From the Editor's desk

By Kamaldeep Bhui

Ahead in mental sciences: cultural, environmental and social campaigns

A new report in 2014 on health provision, the NHS *Five Year Forward View*,[1] conceived that health services should be a social movement, to improve the nation's health with appropriate emphasis on prevention, driven by the patient and public experience of quality and safety. One key recommendation was to rely less on expensive randomised trials that take a long time to complete, but rather consider commissioning following 'evaluation' of innovative interventions. This will permit more rapid testing of service models and the gathering of relevant evidence. The risk is that the general effectiveness of interventions remains in question; local implementation may show benefits, but without a comparator these benefits may be due to many other influences. The need for evidence of cost-effectiveness and less-expensive healthcare is a necessary condition of reform, as all countries face a growing elderly population, greater demands on health systems, and a shortage of skilled professionals. The Mental Health Taskforce report is now published to give a mental health-specific 5-year forward view; 58 recommendations are offered for government bodies, commissioners, providers, policy makers and regulatory bodies.[2] Distributed leadership, systems redesign and co-creation of local solutions for rapid implementation are proposed as drivers for change. These indeed are the tenets that lie at the very heart of social movements. The place of evidence is recognised: mental health-related research and researchers, the report advocates, should not be overlooked in funding formulae for higher education institutions; psychiatry, psychology and mental sciences must not be seen as lesser forms of research just because they encompass diverse spheres of science – from cells, genes and pharmacotherapy to social and cultural influences, and the impact of safe environments and aesthetics on mental health and wellbeing.

Yet, in opposition to a social movement for healthcare, medicine and mental healthcare are making rapid and remarkable progress to identify interventions for prevention and treatment of illness in the biological sciences and neuroscience. In the international mental health research arena, remarkable insights from neuroscience have captured the imagination of research commissioners, universities and national research institutes fostering a measured excitement about the place of the brain sciences, biology and technology in solving the challenges of disease and illness.[3,4] Higher education institutes have seen similar innovations in developing neuroscience teaching.[5,6] However, there are limitations to the neuroscience idiom in health and social policy, and the parameters of a realistic return need some critical inspection.[7] The social life of the brain, or the way the brain enters our social lives in schools, society, and all walks of life, requires unpacking as many of the premises of neuroscience are uncritically accepted in the excited search for a real disease as the basis of mental illness treatments.[8] Fears of reductionism abound from all quarters.[9,10] Yet, as sciences work towards discoveries of disease and pathology, at the same time there remains a deep suspicion of medicine, doctors, brain sciences, and the over-worked 'medical model'.[11] The fears are partly to do with choice and power, in vulnerable and disempowered patients, and with concerns about the influence of the pharmaceutical industry, but also that reductionism may follow to render emotions, distress, human suffering and moral fractures as surface phenomena that are explained away as deriving from core pathologies of brain rather than mind; and thus, this line of reasoning gives rise to the suspicion that people will be treated inhumanely and their citizenship rights and entitlements may be violated. Previous efforts to promote biological and neuroscientific advances in mental healthcare have not been notably successful, and research processes have been over-restrictive, often stifling scientific advance and discovery.[12]

A place for subjectivity and reflective experience in medical practice may restore confidence.[13] Alternatively, promoting recovery and person-centred approaches can provide helpful knowledge about the value and potential of psychiatry to treat illness and promote mental health.[14] So enters the sociological dragon that is proposed to gather intelligence on social causes and social expressions of mental illness as the focus for intervention in real-world contexts. Such interventions may prevent harms and improve recovery in a time-frame that patients and commissioners can apprehend. The ascendency of social research and social movements necessitates more rigour in social enquiry and critical, empirical and interpretive components that are no less difficult to deliver than in neuroscience or biological endeavours. The lessons of poor research need not be rehearsed, but expertise and critically applied knowledge are not easily grown, and must be held in better esteem as the means to credible redesign of complex health systems and mechanisms to improve health outcomes with high, timely and cost-effective impact.

