Chapter

10

More on the Current Climate in Psychiatry

Robert B. Dudas and Elizabeth Fistein

Introduction

In each era, there are a number of contentious issues or crises that plague the profession. In recent times, these included the related issues of changing ways of working in psychiatry and difficulty recruiting and retaining professionals in psychiatry, the extreme focus on eliminating suicide, and psychiatry's critical voices calling for either the complete abolition or the major transformation of psychiatry. In the first section of this chapter, Robert Dudas will describe the changes in the value context of specializing and working in psychiatry. This is followed by Elizabeth Fistein's analysis of the zero suicide ambition from a values-based practice (VBP) perspective. Finally, Robert Dudas looks at some of the values of anti-psychiatry and critical psychiatry.

Specializing and Working in Psychiatry

Robert B. Dudas

Medicine has traditionally been a profession of high prestige. In most societies, becoming a doctor was a popular career choice. The number of applicants generally tended to outnumber the available university places and, in most specialties, the training places for specialty training. This has changed over recent decades. Other, non-medical career opportunities have become more popular and newer, more attractive ones have appeared. Medicine has lost some of its appeal as a career choice. Changing values, such as health increasingly becoming a commodity in many societies and the declining prestige of the medical profession, may play a role in this.

Psychiatry is one of the specialties that has experienced a significant shortage of trainees in the last decade in the UK (CFWI, 2014). It is hard to be precise about the exact cause of this, but Table 10.1 lists some factors that might have played a role. Although some of the changes listed may not be entirely negative, and paradoxically may even be positive developments from a different point of view, all these changes affect the preferences and expectations of final year medical students and doctors already in training.

Factors influencing career choice, working conditions, and retention are closely linked. This section will examine some of the recent positive as well as negative developments and their value associations.

Choose Psychiatry

In the UK in recent years, the Royal College of Psychiatrists (2023) launched its 'Choose Psychiatry' campaign to improve recruitment into psychiatry. Its answer as to why students

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Table 10.1 Factors influencing career choice and retention in psychiatry

	Influencing factor
Changing values and attitudes towards medicine and psychiatry	Changing prestige of the medical profession (Pescosolido et al., 2001) Commercialization of healthcare; health becoming a commodity, consumerism (Timmermans and Oh, 2010) Public attitudes towards psychiatry: • Attitudes towards mental illness (Mehta et al., 2009) • Increasing explicit or implicit expectations from society • Expectation to prevent patient suicide (Gibbons et al., 2019) • Expectation to prevent harm to others (Buchanan and Grounds, 2011) Attitudes of cognate specialisms towards psychiatry (Oliveira et al., 2020; Sebbane, 2014):
Changes in training	• Medical students' experience of psychiatry during their undergraduate years (Kerebih et al., 2019; Khajeddin et al., 2012) • Junior doctors' experience of psychiatry (Holdsworth et al., 2023; Paris, 2005) • Changes to the degree to which learning psychotherapy is considered part of psychiatry training (Paris, 2005) • Strong emphasis on neuroscience (Insel and Quirion, 2005; Schildkrout et al., 2023) • Creation of a separate academic training path (Beattie et al., 2017; HEE, 2020) • Recent changes around core and higher specialty training (uncoupled/run-through)
Changes in ways of working	At individual or team level: • Excessive demands on doctor's role (GMC, 2019) • Increasing workload pressure (GMC, 2019) • Increasing pressure to see patients only once or infrequently owing to supply–demand mismatch • Changing role: less psycho-education or psychotherapy (delegating these to other multidisciplinary team (MDT) members) and more consulting and management of acute and emergency care (Paris, 2005) • More horizontal team structure but unchanged level of personal responsibility of psychiatrist • Less time and opportunity to get support from peers, senior colleagues, and other colleagues; 'the erosion of many informal structures' (Elton, 2019, p. 3) At the level of the healthcare system at large: • The system presenting too many barriers to patient care (GMC, 2019)

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Table 10.1 (cont.)

	Influencing factor
	• Changes in the way psychiatrists are supported as employees (e.g. secretaries, IT, etc.) (Deahl, 2023) • Employers looking after psychiatrists' well-being (GMC, 2019) (e.g. treated them as unique human beings with individual and legitimate choices and preferences in the same way that psychiatrists are expected to treat their patients in a person-centred system); '[g]ood patient care is predicated on good care of the carer' (Elton, 2019, p. 2) • Clinician burnout seen as the responsibility of the clinician instead of as a problem needing to be addressed at organization level (Shanafelt and Noseworthy, 2017) • Blurring of professional line management

should consider psychiatry included having a huge impact on lives, working through new challenges every day as a team, working in a range of settings, having the ability to do part-time working, participating in growing scientific knowledge, and enjoying the high prestige associated with the profession.

In the last few decades, there has been a strong push to portray psychiatry as applied cutting-edge neuroscience (Insel and Quirion, 2005; Schildkrout et al., 2023), often in the context of trying to improve recruitment and retention. In that vein, in the UK the Royal College of Psychiatrists' Gatsby/Wellcome Neuroscience Project has been set up to carry out much-needed modernization and improvement of the neuroscience curriculum and to connect trainers with neuroscientists and the most recent developments in the field. Although this coincided with improved recruitment figures, it is hard to be certain as to what caused this. There were a number of other initiatives at the same time; for example, medical student psychiatry societies have sprung up in many medical schools (e.g. Pandian et al., 2020). Regrettably, and in line with the general trend for decline of investment in the humanities and other non-STEM (science, technology, engineering, and mathematics) subjects worldwide (Goldstein, 2021), we have seen much less of a similar, well-funded and centrally coordinated effort to improve the coverage of any of the other constituting elements of psychiatry, such as psychotherapy, social psychiatry, or the medical humanities, to name but a few. The social sciences, with their emphasis on phenomena above the individual level, help to anchor psychiatry in the right place in terms of its focus and prevent it from moving too far in the direction of neuroscience (especially parts that are irrelevant to psychiatry's subject matter). The natural sciences, although clearly important, are but one pillar on which the clinical and academic branches of psychiatry rest. It is important to note that not everyone who is drawn to psychiatry is interested in genetics, molecular psychiatry, brain imaging, or computational psychiatry. Also, if we as a profession focus on attracting only those who are, we are inevitably going to steer the specialty into one arguably very narrow direction. This may risk not only seriously limiting the potential of our profession to advance our understanding of mental illness and developing treatments for it but also, crucially, losing our identity. Cogent criticism of

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

overreliance on biomedicine and psychopharmacology in psychiatric training has been articulated, highlighting that 'there is a real danger that psychiatric residents are being trained to become psychopharmacological technicians rather than humanistic physicians' (Paris, 2005, pp. 113–114).

