Highlights of this issue

By Derek K. Tracy

Medical models and model medics

Two topics always liable to get psychiatrists hot under the collar: throwing about the phrase 'biopsychosocial' and debating the merits (or otherwise) of functional splits in services. What does biopsychosocial mean to you? Engel coined it in 1977, and it's been a bit of an albatross ever since. Davies & Roache reassess (pp. 3–5), arguing that psychiatry uncomfortably spans biological and psychosocial perspectives on mental illness. They ask whether psychiatry is a science of brain or mind, of individual or society, of dysfunction or deviance. In a highly stimulating editorial they appraise four conceptual aspects: psychiatric classification, psychiatric causation, prevention and treatment of illness, and metaphysics. I'm not sure the biopsychosocial concept is uncomfortable but, like the term 'medical model', its pejorative accusatory misuse may well be. Many truths and levels of explanation can be held at the same time, even when they do not perfectly align: perhaps our responsibility is in whether and how we satisfactorily explain these to others.

Remember the halcyon days when consultants continued care from community to in-patient settings (and it was always sunny and there was no crime or rude behaviour, if memory serves)? Were they as good, or as effective, as some of us seem to recall? Tom Burns and Martin Baggaley debate (pp. 6–9). The widespread move to functional services was neither evidence based, nor the result of significant consultation, but fell from the 2000 NHS Plan (as did, in a similarly evidenceless manner, home treatment teams). Opinions tend to form behind preferred ideas of specialism versus continuity, effective throughput, and job satisfaction/burnout. The most fascinating thing is the lack of research to underpin either model or any of these issues. One figure stands prominent: 50% of the secondary mental healthcare budget is expended on the 3% of patients who are admitted to wards at any given time. That certainly infers a need for some robust work on the topic.

Evidence, bias and clinical practice

We are all signed-up evidence-based practitioners, immune to advertising and spin, caring only for *P*-values less than 0.05 (though I recommend reading David Colquhoun's investigation of the false discovery rate and the misinterpretation of *P*-values). Cristea *et al* test this (pp. 16–23), looking at the impact of sponsorship bias, taking the novel angle of looking at studies comparing medications with non-pharmacological treatments for depression. To date, no one had analysed trials including talking therapies: most investigations of sponsorship bias have focused on medication *v.* placebo studies (the principle being that there's more noise in the standard head-to-head non-inferiority work). They identified 45 suitable trials: those sponsored by industry favoured pharmacotherapy and, problematically,

researchers had not disclosed relevant financial conflicts of interests in five of them.

Girlanda *et al* (pp. 24–30) take a different tack. Why, when we do have good evidence bases, do we not always follow through and implement in practice? (Oscar Daly's editorial on physical illness (pp. 1–2) exemplifies the problem.) There are multiple strategies for embedding guidelines, including disseminating them to staff, having formal educational sessions, audits of practice, and psychological evaluation of factors facilitating or inhibiting uptake. The authors systematically reviewed randomised controlled clinical trials and before-and-after studies evaluating guideline implementation. Fascinatingly there was not a consistent positive effect of guideline implementation on clinical performance. Under the aegis of the Royal College of Psychiatrists and NICE, the National Collaborating Centre for Mental Health is in the process of issuing guidelines on achieving better access to relevant pathways of care, moving beyond 'condition specific' advice (say, on depression). Will these prove more effective in positively enhancing our practice?

Call of duty or final fantasy?

Computer games often evoke the same type of vague and largely unsubstantiated worries and anxieties we find surrounding the topic of violence on television (the term 'screen time' will provoke nervous twitches in parents). All overblown hype? Kaleidoscope (pp. 87–88) reports on the first large study to test the proposed phenomenon of 'internet gaming disorder'. The data suggest that any risks of addiction are minimal – information you might wish to share with, or withhold from, a significant other or child, depending on who is stuck to the game console. Recently, there has been a lot of interest and publicity about the computer game Sea Hero Quest, a free to download (http://www.seaheroquest.com/en/) game testing visuospatial functioning, a key area of deficit in neurodegeneration, which provides data (from over 2.5 million people to date) to research teams at University College London and the University of East Anglia. It won't diagnose dementia, but it is an imaginative way to collect very big data-sets ('tech for good' will be 2017's neologism, replacing the now gauche and passé 'screen time'). However, this is a field filled with hype and even sober broadsheets got caught up in 'dementia cure' stories at the end of 2016 ('tantalising' seemingly the journalistic equivalent of 'statistically significant but with a small effect size'). So it is pleasing to read in this month's *BJPsych* the work of Huntley *et al* (pp. 61–66), who describe a novel cognitive training paradigm in Alzheimer's disease. Thirty patients with mild Alzheimer's disease were randomised to 8 weeks (18 sessions) of either so-called 'adaptive chunking training' or an active control intervention. Chunking is a technique of clustering patterns of information, making it easier to hold in the limited stores of working memory. The novel intervention resulted in significant improvements in verbal working memory and, importantly, transferred to untrained general cognitive functioning. Neuro-imaging data showed that the enhanced performance was accompanied by reduced functional brain activity in specified regions of activity, which can be inferred to represent more efficient cortical processing. It is heartening to see a practical, implementable intervention for Alzheimer's disease.