

The next 25 years*

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It is, of course, foolish even to attempt to predict the future, because the only thing you can be certain of is that you will be wrong, perhaps wildly and embarrassingly wrong. On the other hand, it is important to try to foresee what opportunities and problems are likely to develop at least over the next decade or so, because those opportunities are more likely to be exploited and those problems are more likely to be countered successfully if they have been foreseen. Even if the things I say turn out to be either banal or hopelessly inaccurate, I may at least have stimulated you, particularly those of you who are still on the thresholds of your careers, to think for yourselves what changes the future is likely to bring.

THE IMPORTANCE OF MENTAL ILLNESS

We can be fairly certain that there will be an increasing recognition, by the general public, politicians and the media, of the high prevalence and disabling consequences of mental illness because the ground has already been laid by epidemiological research. In the past few years we have had a major survey by the Office of Population Censuses and Surveys of the prevalence of psychiatric symptoms in British adults (Meltzer *et al.*, 1995; Department of Health, 1996), showing that 18% of women and 12% of men had experienced clinically significant symptoms in the previous seven days. We have also had a formal estimate by Professor Knapp, commissioned by the Health Education Authority, that mental illness currently costs the English economy over £32 billion a year (further details available upon request from the Health Education Authority, Trevelyan House, 30 Great Peter Street, London SW1P 2HW),

which is almost as much as the total cost of the National Health Service (NHS). Most important of all, we have had an estimate of the burden of ill health on the nations of the world (Murray & Lopez, 1996), conducted by the Harvard School of Public Health at the request of the World Bank and the World Health Organization, which suggests that the burden imposed by unipolar major depression alone is greater worldwide than the burden imposed by ischaemic heart disease, cerebrovascular disease, tuberculosis, malaria, AIDS or any form of cancer. A subsequent report estimated that five of the ten leading causes of disability were psychiatric disorders (unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder), that these were corporately responsible for over 10% of the world's total burden of ill health and that this would rise to 15% by the year 2020.

This increasing recognition of the frequency and disabling effects of mental illness will be brought about also by personal experience, that is by the recognition by thousands of ordinary people that some form of mental illness is a serious burden and a source of anxiety to their own family – depressive illnesses, alcohol dependence or phobic anxiety in a sibling or a spouse, or perhaps in themselves; Alzheimer's disease in an aged parent; or anorexia nervosa in a teenage daughter. This recognition will go hand in hand with a slow reduction in the stigma of mental illness, and each will reinforce the other. A lessening of the stigma makes it easier for people to admit to, and eventually to talk about, the disorders that they have observed in their friends, their relatives and in themselves. This increasingly public recognition of the ubiquity of mental disorders then itself reduces the stigma, because the psychological processes on which stigma is based are founded on the assumption that the stigmatised condition – whether it be cowardice, homosexuality, being born out of wedlock, or having a

mental illness – is restricted to an unfortunate minority. This is why the College has chosen 'Every family in the land' as the key slogan of its 'Changing Minds' campaign.

The combination of an increasing recognition of the ubiquity and disabling consequences of mental illnesses and a reduction in the associated stigma should result in an increasing willingness, by politicians and the general public, to devote a higher proportion of health-care spending to the treatment of psychiatric disorders. There is certainly no doubt that the symptoms and illnesses that people complain of always attract more resources than those that they are reluctant to admit to. But stigma has more subtle effects on funding as well. When competition for funds is intense, as it usually is, the lion's share will always tend to go to the most 'deserving' patients and illnesses. And when budgets have to be cut in order to balance the books – a recurring feature of the NHS – the easiest budget to cut has always been, until now, the mental health budget, because fewer people protest. And fewer people protest because they do not regard psychiatric facilities as relevant to the needs of their own family, or if they do they are ashamed to admit it.

