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Highlights of this issue

By Derek K. Tracy

The future's bright

When I am feeling provocative (or cantankerous), I tell trainees they are currently working in what they will come to call 'the good old days'. Busy as things are now, the future population will be larger, older, and have increasing comorbidities (damn that successful healthcare system); finances will be increasingly – ahem – challenging (regardless of National Health Service (NHS) Long Term Plan promises); and recruitment and retention projections are frankly grim (#Choosepsychiatry notwithstanding). Just as today's juniors may, with time, view 2019 nostalgically, little gets the more matured medic warmer and fuzzier than contemplating the days of universal continuity of care between in-patient and community services. Macdonald *et al* (pp. 273–278) assess continuity of care, looking at continuity in individuals with schizophrenia – the chronic nature of this condition makes it particularly pertinent. Data from over 5000 such individuals in a single NHS trust were measured over a decade. It may not surprise you to learn that across this time frame, there was a decline in continuity of care; crucially, where this occurred, it was associated with worse outcomes. The shift to an in-patient/community split was never an evidenced one; it was predicated on presumed enhanced 'throughput' in an era of fewer beds. It is important to see some data on how this has had an impact on those using these services.

Personally, I have always found Frank Holloway to be one of the wisest and most erudite of commentators on mental health, and his Invited Commentary (pp. 279–280) asks if this loss of continuity actually matters. (Disclosure one: I previously worked with Dr Holloway, an experience for which I continue to remain grateful.) He notes how policy documents such as *The Five Year Forward View for Mental Health* inevitably describe 'progress' in 'relentlessly positive terms' yet recurring reconfigurations and searches for efficiencies (in the light of the aforementioned demand:resource crises) have fundamentally fractured care. Lucia Almazan Sanchez from King's College London writes more on the topic in May's Mental Elf blog at: https://elfi.sh/bjp-me17.

Vorsprung durch technik

From remembrance of things past to a digital future, and an analysis piece by John Torous and colleagues (pp. 269–272) offer an optimistic view of digital health tools in early-intervention psychosis. There is a natural appeal here insofar as we have a young and digitally informed cohort, and there might be advantages, for some, in not requiring face-to-face human contact at a vulnerable time. Smartphones and digital wearable devices offer the opportunity to capture real-time data on a wide range of parameters, from psychological status through physical activity to medication adherence. The appeal of potentially very large, yet individualised, data-sets so collected is clear, and the authors propose this includes the 'holy grail' of predicting illness trajectory in this heterogeneous population. They acknowledge that the implementation logistics have yet to be truly tested, but counter that preliminary data on acceptability have been very positive. The early research does not back the conjecture that individuals might feel unduly paranoid about the collection of such information.

Jude Harrison *et al* (pp. 245–247) look at social media and mental health more generally (disclosure two: I am one of the co-authors). Twitter, podcasts and blogs offer new mechanisms for more democratic, rapid and engaged conversations with a far wider range of people. They also bring the challenges of shouting, fighting and a lack of peer-reviewed control. The conversations are happening anyway: where should you as a professional, our College and this *Journal* position ourselves?

Every little helps

Self-management is a growing construct in mental health. It aligns with principles of taking charge of one's life, including determining what is important in recovery; it is a key principle of the aforementioned NHS Long Term Plan; and, back to the opening paragraphs, being brutal, it facilitates an overstretched health service. Lean *et al* (pp. 260–268) systematically reviewed and meta-analysed the data for those with severe mental illness, exploring randomised controlled trials with outcomes of symptoms, relapse, recovery, functioning and quality of life. The findings support self-management interventions, and I personally really appreciated the positive findings on self-rated hope, empowerment and self-efficacy, as well as the 'harder' impacts on symptoms and admission data. The authors' call that this should be part of a standard package of care is well made.

Continuing the theme, Teasdale *et al* (pp. 251–259) meta-analysed the data on dietary intake in those with a severe mental illness. Compared with controls, such individuals had significantly higher dietary energy and sodium intakes. A qualitative synthesis showed this was linked with poor diet quality and eating patterns. Although not designed to determine causality, this is clearly one part of the health disparity found in this group. Linking back to the previous paper, it would be interesting to see more work on both self-management and professional support to facilitate change.

Impossible is nothing

Genetics work in psychiatry frequently attracts external opprobrium, usually from those who understand it least. I am willing to take a(n educated) punt that it is going to underwrite a forthcoming sea-change in our field, which will dismantle diagnostic categories as we know them in a new era of treatment (and yes, arriving before nuclear fusion). Three papers nudge us on a little in this month's *Journal*, with Curtis and colleagues (pp. 248–250) opening up the complex ethics of genetic testing. This is particularly pertinent as the 100 000 Genomes Project has finished recruitment, and analyses will inform UK clinical practice via the new NHS Genomic Medicine Service. They note the growing list of psychiatric conditions where genetic risk may be assayed, although add caution as risk variants have not been fully elucidated in these heterogeneous polygenetic conditions, and we are nowhere close to results guiding interventions. Nevertheless, they argue psychiatry cannot and should not be different to any other specialty, and we will both need to support appropriate testing as well as educate ourselves on clinical genetics.

Kendall *et al* (pp. 297–304) continue, noting how rare copy number variants (CNVs) are associated with a range of neurodevelopmental disorders characterised by cognitive impairment (psychoses, autism spectrum disorders and so forth). Taking data from almost half a million individuals without such pathologies (from the UK biobank), they found that 24 out of 33 analysed CNVs were associated with reduced cognitive performance; there was variability between these, but the 12 schizophrenia-associated ones were associated with particularly marked impairments. Zooming in more, Xiang *et al* (pp. 281–287) conclude with some added specificity, reporting on common and rare CNVs and their association with white matter pathways in schizophrenia.

Finally, if you can take any more Brexit pain, Kaleidoscope (pp. 311–312) reviews data on the association between 2016 voting choice and individuals' cognitive flexibility.