

## Highlights of this issue

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This month's issue does well at not just crossing boundaries but breaking them too, from the legal and ethical through to pharmacological and psychosocial. It even stops along the way at economic aspects of mental disorders, and it is all here under roof. In fact, it is what we hope this journal does best: weaving biopsychosocial threads into a technicolour that exemplifies the microcosm of research splendour.

### Righting the wrongs

It has now been 2 years since the World Health Organization published its QualityRights training and guidance tools. It aims to promote the rights of people living with mental disorders and improve the quality of psychiatric services through myth-busting, group work and the presentation of case vignettes. In their editorial, Moro et al (pp. 49–51) are keen to emphasise that 31 of the 151 reviewers were psychiatrists. They also point out that although the use of alternatives to involuntary practices – such as advance directives and supported decision-making – was strongly encouraged, there is also the acknowledgement that such practices could also potentially put individuals living with mental disorders at risk. QualityRights aims to improve the quality of mental healthcare around the globe. From India to Ghana and indeed across other areas of Africa, Asia and Eastern Europe, psychiatrists have a fundamental role, in collaboration with people with lived experience of mental illness and other stakeholders, in ensuring the delivery of QualityRights and this initiative's success. On the same note, Sashidharan (pp. 52–53) brings us to Trieste in Italy, where social justice in psychiatric practice is now in the firing line. The guiding principles of holistic care that focus on the context, network and social groups of patients, together with a rights-based approach, are now seen as an 'ancient vision' requiring change. Perhaps then, not a change for the good.

Following this thread of both doing things right and doing the right thing, the article by Altunkaya et al (pp. 86–97) outlines the need for long-term economic models to evaluate the cost-effectiveness of new mental health interventions. However, studies are left wanting through short follow-up periods and small samples. Most models do not incorporate the link between short-term side-effects and long-term medication-related comorbidities. In conclusion, the lack of high-quality and validated models may mean that patients are being denied good-value care.

### Longer treatment, better outcomes

There is no established first-line pharmacological treatment for borderline personality disorder (BPD). With this in mind, Grant et al (pp. 58–63) evaluated the clinical effectiveness of brexpiprazole, a drug with high affinity for serotonin, dopamine and noradrenaline receptors that is used in the treatment of schizophrenia and as an adjunct in the treatment of depression.

Eighty participants with an established current diagnosis of BPD participated in a 13 week randomised, double-blind, placebo-controlled study. However, although the primary outcome measure was separated from placebo at the final visit, this was not the case for the first 10 weeks of treatment. The authors conclude that only longer-duration trials can provide

clear evidence of a strong drug effect, and that future studies should be well powered and long enough to better determine what is a placebo response compared with a true drug effect, in order to separate out a longer-lasting placebo effect.

In similar vein, on the theme of follow-up duration, Chen et al (pp. 64–72) used the Taiwan National Health Insurance Research Database to assess 68 096 children who had received methylphenidate (MPH) treatment over a 10 year time frame. MPH treatment was associated with significantly lower all-cause mortality, natural cause mortality, unnatural-cause mortality and mortality from accidents than in controls. The association also remained significant in the subgroups of children who were male or aged 4–11 years. This was all the more striking given that greater comorbidity in the MPH-treatment group implied that higher severity and/or complexity of difficulties was associated with greater prescription and/or uptake of prescriptions. This is the first study to report that a longer interval between first attention-deficit hyperactivity disorder (ADHD) diagnosis and first prescription of MPH is associated with a higher risk of all-cause mortality.

### Striking a balance

The erroneous public view of millennials as 'narcissistic' has done much to damage the validity of narcissistic personality disorder, a category that has, in any case, been dropped from ICD10. Freestone et al (pp. 54–57) argue that it has therefore lost accurate meaning. Yet there remains consensus that, however rare, narcissistic personality disorder does exist and is associated with serious adverse consequences. These include lifetime unmarried status, drug and alcohol dependence, anxiety disorder and elevated risk of coronary heart disease. This is very different from today's 'selfie generation', where supposed 'narcissism' is often a reaction to their situation in an uncertain world and their place within it.

Still on the subject of balance, a short report by Riglin et al (pp. 73–75) found that it was not so much recollection of the age of onset of any symptoms of ADHD that struck the best balance between sensitivity and specificity using area under the curve analysis, but the retrospective endorsement of six inattentive and/or six hyperactive/impulsive childhood symptoms. This suggests that recall of more severe and impairing symptoms may be better than recall of just a few specific symptoms. It also means that, in practice, there is likely to be benefit in asking about specific ADHD symptoms in childhood and acquiring additional information from other sources, such as school reports. Such a diagnosis cannot be taken for granted and requires more painstaking validation.

### Acting on impulse

As psychiatrists, our teaching in phenomenology has sought to differentiate impulsivity – poorly conceived actions and risk-taking – from compulsivity – a maladaptive persistence of repetitive behaviour according to rigid rules and/or as a means of avoiding perceived negative consequences. There was therefore an elegance by design in the short report by Chye et al (pp. 76–78) that used the Impulsive-Compulsive Behaviours Checklist (ICBC) to examine

the frequency of 33 common impulsive and compulsive problem behaviours. The data indicated that variation in connectivity as measured by the ICBC was associated with connection to the inferior frontal region. The potential of this study is that its findings cut across a range of impulsive and compulsive behaviours and therefore may be relevant to the search for transdiagnostic heuristics which have hitherto been defined into discrete mental disorders with an artificial organic and functional divide.