# Ideology, psychiatric practice and professionalism

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Psychiatry, associated as it is with social and cultural factors, has undergone profound changes over the last 50 years. Values, attitudes, beliefs and ideology all influence psychiatry. Deinstitutionalisation, the normalization principle, advocacy, empowerment and the recovery model are ideologies that have been closely associated with policy, service developments and clinical practice in psychiatry. A "new professionalism" is emerging as a consequence of a number of changes in mental health care that needs to be guided by the highest standards of care which are best epitomized in psychiatry as a social contract with society. Looking to the future it is important that the profession recognises the impact ideology can make, if it is not to remain constantly on the defensive. In order to engage proactively and effectively with ideology as well as clinical science and evidence based service development, psychiatry as a profession will do best to approach significant future policy, practice and service changes by adopting an ethical approach, as a form a social contract. Psychiatrists must pay increasing attention to understanding values as expressed by ideologies, working in a collaborative way with other mental health professionals, involve service users and manage systems as well as be competent in clinical assessment and treatment. Whether in time of plenty or in times of deprivation, ideology produces effects on practice and in the context of constantly changing knowledge and the current financial stress this is likely to be more the case (and not less) in the foreseeable future. Psychiatrists must take into consideration the new social problems seen in some high income countries with the increased availability of highly potent "street drugs", perceived threats from various immigrant and minority communities and breakdown of "social capital" such as the decline of the nuclear family.

**Key words:** Ideologies, deinstitutionalization, normalisation, empowerment, recovery, professionalism

**Introduction**

The clinical practice of psychiatry cannot be seen in isolation from trends in society and culture.[1] Society funds (mental) health services and in return expects certain patterns and standards of care. Medicine and psychiatry's contract with society is influenced by attitudes, beliefs, values and ideology, as well as science. Western societies have moved from post Second World War austerity and cold war paranoia, through the social movements of the 60s and 70s, to the neoliberal economics and globalisation of recent decades. These changes in society have had an impact on the way mental health policies and services have developed and therefore on the circumstances and the way in which psychiatrists practice.

In this paper we discuss ideologies that have been closely associated with policy, service developments and clinical practice in psychiatry and mental health care over the past few decades and review their implications for professionalism in psychiatry.

**Ideology**

The Oxford English Dictionary defines ideology as a "manner of thinking characteristic of a 'class' or individual". A social psychological view of ideology would be as a "set of values determined by material or rational considerations".

Psychiatrists, like other groups, have ideologies. In the early post World War II decades distinct psychiatric ideologies could be divided into "custodial" and "humanistic". Alternatively they could be divided into somatotherapeutic, psychotherapeutic and sociotherapeutic, emphasising respectively biological, individual psychological and environmental factors in the aetiology, formulation and treatment of psychiatric disorder.[2,3] Increasingly, however, the deleterious effects of the long stay institutions and asylums, where psychiatrists were practicing, were strongly criticised.[4–7] Such criticisms and the dominant position that psychiatrists held in the asylums fuelled ideologically motivated views of psychiatry and mental health services, some of which persist even today.

The criticisms of asylums and psychiatry gained momentum during the 1960s when United States

and Western European societies were rocked by the civil rights movement, Viet-Nam era anti-war demonstrations and the cultural and sexual revolutions. In the UK, Enoch Powell, the Minister of Health in his infamous "Water Tower Speech", as part of the address to the National Association of Mental Health Conference, March 9, 1961, advocated the reduction of the number of hospital beds and a move towards a local authority community infrastructure for people with mental health problems. In this context, the enactment of the "Maternal and Child Health" and "Mental Retardation Planning" Amendments and the "Mental Retardation Facilities and Community Mental Health Centres Act" in the US in 1963, arguably marked the beginning of changes in mental health services with strong ideological impetus.[8]

The ideologies under review in this article are: the deinstitutionalisation movement, the normalization principle, patient and carer advocacy and empowerment and the recovery model. The impact they have had on psychiatric professionalism has been profound and, arguably, has touched most parts of the world by now.