UNDERSTANDING THE AETIOLOGY

We can be confident that the next 25 years will see major advances in our understanding of the aetiology and pathogenesis of mental disorders. The volume and sophistication of clinical and epidemiological research have both increased out of all recognition in the past 25 years. So too have the scale and sophistication of basic research into the human brain, and the willingness, at least of the American Government, to fund that research. (Sadly, our own Government is less enlightened, although that might change.) It is also very heartening to see – as anyone with a bird's eye view of biological research does – the most able young biochemists, pharmacologists and physiologists deciding that brain research is the most challenging, fascinating and potentially rewarding territory to work in. We can be confident, therefore, that our understanding of fundamental psychological processes such as memory, speech and perception will increase steadily. We can be confident also that the major disorders that cause the most disability are fundamentally disorders of

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cerebral function. It is much harder, though, to predict at what stage an increasing understanding of fundamental mechanisms such as perception and memory will lead to major therapeutic advances. It is often said that the human brain with its hundreds of millions of neurons and billions of synapses is the most complicated machine in the universe and, although the empirical basis for this claim does not bear scrutiny, the brain is certainly an organ of staggering complexity. I remember listening to a lecture by Seymour Kety in the 1960s in which he suggested that the experiments that he and his contemporaries were conducting in their attempts to elucidate the aetiology of schizophrenia might be comparable to attempts by 18th century chemists, totally ignorant of electronics, to understand the difference between a functioning and a faulty transistor radio by dissolving both in a series of acids and then comparing the chemical compositions of the two. It is already clear that schizophrenia is a much more complex disorder than Kety and his contemporaries assumed, and it may well be more complex than any of us have yet realised.

THERAPEUTIC ADVANCES

In the 1950s, while I was a medical student, psychiatry acquired, by the most amazing good fortune, a series of highly effective therapies that were all chance discoveries. The therapeutic effects of phenothiazines, tricyclic antidepressants, monoamine oxidase inhibitors and lithium were all discovered fortuitously within a few years of one another by a gifted researcher who was looking for something quite different, and even now our understanding of how these drugs work is very incomplete. We may, of course, acquire other highly effective and novel therapies in equally fortuitous ways in the future. Sooner or later, though, we are going to acquire potent new therapies not by luck but by a rational process of development based on at least a partial understanding of aetiology. Indeed, the cholinesterase inhibitors currently used for the treatment of Alzheimer's disease are the harbingers of this new era. These drugs owe their development to the demonstration, independently in Newcastle and Edinburgh in 1976, that the brains of patients dying of Alzheimer's disease had a reduced content of acetylcholine and choline acetyltransferase.

Although these cholinesterase inhibitors are only modestly and temporarily

effective, Alzheimer's disease seems closer to yielding its secrets than any other major psychiatric disorder. Certainly, dramatic and unforeseen advances have been made in the past decade. At least three different genes have been identified and sequenced, apolipoprotein E has been identified as a potent risk factor and the events leading to the hyperphosphorylation of tau protein and the conversion of amyloid precursor protein to the insoluble beta A4 protein of the amyloid plaques are becoming increasingly clearly defined. Several drug companies are already developing amyloid protease inhibitors or amyloid precursor protein antagonists, and it is likely that within the next decade or two a means will be found of preventing or delaying the deposition of amyloid. When this happens, the consequences for the image of the psychiatry of old age will be almost as profound as those for patients, their families and the nursing home industry.

It is likely, too, that within the next five years several susceptibility genes for schizophrenia, infantile autism and bipolar disorder will be identified and sequenced. Hundreds of millions of pounds will then be spent by the pharmaceutical industry in a race to develop novel therapeutic agents to block or enhance the actions of these genes. Although our understanding of the pathogenesis of schizophrenia and affective disorders has advanced very little in the past 25 years, it will be surprising if the identification of susceptibility genes does not result in major therapeutic innovations within the next 25 years.

