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January Highlights

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I used to think that the day would never come, I'd see delight in the shade of the morning sun[1]

That there are ethnic inequalities in involuntary admission under the UK's Mental Health Act is not a new finding. Isn't that statement appalling? That this continues is beyond frustrating. The data are there, they are clear, they are consistent. What will it take to shift this? How long do we have to stare at this open inequity and seemingly accept that it's how things are? I sometimes wonder which elements of contemporary psychiatric practice will seem most arcane, bizarre or wrong-headed to future generations. This will clearly sit in that category. Something we all already know is wrong, something to which we can all contribute to redress, and yet something that forever appears to be someone else's business. Glacial incremental change – if we are even hitting that speed – that can sit shamefully on the shelf that also contains the gender pay gap and ethnicity data on promotions to the most senior levels of the National Health Service (NHS). In 1839, at the Hanwell Asylum in West London, John Conolly ended centuries of practice of mechanical restraint in just 3 months:[2] where there is real will, great change can happen rapidly. It won't occur via committee minutes and a Gantt chart.

Fonseca Freitas et al (pp. 27–36) note that it has been less explored whether these involuntary admission data are affected by clinical practice. This is a crucial question: reframing my opening rant, is our inequity actually in how we treat people, leading to greater rates of deterioration and more likely involuntary care, or are we 'just' detaining people under section because of who they are? The authors took data from 13 years of a single NHS trust's electronic healthcare records to search for any mediating issues in the 12 months before a first psychiatric admission. They found some modest variation in clinical care provided: having psychological therapy and a care plan was associated with reduced admission likelihood, whereas more home treatment or crisis care was linked with an increase, and there were some variations based on ethnicity. Nevertheless, the impact was modest and of small magnitude. One might feel some positivity that there do not appear to be huge differences in how we care for people (though such gaps do exist). However, it just turns the question back to us – to us all, to *you*: if it is not the care we provide – or, if you're feeling particularly disingenuous, 'disengagement' from 'hard to reach' communities – that mediate involuntary detentions, then it is decision-making and professional judgements when evaluating people at their most vulnerable.

Rohit Shankar et al (pp. 1–3) take us from what is in front of our eyes every day – but evidently ignored – to that which is perhaps too often forgotten: post-COVID syndrome in adults with intellectual disability. They note that this cohort of individuals was left behind during the initial ravages of the pandemic, when they suffered a mortality three times that of the general population. Although they were subsequently prioritised for the vaccination programme, it is a concern that people with intellectual disabilities (PwID) are all too likely to be disproportionately affected in the longer term. We are increasingly becoming familiar, through the literature or personal experience, of the potential for post-infective lingering difficulties of 3 months or more that are not explicable by other causes, though science is behind in understanding the pathophysiology. The authors' call to prioritise PwID as we move forward is well made.

My morning sun is the drug that brings me near, to the childhood I lost, replaced by fear[1]

Attention-deficit hyperactivity disorder (ADHD) is common in prisoners, affecting perhaps one in four, a figure about ten times that of the general adult population. One can imagine complex bidirectional effects of an additional health burden on typically already socioeconomically disadvantaged individuals – notably also one that adversely affects education and risks more impulsive and antisocial behaviour, as well as the converse of incarceration hindering appropriate care. Add to this a commonly wide range of extra mental health and substance use disorders, and it's not a recipe for good outcomes, though this is an understudied population in terms of treatment responses. Asherson et al (pp. 7–17) report on an 8 week double-blind randomised controlled trial (RCT) of osmotic-release oral system methylphenidate in male prisoners aged 16–25 years who met criteria for ADHD. Interestingly, compared with the placebo arm, those on the active intervention showed no statistically significant improvement on any measure, whether primary symptom reduction or secondary factors including emotional dysregulation, violent attitudes, or prison and educational staff ratings. This persisted even when controlling for the confounders of childhood trauma, symptoms of borderline personality disorder, emotional dysregulation and anger scores. In his accompanying editorial, Samuele Cortese asks what happened and what this means (pp. 4–6). The limitations of RCTs are identified and contrasted with successful results from some within-individual trials that compare outcomes when on and off medication. For this particular cohort, the dosing might not have been adequate at all times, particularly if it was pharmacodynamically affected by higher than average rates of illicit stimulant use. Cortese reasons that the well-designed study asks further questions rather than changing practice or clinical recommendations for prison populations.

Byng et al (pp. 18–26) continue the theme on the mental health of prisoners. Their 'Engager' RCT explored whether an active intervention of 3–5 months of psychological and practical support after prison release improved outcomes. They were particularly interested in common mental health problems and substance use, including 280 men with likely mental illness. All were serving sentences of 2 years or less, had between 4 and 20 weeks of this remaining at the time of recruitment, and were randomised to the intervention or care as usual. Once again, there was failure of the active intervention to show a significant difference over placebo. Our standard interventions are letting down a most vulnerable group worthy of care and our best efforts.

References

1 New Order. *True Faith*. Factory Records, 1987.

2 Towers K, Sachar A, Hilton C, et al. John Conolly – a legacy and a future obligation. *BJPsych* 2023. Available from: https://doi.org/10.1192/bjp.2022.95.

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