibly bring benefits.

“I think it’s good practice to have a “contract”. A sort of formal “contract”, but would it be legally enforceable? No. It probably would be on paper, because getting people to enter into that sort of agreement, whether just “I will do my best to attend appointments, engage in therapy, etc”; and on the other side the psychiatrist say “I will turn up to my clinics as well and I will listen to you and give
you the best possible advice and treatment”. That just puts the relationship onto another footing.” (Interview)

“As long as a piece of A4 had been negotiated I would do what I’d agreed, as far as I could. It’s a quid pro quo, the doctor has agreed his side, this is your side of the bargain.” (Focus group)

The majority view, however, was against such a development. Many respondents emphasised the need for a good, honest, two-way conversation between psychiatrist and service user, leading to a mutually agreed understanding. This fell short of then drawing up a written “contract”. It was pointed out that in many ways the Care Programme Approach (CPA), where it is used, and more recently Care and Treatment Planning in Wales, already provided a formal, written procedure setting out mutual expectations in the care of individuals with a mental illness, which would make any further written contract potentially confusing and repetitious.

“I don’t think I’d be in favour of a written “contract”. A, it’s time-consuming; B, you’re assuming that people understand what you’re talking about, can read, all those difficulties that might arise originally and you know I think people need to be grown up about this. I think it’s about the dialogue that you have initially at the beginning.” (Interview)

“I immediately feel resistance to that, it’s almost being treated like a child. Also, medication is a particular issue. You might tick a box saying you would take your medication, you then take it and get bloody awful side effects, so you stop taking it, and then you’re seen as subversive or non-compliant.” (Interview)

“It sounds very much like a CPA form”. (Interview)
Although there are specific facets of psychiatric care that need to be taken into account in considering psychiatry’s “Contract with Society”, the evidence suggests that this “contract” is not fundamentally different to that which exists between other NHS health care providers and society. Accordingly, the role and responsibility of psychiatrists under the “contract” is similar to that of any doctor. The reciprocal responsibilities of the State (and its component parts) apply to all health care under the NHS, not just psychiatry.

The current psychiatrists’ “Contract with Society” is not well understood by stakeholders. The benefits of a greater understanding could include a greater consistency among psychiatrists in adhering to the ‘new professionalism’. It would also help society towards appreciating the personal, social and economic cost of mental ill health, the importance of recovery and the role of appropriate interventions. All of which would help to reduce the stigma of mental ill health.

There is little enthusiasm for making the “contract” more explicit in a formal, written form.

What psychiatry might do?

The evidence highlighted a number of issues around psychiatry’s contribution to the “contract”.

• There were a number of challenges that psychiatry needed to overcome in order to fulfil expectations. These included resource pressures; the stigma associated with mental ill health; a lack of public understanding about psychiatry’s role; mistrust of the profession based partly on historical grounds, but also on people’s personal experience of a poor care and attitudes from some psychiatrists; an over-reliance on medication in treatment; and a sense of being de-professionalised and undervalued.

• There are perceived to be ‘good’ and ‘bad’ psychiatrists. While there is a generally high regard for psychiatrists’ clinical skills, they need to overcome a perception that they are too focused on medication, and become more expert in offering other options for their service users, in a recovery-based model of care. It is clear that many psychiatrists fall short of service users’ (and sometimes health care colleagues’) expectations in terms of their interpersonal skills and attitudes, even to the point of being labelled arrogant. The profession is expected to ensure that all its members are imbued with the values of empathy, honesty and integrity. They should be advocates for their service users, inside and outside mental health services; and have the skills to establish therapeutic relationships of mutual respect with service users and good working relationships with colleagues.
• There is an expectation that psychiatrists will, within the boundaries of professional patient confidentiality, support carers in the difficult role of caring, providing them with helpful information and listening to and valuing carer views. It is accepted that there may be times when this is not appropriate for example if the circumstances suggest that it is carer / family issues which are contributing to an individual’s mental distress.

• Psychiatrists are expected to be leaders, but by example rather than by diktat. They need to actively participate in research, national and local policy development, management and service planning, and to understand ‘the whole business of health’, and where psychiatry fits in. They should work collaboratively in partnership across practice and professional boundaries to ensure service users receive optimum, integrated care, and contribute their expertise more in primary care, community and acute settings. They are expected to play an active role in prevention agenda, using their expertise to advise on how to reduce the risks of developing mental illness.