**Ideology and aspiration**

*Deinstitutionalisation*

The deinstitutionalisation movement's main aim was to replace long-stay psychiatric hospitals with less isolated community mental health services. The emerging use of effective new psychotropic medication in the 1950s, legislative initiatives, such as for example John Kennedy's New Frontier programme, changes in public opinion about those with mental health problems and governments desire to reduce cost gave impetus to this movement and its aims. Deinstitutionalisation first focused on reducing the size of the population in long stay institutions by releasing individuals to community facilities such as supported housing. The concurrent development of Community Mental Health Centres aimed to reduce numbers of new admissions, length of inpatient stay and number of readmissions into hospital. The movement gained momentum and spread gradually worldwide when it adopted philosophies from the civil rights movement in the US. Overall, professionals, civil rights leaders and humanitarians saw the

shift from institutional confinement to local care as the appropriate approach; however, concerns and fears were expressed as well, mostly by psychiatrists but also some patients, carers and other members of the community. Historians suggest a combination of social policy, anti psychiatry and consumer activism contributed to the implementation of deinstitutionalisation.[9] In France the reform of psychiatric institutions became a political issue and for some groups of radical mental health professionals it was seen as defending a politically alienated individual.[10] There was also an association of the timing of psychiatric reforms with the wider planning movement in France in the 60s and 70s that led to the emergence of the "secteur" in psychiatry (ibid). The "secteur" was primarily a planning device, even though psychiatrists thought that it brought about new ways of thinking about their work. In the following years the "secteur" was considered as the French way of deinstitutionalisation. The radical psychiatric reforms in Italy introduced by Basaglia, founder of the Italian Psychiatric Democratic Movement in the 70s, also had a strong political flavour.

### Normalisation

The normalisation principle emerged from practical work in services for people with intellectual and developmental disabilities in Scandinavian countries.[11,12] The parents' movement there demanded standards in relation to facilities and treatment programmes. The aim was to make available to all people with disabilities living conditions and lifestyles which were as close as possible to the mainstream. In the United States[13,14] Wolfenberger expanded the normalisation principle into a comprehensive ideology with detailed guidelines for providing and evaluating human services. Wolfenberger[15] introduced a new term for normalisation, namely Social Role Valorisation. This new concept championed the establishment of socially valued roles for people with intellectual and developmental disabilities. The reasoning was that if a person engages in valued social roles, s/he is likely to enjoy those social goods generally wished for and available in society. There was little sound theory or scientific evidence to support the vision, either in terms of mental development or institutional change.[16] With some exceptions, psychi-

atrists remained reserved and sceptical. Reservations notwithstanding, the normalisation principle captured the imagination and commitment of many professionals, service planners, service providers and others. Normalisation workshops were led by charismatic individuals whose vision about how to revolutionise human services became contagious. Some psychologists numbered among the leading advocates. There is no doubt that over the past few decades every policy initiative for people with intellectual and developmental disabilities has explicitly stated its commitment to deinstitutionalisation and the principle of normalisation.

### Advocacy and empowerment

Many mental health service users describe personal experiences of not being listened to within the mental health system. A lack of an ongoing, constructive dialogue between service users and professionals has been a major source of dissatisfaction.

John O'Brien,[17] a widely known advocate for people with intellectual and developmental disabilities, defined advocacy as "...*the creation by the advocate of a relationship with a person who is at risk of social exclusion and chooses one or several of many ways to understand, respond to and represent that person's interests as if they were the advocate's own*...". Also known in the UK as service users' participation, advocacy has the main aim of supporting service users to speak out and persuade providers of services to listen to them.

Advocacy and empowerment broke on the scene with the establishment in the United States of what is currently known as Arc (*http://www.thearc.org/ page. aspx?pid=2338*). Previously called the National Association for Retarded Children and Citizens, it was led by parents of children with intellectual and developmental disabilities who had been active even before the first ideas of deinstitutionalisation and normalisation emerged. Arc, with many branches around the world, has been promoting and protecting the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes.

The Advocacy movement for people with intellectual and developmental disabilities has been

campaigning for self-determination and self-advocacy on the principle that all people with intellectual and developmental disabilities should be defined by their own strengths, abilities and inherent value, not by their disability. The overall vision is that with appropriate resources and supports they can make decisions about their lives. It is important that people with intellectual and developmental disabilities, their parents, siblings, family members and other concerned members of the public have meaningful opportunities to inform and guide the direction of organizations that are involved in their welfare, including determining policy and positions on important issues.

### Recovery

The origins of the recovery model can be traced in early Alcoholics Anonymous programmes. The recovery model itself first emerged in the early 1990's and is one of the most recent ideologies in psychiatry. It is a product of deinstitutionalisation and driven by the understanding that people with mental illness have multiple residential, vocational, educational, and social needs and require more than just treatment for symptoms.

