第12回世界精神医学会横浜大会
精従懇特別フォーラム「精神保健福祉の変革」

シンポジウムⅣ（日本の精神保健改革にむけた提言）

2. Summary of Main Points Made at the Yokohama Symposium

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- The morality of a country can be judged by the way it treats its mentally ill. Where mental illness is respected, where it is treated like any other illness and resources are put into treatment services, the country itself can be respected. Where it is not respected, where it is met with prejudice and fear, where the mentally ill are hidden away or punished, the country cannot be respected.

- I would not presume to "instruct" another country on how best to set-up mental health services, but there are some parallels with the way our own Government in the United Kingdom has made mental health one of its three main health priorities, along with the treatment of heart disease and cancer. We, too, have a National Service Framework and some of our experiences with trying to put that into practice may be useful. I would highlight four main areas:

1. Numbers

a) It is easy for services to be overwhelmed by the number of patients referred to them. Services will need to make a careful distinction between what the public may DEMAND, what they really NEED, and what it is possible for a service safely to PROVIDE given the resources available. Quality of services must not be sacrificed for quantity.

b) Psychiatrists need to be clear about what is a psychiatric problem, that they can treat, and what is a socio-economic problem, that they cannot treat. If they had their way, politicians would make psychiatrists responsible for poverty, public order, suicide rates and teenage pregnancy! All of these have socio-economic components over which we have no power.

c) Sometimes psychiatry makes this more confusing by our systems of classification (ICD and DSM) that appear to extend the concept of mental disorder beyond the boundaries of illness. Are "grief reactions" really illness when they are the normal (and necessary) reactions to personal losss? Can "post-traumatic stress disorder" be called an illness when it is the expectable reaction of anyone to major catastrophe? Should we talk about "conduct disorder" in children when it is the understandable behaviour of children living in socially deprived families?

d) Consultant psychiatrists need to examine their rôle within multi-disciplinary treatment teams. It is a waste of resources if they become "bogged down" in lower levels of work in primary and secondary care. They should be freed to make use of their training and experience as "consultants" in the proper sense of the word—seeing the most difficult cases, advising on others and acting as managers and leaders of services. This relies on a change of attitude—on the willingness of other members of the team to take on some of the responsibilities currently done by psychiatrists, and on the willingness of psychiatrists to give them up.

e) The aim of all mental health services should be to help patients, together with their carers, to take as active a part in their own treatment as possible. They should be empowered to take charge of their own lives rather than be made reliant on the decisions of others.

2. Image:

a) We have a paradox. Listening to the public, the media who represent them and politicians who live off their headlines, you would think that the mentally ill are a small minority who are treated by lazy and incompetent doctors. And yet our clinics are overflowing with ordinary people demanding more and more help from skilled and conscientious psychiatrists run off their feet in trying to satisfy them!

b) The reality is that one in four of us will develop a mental health problem in our lifetime and every family in the land will be touched by mental illness in one way or another. All of us are vulnerable as we are to any other illness. There is no THEM and US. Until this is truly understood, mental illness will still be feared and the image of the mentally ill and psychiatry will still be awful. Part of the responsibility of Government is to help redress that image, by confronting stigmatizing attitudes wherever they arise.

c) Mental health legislation is necessary to allow mental health teams to make decisions on behalf of patients whose illness has temporarily made them incapable of making them for themselves. Any Mental Health Act should be fair, workable and effective. A patient's liberty should not be taken away without offering treatment in return that cannot be offered in any other way. That treatment should be given in as least restrictive an environment as is compatible with the patient's safety. Mental health legislation should be exactly that. It should not be used as a public order act in disguise.

d) Resources should be put into mental health promotion and the prevention of mental illness, as much as the treatment of illness once it has arisen.

3. Change:

a) All services will need to change from time to time to reflect our growing knowledge of the causes of mental illness, the pattern of its distribution and how best to provide for its treatment. But change needs to be evidence-based. Too often it has appeared to be driven by dogma to the point of change-for-change's sake. Services cannot satisfactorily treat patients if they are undermined by this lack of stability.

b) As services are modernized, a false distinction has sometimes been drawn between community

services (seen as 'good' and 'successful') and in-patient services (seen as 'bad' and a sign of 'failure'). They are equally necessary and complementary parts of any mental health service; but in-patient work has got left behind, starved of expertise and resources. Similarly, less 'popular' sub-specialities in psychiatry—such as work with prison populations, the learning disabled and children—need special attention if they are not to miss out in the competition for limited resources.

c) Government money allocated to mental health services must be tracked down to its proper targets. It is all too easily diverted by managers into other areas with a higher public profile —such as reducing surgical waiting-lists. New services cannot safely be provided unless they are properly funded. Psychiatrists should not be blamed for failures due to under-funding.

d) Social conditions, such as housing, are just as important to mental well being as psychiatric treatment. It is no good getting diagnosis and treatment right if patients are then put back to live in conditions that are guaranteed to make their illness worse.

4. Recruitment

In most countries, mental health services have a problem with recruitment. We cannot attract enough people into psychiatry, psychology, mental health nursing and social-work to meet the needs of services. If all the above lessons are learnt, the morale of the professionals will be lifted, recruitment will improve, patients and their carers will get a better service and everyone will work more co-operatively together. If the lessons are not learnt, morale will deteriorate, recruitment will get even worse, services will be poor and everyone will blame everyone else. It should be an easy choice for Governments to make!