• Psychiatrists should also be campaigners, getting their views across to a wide range of audiences, and fighting for their profession and service users. They should be expected to engage in debates and destroy myths surrounding mental illness. In addition to their responsibility to help service users access good and accurate information, psychiatry has an important educational role to play. If it is done well, this includes providing information to the general public, the media and health care professionals and other public sector workers about mental illness and the role and responsibilities of the profession. This will require a concerted effort by the profession in view of current low levels of understanding, and widespread mistrust.

• Psychiatry needs to demonstrate openness and honesty about what it can, and what it can’t be expected to achieve. It should explain better what it does, and the rationale for many of its practices, particularly around the use of psychiatric medication. Its perceived failure to do so is considered to be a major stumbling-block to its credibility and a cause of much of the mistrust that it faces.

What society might do to fulfil expectations in the “contract”?

The key issues we highlight here relate to expectations of the State (including politicians and policy-makers), other health professionals, service users, carers, the media and the general public.

The State

• On their side of the “contract”, Governments across the UK are expected to ensure that psychiatric services (and other mental health services), and research, are adequately funded to meet assessed levels of need in their populations; that the role of
psychiatry in health care is recognised and accorded appropriate priority in health strategy and policy; that psychiatry operates on a level playing field with other health care specialties; and that, so long as psychiatry demonstrates its competence and benefit to the public good, the profession is granted autonomy and powers of self-management. This means that politicians and other relevant policy-makers require a good understanding of the issues and challenges facing psychiatry.

• There are additional expectations of governments, including that they promote good mental health among their populations, contribute towards tackling the stigma that surrounds mental ill-health, and inform and educate the general public on mental health issues. This can involve a range of government departments, not least education departments, which should be expected to ensure that children have opportunities at school to learn about mental health and emotional well-being.

• Society’s problems are commonly cited as being a major factor in the development of mental health problems. While it is unrealistic to expect governments across the UK to resolve these problems overnight, there should be a clear expectation on governments across the UK to ensure that all their policies (whether they be in the fields of health, social care, housing, employment, criminal justice or welfare) are assessed in terms of the risk they pose to public mental health and well-being, and to tailor them accordingly.

Other health professionals

• If psychiatrists are expected to work collaboratively with other health professionals, respecting and valuing their expertise, then the same applies reciprocally. Psychiatrists should expect other staff within health and mental health services to be skilled, competent, professional and collaborative. Particularly for colleagues working outside direct mental health care, there should be an expectation that they are ‘psychologically-minded’, and have a basic understanding of mental illness and its care and treatment. This is something that needs to be reflected in early training and continuing professional development for all health and social care staff, which is the responsibility of national training and education organisations and professional bodies.

Service users

• Expectations of service users vary. Some psychiatrists, and other health professionals, argue there should be no expectations on service users at all. This is partly because their illness may mean that at times they are unable to fulfil any expectations placed on them; but also that the reality of psychiatric care, including the threat of compulsory treatment, means it is not surprising when some service users chose not to engage. However, it is noted that the NHS Constitution
sets out responsibilities for all service users. Further, the evidence strongly suggests that outcomes are generally better when service users do engage with psychiatric services and participate actively, on their own terms, in their own care. Service users themselves place significant emphasis on being involved in discussions and decisions about their care and treatment.

**Carers**

- Pressures on carers should not be underestimated and expectations of them should not be unrealistic. The evidence suggests that carers might be expected to raise concerns they have about the person they are caring for with psychiatric services, be open and honest in what they say, help facilitate service user engagement with psychiatric services and support them in their daily lives. Carers’ unique perspective on the service user and their circumstances is considered a key element in promoting the their wellbeing and recovery.

**The media**

- The media could play a significant role in raising the profile of psychiatry and building public confidence in it. However it cannot be expected simply to take on board psychiatry’s agenda. It can be expected to report on mental health issues, including those involving psychiatric services, accurately, and in an informed, responsible and balanced manner. It should not scaremonger or sensationalise stories by misrepresenting the facts and only giving an incomplete picture. Journalists who work on mental health stories should be expected to have at least a basic understanding of the role and responsibilities of psychiatrists and psychiatric services.