Psychiatry – lying at the intersections of neuroscience, psychology, social care, sociology, anthropology, philosophy, and law – occupies a unique position in that it behaves in some respects as an exact science but in other respects as a so-called inexact science. Whilst in the exact sciences there is an expectation that a problem has one correct explanation or solution, in the inexact sciences this is not so, and multiple perspectives or interpretations are not just possible but often desirable or essential. In psychiatry, perhaps even more so than in other specialties, it is often the case that one can choose from a variety of clinical approaches which may all lead to the same outcome and it is difficult to say that one approach is better than the other. The preclinical science subjects, mainly including natural sciences as opposed to social science and humanities subjects, prepare medical students more for the 'only one solution can be correct' type of thinking. Clinical training primes students for some of the skills required for handling uncertainty and unpredictability, which is inherent in medicine, but these skills would be much less honed at that stage. This makes it less likely for students to choose psychiatry.

In the current climate, psychiatrists are increasingly under pressure to see patients only once (typically for an initial assessment) or infrequently (e.g. specifically for a medication review) and to adopt a multidisciplinary approach whereby much (if not most) of the contact is delegated to other professionals, most often psychiatric nurses or psychologists. This creates a problem for psychiatrists as seeing the patient only once or for a limited number of times offers only a cross-sectional view, a snapshot; at best they have a limited opportunity to get to know their patients as people, which was often why they came into this profession. It is also hard to remain part of the therapeutic dialogue with the patient this way. If this is the working mode that medical students and psychiatric trainees see, it can discourage them from choosing psychiatry, especially if developing a deeper understanding and building a therapeutic relationship with the patient was an important motivation for them to come into psychiatry.

Importantly, both recruitment and later retention can be affected by what psychiatrists feel they are expected to manage. Most psychiatrists, for example, feel that it is their responsibility to prevent highly unpredictable events such as patient suicide and also feel pressured by others to do so whilst knowing that suicide is only preventable to some degree (Gibbons et al., 2019).

But it seems that, at least for now, all is not lost. In the UK, it has been recognized at the highest levels that meeting future patient demand will require more psychiatrists (GMC, 2019) and that freshly graduated doctors need to have more exposure to the specialty at foundation year level if shortages are to be reduced (HEE, 2020). There are some positive signs that interest in psychiatry among medical graduates may be improving. The GMC Workforce Report described, 'after years of stagnation and decline' (GMC, 2019, p. 4), a small increase (2%) in the number of doctors in psychiatry training, and according to the Royal College of Psychiatrists (2019, n.p.), in 2019 the number of junior doctors choosing psychiatry was 'at an all-time high', with 92% of the training places filled, which they associated with an increase in public awareness owing to more investment into mental health services by the government and the College's 'Choose Psychiatry' campaign.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Working in Psychiatry

The change over recent decades in how clinical psychiatry is done has been tremendous. In his editorial in the *British Journal of Psychiatry*, Martin Deahl laments the pressure from managers and the 'veneer of quality improvement while at the same time witnessing services unravelling' (Deahl, 2023, p. 2). Indeed, funding for core services becoming increasingly insufficient is a major obstacle to providing person-centred care. Today's psychiatric trainees socialize into a profession struggling with underfunding and resultant supply–demand mismatch characterized by chronic staff shortages and long waiting lists (Punton et al., 2022). With the reduction of inpatient bed numbers, it is now only the sickest who get admitted, if at all. Admitting patients for longitudinal assessment or for a change of environment has become a luxury hardly seen anymore. Patients nowadays can only spend a very short spell on the ward, sometimes as brief as a few days, before they are back in the community, often under the care of an extremely overstretched crisis resolution and home treatment team. Care is spread very thinly, allowing little time to really get to know the patient.

The way consultant psychiatrists work has changed tremendously too. Joel Paris (2005, p. 112) describes how Heinz Lehmann, whilst addressing the Canadian Psychiatric Association in a lecture in 1985, argued that psychiatrists 'needed to change their role from that of expert psychotherapists to managers of acute and emergency care, and to carry out less direct treatment by becoming consultants to the mental-health community'. In Lehmann's vision, psychiatrists would not need to have much knowledge about therapy but would have in-depth knowledge of psychiatric symptoms. Paris (2005, p. 112) wonders if the pendulum has swung too far and psychiatrists are becoming 'DSM robots and pill-pushers'. This is not hugely dissimilar to the ethos of New Ways of Working (NWW; see CSIP and NIMHE, 2007, p. 12), described as 'a cultural shift' involving rethinking values, in that many of the psychiatrist's roles would be taken over by other, non-medical members of the multidisciplinary team (MDT) and the psychiatrist's involvement in the personal, daily therapy would be more light-touch. Unfortunately, the second half of Lehmann's prediction may not have materialized so much. What appears to be required of the psychiatrist nowadays is not so much increasing diagnostic knowledge and skills; on a practical level, it is information technology (IT) and admin skills that seem more and more relevant. There is a conflict of values implicit in these new ways of working: primarily management values versus clinician values. The declared drivers of NWW include relieving the psychiatrists with very high workload (and reducing the need for a very expensive locum psychiatrist workforce) by shifting some of their tasks to non-medical colleagues, for whom these activities might represent development opportunities, and thereby improving the sustainability of already overstretched healthcare systems. Although psychiatrists are trained to be therapists (and therapy is meant to include a broader concept here than just psychotherapy), the implementation guide is clear about the expectation that '[a]ll consultant practitioners will have to prove they are worth the investment made in them, and they will need to be flexible and adaptable in their roles in order to achieve this' (CSIP and NIMHE, 2007, p. 23).

