Mental health legislation

At the time of writing (December 2018), the UK government has just published a review of the current Mental Health Act 1983 for England and Wales. This was previously amended in 2007 following an extensive review. The positive overarching sentiments are that the language, values and principles of existing legislation are dated in their representation of the patient–professional relationship, and that there are insufficient protections for detained patients. A rights-based approach is promoted but interpreted as more reviews of care within the existing structures and the same or higher thresholds for compulsory treatments, rather than rights to alternatives, and different systems and philosophies of care in which coercion and detention play a lesser role. Promoting better application of advanced directives, community treatment orders and capacity-based legislation all aim to reduce coercive practices, such as forced medication, detention in hospital and over-reliance on pharmacotherapy.

It is recommended that police cells and prisons are no longer considered places of safety, raising uncertainty about how to manage imminent risk in community and hospital settings. The emphasis on rights and choice is limited to more frequent tribunals and review of care within a fixed time frame, and greater use of Section 3 treatment orders, and less use of Section 2 for assessment. Service users and a variety of health professionals are an essential part of care systems, alongside the police, social care and local agencies. All will need to develop alternative safe care pathways and equipped assessment suites. An underlying sentiment is that detentions will continue, perhaps at the same escalating levels. Although ethnic disparities are identified there are no specific plans to reduce detentions generally or in specific ethnic groups.

News media have highlighted many stories of failed care rather than emphasise the many positive stories. For example, some in the media have commented that the Mental Health Act leaves patients feeling neglected, abused and unable to choose their preferred form of care. Service users have commented. They seek a more radical approach, with minimum systemic reliance on coercive care practices. We will need more investment in place-based care systems. It is unclear which of the many recommendations will be progressed, and whether there are sufficient resources to deliver these, given the financial constraints in which public services operate.

There is strong recognition of the dedication and professionalism of practitioners, who operate within an ethical framework in spite of frequent disruptive political and financial constraints. The overarching message is more resources for community care, compassionately delivered, through a skilled workforce that reflexively questions its own standards and can help offer flexibility, and a needed transition to new practice standards and a new contract with each patient and society. Many countries around the world inherited legislative frameworks from the UK, and so the review may have greater ramifications, especially in countries with similar health systems. At this time, the government is considering the future plight of the UK as a member state in the European Union, and these political uncertainties may diminish collective attention on a potentially watershed moment in mental health care in the UK.

Critical BJPsych

We wish the Critical Psychiatry Network (CPN) a happy tenth anniversary. CPN questions the veracity of scientific evidence, the transparency and standards of practice in the production of knowledge, especially related to pharmacological medications but not excluding claims made of psychological and sociocultural actions. CPN accepts the need of medicine, a mental health act and even the notion of disease and illness as relevant albeit disquieting if one wishes to pursue a purely social model of mental illness (see Double, pp. 61–62). CPN is also not entirely aligned with but certainly closely associated, says Double, with antipsychiatry movements.

The BJPsych attends to such concerns on a regular basis, focused not unexpectedly on the robustness of the scientific evidence, but also ensuring the values and ideologies that may have influenced the production of knowledge. The scrutiny of the Royal College of Psychiatrists, our partner professional societies and the experiences of patients together provide a moral compass through which evidence is ultimately judged. We offer publication of as much supplementary information as possible to ensure transparency, and ask for declarations of conflicts of interest in support of positive academic practice. We are developing higher standards of conduct and reporting of all study designs, applied to environmental, legislative, social, cultural, psychological, pharmacological and neuromodulatory interventions, each with its own model of mind.

The BJPsych will soon be issuing more firm advice mandating preregistration of protocols for trials and systematic reviews. We will not publish papers with protocol violations that can result in revised analytic plans, outcomes switching and selective reporting. We ask that you use standard reporting frameworks, and pay attention to the criteria for authorship and statements that set out author contributions. I wish to publish research that provides definitive evidence of major advances in clinical care, practice or policy, conducted within a strong ethical framework and with the highest levels of research integrity.

Complexity in local–global mental health

There are many types of mental illnesses with contrasting patient experiences and expressed symptoms. These variations are rarely foregrounded in discussions of the limitations of existing psychiatric practice, many arguments being couched in a singular concept of a mental illness or a mental disorder. Diverse illness experiences reflect different social, cultural and psychological expectations and affordances, as well as underlying pathophysiology. One ambition of progressive science is to disentangle, or even better, link and co-map diverse models of illness alongside patient experience in order to enlighten the deliberations about promoting recovery and mental health. In contrast to these epistemological differences and debates in global mental health, some major injustices overshadow these concerns.

Most people in the world do not receive support, care or any intervention for mental illnesses. People in low- and middle-income countries do not automatically have entitlements to free care of any sort, be that social, psychological or health interventions. Many countries do not have legislation or policies. How do geopolitical determinants of illness, political economies, disadvantage, cultures of care, health systems and care practice interact to lead to disabilities, coercive care, premature mortality and health inequalities of those with severe mental illness? To tackle these
ethical-ideological territories, we need the full spectrum of discipli-
ary and methodological strengths.

The BJPsych is primarily a research journal. This issue includes
evidence of pharmacological and social interventions, and studies
from genetics, global health, cognitive psychology. The editorial
on the CPN movement explains how CPN relates to antipsychiatry
and reflexive psychiatric practice and research. The plea is to raise
the bar for what is needed for progressive and critical analysis of
the evidence that informs the fairer and safer production of knowl-
dge and health systems, and the selection of interventions (Double,
pp. 61–62).

A new study from India show less stigma and therefore greater
willingness to seek help following group-based anti-stigma cam-
paigns (Maulik et al., pp. 90–95). A progressive health, legal and pol-
itical framework in India offers fresh opportunities to recognise a
rights-based approach and ensure resources and health systems
are responsive and accessible to all irrespective of levels of
extreme poverty (Duffy & Kelly, pp. 59–60). These legislative
changes perhaps hold lessons for local deliberations on empower-
ment and advocacy within a resource-limited environment.

Much research is devoted to better understanding how mental
illnesses differ, or are more similar than is thought in terms of aeti-
ology, symptom profiles and effective care. Harold et al. (pp. 96–102)
show that polygenic risk scores for schizophrenia are highly corre-
lated with anxiety disorders and manic and hypomanic episodes,
suggesting shared aetiologies. Clozapine supports recovery in
people receiving a diagnosis of schizophrenia and not responding
to conventional treatments. Ponsford et al. (pp. 83–89) show cloza-
pine may reduce the levels of antibody essential for an effective
immune response, perhaps explaining the excessive use of antibio-
tics for comorbidities.

De Sousa et al. (pp. 103–112) show that poor performance on
socio-cognitive tasks, in patients with schizophrenia spectrum dis-
order, is associated with the severity of thought disorder, alogia
and disorganised symptoms. People developing psychoses have
appalling opportunities for paid employment, and this itself can
deprive them of a positive identity, adequate income, dignity and
social and societal roles. Killackey et al. (pp. 76–82) test the
impact of individual placement support on employment in a large
cohort of people with a first episode of psychosis. Although they
report improvements in the first 6 months, these are not maintained
after 1 year. They conclude that the spread of good practice to the
control group may have negated the persistence of the advantage
in the intervention group. Importantly, educational supports were
recommended for future interventions.

Lifestyle interventions (including social and psychological and
behavioural tasks) that effectively reduce obesity in populations
appear ineffective among people with severe mental illness and
schizophrenia (see Holt et al. (pp. 63–73) and Coventry et al
(pp. 74–75). The authors consider that high levels of prescribing
of antipsychotics may explain this, and that we need to develop
superior targeted interventions including educational supports.