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From the Editor's desk

By Kamaldeep Bhui

Archimedes: on buoyancy and bother

Seven people died this week (at the time of writing, late November 2014) by suicide after they were turned away from services because there were no beds.[1] Mental illness beds have been closed as part of the move to the community where specialist services have grown over the past two decades, but suddenly, these services are now also being removed with no provisions to improve in-patient care.

Mental healthcare seems to be sinking in political and commissioning priorities even though we know that mental illness kills people just as much as and alongside cancer, diabetes, cardiovascular disease, hepatitis and smoking.[2–6] The stark reports of preventable suicide are suggestive of insufficient funds for basic, safe services. The National Health Service Chief Executive Simon Stevens has stated that healthcare will need more investment. What priority will be given to mental illness?

There is widespread recognition of a need for more effective and cost-effective interventions, better-quality services, more preventive interventions and intelligent use of data. Yet despite the consensus and leadership from NHS England (Professor Geraldine Strathdee) and Public Health England (Gregor Henderson), the new Associate Registrar for Public Health at the Royal College of Psychiatrists (Peter Byrne), and mental health professionals more generally, our collective voices in a high-income country, a democratic society of values and principles, are not making an impact. Why are mental illnesses invisible and the lives of people with mental illness ignored?

Archimedes derived his buoyancy principle, legend would have it, by testing that a crown of 'gold' and the gold used to make the crown weighed the same. Yet, the two objects displaced different volumes of water, suggesting the 'gold' crown to contain within it, and be corrupted by, silver. The two objects weighed the same and to most looked the same, but the careful granular inspection revealed contrasting worth and value. Archimedes was willing to notice and investigate, as he was sufficiently troubled by the illusion of similarity. New research evidence can sink or raise specific interventions. However, stigma and political opinion can powerfully assign varying levels of priority to mental illness and this also affects the buoyancy of services and funding for research.

Stigma is often proffered to explain a lack of attention to mental illness; the brain sciences hold promise but psychiatry is still waiting for its 'Higgs boson moment' as Professor Nick Craddock calls it.[7] If there were such a moment, it might motivate greater resourcing of research and services, and commitment from politicians and commissioners. The focus on brain sciences and the genome offers great promise for a eureka moment for treatment and prevention. Less momentous interventions – for example, better information for patients and the public about genes and brain sciences – may empower and reduce stigma more effectively.[8] There is already a substantial body of evidence on effective health interventions and the economic impact of not treating or not preventing. At the same time, some eccentric opinions still survive, for example, that mental illness does not exist, or it is not a medical illness, or we only need a psychosocial intervention for all mental illnesses, while people with mental illness are dying too early of cancer and heart disease and suicide, living in distress and are turned away from services. This collective failure to put in place adequate safeguards has not been witnessed for decades. Is it stigma about mental illness that continues to shape perceptions that drive this dismissal of a crisis in care?[9]

Professor Helen Lester championed the provision of person-centred healthcare for people with psychosis and challenged stigma from health professionals, including doctors. In her outstanding lecture titled 'Being bothered about Billy' (see https://www.youtube.com/watch?v=tqyACm5OQOM), she showed that physical care and psychiatric care are inextricably bound by a concern for the patient, by compassion, by notions of fairness and equity, and by being bothered. Politicians, commissioners, practitioners and managers should all be bothered, because Billy is their friend, neighbour, brother or sister, father or mother. Billy may also be your doctor, your MP, your child's teacher or good friend.

This month's *BJPsych* shows the best from seriously bothered researchers who have spent huge amounts of time with much personal sacrifice to generate evidence of progressive care and to advance our understanding and concern about the experience of mental illness. From addictions research, Lorrenzetti *et al* (pp. 77–78) show damage to the hippocampus and amygdala of heavy cannabis users, an organic and pathological effect of risky habits. Are illicit drugs evil? Yet, scientists are also trying to rediscover 'gold dust' in early attempts to use illicit drugs as treatments: LSD may be helpful in alcohol misuse (Sessa & Johnson, pp. 1–3) and MDMA for PTSD (Sessa & Nutt, pp. 4–6). Sinyor *et al* (pp. 72–76) examined suicide notes and show these to have significant implications for judgements about testamentary capacity that can affect children, families and loved ones, but suicide notes are rarely used to make judgements about capacity. For electroconvulsive therapy (ECT; Spaans *et al*, pp. 67–71) and cognitive bias interventions (Cristae *et al*, pp. 7–16), the evidence in the month's *BJPsych* challenges long-standing legends by showing favourable effects of ECT but questionable effects of cognitive bias interventions. And there is more evidence that hepatitis and treatment for it, and diabetes care, are hazards for people with mental illness (Sarkar *et al*, pp. 45–51; Calkin *et al*, pp. 52–57). Ground-breaking clinical epidemiology identifies points of intervention to improve resilience in young people and prevent psychopathy (Vidal-Ribas *et al*, pp. 17–25; Auty *et al*, pp. 26–31). An essential element of psychiatric practice is to understand the patient experience, and the relationships people have with their illness. Studies of psychopathology and perspectives from the medical humanities play a key role in bringing us closer to ways of expressing and coping with experiences of personal distress (Fineberg *et al*, pp. 32–38; Luhrmann *et al*, pp. 41–44; Jones, pp. 39–40).

The practice of psychiatry, mental healthcare more generally and clinical research need people who are bothered. The research evidence needs bothered politicians and commissioners to ensure that it is implemented. Although I wish you all a Happy New Year, with good wishes to your families, friends and communities, I also hope there is enough bother in the coming months to avert future tragedies.

1 Buchanan M. Seven mental health patients died waiting for beds. *BBC News* 28 November 2014 (http://www.bbc.co.uk/news/uk-30236927).

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3 Boden R, Molin E, Jernberg T, Kieler H, Lindahl B, Sundstrom J. Higher mortality after myocardial infarction in patients with severe mental illness: a nationwide cohort study. *J Int Med* 17 November 2014 (doi: 10.1111/joim.12329).

4 Ribe AR, Laursen TM, Sandbaek A, Charles M, Nordentoft M, Vestergaard M. Long-term mortality of persons with severe mental illness and diabetes: a population-based cohort study in Denmark. *Psychol Med* 2014; **44**: 3097–107.

5 Kisely S, Crowe E, Lawrence D. Cancer-related mortality in people with mental illness. *JAMA Psychiatry* 2013; **70**: 209–17.

6 Musuuza JS, Sherman ME, Knudsen KJ, Sweeney HA, Tyler CV, Koroukian SM. Analyzing excess mortality from cancer among individuals with mental illness. *Cancer* 2013; **119**: 2469–76.

7 Craddock N. Psychiatry needs its Higgs boson moment. *New Scientist* 29 April 2013 (http://www.newscientist.com/article/mg21829140.200-psychiatry-needs-its-higgs-boson-moment.html).

8 Costain G, Esplen MJ, Toner B, Scherer SW, Meschino WS, Hodgkinson KA, et al. Evaluating genetic counseling for individuals with schizophrenia in the molecular age. *Schizophrenia Bull* 2014; **40**: 78–87.

9 Sharac J, McCrone P, Clement S, Thornicroft G. The economic impact of mental health stigma and discrimination: a systematic review. *Epidemiologia e Psichiatria Sociale* 2010; **19**: 223–32.

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