Another important emerging issue is the strengths and weaknesses of IT. Notwithstanding the clear advantages when it comes to pulling out data for managers or researchers, most current electronic patient record systems are unnecessarily complicated, take longer to use, and offer few advantages over pen and paper. The change from paper notes to electronic could have freed up time if it had taken advantage of what cutting-edge

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

IT can offer nowadays; instead, it often replicates and multiplies the admin burden. Unlike pen and paper, electronic patient record systems almost invariably require a lengthy approval procedure and a significant amount of extra training just to be able to use them. They often have so many functions that no one in the hospital really knows how to use all of them. Clinicians are routinely required to enter a lot of data that will hardly ever be used for anything. Whilst there is no scientific evidence for the clinician clicking away at a computer for long hours improving patients' mental health, collectively we have allowed these record systems to take further time away from talking to patients or their relatives. What Deahl (2023) calls the 'functionalisation' of care (i.e. splitting the patient's journey within the healthcare system into many separate teams, such as inpatient, home treatment, community, primary care mental health) causes repeated unhelpful disruptions to continuity of care and the siloing of expertise and services. This type of division of labour increased productivity during the Industrial Revolution but doing it in psychiatry turns a blind eye to the important fact that human beings are very different from machines or other factory products that need to be assembled.

Another problem that psychiatrists acutely feel is the gradual, but by now almost complete, demolishment of the personal support we once had in our jobs. Most psychiatrists no longer have a medical secretary. People who used to provide this extremely important support have been huddled into impersonal 'admin hubs', often in geographical locations away from the team, expected to support many psychiatrists and therefore knowing none of them really well. In a clinical service dealing with people, this has had a devastating effect in many ways. Part of the problem is that the crucial contribution they provided, through talking to patients on the phone or on arrival at the clinic, helping the consultant sort out their busy timetable, taking care of annual and professional leave admin, and a myriad other things one needs in order to successfully function in a demanding person-centred job, is difficult to quantify or express in financial terms. The effect of taking them away is already reflected very visibly only a few years down the line in the plague-like retention problems in most systems.

In summary, clinical practice in psychiatry has changed very significantly over recent decades. Whilst some of these changes have been positive, an important lesson that can be distilled from a review of the values involved therein is that for any system to function well and in a sustainable way, there has to be some sort of alignment between the values of the stakeholders. Psychiatrists will be able to provide person-centred care only if their own needs, concerns, and preferences are also taken into consideration. The fact that it is when they are not that has the most important effect on recruitment and retention has been picked up by the Royal College of Psychiatrists, and it has now included well-being among the aspects it monitors when approving consultant job descriptions for the UK's National Health Service (NHS). To create a healthy alignment will require continual, genuine, and intelligent dialogue with the general public.

The Expectation of Managing Risk: Eliminating Suicide

Elizabeth Fistein

Healthcare systems do not always function safely; common adverse events include medication errors, hospital-acquired infections, and surgical complications. The World Health Organization (2019) estimates that the occurrence of adverse events, resulting from unsafe care, is likely to be one of the ten leading causes of death and

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

disability worldwide. The principles of patient safety and healthcare improvement have been growing in influence in the two decades since the publication of the landmark report *To Err Is Human* (Donaldson et al., 2000). The belief that no patient should come to harm as a result of seeking healthcare is now so widely held that many consider it a core principle of healthcare delivery.

More recently, the call to apply the ideas of patient safety to the protection of users of psychiatric services has led to the development of the Zero Suicide movement. This movement is based on the belief that the suicide death of someone receiving psychiatric care is equivalent to death caused by medication error or hospital-acquired infection: a preventable event that should be eliminated using the principles of patient safety and quality improvement (Zero Suicide Institute, n.d.). The movement has become international, with representatives from twenty countries signing the 2018 Rotterdam Declaration (Zero Suicide International 4, 2018).

In this section, we will analyse the concept of suicide elimination, using the lens of values-based medicine (VBM). The conclusion that suicide elimination is a reasonable goal is based on the following premises:

- Suicide deaths are preventable.
- Suicide is a form of harm equivalent to other patient safety errors.
- Suicide should be eliminated.

Each of these statements is examined in turn in this section.

'Suicide Deaths Are Preventable'

The premise that suicide deaths are preventable is a statement of fact. It is worthwhile, therefore, examining the evidence that supports this statement.

People who are about to attempt suicide cannot be accurately identified: there is no single risk assessment tool that can accurately predict suicide (Lotito and Cook, 2015; Steeg et al., 2018); some people who are going to die by suicide will not be identified and some who are not will be identified as high risk (Nielssen et al., 2017). Suicide is not, therefore, *completely* preventable. This is acknowledged in Zero Suicide training materials: 'It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize' (Education Development Center, 2018, n.p.).

The use of language such as the statement 'suicide is preventable' has rhetorical force. It encourages people to think of suicide as a socially embedded phenomenon rather than simply the choice of an individual (Durkheim, [1897] 1966) and to take responsibility for reducing suicide rates. Setting such an ambitious objective challenges psychiatric healthcare providers to find ways of improving suicide prevention. The benefit, if they are able to rise to this challenge, is fewer people dying in despair.

The risks associated with this position manifest when a suicide is not prevented: if suicide is preventable, but nonetheless occurs, blameworthiness may attach itself to everyone who failed to prevent it. People involved in adverse events in healthcare are now called 'second victims' (Scott, 2019), referring to the impact of these events on healthcare workers. If a reduction in suicide rates is accompanied by an increase in the harm caused by the deaths that are not prevented, then the question of whether or not it is an acceptable risk to take is open for discussion. This is acknowledged in the Zero Suicide movement: whilst asserting that 'if depression care were truly perfect, no patient would die from suicide',

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Coffey and Coffey (2016, article subtitle) acknowledge that pursuing perfection is most successful within a just culture. A just culture is a systems approach to patient safety that does not seek to blame and punish individuals when mistakes happen but holds everyone working in an organization accountable for monitoring the system, reporting 'near misses', and making things safer for all (Boysen, 2013).

The second issue raised by the fact that suicide risk assessment is an imperfect process is the question of how to respond to people identified as being at high risk of attempting suicide. This is especially pertinent if they are reluctant to accept help.

'Suicide Is a Form of Harm Equivalent to Other Patient Safety Errors'

Designing safer systems for psychiatric hospitals can be an effective means of reducing deaths from suicide. A well-known example is the reduction in rates of death by hanging among people receiving inpatient psychiatric care achieved by identifying and removing potential ligature points from psychiatric wards (Hunt et al., 2012).

The Zero Suicide movement has issued a call to action to improve safety and the quality of suicide care in psychiatric systems. One can think of this approach as the modern-day manifestation of one of the oldest values of medicine: 'First, do no harm' (Hippocrates of Cos, 1923).[1] However, some factors that place patient safety at risk in psychiatric units (e.g. self-inflicted harm, the use of physical restraint to prevent self-harm) differ from the kind of errors that lead to harm in the general hospital setting, creating a tension between maximizing patient safety and maintaining patient autonomy (Thibaut et al., 2019).

