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From the Editor's Desk

Ethics, ideologies and critical psychiatry practice

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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 reform of the balance of powers in decisions about detention, with rights to alternative care systems, adequately resourced and 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 expectancies 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 disciplinary 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 knowledge 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 campaigns (Maulik *et al*, pp. 90–95). A progressive health, legal and political 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 empowerment 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 aetiology, symptom profiles and effective care. Harold *et al* (pp. 96–102) show that polygenic risk scores for schizophrenia are highly correlated 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 clozapine may reduce the levels of antibody essential for an effective immune response, perhaps explaining the excessive use of antibiotics for comorbidities.

De Sousa *et al* (pp. 103–112) show that poor performance on socio-cognitive tasks, in patients with schizophrenia spectrum disorder, 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.

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