The disciplinary tensions are challenging and the reality is far more complex than is comfortable for the neuroscientist, sociologist, psychologist or doctor/psychiatrist. There is no maturation of brain architecture without input from the social environment. Early-life biology, cognitive, social and environmental maturation occur in synchrony in an interactive dance throughout the life course, showing accumulations of risks and vulnerabilities as well as protective influences and resilience. In this issue of the *BJPsych*, both Prosser *et al* (pp. 309–311) and Rego (pp. 312–313) decry the poverty of scholarship around neuroscience, psychology, and pharmacology as oppositional and rival ideologies and praxis. All movements in science, including the salience given to neuroscience and biology, are made not only on scientific discovery and facts, a painfully slow process, but are themselves cultural and social constructions of science; such constructions become ideologies when invested with convictions that are unassailable; such ideology can drive investment in anticipation of healthier populations and better, safer and more efficiently run health services. Limited resources mandate difficult decisions which are then informed by the way we see mental and behavioural disorders as social or biological things, worthy of social or biological thing-remedies. A critical gaze reveals that culture is also overlooked in sociological, psychological, psychiatric and environmental analyses. Cultural psychiatry, an inherently multidisciplinary clinical and academic endeavour, involves psychiatric epidemiology, medical anthropology and sociology, cognitive science and social psychology; the cutting-edge perspectives offer an integrative view of culture as a core feature of human biology and at the same time interrogate the cultural constructions of biological theory.[15] There is also recognition that psychological processes are not exclusively located within the individual, in the brain, but also in the discursive and social and relational process that exists between people and in communities, collective beliefs and traditions. Health provider organisations, the services and the professions each have their own cultural mores and traditions that need forethought to harness talents for a more cohesive patient experience.

Research that shines light on these complexities, and informs balanced commissioning of empirical and service-related research,

as well as appropriate health and social care, is in short supply. How would this thinking apply to schizophrenia, depression, bereavement, personality difficulties, substance misuse, and what consequences would face service providers and commissioners? When a person suffers with illness, the very skills used to adjust, appraise, adapt and restore hope are undermined if the thinking, judgement, perspective and emotional equipoise are disrupted. And there are social reactions and strain on fitting into families, friendships, society and employment. There are also profound and sometimes distressing personal negotiations of self-worth, value, and identity. In this issue, Corrigan (pp. 314–315) debates whether responses to stigma should adopt expectations of normalcy or solidarity, the latter requiring better fit of services and societies around people with mental illnesses, redesigning the culture of care rather than the structure of services and the buildings. Angermeyer *et al* (pp. 389–397) show cultural variance in stigma, and the need to consider this when working globally but also locally with culturally diverse populations.

Social, pharmacological, psychological and biological dimensions are all invoked by new research in this month's *BJPsych*. Kendall *et al* (pp. 316–319) and Taylor & Perera (pp. 320–321) debate the value and evidence emerging from clinical guidelines; specifically, they advance difference perspectives on the recommended balance of psychological and pharmacological interventions for psychosis, and much of the debate includes social and ethical perspectives or values alongside facts. Refining what is known about the pharmacological and psychological balance in recovery following depression, Huijbers *et al* (pp. 366–373) report a shorter time to relapse when antidepressants are stopped following mindfulness-based cognitive–behavioural therapy. Stange and colleagues (pp. 352–358) find affective instability is associated with poorer and delayed recovery in depression, suggesting that a better understanding of emotional dysregulation may offer a powerful target for intervention.[16] Yet, as if to reinforce the need for a social movement to tackle the social determinants of poor mental health, Bonde *et al* (pp. 330–336) report that depression equally follows many types of traumatic experience such as natural and technological disasters, terrorism, and military combat. Mood disorders are associated with cardiovascular disease (Martin *et al*, pp. 343–351), and cardiovascular disease is one cause of premature mortality in people with mental illnesses. Baxter *et al*'s meta-review of interventions to reduce premature mortality (pp. 322–329) shows the positive outcomes of pharmacological interventions, and service organisation, as well as adherence to guidelines, so revealing a granularity of evidence that is patterned by different patient populations and contexts.

In a very different context, a low-income country with few services or mental health specialists, nurse practitioners can improve depression scores by behavioural activation alongside problem solving and strengthening social networks (Chowdhary and colleagues, pp. 381–388). We need mechanisms to learn from such studies and import the evidence into practice and to do so through systems redesign but also by harnessing the talents of research scientists and clinicians working in close partnership with patients and the public, especially to negotiate social perspectives and values alongside the facts of evidence.

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