Recovery is often referred to as a process, outlook, vision, and conceptual framework or guiding principle.[18] One definition has been "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".[19]

Rethink[20] in an overview statement suggest that "*recovery can be defined as a personal process of tackling the adverse impacts of experiencing mental health problems, despite their continuing or long-term presence. It involves personal development and change, including acceptance that there are problems to face. Also a sense of involvement and control over one's life, the cultivation of hope and using the support from others, including direct collaboration in joint problem-solving between people using services, workers and professionals. Recovery starts with the individual and works from the inside out. For this reason it is personalised and challenges traditional service approaches*."

Although the concept of recovery had previously been recognised for physical illness and disability,[21] it had received little attention with respect to people with mental illness.[22] The concept of recovery from physical illness and disability does not mean that the suffering has disappeared or all the symptoms removed or that functioning has been completely restored.[23] For example, a person with paraplegia can recover even though the spinal cord has not. Similarly people with mental illness can recover even though the illness is not "cured." For many people, the concept of recovery is about maintaining control of their lives despite experiencing mental health problems. Putting recovery into action means focusing care on building resilience, not just treating symptoms.

Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health.[24] Professionals, friends and families can be overprotective or pessimistic about the potential of people with mental health problems. Recovery is about looking beyond those limits to help people achieve their own goals and aspirations. The model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning. Recovery emphasises that, while people may not have full control over their symptoms, they can have control over their lives. It is about seeing beyond a person's mental health problems, recognising and fostering their abilities, interests and dreams.

A recovery approach has been adopted as the guiding principle for mental health or substance dependency policies of several countries and continues gaining increasing acceptance. In many cases practical steps are being taken to organize mental health services on a recovery model.[25]

## Ideology in practice

### Deinstitutionalisation in practice

The closure of mental asylums and deinstitutionalisation was perhaps the largest social experiment of the 20th century and has had variable degrees of

success.[26] Although it has been positive for the majority of patients, it has also had severe shortcomings.

Psychiatrists raised early concerns about deinstitutionalization and community care in the US, without being heard.[27] Bacharach[28] concluded early that deinstitutionalization in that country failed to address the needs of the diverse population of patients. In Britain, Kathleen Jones,[29] a professor of social policy, criticized the destructive effect on psychiatry of ideologies that led to a precipitate reduction in inpatient beds.

Despite such concerns and experiences, deinstitutionalisation has progressed relentlessly internationally, more so in some countries than others. Successive legislation and service planning in the UK, for example, reinforced deinstitutionalisation and promoted community care, so that today there are almost no long stay mental institutions in the country. Regrettably, despite such change, the comprehensive community care defined[30] as "services that provide a full range of effective mental health care to a defined population, dedicated to treating and helping people with mental disorders, in proportion to their suffering or distress, in collaboration with other local agencies" remains an aim and not a current reality.

Patients have too often been discharged without sufficient preparation or support and a high proportion became homeless or ended in prison instead of asylum. The "out of sight, out of mind" policy of Victorian era seems to have been replaced by an "out of hospital, do not mind" policy, in which the overriding prerogative seems to be to hasten discharge not recovery. Expectations that community care would lead to further social integration have not been fulfilled and many patients remain secluded in sheltered environments and have extremely limited social contacts and no prospect of work.

Even though the UK has a well developed primary care sector, a relatively sophisticated range of hospitals and community based specialist mental health services and widely praised policies,[31] most people with mental disorders do not receive appropriate health care and their many needs remain significantly unmet.[32] Priebe et al[33] have expressed concern that a

process of "re-institutionalization" may have started, with increasing numbers of new forensic psychiatric beds and relentlessly rising numbers of mentally ill people in the prison population. Struggling clinicians have to carry out care to the best of their abilities in what are unsatisfactory policy and service environments (ibid).

A period of unprecedented investment of funds in mental health services by the Labour government (1997–2010) notwithstanding, many senior practicing clinicians continue to express alarm about the quality of services people receive.[34,35] Tyrer[36] points out that the remaining inpatient psychiatric units have lost their therapeutic spirit and members of staff look demoralized and discontented.

The process of deinstitutionalisation for people with intellectual and developmental disabilities has fared well compared to that for mental disorders. It evolved more gradually and selectively and was driven by the normalisation principle. It resulted in less recidivism and was accompanied by low rates of readmissions. Perhaps the fact that it is more difficult to deny the presence of actual disability in this group, compared to the mentally ill, has made the crucial difference in this respect, in that more care has been taken with this group.

