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From the Editor's desk

By Kamaldeep Bhui

Is psychiatry too political?

Writing on the morning of 10 November I am aware of all the Remembrance Sunday ceremonies taking place to commemorate the tragic loss of life associated with wars. A series of ceremonies reach even children's football matches played on village greens, schools, universities and hospitals. Psychiatric research investigates the impact of war and conflict on civilians and on soldiers, but rarely what causes war and conflict and how to prevent these.[1,2] Such an aspiration might be considered too political and outside the scope of medicine, until we have to deal with the consequences of war. Fears about politicisation of medicine abound because of the historical abuses by nations at war.[3,4] There is less understanding of what local politics and psychiatry share as common endeavours in today's world of population health and publically funded services. Local politics, local governments and public preferences are important components of preventive psychiatry. Earlier this week, a senior highly renowned and brilliant medical (non-psychiatric) colleague of mine queried that much psychiatric research seemed political, and dismissed it as being outside the realms of medicine and medical sciences – not least my own areas of research on health inequalities. I deliberated with some alacrity why political engagement was something to be celebrated not stigmatised, as psychiatric research informs decisions of importance to local people and is of great societal and health benefit. And there are devastating effects on health if public policy or laws are not evidence-based.

The role of psychiatric research is to create knowledge in order to improve aspects of public mental health, public life as well as medical practice. Evidence-free political decisions are too influential. Medical practice and healthcare are politically influenced activities.[5–7] It does not take too long to identify examples of political influence. The deliberations over 'Obamacare' in the USA and failures to address the mental health of populations,[8] the recent reduction in funds for mental healthcare in the UK, the deregulation of health provision and opening up of the market to private providers are stark reminders of this. Public accountability and resourcing in the UK have always made healthcare politically sensitive and controversial.

This month's issue of the *Journal* illustrates how evidence can remove political uncertainty, and inform policy and practice with recommendations that might otherwise be dismissed as political rhetoric. Owen *et al* (pp. 461–467) show that the assessment of decision-making capacity needs to factor in different reasoning processes in psychiatric and non-psychiatric medical settings. Rugkåsa & Dawson (pp. 406–408) call for a reappraisal of community treatment orders, as the evidence gathered after a change in legislation shows these are not effective at reducing revolving-door experiences for patients, and that intensive care practices (more care rather than more laws) may be more effective.

The stigma associated with psychiatric disorders and the lack of 'parity of esteem' have received significant attention.[9] This awareness should help nurture and nourish a profound revision of the attitudes of the public, policy makers, commissioners, medical and non-medical practitioners, and politicians, local and national. What happens without this?

Allan *et al* (pp. 453–460) show that depression is common following stroke, but it is rarely treated. Wider recognition of the psychiatric consequences of medical disorders is needed. As a partial remedy, Thiels (pp. 399–400) argues that psychiatrists might benefit from training in neurology. The majority of people (70%) with common mental disorders still receive no intervention in the UK, and there is evidence from the USA that common mental disorders will affect at least 50% of the population during their lifetime.[10,11] We are failing to identify and treat childhood anxiety disorders, with significant risk of more severe adult disorders, and of disruption to learning and the development of relational skills (Thirlwall *et al*, pp. 436–444; Cartwright-Hatton, pp. 401–402). Thirlwall and colleagues report that a brief form of cognitive–behavioural therapy delivered by non-experienced lay therapists seems effective. Perhaps more non-clinicians can be helpful in managing these common states of distress in the community? Sharpe *et al* (pp. 428–435) show that teachers can deliver body-image lessons to improve body-related self-esteem and lessen the idealisation of thinness.

Parents and poverty provoke quite a response when public authorities fear that children are abused or not offered adequate care, but poverty in children, and the ability of parents to feed themselves and their children, is rarely given as much media attention.[12] Barker and colleagues (pp. 417–421) show that maternal depression is associated with poor prenatal nutrition, and it is the poor prenatal nutritional environment rather than the depression that is most directly associated with poorer cognition of children aged 8. What provisions are there for parents who are unable to provide a nourishing environment for themselves and their children? Can medicine alone resolve this health challenge?

Social status and health inequalities are known to be caused by and to cause psychiatric disorders. Millner *et al* (pp. 409–416) show that the highest risk of suicide is in low-status occupations, but are interventions targeted at these groups? Suicide rates in Japan have been high for some time; the recession and the cultural response to adversity are often blamed.[13,14] Irrespective of aetiological factors, Nanri and colleagues (pp. 422–427) show that a healthy diet of fruit and vegetables, soy products, potatoes, seaweed, mushrooms and fish (not a Japanese or Western diet) is associated with a much lower risk of suicide. What are governments and health agencies doing about food in schools and hospitals, and population trends in nutrition?

Preventing war may be too political, but preventing cognitive impairments in children, ensuring adequate nutrition for mothers, considering dietary influences as critical mental health interventions, developing legislation that is not coercive and is evidenced, and including non-clinicians and trained lay therapists as well as a wider range of local public servants may be the only way to improve population mental health, but in that realm we are not political enough. Psychiatric research needs to inform political decisions where these have an impact on health.

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