Prevention of hospital-acquired infections, medication errors, and wrong-site surgery is achievable through the design of safer systems and the training and management of staff to reduce human error, assisted by the fact that patients themselves do not want these events to occur. Inpatient self-harm and suicide differ from other patient safety issues in that they involve events that the patient (albeit in the context of disturbed mental state) wills and brings about through their own actions. Prevention of these critical incidents usually involves some degree of coercion, justified by the intention to protect patients from harm. Whether or not such paternalism is justifiable is a question of the relative value placed on the prevention of (self-inflicted) harm and on individual liberty. Furthermore, given that suicide risk assessment is imperfect and some people identified as high risk would not have gone on to die by suicide, some people will be deprived of their liberty in order to prevent a suicide that was never going to happen. The question of how many people it is acceptable to detain in order to prevent one suicide is a question of values, not fact (Szmukler, 2003), and is open to legitimate disagreement.

The Rotterdam Declaration sets a vision for Zero Suicide Healthcare where people who seek psychiatric treatment 'will experience that suicidality can be discussed openly, is treated directly and managed in a least restrictive, recovery-oriented way' (Zero Suicide International 4, 2018, p. 3). Nonetheless, a values-based decision to focus on inpatient safety may have unintended adverse consequences: creating a restrictive and 'clinical' environment in which people are reluctant to stay to receive treatment (potentially leading to increased rates of psychiatric detention); increasing use of sedation and restraint to prevent self-harm (potentially leading to increased rates of physical injury, increased psychological trauma in patients, and increased moral injury in staff); and fostering a risk-averse culture where inpatients are protected from death by suicide in the short term but

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

may not learn the psychological coping strategies needed to resist suicidal ideation once they are re-exposed to access to lethal means in the community.

'Suicide Should Be Eliminated'

This is the most obviously value-laden premise in the argument for suicide elimination. Adoption of the goal of suicide elimination implies that (1) suicide is always a form of harm and that (2) it is a form of harm that outweighs the potential adverse consequences of its successful elimination. In other words, suicide is not only a tragedy but also the worst possible outcome, whatever the circumstances. If this reflects the values of everyone who will be affected, this is perhaps unproblematic. However, if suicide elimination imposes the values of one set of people onto another, it risks causing moral harm and undermining its own legitimacy.

The question of whether suicide is sometimes a legitimate response to a tragic conflict has been addressed in a variety of ways. In the non-Western traditions, a diversity of positions regarding the moral permissibility of suicide exists (Battin and Mayo, 1981). Ancient and Classical Western thinkers also differed in their views. Plato claimed that suicide is disgraceful and that those who die this way should be buried in unmarked graves. Aristotle argued that self-killing does not treat oneself unjustly so long as it is done voluntarily, but concluded that suicide is somehow a wrong to the state or the community. The Stoics argued that, in the absence of the 'natural advantages', such as health, considered necessary for flourishing and living a good life, it can be wise and appropriate to end one's own life (Cholbi, 2017). Early Christian thinkers opposed suicide, as a natural extension of the fifth commandment, 'Thou shalt not kill', and this became part of Christian doctrine and canon law – a ban on funerals for people who died by suicide was part of the legal code of the Catholic Church until the 1980s (Dine, 2020). Suicide was a criminal offence in many Western countries until liberalization in the modern era.

In recent years much work has been undertaken to de-stigmatize suicidality and mental ill-health (including the work of the Zero Suicide Alliance in the UK). People are encouraged to reach out to others if they experience suicidal ideas, and to access help and support, including psychiatric treatment for any underlying mental illness. Despite the lingering use of language such as the phrase 'commit suicide', suicide is no longer unlawful in the UK and people are free to end their own lives (Suicide Act 1961). In a democratic, pluralistic society, is it legitimate to aim to eliminate a lawful act?

There are numerous reasons why suicide may be evaluated as a serious harm which should be prevented, even if it is not criminalized: its irreversibility and the complete loss of potential for flourishing, especially in the context of disordered mental state; the grief of bereaved loved ones; the traumatization of witnesses; and the potential for increasing the likelihood that others will act on suicidal ideas.[2] However, there are also legitimate reasons why some deaths by suicide may be evaluated differently: as rational choices to escape unbearable suffering (physical or psychological) or simply as a response to life carrying on after the 'good life' has ended.

Given this plurality of values, the aim of eliminating suicide completely could be criticized for failing to recognize that it is value-laden – 'values blindness' (Fulford, 2007) – or that it is based on values that are not necessarily shared by others – 'values myopia' (Fulford, 2007).

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

In summary, the lens of VBM reveals that the fundamental principles on which Zero Suicide is based are not value-neutral. The values of Zero Suicide, some explicit and some hidden, may not be sufficiently widely shared to justify a universal goal of suicide elimination. Furthermore, a decision to prioritize suicide prevention over other activities could potentially reduce patient autonomy, prolong suffering, and impede recovery. Where a policy creates conflict between values, or where there is plurality of values held by those who will be affected by a policy, VBP suggests an alternative approach.

The Case for a Values-Aware Approach to Suicide Reduction

Target-driven approaches in healthcare management are widespread and bring with them both advantages and disadvantages. The old management adage 'You get what you measure' suggests that if you want to achieve an objective, you need to quantify it and monitor it, holding everyone in the organization accountable for the results. This creates a sense of shared purpose, enabling change. However, there are now numerous examples of target-driven healthcare initiatives distorting priorities (as the thing that is not being measured is no longer pursued) and even leading to harm, if the values of support for patient dignity are eclipsed in the pursuit of efficiency (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

The elimination of suicide makes an appealing target for health service improvement, as suicide rates are relatively easy to measure, especially in comparison with factors such as suicidal ideation or mental distress. However, target selection is a value-laden process and close attention to the values that underpin the choice of target is necessary to reduce the risk of creating perverse incentives and unintentionally damaging patient care (Fistein and Malloy, 2017).

The principles of VBP encourage a focus on process – the goal itself is less significant than the process followed to select it. The call is to focus on the perspective of patients and to balance legitimately different value perspectives by listening to and exploring the nature and extent of differences in values, aiming for mutual understanding and respect (Fistein and Malloy, 2017).

Someone who dies by suicide suffers the harm of losing their life – something that they had, presumably, ceased to value at the time of their suicide attempt, even though it may have been something that they would have come to value again had they not died. It is striking, however, that much of the harm associated with suicide is experienced by others, especially people who valued the life that has been lost. Balancing the different perspectives of the suicidal person, their future self, and those who would be affected by the suicide is no simple matter. Nonetheless, VBP calls on us to try.