### Normalisation in practice

Overall the ideology of normalisation has been a unifying and positive force among those who have worked to end the social exclusion and devaluation experienced by people with intellectual and developmental disabilities. Lakin and Bruininks[37] suggest that the normalisation principle was widely accepted as a concept because of its elegant simplicity in providing both a utilitarian and an egalitarian guide to measuring the coherence of services for people with intellectual and developmental disabilities.

The prescriptive nature of the normalisation principle and social role valorisation had an undoubted appeal to two contrasting but important professional groups. Firstly, a significant number of administrators who had previously had little experience of providing services, but who were seeking some kind of conceptual template against which to judge the quality, efficacy and effectiveness of their services.

Secondly, to the many inexperienced, untrained and unsupported front-line staff who were searching for a comprehensive set of practice guidelines which could be applied easily and quickly.[38] However, the crucial point that advocates of the normalization principle missed, was that it was an ideology to help guide but not dictate thought and action. To achieve best results it needs a sensitive and pragmatic approach, not an inflexible and dogmatic one.

### Advocacy and empowerment in practice

The provision of advocacy and empowerment for people with mental health problems has increased significantly over the past 20 years. Advocacy has been well received in general, including psychiatrists and is no longer perceived as a marginal activity. In some countries, including the UK, service users' participation is recognised in policy, legislation and research. In several countries there are now independent experienced providers of advocacy services designed to support those who are vulnerable. They help make informed decisions and secure the rights and services to which they are entitled.

### Recovery in practice

Failures in the implementation of policies of deinstitutionalisation confronted the psychiatric profession, as well as others, with new challenges and radically changed thinking about how the mental health system should be organised and delivered. This new way of thinking about services and about the people laid the foundation for the gradual emergence and acceptance of advocacy of the recovery vision in the 1990s. Consequently recovery, as well as advocacy and empowerment, has been increasingly adopted in policy and training. However there has been debate about its intentions, nature and outcomes.

The ideology of recovery has been interpreted by some critics as implying that everyone can fully recover through sheer willpower and, therefore, as giving false hope and implicitly blaming those who may be unable to recover in symptomatic or functional terms. It has been argued that true recovery requires improvement in symptoms of mental illness and, unless additional resources are made available, either symptomatic treatment or recovery or both will remain deficient.

There have also been tensions between the recovery model and "evidence-based practice" models. Tyrer[39] casts doubt on the way the recovery model has been used in psychiatry, by stating that it has been overused driven by policy with questionable evidence-base. Others have perceived cultural biases in the "North American" model and practice of recovery, as well as the lifestyles that might be considered acceptable or valuable.[40]

In response, the critics have themselves been accused of failing to recognize that the model is intended to support a person in their personal journey rather than achieve a given outcome. Recovery relates to social and political support as well as individual empowerment. Many have argued that the critics undermine consumer rights and yet others emphasise that service user led research should be viewed side by side with professional led research.

### Aspiration, practice and psychiatric professionalism

In March 1961 Enoch Powell, minister responsible for health in the UK at the time stated:

"I *have intimated to hospital authorities who will be producing the constituent elements of the national hospital plan that in fifteen years' time, there may be needed not more than half as many places in hospitals for mental illness as there are today... Now look and see what are the implications of these bold words. They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today. This is a colossal undertaking, not so much in the physical provision which it involves as in the sheer inertia of mind and matter that requires to be overcome... Do not for the moment underestimate their power of resistance to our assault...*".

Was this, rather than legislation in the US, the signal for ideology driven reform of psychiatric services? Enoch Powell was certainly a deeply ideologically driven politician with libertarian commitments. He was also highly likely to have been knowledgeable about intellectual and policy developments in the US![48,49]

As we have seen, the ideologies of deinstitutionalisation and normalisation that swept across countries were received with caution, even hostility, by many

psychiatrists. They argued that these ideologies were based on theory rather than evidence. They perceived a potential gap between what theory promised and what could be achieved in reality, as it seemed evident that their implementation in practice required significant additional resources. These doubting psychiatrists were accused of defending the status quo in order to maintain their professional dominance. In contrast, other mental health professionals, mostly psychologists but also nurses were more welcoming and some of them became leading advocates. Service users and policy makers also embraced these ideologies for different reasons.