**The general public**

- The evidence suggests that there should be an expectation on the general public to take responsibility for educating itself better about mental health issues generally, and the role of psychiatrists in particular. This is considered a crucial step both towards a better understanding of how they themselves might reduce the risk of developing mental illness, as well as improving public attitudes about mental illness and reducing the stigma around mental illness.
ANNEX A

Methodology
The report looked at evidence gathered from published literature on the issue, online surveys and interviews and focus groups.

The literature
The primary source of published views on the issue came from a collection of essays contained in _Psychiatry’s Contract with Society_ (ed. Bhugra, Malik and Ikkos, 2011). These essays were analysed to summarise key themes and messages.

Review of recent literature
A review of recent (primarily 2011-2014) literature was carried out to highlight relevant perspectives and research in relation to the mutual expectations and responsibilities between psychiatry and society published subsequent to Psychiatry’s Contract with Society. UK-based research was prioritised although international reports were also included where they offered relevant guidance for a UK healthcare context. The literature included in the review emerged from the following search terms:

- Mutual expectations AND psychiatry and society
- Reciprocity AND psychiatry and general public
- Psychiatry AND New professionalism

33 peer-reviewed journal articles were included which were relevant to aspects of the interaction between psychiatry and wider society. A thematic analysis of the literature was carried out to identify key messages which shed light on the issue of psychiatry’s implicit “contract” with society.

Online surveys, interviews and focus groups
Evidence was gathered from two online surveys conducted by the Mental Health Foundation.

1. Future of Mental Health Services (FOMHS) survey (2013)
The Mental Health Foundation issued a formal Call for Evidence between December 2012 and May 2013, as part of its major Inquiry into the future of mental health services. A total of 1,533 responses were received from
a range of mental health service users, carers and family members and health professionals. An average of 5% of responses to the FoMHS survey related to psychiatry or the psychiatric profession and was isolated for further content analysis.

2. Expectations, roles and responsibilities of psychiatry and society (2014)

An online survey (Contract between psychiatry and society) elicited the views of mental health service users and mental health professionals and other members of the general public in regards to the mutual expectations, roles and responsibilities of psychiatry and wider society. Survey questions were informed by findings from the literature (see above), as well as the analysis of data collected from the FoMHS survey. Thematic analyses were carried out on 151 responses from across the UK to identify perceptions and views in regards to mutual expectations between psychiatry and of society.

Interviews and focus groups

Twelve individual semi-structured interviews were carried out either in person, over the telephone, or via Skype. Participants included senior figures in psychiatry, general practice, nursing, social work, occupational therapy, psychology, mental health service management, the voluntary sector and the media. Interviewees are listed in Annex B. A focus group was carried out with three members of the National Survivor and User Network (NSUN). A second focus group, arranged through Lewisham Carers, elicited the views of four carers of people with mental health problems (three of whom indicated they themselves had mental health problems).

ANNEX B

Interviews and focus groups

The following senior figures kindly agreed to be interviewed for this report. Their views were invited, and given, on a personal basis, and therefore do not necessarily represent their organisation(s). Any views or direct quotations used in the report have been anonymised, simply referenced to ‘Interview’.

- Dame Sue Bailey, Chair of the Children and Young People’s Mental Health Coalition
- David Brindle, Public Services Editor, The Guardian
- Paul Farmer, Chief Executive, Mind
- Fran Fuller, Chair, British Association of Social Workers
- Jamie Hacker-Hughes, President Elect, British Psychological Society
• Iona Heath, Immediate Past President of the Royal College of General Practitioners
• Geoff Huggins, Head of Mental Health, Scottish Government
• Ian Hulatt, Mental Health Adviser, Royal College of Nursing
• Matthew Patrick, Chief Executive, South London and Maudsley NHS Foundation Trust
• Genevieve Smyth, Professional Affairs Officer - Mental Health and Learning Disabilities, College of Occupational Therapists
• Bill Walden-Jones, Chief Executive, Hafal, Wales
• Sir Simon Wessely, President, Royal College of Psychiatrists

Two focus groups were held, involving a total of 7 attendees from

• The National Survivor and User Network (NSUN)
• Lewisham Carers Mental Health Advice Session

ANNEX C

Literature references


Jakovljevic, M. and Ostojic, L. (2013) Professionalism in contemporary medicine: if it is an important academic issue, then surely it is a “hot” issue as well. Medicina Academica Mostriensia, 1 (1): 6-17


Mental Health Foundation (2103) Starting Today: The future of mental health services. [Available online: http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/]

Mental Health Foundation