One reason to be concerned about suicide is the evidence that it is often associated with severe mental illness – cognitive distortions such as beliefs that one is trapped, helpless, and hopeless (O'Connor and Kirtley, 2018) – and therefore may not represent a rational decision or the genuine, authentic will of the person who has died. What does seem clear is that behind the impulse to end one's own life lies a great deal of distress and suffering (O'Connor and Kirtley, 2018) and that both the suicidal person and those that would prevent their suicide place high value on ending that distress and suffering – they are simply choosing different means to achieve this end. Furthermore, to simply aspire to eliminate suicide rather than the suffering that drives suicidality risks arriving at an inhumane solution where people thought to be at risk of dying by suicide are deprived of their liberty in order to save their lives, but at the cost of their continued suffering.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

A values-aware approach to suicide prevention would acknowledge the purpose of a Zero Suicide initiative: to strive to eliminate the distress and suffering that drives suicidal behaviour and that affects the 'second victims' of suicide. The focus would be on resourcing high-quality mental health care for all who would benefit from it and making this care accessible and acceptable to as many people as possible.

In comparison with a target-driven approach, underpinned by the values of management science, a VBP approach, underpinned by the values of psychiatry, has numerous advantages:

- By balancing the multiple values of patients and service providers, respect for autonomy can remain at the heart of medical care.
- Providing care that is consistent with the values of those who need to access it reduces the need for coercion and increases the scope for practice consistent with the rights, will, and preferences of patients.
- By concentrating on quality of care for all, rather than identifying high-risk individuals, the problems associated with imperfect risk-assessment tools (false positives and false negatives) are reduced.
- Reducing distress and suffering through the provision of effective, evidence-based treatment for mental ill-health should reduce the downstream consequences of that distress, including suicide.
- Reducing the likelihood of blame attaching to failures to prevent suicide should enable more focus to be placed on quality improvement in the context of a just culture.

Values Questioned and Debated

Robert B. Dudas

In medicine, in general, the sick and their carers place their trust in the doctor and the wider healthcare team to provide beneficial medical treatment. In psychiatry, this is often not the case. There is a much greater degree of value diversity and less alignment between how the doctor and the patient see the problem and the possible solutions for it. People with mental illness may deny that there is a problem even when others around them indicate this to them, disagree with the diagnosis, and decline treatment.

But it is not just patients who can disapprove of psychiatric practice; sometimes even people who have not been affected by mental illness personally or through their loved ones do so. Psychiatry is probably the only medical specialty that has a whole movement opposing it: *anti-psychiatry*. Academics and clinicians in other, often cognate, fields (and very occasionally within psychiatry), philosophers, journalists, and various others have questioned the validity of the concept of mental illness, identified the role of psychiatry in social control (as opposed to providing medical treatment), or called for the abolition of psychiatry.

A description of the history, possible causes, and various forms of these criticisms is beyond the scope of this section. From our perspective here, it may, however, be helpful briefly to examine the values attached to these viewpoints. What are their end goals or terminal values? Are these terminal values primarily personal or social? As we as humans always live in a social world, we also need to examine how these values relate to similar values of others in the immediate as well as the broader social environment of the person affected by mental illness. How and through what means do the proponents of various

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

criticisms against psychiatry seek to achieve their terminal values? What are their instrumental values? What are the other values associated with the issue that need to be taken into consideration? And, crucially, do the instrumental values attached to these viewpoints help them attain their terminal values or end goals or detract from them?

One of the cardinal preferences of anti-psychiatry is for *the abolition of psychiatry*, at least in its current form. The main argument is often that psychiatry restricts the autonomy of the person by labelling them with a medical diagnosis and treating them (often against their will) because they do not fit societal expectations. Putting aside the question of whether we regard them as an illness, if we accept that presentations with mental symptoms, suffering, and functional impairment exist, we need to consider how they can be addressed. This is often accepted even by those advocating for the abolition of psychiatry; it is only the ways in which they believe that the individual and society should address it that differs (e.g. empowering people as opposed to giving them medical treatment).

As a thought experiment, we could look at what the effects would be if psychiatry ceased to exist completely. What would happen to those who are psychiatric patients in the current system? Would other medical specialties take over their care? Or would they be supported completely outside medicine? And would there be people left without any meaningful and reliable help as a result? It is more obvious with some patient groups than with others. People with delirium could perhaps be initially investigated by emergency doctors and then treated entirely by physicians or geriatricians, although these specialists often request input from psychiatrists to confirm the diagnosis (and exclude other, non-organic conditions that can present similarly) and also to advise on management, probably to a large extent because psychiatrists have much more experience with managing psychotic symptoms, aggression, and other behavioural symptoms. Mental disorders owing to a general medical condition are similar in that by treating the underlying physical condition one would expect the mental health symptoms to improve too. Of course, this is not always the case, and patients are often left with a psychiatric condition, for example post-traumatic stress disorder or depression, after recovery from their physical illness. Although geriatricians and neurologists could diagnose and treat dementia, they would need to expand their services and skills significantly if they were to look after dementia patients in the community with problematic behavioural and psychiatric symptoms of dementia (e.g. agitation, aggression, depression, hallucinations, delusions, wandering). These symptoms often lead to carer exhaustion and require the careful planning of a care package or consideration of various residential placement options. This work involves the skilful balancing of patient autonomy and quality of life with safety and other considerations. This work in the UK is done by psychiatrists specializing in old age psychiatry and encompasses a significant amount of mental capacity assessments and safeguarding work (prevention of abuse and neglect in this vulnerable population), interfacing with Social Services and care homes and care agencies. What would happen to people with schizophrenia, bipolar illness, or personality disorders is even less obvious. Psychological treatment services do not tend to take on patients with these conditions whilst they are still floridly psychotic, actively suicidal or violent, not eating and drinking, or unable to engage in talking therapy. Who would manage the risks in such cases? Any new subspecialty growing out of neurology or medicine would need to provide so much of the same type of support that it would become psychiatry in all but name.