We have also seen that there has been increased acceptance of the newer ideologies of advocacy and recovery by psychiatrists. Perhaps the increased acceptance of newer ideologies reflects less their greater merit in theory or evidence, compared to the older ones, and more the changed circumstances in which psychiatrists have practiced in recent years. These new circumstances include the closure of asylums, the increasing role of primary care in mental health, the growth of allied professions (psychology, nursing and social work) and the engagement of patients in service delivery as "experts by experience". Citizens and patients in many countries are now better informed about their conditions and their treatments, while their human rights have been increasingly recognised in legislation. In many countries there has also been an increased dominance of neoliberal politics and the emergence of the entitlement society.

Two significant trends over the last twenty years in USA and UK have changed the delivery of mental health care. They are the rise of for-profit managed care and evidence-based practice.[8] Managed care systems have dramatically reduced length of stay for psychiatric inpatients, while health maintenance organisations (HMO) in the USA have been contracting non-psychiatrists to offer different treatment modalities even to employees at their work place. The introduction of "care management" in UK has established community-based mental health care and reducing mental health expertise base in hospitals. Mental health care is not only provided in hospitals but in a variety of community settings such as residential houses, prisons, courts, schools, sports centres etc. In part this reflects the expansion of translational research in psychiatry which was bound to influence the provision of mental health care and the boundaries between researchers and clinicians. In addition, networks of global collaboration between mental health professionals, researchers and organisations, profit and non-profit, may be expected to influence the standardisation of diagnoses and therapeutic interventions.

During the same time, health care has evolved into huge enterprise, what some may be tempted to call an "industrial complex". As such, the medical profession has become a component of an industry in which issues of public policy, market forces, and consumer demands are key influences, along with developments in the clinical sciences.[41] Increasingly non-professional workers are delivering health-care in psychiatry and beyond. Is all this a contemporary trend towards de-professionalization of psychiatry? Is the story of post war psychiatry one of a process whereby clinicians have gone from being independent professionals to becoming case mangers, from "practitioners of an art to providers of technological services"?[42]

Professionalism in medicine is defined[43] as "the norms that guide the relationships in which physicians engage in the care of patients". A "new professionalism" is emerging as a consequence of this industrialisation of healthcare and advances in information technology, improved literacy about health care in the community and changing social expectations.[40] This implies in psychiatry a contract between the medical profession and society.[44]

Looking to the future, it is important that the profession recognises the impact ideology can make, if it is not to remain constantly on the defensive. In order to engage proactively and effectively with ideology as well as clinical science and evidence based service development, psychiatry as a profession will do best to approach significant future policy, practice and service changes, by adopting an ethical approach as a form a social contract.

Bhugra et al[45] identified specialised training and skills, expert assistance, trustworthiness, efficacy and devotion to serve the best interests of society as core

components of professional ethics. Ikkos[46] emphasises that psychiatrists must maintain an unflinching focus on the human rights, welfare and social inclusion of people with mental illness and learning disability, as they are amongst the most vulnerable in society. Ikkos et al[44,47] add that the profession must at the same time attend increasingly to choice and personalization in mental health services. They conclude that the essentials of psychiatric professionalism are the 7 Es: attention to *evidence*, *emotions* and *ethics*, *engagement* in service development and quality assurance, integration of these in clinical *expertise*, *education and research* for future care and commitment to the *empowerment* of patients.

## Discussion

A brief paper like this cannot do full justice to the complexities of issues involved. Some might argue that ideology in mental health goes further back to the therapeutic community movement of Maxwell Henderson, yet others would point to the importance of the religious ideologies of compassion, which drove both Christian and Muslim societies to establish mental health care in religious institutions in long distant years. All we have attempted to illustrate here is a preliminary sketch of some ideas and developments relevant to ideology and mental health. As Powell's quote confirms, ideology is a powerful motivator for change.

Another limitation of our article is the limited analysis of ideology itself. We have aimed at what may be hopefully a reasonably clear exposition of some ideologies directly related to mental health. However, we have not attempted a review of ideologies which operate at the broader societal level. One of the interesting characteristics of developments in mental health in the last 50 years is that they commanded considerable consensus. Yet right wing libertarian ideologues have very different motivations from their more communitarian adversaries. Their differences notwithstanding, they seem to have argued for a common cause. Perhaps the more extreme elements on each side argued more fervently and therefore effectively and overcame the hesitations of their more moderate colleagues, including sceptical psychiatrists and others.

