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From the Editor's desk

By Kamaldeep Bhui

Medicine, psychiatry, empiricism and a little magic

To better meet the high standards expected by our readers and members of the Royal College of Psychiatrists, we asked what they thought of our journals. Although only a smallish proportion of you responded, it seems the print version of the *BJPsych* is highly valued. Other suggestions were to retain more clinically relevant papers rather than 'impenetrable statistical' details that are glossed over. Each specialty still favours more papers from its own tribe, and the traditional dualisms were prominent among the responses: biological *v.* sociological, genetic *v.* non-genetic, qualitative *v.* quantitative, short *v.* long, interesting *v.* boring, statistical *v.* narrative. Some wanted a more 'scientific' journal, some more original research rather than reviews, and some no longer had time to devote to reading a scientific journal owing to the demands of everyday practice. I have every free text comment about the *BJPsych*, so whatever you said is noted. Clinical updates of an educational nature were proposed, and surprisingly, the obituaries section seemed very popular. Obituaries are published occasionally in the *BJPsych* and regularly in the *Psychiatric Bulletin*. Henry Rollin was the editor for the obituary section almost up until his death in February 2014, aged 102 (his own obituary was published in the *BMJ* and the *Psychiatric Bulletin*). Before Rollin's death, my predecessor Peter Tyrer paid tribute to the incredible life of Rollin as the first 'centenarian *extraordinaire*' who was a member of the College and a psychiatrist.[1] At the same time Peter challenged future editors to honour future centenarian members of the College. I ask for your help to achieve this, so do inform me of extraordinary people who have given much to patients, the profession and society.

Rollin gives a detailed account of the establishment of the Royal College of Psychiatrists and the *BJPsych*.[2] His historical papers appear to have such resonance today that reading them offers an opportunity for us to improve the practice of psychiatry. In a description of psychiatry a hundred years ago[3] (written in 2003) he concludes that 'The composite picture of psychiatry in Britain at the end of the Victorian era and a little beyond is chiefly one of unremitting gloom'. A sentiment that Dinesh Bhugra, a former President of the Royal College of Psychiatrists and President Elect of the World Psychiatric Association, has asked us to guard against through a revitalised professional identity,[4] despite the recession and its impact for mental healthcare.

Rollin offers quotations from leading psychiatrists in Victorian times that hold haunting similarities to many of today's dilemmas.[3] He quotes George Savage from his 1891 *Lancet* paper: 'There will be few who will not share his [Dr Savage's] opinion as to the efficiency of restful, pleasant surroundings in the treatment of mental disorder as compared with the virtues of medicine out of the bottle'. Are we not still on this eternal quest for non-pharmacological solutions alongside the proportionate use of medication (see editorial by Mahli & Geddes, pp. 337–339; and Kapil *et al*'s short report (pp. 407–408) on Z-drugs)? In order to provide more effective treatment we need to better understand, or stratify, the causes of premature mortality, and improve existing diagnostic and clinical classifications through scientific advances in neuroimaging, epidemiological and clinical studies (see Class *et al* (pp. 355–361), Scott *et al* (pp. 362–368), Dorrington *et al* (pp. 383–389), Pujol *et al* (pp. 369–375), Beucke *et al* (pp. 376–382), Russ *et al* (pp. 348–354), Lukaschek *et al* (pp. 398–406)).

