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From the Editor's desk

By Peter Tyrer

Smoke gets in your eyes

I was once treating a patient with schizophrenia whose cigarette-smoking was so incessant it was often difficult to discern her features through the dense smog that wreathed her like an extra layer of clothing. This was, of course, before smoking restrictions ended this once common experience in psychiatric wards, with a reasonable degree of success.[1] I am generally tolerant about breathing in other people's smoke, but in her case I did broach the question about the possibility of at least a short period of abstinence during the smoking day. 'Of course not', she rounded on me aggressively, 'you force on me all those terrible drugs of yours and the only way I can get a proper clear out is to smoke'. Further enquiry revealed that this procedure in her mind was like the fumigation of a greenhouse – it cleaned out all the rubbish we had deposited in her system and allowed her to feel fresh and new and free of pollution. So, obviously those advertisements illustrating the accumulation of tar in the lungs after cigarette smoking had about as much effect on her thinking as our attempts to alter her paranoid delusion with antipsychotic drugs. It would not have surprised Saravanan *et al* (pp. 454–459) that this belief was accompanied by a low degree of insight and that she showed few signs of remission of any of her symptoms. But, before we get too pessimistic, there are other papers in this issue that help to explain why the combination of psychosis and substance misuse is so common[2] and so difficult to manage,[3,4] but also give hope of eventual success. Boden *et al* (pp. 440–446) reinforce the findings of another recently published paper[5] showing an association between smoking and depression. So, if this is true, what is perpetuating the addiction? Munafò & Araya (pp. 425–426) suggest it may be linked in a complex way to our genetic structure.

Henquet *et al* (pp. 447–453) report the fascinating findings that cannabis 'removes negative affect' (i.e. makes you feel great) to a much greater extent in patients with psychosis than in controls, even though it also made their psychotic symptoms, or more specifically their delusions, worse. They suggest that gene–environment interactions may account for these differences, but of course it is also relevant that their levels of negative affect were higher than those of controls when they took their cannabis. Schennach-Wolff *et al* (pp. 460–466) offer a predictive index of response to antipsychotic drugs that may be of help for those clinicians who, like me, tend to see the patients for whom we have to ring the changes of drug therapy before we find one that genuinely helps, but one wonders whether cannabis use ought to be factored in here too. As substances are now only part of dependent behaviour, we ought also to consider internet addiction as a precursor of psychiatric disorder, as Fu *et al* (pp. 486–492) suggest, particularly in the form of depression. What is clear from these findings is that, as in almost all behavioural experiments, immediate gain trumps later loss, and it seems that only when we have treatments such as vaccines that prevent this immediate gain will we have a clear therapeutic way forward. Meanwhile, my patient has left the smoke-free environment of her former psychiatric ward to live in sheltered accommodation. I know she thought 'sheltered' implied that she could continue to smoke as she liked, but I suspect the long arm of policy has now caught up with her and that she will be spending many hours in the unsheltered wind and rain balancing its disadvantages with the cool feel of nicotine satisfaction coursing through her veins.

Getting expert opinion when needed

A good medical service deploys its staff in the right places at the right times. The most influential, and probably the most important, of these staff are the consultants. When they are absent at critical points in a patient's care pathway this can be disastrous. In a series of inquiries into adverse medical outcomes by the National Confidential Enquiry into Patient Outcome and Death (www.ncepod.org.uk/reports.htm) the absence of consultants' input during acute illness was a major criticism, and there are now calls for a change in practice.[6] Psychiatrists should not be complacent either and our recent high-profile debate highlights the importance of consultant input.[7] I was reminded on appointment to a Chair at Imperial College 19 years ago that the collective term for a group of professors was 'an absence' and have guiltily tried to correct this ever since in my practice. One of the recurrent worries of patients who have been through many psychiatric systems is that they cannot see the consultant when they feel it is needed, and this does not seem to have changed despite the dramatic increase of 48% in the number of consultant psychiatrists in the UK noted in David Goldberg's review[8] in the *Journal*.

One of the nine domains incorporated into a 360-degree appraisal for consultants is 'availability'[9] and this might be given greater focus in future. Patients regard this as much more than meeting the consultant together with the world and his wife at big review meetings. If we really believe in patient choice and offering greater responsibility in decision-making, we should be there when required as well as at other times when our special skills need to be deployed.

1 Lawn S, Campion J. Factors associated with success of smoke-free initiatives in Australian psychiatric inpatient units. *Psychiatr Serv* 2010; **61**: 300–5.

2 Menezes PR, Johnson S, Thornicroft G, Marshall J, Prosser D, Bebbington P, et al. Drug and alcohol problems among individuals with severe mental illness in south London. *Br J Psychiatry* 1996; **168**: 612–9.

3 Zammit S, Moore THM, Lingford-Hughes A, Barnes TRE, Jones PB, Burke M, et al. Effects of cannabis use on outcomes of psychotic disorders: systematic review. *Br J Psychiatry* 2008; **193**: 357–63.

4 Turkington A, Mulholland CC, Rushe TM, Anderson R, McCaul R, Barrett SL, et al. Impact of persistent substance misuse on 1-year outcome in first-episode psychosis. *Br J Psychiatry* 2009; **195**: 242–8.

5 Pasco JA, Williams LJ, Jacka FN, Ng F, Henry MJ, Nicholson GC, et al. Tobacco smoking as a risk factor for major depressive disorder: population-based study. *Br J Psychiatry* 2008; **193**: 322–6.

6 Wise MP, Frost PJ. Consultants: a chronic problem for acutely ill patients. *Clin Med* 2010; **10**: 108–9.

7 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

8 Goldberg D. Improved investment in mental health services: value for money? *Br J Psychiatry* 2008; **192**: 88–91.

9 Lelliott P, Williams R, Mears A, Andiappan M, Owen H, Reading P, et al. Questionnaires for 360-degree assessment of consultant psychiatrists: development and psychometric properties. *Br J Psychiatry* 2008; **193**: 156–60.