Although psychiatry brings, as part of its medical approach, natural sciences methodology to the study of mental disorders, which are understood to have varying degrees of contribution from genetic and psychological components, what no other specialty or

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

profession could do, or would want to do, it is not neuroscience. What uniquely enables psychiatrists to help those patients most in need of psychiatric help is the act of combining natural science and the social sciences. The criticism that we cannot ignore the fact that living circumstances and social and/or societal factors are crucially involved in the causation and recovery from most forms of mental illness has been justifiable. However, psychiatry, at its best, carefully considers biological, psychological, social, and existential aspects of mental illness and generates options relating to each of these aspects. And another important contribution: psychiatrists are experts at interviewing the patient and their family to explore their narratives and to help them make adaptive changes in their narratives in a way that promotes hope, agency, and recovery.

If psychiatry was abolished, important questions would remain from a values point of view. Would it really lead to more autonomy and personal freedom for people affected by severe mental illness? Would they achieve these important terminal values to a greater degree if they were left without psychiatric help? Would being supported only by other medical specialties, non-medical services, voluntary organizations, the police, or the criminal justice system enhance their autonomy and self-direction? Or is it that the appropriate instrumental value to achieve these is not the abolition of psychiatry?

Abolishing psychiatry could also contribute to an increasing (rather than a decreasing) conflict between the patient's own personal terminal values (e.g. retaining the autonomy to make one's own decisions even during severe mental illness versus having a healthy and comfortable life, both in the here and now and in the future). One of the value conflicts often discussed is that between personal versus social/communal values, such as in the context of detention to hospital for treatment: the autonomy of the patient versus the protection of society in the case of people who may become violent when ill, for example. Although detention often causes significant distress and whenever possible should be avoided, it can also be at the same time in the interest of the individual, not just society, as not being detained and acting violently in their social environment would also have (often long-term) negative consequences for them. These can range from retaliation by others and having to live with intense guilt feelings when they recover from the mental illness and realize what they have done and the impact of that, to being liable to pay a fine or compensation, losing a job or relationship, enduring various forms of exclusion from social participation, and/or incurring criminal charges. Not detaining to hospital for treatment those who trespass against the law during their severe mental illness leading to a gross distortion of reality testing, such as delusions and hallucinations, but treating them as criminals would go against the values of most people. Similarly, shall we abandon people when they are at great risk of harming themselves or being exploited or retaliated against by others? Shall we leave them to fend for themselves when they are very apparently not able to? Shall we leave them without treatment when that treatment has the potential to restore their mental capacity to make decisions for themselves and to improve their agency? This would conflict with the values of the majority of people living in the patient's community and also those of the relatives of most patients, and even many of the patients themselves when they are well. The approach of basing all treatment on consent by the patient, as advocated by some, fails when the person lacks the mental capacity to give that consent owing to severe mental illness, such as florid psychosis or mania, or severe depression. Personal autonomy is never absolute, even if we isolated ourselves from the rest of society (which is impractical), because within-person factors also do limit it for all of us. But coming back to balancing personal versus communal values, what may seem sensible from a personal perspective may not seem

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

so from a communal perspective. For example, some may argue that the patient has the right to choose to remain psychotic. Notwithstanding the complex question of whether the patient has the capacity to make a choice in such a situation, this right is not absolute; when it starts impinging on somebody else's rights, it can become a problem. Indeed, it has been argued that for drawing the line between mental disorder and non-disorder, we must consider not just harmful-for-the-individual but also harmful-for-others evaluations (Brülde, 2007). Wanting a rather high degree of exemption from the complex web of rights and responsibilities inherent in living in society comes with a variety of consequences, too. True, it steers one away from a medical solution in this case, but what does it steer us towards instead? The criminal justice system or a pariah existence on the fringes of society? Would that not just mean that it all comes full circle? Surely, this would be very different from the originally declared terminal values.

Critical psychiatry does not call for the abolition of psychiatry – in fact, many of its proponents are practising psychiatrists themselves – but it draws attention to problematic areas in psychiatric theory and practice in order to provide constructive criticism (Middleton and Moncrieff, 2019). However, the ways it problematizes these is not always consistent with the methodology of mainstream psychiatry, and whilst some welcome it as a sort of reflective function of psychiatry, others feel that its approach is destructive (Tyrer, 2019).

Its scope is wide, ranging from the implications of using the biological model of mental disorder, through the overuse of medications, the power imbalance in the doctor–patient relationship, the role of the patient–therapist relationship in psychotherapy, the sick role, the tension between the patient's best interests and the (assumed) social control function of psychiatry, and epistemic injustice, to societal changes and social and political influences on psychological well-being.

But what are some of the values that drive critical psychiatry? One area that critical psychiatry concerns itself with is the overuse of medications in psychiatry. Critical psychiatrists tend to accept that medication can be helpful but call for more transparency about the limitations in our understanding of the pathomechanism of mental illness or how medications work. In this context, health appears as a terminal value and honesty as an instrumental value. Many critical psychiatrists see psychiatric medications as chemicals that alter brain function and human experience, which – coupled with other support – can be helpful in overcoming mental illness, but they feel that the decision about using them needs to be based on this understanding and made much more collaboratively with the patient than they see happening in current practice. They call this collaborative prescribing using a drug-centred (as opposed to a disease-centred) approach. According to this approach, the clinician should explain that the medication is not to correct some sort of abnormality but will alter both desired and undesired emotions, and can cause side effects and discontinuation symptoms; the clinician should also explore the patient's expectations around all of this. Critical psychiatrists take issue with portraying unwanted emotions or behaviour as the result of abnormal brain chemistry, among other reasons, on the grounds that this places the problem with the individual rather than with society. Many practising psychiatrists and trainee psychiatrists would recognize this as how they have been working already. Much of what critical psychiatry stood for has now been absorbed by mainstream psychiatry. Psychiatry as a profession has become rather critical of its own practices and is continually evolving. This self-reflective stance, being critical of our own theory and practice in a constructive way, plays an important role in keeping our profession on a sound ethical

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

footing. Not unchallengeable, not universally viewed as something positive or perfect, but ethical. Psychiatry has been and is a broad church: some of us will call themselves critical psychiatrists; most will apply their critical ability as part of their professional good practice; and a few will continue to hold views that are now considered out of date.

In conclusion, any extreme position here that singles out one value or only a few values at the expense of considering all the relevant values ignores the complexity of values in psychiatry. Also, focussing on earlier practice that occurred in a context different from the current times or on exceptional cases that represent excess or abuse instead of examining typical clinical practice and training in psychiatry draws attention and resources away from addressing the main issues (Dudas, 2020). One of these is that there are conflicting terminal values here. Just one example of this is personal autonomy *versus* the rights and freedoms of others, including protection of the morals and health of others. There are also conflicting instrumental values with an impact on exactly how we should achieve the above terminal values and a balance thereof.