In a history of psychiatry,[3] Rollin quotes Henry Rayner's lecture at St Thomas' Hospital (reported in the BMJ on 23 April 1898): 'The bane of alienism in the past has been its isolation from general medicine. So long as the treatment of mental disorders is restricted to separate institutions set apart for the purpose, so long will endure the foolish prejudice that a stigma of disgrace and of horror attaches to it'. So much of our current policy and practice efforts are around reducing premature mortality because of medical illness among people with mental illness; and many believe that psychiatry should be more closely aligned with medicine rather than see itself as a social science. And we still have, in the UK at least, separate hospitals and services for people with mental illness and medical illnesses, and increasing spread of providers into the charitable sector and local government outside of healthcare (addiction services for example). This trend raises questions about the place of psychiatry in medicine and in the wider ecology of mental healthcare. We need to promote the literacy around and more precise definitions of states of emotional distress that: (a) are normative and represent mental health as a social phenomenon requiring socialised solutions away from healthcare; (b) warrant more intensive and professional social and psychological interventions and pharmacotherapy; and (c) need complex packages of specialist and intensive care from multidisciplinary teams. Mixing up these categories in the allocation of resources and organisation of services risks failing patients and the public alike. As a critical cultural psychiatrist with a strong inclination towards both anthropological and epidemiological research, I was enchanted by Rollin's provocative piece on the 'indivisibility of magic and psychiatry' which concludes that psychiatry is so complex and that is why it lends itself to extreme empiricists as well as to magic and spells.[5] This perhaps explains why, as Rollin puts it, the professions and the public, and I would add commissioners, seem (even now) to be on quest for easier (magical) solutions to very complex and challenging eternal problems of which we are reminded when reading the history of British psychiatry and mental health provision from around the world.

The Chief Medical Officer's (CMO) remarkable annual report on public mental health seems to signal a critical point in our history and cuts through many of these exacting debates.[6] It was launched at the Royal College of Psychiatrists in September 2014 and asserts the distinction between mental health promotion, preventing mental illness and treatment, recovery and rehabilitation (from the WHO 2013–2020 Action Plan; see http://www.who.int/mental_health/action_plan_2013/en/) as the most helpful organising framework. The CMO's report speaks to modern dilemmas as the palimpsest of the issues raised by Rollin's historical analyses. Specifically, drastic, indeed Victorian-like, cuts to mental health services have been witnessed in the UK (see http://www.bbc.co.uk/news/health-25331644) amounting to an average of 2% over the past 2 years, and some organisations experienced cuts of up to 30% of their budgets (as reported at the launch of the CMO report). The report revisits the variable notion of mental illness, mental health and well-being. It provides a comprehensive and detailed analysis of the evidence on what works and for whom. While the professionals and commissioners alike grapple with more efficacious, cost-effective and safe treatments for those most in need, we also need appropriate public mental health policies and practices to support those with common states of distress that do not meet the threshold for specialist care. The report tackles stigma, and ways of preventing premature mortality through parity of esteem. And much is

needed to remedy and prevent work stress and sickness absence, and reduce health inequalities through the research on more effective treatments and services. The relationship between medicine and psychiatry is explored, alongside the contract with society and our duty to provide evidence-based treatments, although the basis of evidence and the value given to different forms of evidence remains contentious. The report reminds us that psychiatry is a medical discipline. It also illustrates the incredible complexity of mental illness and various emotional states, which Rollin argued create the conditions for magical thinking and spell-casting. The profession requires the brightest and the best, the most ethical and the most progressive to continue a journey towards the most humane and hopeful ways to recovery, while also helping the wider population to better understand the mind and how to look after ourselves, our families and our communities.

1 Tyrer P. A centenarian *extraordinaire*. *Br J Psychiatry* 2011; **199**: 360.

2 Rollin HR. The evolution of the *British Journal of Psychiatry*. *Br J Psychiatry* 1991; **159**: 33–6.

3 Rollin HR. Psychiatry in Britain one hundred years ago. *Br J Psychiatry* 2003; **183**: 292–8.

4 Bhugra D, Gupta S. Alienist in the 21st century. *Asian J Psychiatry* 2011; **4**: 92–5.

5 Rollin HR. Magic and mountebanks in the development of psychiatric thought. *J R Soc Med* 1992; **85**: 381–5.

6 Davis SC. Public mental health: evidence based priorities. In: *Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities – Investing in the Evidence*. Department of Health 2014.

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