We should not assume, though, that all the important therapeutic advances of the future will be pharmacological. In the past few years we have seen the development, mainly by clinical psychologists, of potent psychological therapies for anxiety states, for drug-resistant hallucinations and delusions and perhaps for reducing the risk of relapse in bipolar disorder, and it will be very surprising if other effective psychological and social therapies do not continue to be developed and deployed.

PSYCHIATRY AND MEDICINE

Psychiatry will probably become progressively more 'biological' over the next 25 years and less conceptually isolated from the rest of medicine. At present we are the most backward branch of medicine in the sense that we understand the aetiology and

pathogenesis of the conditions we treat less well than any other medical speciality. As a result, we are the only speciality that is still forced to define most of its disorders by their clinical syndromes. There is no need to be defensive about this 'backwardness' though. It is an inevitable consequence of the complexity of the structure and functions, and experimental inaccessibility, of the human brain compared with those of, for example, the heart, the kidney or the skin. But although we will almost certainly remain different in this sense, the perceived differences between mental and physical disorders will almost certainly narrow as psychiatry starts to acquire the technological trappings of internal medicine. As functional magnetic resonance imaging becomes a routine diagnostic tool, and changes in regional cerebral blood flow in response to mental tasks come to be measured in much the same way as electrocardiogram responses to exercise are monitored by cardiologists at present, psychiatry will come to seem less different, both to patients and to other doctors.

Not only will psychiatry become more 'biological' as it becomes progressively easier and more important to study the cerebral changes accompanying psychological processes, the rest of medicine will probably become more aware of and interested in psychological and social influences on morbidity and mortality. The huge, unexplained differences in mortality between different civil service grades revealed by Michael Marmot's Whitehall studies (Marmot *et al*, 1984, 1991), the fundamental changes in the education of medical students envisaged by the General Medical Council's (1993) manifesto *Tomorrow's Doctors*, the evidence that simple psychological treatments can alleviate the symptoms and reduce the treatment-seeking behaviour of many patients with somatic symptoms and the demand from patients themselves for a new kind of doctor-patient relationship will all tend to impel physicians and surgeons to think and behave in more holistic ways. We might even achieve a general recognition, by informed laymen as well as by the rest of the medical profession, that there is no fundamental difference between mental and physical illnesses, and that arguments about whether the chronic fatigue and irritable bowel syndromes are 'organic' or psychiatric disorders are devoid of meaning.

There will, though, be other changes over the next 25 years that will create new difficulties and problems for psychiatry. Three of the main social or economic

changes that will almost certainly have a major impact, not just on psychiatry but on the whole of medicine, are: the rise of consumerism and changing public attitudes to doctors; the increasing determination of governments to limit expenditure on health care; and increasing competition between different health-care professions.

CONSUMERISM

Organisations representing people whom most of us still regard as patients, but who regard themselves as clients, users or even as survivors, will undoubtedly become better organised, more confident and more influential in the future. Organisations like Mind, SANE, the National Schizophrenia Fellowship and the Manic Depression Fellowship are already consulted by the Health Departments more frequently and more ostentatiously than we are on such issues as whether or when mental hospitals should be closed and the objectives of mental health policies. This was conspicuously true, for example, of the consultations leading up to the formulation of the recently published National Service Framework for Adult Mental Illness (NHS Executive, 1999). Increasingly, these user organisations will be demanding a major voice in policy decisions at all levels (national and local), in clinical governance, and in the training of psychiatrists, and this is being deliberately encouraged and assisted financially by the Health Departments.