Is there a solution to this? A useful first step would be creating a framework within which these values can be made explicit, understood, acknowledged, and negotiated (i.e. represented, questioned, challenged) – and VBP can offer a methodological contribution for this work. Such a framework would need to enable decisions that affect the appropriate circle of stakeholders, neither unnecessarily wide nor unnecessarily narrow. An important component of this framework could be stakeholders' tribunals (see Chapter 4). Another useful step would be developing ways of handling dissensus in this context. The concepts that not all authority is necessarily harmful and that membership of a community involves accepting the attendant rights and responsibilities are germane to this. Honest public discussion facilitated through this framework needs to be an indispensable part of this process if we are to achieve progress and avoid harmful polemics.

Conclusion

Consistent with its immensely value-laden nature, psychiatry seems to be at risk of extreme positions. Unfortunately, taking extreme positions always runs the risk of ignoring or going against the values of a significant number of the stakeholders. With the changing values of society having an impact on the prestige and quality of working life in the profession, psychiatry has experienced recruitment and retention challenges. Psychiatry needs to make sure that it improves the quality of not just the neuroscience but also the social sciences and humanities content of its training programmes, if it wants to remain relevant to treating mental illness, to keep its identity, and to continue to attract and retain high-quality clinicians and researchers. This will also equip psychiatrists to make better decisions on how to take part in the work of the MDT, when to delegate, and what resources to request for the best outcome for patients.

Although demands on psychiatry to manage risk to self or risk to the public are continually made, VBP-informed analyses can help all stakeholders recognize what psychiatry can or should manage, where its remit ends, and why. Such analyses are also indispensable in laying bare essential misunderstandings about psychiatry and, of course, in accepting and responding appropriately to legitimate and constructive criticisms.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Notes

1. The Hippocratic Oath includes the promise 'I will abstain from all intentional wrong-doing and harm'.
2. If we accept that suicide elimination is a legitimate aim, a related question arises – is this aim always or solely the responsibility of psychiatric services? Should psychiatrists concern themselves with suicidality that is not a consequence of mental ill-health? And should wider society take greater responsibility for the social determinants of mental ill-health and of despair? These questions, however, are beyond the scope of this chapter.

References

Battin, M. P. & Mayo, D. J. eds. 1981. *Suicide: The Philosophical Issues*. London: P. Owen.

Beattie, S., Crampton, P. E. S., Schwarzlose, C., Kumar, N. & CornwalL, P. L. 2017. Junior doctor psychiatry placements in hospital and community settings: A phenomenological study. *British Medical Journal Open*, 7, e017584.

Boysen, P. G. 2013. Just culture: A foundation for balanced accountability and patient safety. *Ochsner Journal*, 13, 400–406.

Brülde, B. 2007. Wakefield's hybrid account of mental disorder. *World Psychiatry*, 6, 163–164.

Buchanan, A. & Grounds, A. 2011. Forensic psychiatry and public protection. *British Journal of Psychiatry*, 198, 420–423.

Care Services Improvement Partnership (CSIP) & National Institute for Mental Health in England (NIMHE) 2007. *New Ways of Working for Everyone: A Best Practice Implementation Guide*. https://shorturl.at/IM3D1.

Centre for Workforce Intelligence (CFWI) 2014. *In-Depth Review of the Psychiatrist Workforce*. London: CFWI.

Cholbi, M. 2017. *Suicide. In* Zalta, E. N. (ed.), *The Stanford Encyclopedia of Philosophy. Fall 2017 ed.* https://plato.stanford.edu/entries/suicide/.

Coffey, M. J. & Coffey, C. E. 2016. How we dramatically reduced suicide: If depression care were truly perfect, no patient would die from suicide. *NEJM (New England Journal of Medicine) Catalyst*, 2. http://catalyst.nejm.org/dramatically-reduced-suicide/.

Deahl, M. 2023. General psychiatry, still in no-man's land after all these years. *British Journal of Psychiatry*, 224(3), 86–88.

Dine, R. L. 2020. You shall bury him: Burial, suicide and the development of Catholic law and theology. *Medical Humanities*, 46, 299–310.

Donaldson, M. S., Corrigan, J. M. & Kohn, L. T. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press.

Dudas, R. B. 2020. The discontents of psychiatry: What can the history of psychiatry and values-based medicine contribute to resolving them? In Marková, I. S. & Chen, E. (eds.), *Rethinking Psychopathology: Creative Convergences*. Cham: Springer International, pp. 145–152.

Durkheim, E. M. [1897] 1966. *Suicide: A Study in Sociology*. Translated by J. A. Spaulding & G. Simpson; edited by G. Simpson. New York: Free Press.

Education Development Center 2018. *Zero Suicide in Health and Behavioral Health Care*. https://zerosuicide.edc.org/sites/default/files/Transforming%20Systems.pdf.

Elton, C. 2019. Doctors can't care for patients if the system doesn't care for them: An essay by Caroline Elton. *British Medical Journal*, 364, l968.

Fistein, E. & Malloy, D. C. 2017. Healthcare leadership and applied philosophy: An essential resource. *Healthcare Management Forum*, 30, 218–220.

Fulford, B. (K. W. M.) 2007. Facts/values: Ten principles of values-based medicine. In Radden, J. (ed.), *The Philosophy of Psychiatry: A Companion*. New York: Oxford University Press, pp. 205–234.

Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G. & Hawton, K. 2019. Effects of patient suicide on psychiatrists: Survey of experiences and support required. *British Journal of Psychiatry Bulletin*, 43, 236–241.

General Medical Council 2019. *The State of Medical Education and Practice in the UK*. The Workforce Report. London: GMC. www.gmc-uk.org/-/media/documents/somep-2019—full-report_pdf-81131156.pdf.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Goldstein, B. 2021. Decline of the humanities: Where does it STEM from? *Cornell Diplomat*, 24 November, 28–30. www.thecornelldiplomat.com/issue6/2021/11/24/decline-of-the-humanities.

Health Education England (HEE) 2020. *Supported from the Start; Ready for the Future: The Postgraduate Medical Foundation Programme Review*. https://shorturl.at/PRElf.

Hippocrates of Cos 1923. *The Oath*. Loeb Classical Library. Cambridge, MA: Harvard University Press. https://doi.org/10.4159/DLCL.hippocrates_cos-oath.1923.