It is a common error of young psychiatrists in training to believe that concentration on the study of the brain will reveal the substance of the specialty. This belief is not supported by the evidence, yet it persists well into later practice in many. This is not entirely negative in its consequences, because of all medical specialists psychiatrists need to have the best understanding of the brain. We do not find ourselves in the relatively comfortable position of neurologists who can identify concrete lesions. We have the bigger challenge of understanding the integrative function and malfunction of the brain in a wider context and this demands deeper understanding. Others have emphasised the importance for clinical practice of placing study and understanding of the brain on a par with understanding of family, relationships and culture. Here we have attempted to add ideology to what is a long list of relevant concerns.

Psychiatrists must pay increasing attention to understanding values as expressed by ideologies, working in a collaborative way with other mental health professionals, involve service users and manage systems as well as be competent in clinical assessment and treatment.

Whether in time of plenty or in times of deprivation, ideology produces effects on practice and in the context of constantly changing knowledge and the current financial stress this is likely to be more the case (and not less) in the foreseeable future. Psychiatrists must take into consideration the new social problems seen in some high income countries with the increased availability of highly potent "street drugs", perceived threats from various immigrant and minority communities and breakdown of "social capital" such as the decline of the nuclear family. There is also an increasing emphasis on "market" models for health care-based on transactions of health "goods", provided by "suppliers" (mental health professionals) and "chosen" by "consumers (patients)" with some expectations that the "market" then takes care of quality and rationing. Psychiatric practice will no doubt continue to evolve and psychiatrists will need constant renewal of knowledge and skills to keep up to date with scientific, technical and organisational developments. Challenging though this may be, it is necessary in order to secure and develop psychiatry's contract with society, fulfil our professional role and transform public perceptions and expectations of mental health.

# Ιδεολογία, ψυχιατρική πρακτική και επαγγελματισμός

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Η Ψυχιατρική, η οποία αναντίρρητα συνδέεται με κοινωνικούς και πολιτισμικούς παράγοντες, έχει υποστεί ριζικές αλλαγές κατά τη διάρκεια των τελευταίων 50 ετών. Αξίες, πεποιθήσεις και ιδεολογίες άσκησαν σημαντική επιρροή στη διαμόρφωση της σύγχρονης ψυχιατρικής. Η αποϊδρυματοποίηση, οι αρχές της ομαλοποίησης, η συνηγορία και το μοντέλο της αποκατάστασης αποτελούν ιδεολογίες που έχουν συνδεθεί στενά με τις πολιτικές, τη διαμόρφωση των συστημάτων παροχής υπηρεσιών ψυχικής υγείας και την κλινική ψυχιατρική. Ατενίζοντας το μέλλον, είναι σημαντικό για την Ψυχιατρική να αναγνωρίσει τις επιπτώσεις που μπορεί να έχουν οι ιδεολογίες στην κλινική πράξη. Οι ψυχίατροι πρέπει να δώσουν μεγαλύτερη προσοχή στην κατανόηση των αξιών όπως εκφράζονται από ιδεολογίες και να συνεργαστούν ενεργά με άλλους επαγγελματίες ψυχικής υγείας και με τη συμμετοχή των χρηστών των υπηρεσιών στη διαχείριση των συστημάτων παροχής υπηρεσιών ψυχικής υγείας, καθώς και στην κλινική πράξη και στις θεραπευτικές μεθόδους. Οι ψυχίατροι πρέπει να λάβουν υπόψιν τους τα νέα κοινωνικά προβλήματα που εμφανίζονται σε ορισμένες χώρες υψηλού εισοδήματος με την αύξηση της χρήσης των ναρκωτικών, τις προκλήσεις από διάφορες ομάδες μεταναστών και μειονοτικών κοινοτήτων, καθώς επίσης και τη μείωση του «κοινωνικού κεφαλαίου», όπως π.χ. η πυρηνική οικογένεια. Ένα σχήμα «νέου επαγγελματισμού» αναδύεται ως συνέπεια σειράς αλλαγών στον τομέα της ψυχικής υγείας που πρέπει να καθοδηγείται από τα υψηλότερα πρότυπα φροντίδας. Ο καλύτερος τρόπος για να συνοψιστεί το νέο αυτό πρότυπο επαγγελματισμού στην ψυχιατρική είναι ως ένα κοινωνικό συμβόλαιο με την κοινωνία.

**Λέξεις ευρετηρίου:** Ιδεολογίες, αποϊδρυματοποίηση, ομαλοποίηση, συνηγορία, αποκατάσταση, επαγγελματισμός.

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