At present we are finding this rather uncomfortable, particularly as some user representatives are very strident, and deeply critical of their own experiences of psychiatric services. Even so, it is vital that we come to terms with this manifestation of consumerism and form alliances with at least some of these organisations. The voice of the consumer is going to have an increasingly important influence on the development of all service industries, both public and private, over the next decade and it would be folly to try to ignore this, particularly as the areas where we and our patients share a common interest are far more fundamental than those that divide us. We and they have a common interest, for example, in combating the stigma of mental illness and in persuading the Health Departments and purchasing authorities to devote more resources to mental health. In the past few years Mike Shooter, as Chairman of the Royal College of Psychiatrists' Patients'

and Carers' Liaison Group, has pointed us in the right direction and improved our relationship with Mind and other mental health charities, but much more will need to be done, from both sides, in the years to come. In partnership with patient organisations we can be very influential, but if we fall out with them or refuse to listen to them they have the capacity to damage our reputation quite badly.

PUBLIC ATTITUDES TO DOCTORS

We are all well aware not just that consumerism is a rising power but that public attitudes to doctors are changing. To some extent this change, which one might summarise as 'the death of deference', affects all authority figures and all experts, from the Archbishop of Canterbury to nuclear physicists. But attitudes to doctors, and particularly to NHS consultants, have changed particularly rapidly in response to the repeated revelations of consultant incompetence with which the public has been regaled in the past few years – the Birmingham pathologist whose inaccurate reports resulted in teenagers having arms or legs amputated unnecessarily; an almost endless series of cervical and breast-screening scandals; the cavalier behaviour of the gynaecologist Rodney Ledward; and the awful saga of cardiac surgery in Bristol. These revelations have damaged public trust in doctors and damaged the prestige of British medicine. We would do well to ask ourselves why this has happened so suddenly, at a time when, in reality, the average competence of British doctors is probably higher than it has ever been before, and why each of these scandals has been fanned so assiduously by the media. There are probably several different elements to the public's reaction: a sense of shock at what they see not just as incompetence but as a breach of trust, because other doctors knew what was happening but said nothing; an element of retaliation for the arrogant behaviour of some consultants; and perhaps also the unseen hand of a Government that is happy to see the medical profession cut down to size in the eyes of the public. Probably British medicine will slowly recover from this damage, but never completely. The balance of power between ourselves and both the Government and our patients will be permanently changed.

INCREASING FINANCIAL CONSTRAINTS

Doctors will also be faced with a progressive loss of clinical autonomy as well as of prestige, not just in Britain but in all industrial countries. It is clear that our present Government is determined to restrict the prescribing of expensive medicines and the introduction of expensive new technologies, and that its new National Institute for Clinical Excellence will be the most important mechanism for achieving this aim. Future governments are likely to share this determination even if they use different means. Our College has been a strong proponent of evidence-based medicine and the use of evidence-based guidelines from the beginning and I hope that it will continue both to develop guidelines itself and to do all that it can to promote their use. There is a risk, though, that future governments, desperate to control health-care costs, will start to suborn the process of guideline development and transform what ought to be a distillation of all relevant clinical evidence as an aid to clinical decision-making into a management protocol based largely on financial considerations. Time will tell, but the management protocols recently imposed by some American health maintenance organisations are not an encouraging precedent. The dividing line between guidelines that encourage and facilitate cost-effective medicine and protocols that impose inflexible management strategies is a fine one, but it is vitally important both to the self-respect and professionalism of physicians and to the well-being of the numerous patients who are not suffering from isolated, neatly-defined disorders.

The determination of future governments to control the cost of the NHS may also lead to increasing restrictions on the scope of the Service (such as the withdrawal from long-term hospital care that we have already experienced) and a progressive withdrawal of funding from therapeutic activities and regimes that cannot prove that they are cost-effective. For this reason the future may bring selective pressures on, for example, liaison services in general hospitals, rehabilitation programmes and some forms of psychotherapy, not because they are demonstrably ineffective but because of the difficulty in providing formal evidence that they are cost-effective. There are only likely to be two effective means of defending services of this kind: to design and carry out the necessary clinical trials

before it is too late; and to mobilise the considerable support of patient organisations.

