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From the Editor's desk

By Peter Tyrer

The whys and wares of the yellow van

I lived in Nottingham when my children were growing up. This city, sometimes known as the Queen of the East Midlands, where many men went to find their future wives as so many jobs there were for women in the hosiery trade, had one omnipresent threat. I encountered this when playing the fool, as fathers sometimes do, with my children one day 25 years ago. Suddenly, after the exhibition of one of my strange eccentricities, my elder daughter turned to the other and said knowingly, 'shall we send for the yellow van?' Now the sense of the word 'shall' in the East Midlands differs from elsewhere in the country. It is often used as an imperative and has a menacing element of control attached to it. My nerves trembling and curiosity aroused, I enquired further and found that the psychiatric hospital in the city where I worked, Mapperley Hospital, the former Nottingham Asylum, used to have a fleet of yellow vans that were used to bring patients into the asylum. The matriarchs of Nottingham, no doubt exhausted after the joint tasks of double-overlocking garments during the day and caring for children in the evenings, repeatedly used the threat of the yellow van as a form of parental control and so helped to raise the status of stigma in the city against the mentally ill. My further research revealed that the yellow vans were almost the only overt presence of the mental health services in the city; everything else was hidden behind the high walls of the asylum up on the hill. These vans may have had other tasks, but to the population of Nottingham they had only one purpose, to take the mentally ill, usually against their wishes, out of normal society.

Society has changed for the better and now usually wants to promote the positive side of our new yellow vans. They are community markets, equivalent to the mobile libraries that operate in rural areas, bringing enlightenment, education and edification to the people. In this issue we see the benefits of our new vans at work. The people with common mental disorders who sought care from these services 10 years ago when they became unwell, now, according to Colman *et al* (pp. 327–331), are much healthier than those who eschewed a visit. The vans now have glass-fronted exteriors where many remedies are advertised. Some are widely used to improve lifestyle, such as melatonin for those with shift-work and jet-lag problems (Arendt & Rajaratnam, pp. 267–269), but in promoting these we also need to warn about the real dangers of other lifestyle enhancers such as ecstasy (de Win *et al*, pp. 289–296). Other treatments are central to our core work, but we must not always believe what we read in these advertisements, as the second generation of therapies is not necessarily superior to the first (Miller *et al*, pp. 279–288).

The gentle fingers of good mental healthcare now appear to be probing further afield, with attempts to provide psychological interventions by instruction without human contact. The jury is still out on this one, as the effects are currently modest (Andersson & Cuijpers, pp. 270–271) but slowly and incrementally we are adding to the evidence (Knoop *et al*, pp. 340–341). The yellow van people are also coming into general hospital clinics, where practitioners already there are now combining psychiatric with medical skills. The success of this is shown by Seivewright *et al* (pp. 332–337) in the treatment of health anxiety, which, together with other encouraging signs of success with depression,[1] suggests an expanding role for liaison psychiatry. So perhaps when the yellow van has finished showing off its wares around the community during the day it may find its parking place in the evening in the IT centre or the general hospital, and not always in the bay marked 'psychiatry'.

Double whammies for troubled LAMIs

World Mental Health Day is 10 October and its theme this year is scaling up services through citizen advocacy and action. This is desperately needed in the 90% of countries with only 10% of the world's resources and we need to draw attention to this constantly.[2,3] Now, I lack political correctness – I realise it is important but a gremlin inside me always seems to make me forget – and still refer to low- and middle-income (LAMI) countries as poor ones. I do this because I am emphasising their economies, not necessarily their performance, but the paper by Large *et al* (pp. 272–278) shows they are linked intimately. When the gross national product (GNP) of a country is low, a much higher percentage is needed to provide a given standard of mental healthcare; the trouble is that this is invariably not the case. What Large and his colleagues show is that that even a small amount of extra resources to mental health services yields greater dividends when given in LAMI countries than in richer ones, and supports the conclusions of Chisholm *et al*[4] that the cost of scaling up these services is both feasible and eminently possible. More bangs for your bucks indeed; this is surely an investment worth making to reduce the 10/90 divide.

1 Strong V, Waters R, Hibberd C, Murray G, Wall L, Walker J, McHugh G, Walker A, Sharpe M. Management of depression for people with cancer (SMaRT oncology 1): a randomised controlled trial. *Lancet* 2008; **372**: 8–10.

2 Saxena S, Paraje G, Sharan P, Karam G, Sadana R. The 10/90 divide in mental health research: trends over a 10-year period. *Br J Psychiatry* 2006; **188**: 81–2.

3 Patel V, Kim Y-R. Contribution of low and middle-income countries to research published in leading general psychiatry journals, 2002–2004. *Br J Psychiatry* 2007; **190**: 77–8.

4 Chisholm D, Lund C, Saxena S. Cost of scaling up mental healthcare in low- and middle-income countries. *Br J Psychiatry* 2007; **191**: 528–35.

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