Holdsworth, R., Browne, H., Ilsted, R. & Beezhold, J. 2023. Fish out of water: Junior doctors' experiences of psychiatry. *European Psychiatry*, 66(Suppl 1), S1122.

Hunt, I. M., Windfuhr, K., Shaw, J., Appleby, L. & Kapur, N. 2012. Ligature points and ligature types used by psychiatric inpatients who die by hanging: A national study. *Crisis*, 33, 87–94.

Insel, T. R. & Quirion, R. 2005. Psychiatry as a clinical neuroscience discipline. *Journal of the American Medical Association*, 294, 2221–2224.

Kerebih, H., Salelew, E. & Hailesilassie, H. 2019. Factors associated with medical students' choice of psychiatry as future specialty: A cross-sectional study. *Advances in Medical Education and Practice*, 10, 751–758.

Khajeddin, N., Riahi, F., Salehi Veysi, M., Hoseyni, H. & Izadi Mazidi, S. 2012. Do medical students' attitudes toward psychiatry and their intention to pursue psychiatry as a career change during psychiatric attachment? *Iranian Journal of Psychiatry and Behavioral Sciences*, 6, 53–61.

Lotito, M. & Cook, E. 2015. A review of suicide risk assessment instruments and approaches. *Mental Health Clinician*, 5, 216–223.

Mehta, N., Kassam, A., Leese, M., Butler, G. & Thornicroft, G. 2009. Public attitudes towards people with mental illness in England and Scotland, 1994–2003. *British Journal of Psychiatry*, 194, 278–284.

Mid Staffordshire NHS Foundation Trust Public Inquiry 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. HC 947. London: Stationery Office. https://assets.publishing.service.gov.uk/media/5a7ba0faed915d13110607c8/0947.pdf.

Middleton, H. & Moncrieff, J. 2019. Critical psychiatry: A brief overview. *British Journal of Psychiatry Advances*, 25, 47–54.

Nielssen, O., Wallace, D. & Large, M. 2017. Pokorny's complaint: The insoluble problem of the overwhelming number of false positives generated by suicide risk assessment. *British Journal of Psychiatry Bulletin*, 41, 18–20.

O'Connor, R. C. & Kirtley, O. J. 2018. The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 373, 20170268.

Oliveira, A. M., Machado, D., Fonseca, J. B., Palha, F., Silva Moreira, P., Sousa, N., Cerqueira, J. J. & Morgado, P. 2020. Stigmatizing attitudes toward patients with psychiatric disorders among medical students and professionals. *Frontiers in Psychiatry*, 11, 326.

Pandian, H., Mohamedali, Z., Chapman, G. E., Vinchenzo, P., Ahmed, S., Mulliez, Z., Bruce, H., Burn, W., Korszun, A. & Tracy, D. K. 2020. Psych socs: Student-led psychiatry societies, an untapped resource for recruitment and reducing stigma. *British Journal of Psychiatry Bulletin*, 44, 91–95.

Paris, J. 2005. A shrinking perimeter. In *The Fall of an Icon: Psychoanalysis and Academic Psychiatry*. Toronto: University of Toronto Press, pp. 92–114.

Pescosolido, B. A., Tuch, S. A. & Martin, J. K. 2001. The profession of medicine and the public: Examining Americans' changing confidence in physician authority from the beginning of the 'health care crisis' to the era of health care reform. *Journal of Health and Social Behavior*, 42, 1–16.

Punton, G., Dodd, A. L. & McNeill, A. 2022. 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PLoS (Public Library of Science) One*, 17, e0265542.

Royal College of Psychiatrists (RCPsych) 2019. Number of junior doctors choosing psychiatry at all time high. Press release, 11 July. www.rcpsych.ac.uk/news-and-features/latest-news/detail/2019/07/11/number-of-junior-doctors-choosing-psychiatry-at-all-time-high.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012

Royal College of Psychiatrists (RCPsych) 2023. Choose psychiatry: Choose to make a difference. www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry.

Schildkrout, B., Niu, K. & Cooper, J. J. 2023. Clinical neuroscience continuing education for psychiatrists. *Academic Psychiatry*, 47, 297–303.

Scott, D. A. 2019. Suicide and second victims. *Anaesthesia*, 74, 1351–1353.

Sebbane, D. 2014. Improving the image of psychiatry and psychiatrists: Results of a French national survey. *European Psychiatry*, 29, 624–625.

Shanafelt, T. D. & Noseworthy, J. H. 2017. Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings*, 92, 129–146.

Steeg, S., Quinlivan, L., Nowland, R., Carroll, R., Casey, D., Clements, C., Cooper, J., Davies, L., Knipe, D., Ness, J., O'Connor, R. C., Hawton, K., Gunnell, D. & Kapur, N. 2018. Accuracy of risk scales for predicting repeat self-harm and suicide: A multicentre, population-level cohort study using routine clinical data. *BMC (BioMed Central) Psychiatry*, 18, 113.

Suicide Act 1961. An Act to amend the law of England and Wales relating to suicide and for purposes connected therewith. 9 and 10 Eliz. 2. c. 60. London: UK Parliament.

Szmukler, G. 2003. Risk assessment: 'Numbers' and 'values'. *Psychiatric Bulletin of the Royal College of Psychiatrists*, 27, 205–207.

Thibaut, B., Dewa, L. H., Ramtale, S. C., D'Lima, D., Adam, S., Ashrafian, H., Darzi, A. & Archer, S. 2019. Patient safety in inpatient mental health settings: A systematic review. *British Medical Journal Open*, 9, e030230.

Timmermans, S. & Oh, H. 2010. The continued social transformation of the medical profession. *Journal of Health and Social Behavior*, 51, S94–S106.

Tyrer, P. 2019. Critical psychiatry is becoming Luddite: Commentary on . . . critical psychiatry. *British Journal of Psychiatry Advances*, 25, 55–56.

World Health Organization 2019. Patient safety [10 facts]. www.who.int/news-room/facts-in-pictures/detail/patient-safety.

Zero Suicide Institute n.d. Zero suicide. https://zerosuicide.edc.org/.

Zero Suicide International 4 2018. *4th International Zero Suicide Summit, Rotterdam 2018: The Rotterdam Declaration*. www.zerosuicide.org/_files/ugd/686ed3_68bda2e0591c40acb9d6b7154f2cd3b5.pdf.

Downloaded from https://www.cambridge.org/core. IP address: 18.97.9.174, on 13 Nov 2026 at 23:09:15, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781108883535.012