Although we can probably assume that there will continue to be a slow, steady increase in the number of consultant psychiatrist posts in the NHS and a similar slow increase in numbers of psychiatric trainees and non-consultant career-grade posts, these increases will almost certainly be inadequate to keep pace with rising public expectations of psychiatric services and rising numbers of referrals to those services. The time available for individual patients will, therefore, almost certainly be reduced, particularly the time available for face-to-face contact: for talking to them and listening to them. This will have, and has already started to have, two consequences: private practice will expand as middle-class dissatisfaction with NHS services increases; and NHS consultants will increasingly become managers who spend much of their time directing and coordinating the therapeutic activities of other people rather than treating patients themselves.

COMPETITION BETWEEN PROFESSIONS

It is likely, too, that there will be increasing competition between the various professions involved in the treatment of mental disorders, and that this will be encouraged by the Health Departments in the hope that a take-over of medical functions by other health professionals who can be paid less will help to reduce costs. Clinical psychology has expanded faster than psychiatry in the past 30 years and could expand faster still if NHS managers decided to increase the number of training posts available. There is certainly no lack of psychology graduates wanting to pursue clinical training. Against this background it is worrying that, although the main behavioural and cognitive forms of psychotherapy were originally developed by psychiatrists (by Joseph Wolpe in South Africa and Aaron Beck in Philadelphia), these highly effective therapies have now largely been taken over by clinical psychologists. As a result it is they who are now seen by the Department of Health as the main exponents of evidence-based and cost-effective forms of psychotherapy, and NHS funding will inevitably be targeted increasingly on therapies that are demonstrably evidence-based and cost-effective. In addition, British clinical psychologists are busy developing new

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and highly effective psychological therapies for a variety of different anxiety disorders, for drug-resistant hallucinations and delusions and perhaps also for reducing the risk of relapse in bipolar disorder.

It is not difficult, therefore, to visualise a scenario in which an increasingly large and self-confident profession of clinical psychology, equipped with doctorate degrees, consultant titles and a wide range of therapeutic skills of proven efficacy, might seem before long, both to general practitioners and to the Health Departments, to be the most important source of therapeutic skills and professional advice in the mental health field. We cannot even take it for granted that the right to prescribe medication will continue to be restricted to ourselves and other medical practitioners. Within the next year or two both nurses and pharmacists seem likely to acquire prescribing rights, initially under closely circumscribed conditions, as a result of the recommendations of the recent Crown Report (Crown, 1998); and both professions will almost certainly press for those rights to be extended in the future. In California, clinical psychologists may well be on the brink of acquiring the right to prescribe antidepressants and neuroleptics, and what happens in California has a habit of happening here 10 years later, whether or not it seems sensible to us.

Community psychiatric nurses will probably also want to prescribe independently of us, and perhaps also to become the leaders of the multi-disciplinary teams of the future. At present they are weak politically, under-skilled and uncertain about their role, but this state of affairs will not continue indefinitely. Consider, for example, how the relationship between midwives and obstetricians has changed in the past 20 years.

I am not suggesting that the aspirations and increasing influence of these other professions should necessarily be seen by us as a threat. Indeed, I am convinced that we need a more effective dialogue both with clinical psychologists and with psychiatric nurses. But it is in the nature of professions to seek to expand both their membership and the territory covered by their expertise.

This often brings them into competition with one another and in our case competition is likely to be encouraged by the Department of Health. Psychiatry can only hope, therefore, to continue to provide the leaders of multi-disciplinary teams if the psychiatrists of the future have a demonstrably wider range of both clinical and managerial skills, and a greater depth of expertise, than members of other mental health professions. At present, I sense that we have less well developed psychotherapeutic and managerial skills than we ought to have.

CONCLUSION

I have tried to describe some of the opportunities and also some of the challenges that psychiatry is likely to be presented with in the next 25 years. For my own part I am far more excited by the opportunities than daunted by the challenges, but at this stage it is not my views that matter, it is those of psychiatrists at the beginning rather than the end of their careers.

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