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# Highlights of this issue

Edited by Kate Adlington

## 'The rights of every man are diminished when the rights of one man are threatened'[1]

Scrutiny of the World Health Organization (WHO) over the past year has been (dare I say) unprecedented and was intensified by the controversial in–out–in US policy dance. Research demonstrating the positive impact and value of WHO initiatives is therefore timely. A pragmatic implementation trial published in the *British Journal of Psychiatry* this month by Pathare et al (pp. 196–203) provides just that.

Based in Gujarat, India, it describes the roll out and evaluation of the WHO 'QualityRights' initiative – a participatory framework designed to promote human rights within mental health services. Where QualityRights was implemented over a year, people using the services were more likely to report an increase (albeit small) in empowerment and satisfaction compared with standard services. Mental health peer support volunteers were introduced for the first time in India – a ground-breaking feature that will hopefully pave the way for further peer support initiatives across the region. Staff also showed improved attitudes about coercive practice (that attitudinal change was less among doctors is food for thought).

Indeed, staff attitudes are essential in upholding human rights and bringing change in all settings, particularly when reducing coercive practice. No small task, as Pathare et al point out, when 'fundamentally changing mindsets and practices that have been entrenched for decades.' In their umbrella review of randomised trials of non-pharmacological interventions to reduce coercive treatment in mental health services, Barbui et al (pp. 185–195) found staff training to reduce use of restraint had the most robust evidence for efficacy. Unfortunately, they also found that research in this area of coercive practice minimisation is globally sparse and virtually non-existent in low-income settings.

Given coronavirus disease 2019 (COVID-19) has disrupted or halted critical mental health services in 93% of countries at a time of increasing demand,[2] efforts to reduce coercive practice risk slipping even further down the agenda. Ways of working that promote the human rights in mental health particularly in low-resource settings or where they are not enshrined in law – as was the case in Gujarat – will be vital on the long path to recovery.

## Healthcare policy hokey cokey

The USA is not the only country doing the hokey cokey with their healthcare policy. In England, plans for a partial reversal of the 2012 Health and Social Care Act are gathering pace, aiming to reduce the competition and private sector involvement that was championed only 9 years ago. Some researchers are still unpicking the impact of this last major National Health Service (NHS) restructure. In a short report, Roberts et al (pp. 230–232) explore the impact of the Lansley reforms on specialist alcohol treatment provision – in particular the decentralisation of NHS commissioning responsibilities to local authorities. Using local authority data they found an increase in alcohol-related hospital admissions and a reduction in spending and treatments received. Despite being a stated aim of decentralised commissioning, they, in fact, found no targeted increased funding in areas with high alcohol dependence and deprivation.

Homelessness is intrinsically intertwined with substance misuse and is another issue that has seen retrograde steps over the past decade. In their editorial, Killaspy & Priebe (pp. 179–181) highlight the stark facts that rough sleepers have doubled since 2010 and two-thirds have substance misuse problems. Yet there is a dearth of evidence about which mental health supported accommodation options are best to support such individuals. A related randomised controlled trial was hindered by clinician reluctance to randomise – of 1432 people screened only 8 were randomised. Although this disconnect in the assumption of equipoise between researcher and clinician may be unusual, I can understand how, in such a vulnerable population with a high risk of experiencing violence, clinicians may feel reluctant leaving something as fundamental as a person's shelter and place of safety to chance.

Homelessness and substance misuse also both mediate the use of violence and aggression by people with serious mental disorders. In their national case series examining trends in homicide, Flynn et al (pp. 210–216) find an increase in the relative contribution of mental disorder as a proportion of all homicide, despite a decline in overall rates. I was shocked if not surprised that substance misuse comorbidity had an impact on sentencing decisions – with a related drop in hospital order referrals. The authors strongly call for a concerted approach to tackling alcohol and drug use to reduce the risk of homicide in mental health patients. Whatever the future NHS reforms hold for drug and alcohol services, these studies suggest improvements in available treatments could have a far-reaching positive impact across the healthcare, housing and criminal justice systems.

Of course, policy reform is no panacea. April's 'Kaleidoscope' (pp. 235–236) explores how 'cultural tightness', not governmental edicts or healthcare systems, determines COVID-19's spread. It also looks at biases in how gender and ethnicity influence how much time recruiters spend looking at CVs.

## Solving the 'mental health productivity puzzle'

Looking to a more optimistic future, the UK government has pledged to spend £2.3 billion more on mental health services over the next 5 years. In their editorial, Maddison et al (pp. 182–184) wonder how to solve the 'mental health productivity puzzle' to get the greatest value for this money. Reducing unwarranted variation between services could save a further one billion pounds per year. Using consistent outcome measures across services could help with these calculations. In person-centred medicine we try to ask 'what matters to you?' – but I wonder how answers to this question can be measured objectively and consistently across a complex system?

One piece of the puzzle could be providing prompt access to liaison psychiatry services. In their retrospective study of 4500 patient case notes, Vulser et al (pp. 204–209) found an association between earlier liaison psychiatry intervention and shorter length of stay in an acute general hospital setting. Faithfully following guidelines could be another puzzle piece and an effective way of reducing variation. Jin et al (pp. 224–229) use clever modelling methodology to show that strict adherence to the National Institute for Health and Care Excellent schizophrenia guidelines for cognitive–behavioural therapy, family interventions and clozapine prescription is cost-effective compared with standard care. Commissioners may need to increase short-term spending to strengthen the necessary services, but cost savings are then predicted if guidelines are consistently followed in the longer term. However, relying on such a prolonged period of stability to solve the productivity puzzle may be overly optimistic in an ever-changing complex maze of a healthcare system.

## References

1 Kennedy JF. *Report to the American People on Civil Rights* [transcript]. John F. Kennedy Presidential Library and Museum, 1963 (https://www.jfklibrary.org/learn/about-jfk/historic-speeches/televised-address-to-the-nation-on-civil-rights)

2 World Health Organization. *The Impact of COVID-19 on Mental, Neurological and Substance Use Services: Results of a Rapid Assessment*. WHO, 2020 (https://www.who.int/publications/i/item/978924012455).



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