BJPsych | The British Journal of Psychiatry (2016) 208, 398–399

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

Treatment is necessary!

I read the editorial by Shiers *et al*[1] with some interest largely due to my previous attempts at highlighting this issue both in mental health trusts and to the readership by previous responses and articles.

However, I have been left mildly disappointed again with the tenor of the article, which did not mention the increased risks of mortality without treatment: something an editorial in the *BJPsych* should be mentioning! We have several past and recent longitudinal studies[2] which clearly highlight the risks of increased mortality without antipsychotic treatment. I have followed this trend of certain health professionals not advising patients to go on to antipsychotic medication because of risks to physical health. The trend took a further (dangerous) turn when a study was granted ethical approval which allowed patients with psychotic symptoms not to be treated with antipsychotic medication,[3] and some regarding it as a proof of concept that cognitive therapy is an alternative to antipsychotics.

An article in the *BPsych*[4] clearly discredited cognitive–behavioural therapy as a viable alternative, but was not given the same media coverage as the pilot study by Morrison *et al*.[3] My day-to-day work involves being based in an early intervention team and despite being aware of what needs to be done to monitor physical health, poor investment and increased demand (with the upper age limit now correctly abandoned, see www.nice.org.uk/guidance/cg178/chapter/1-recommendations#first-episode-psychosis-2), we struggle to monitor all our patients to the standard we would like to achieve.

Despite the above factors, there are other issues to consider, including the stigma of the diagnosis and taking medication, lack of family support and working memory deficits[5] to name a few, but readily ignored. I wish the editorial could take a more unbiased role rather than continue to bash on about one factor, i.e. antipsychotic medication and its side-effects. Untreated patients also have higher morbidity risks, which I feel the editorial did not highlight.

Looking at it from a systems theory point of view would have led to a more balanced reading. However, I laud the attempt of this editorial and the attempt to reduce the inequalities and mortality gap.[6]

Declaration of interest

M.K works in an early intervention in psychosis service.

1 Shiers D, Bradshaw T, Campion J. Health inequalities and psychosis: time for action. *Br J Psychiatry* 2015; **207**: 471–3.

2 Tiihonen J, Mittendorfer-Rutz E, Torniainen M, Alexanderson K, Tanskanen A. Mortality and cumulative exposure to antipsychotics, antidepressants, and benzodiazepines in patients with schizophrenia: an observational follow-up study. *Am J Psychiatry* 7 Dec 2015 (doi: 10.1176/appi.ajp.2015.15050618).

3 Morrison AP, Turkington D, Pyle M, Spencer H, Brabban A, Dunn G, et al. Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial. *Lancet* 2014; **383**: 1395–403.

4 Jauhar S, McKenna PJ, Radua J, Fung E, Salvador R, Laws KR. Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br J Psychiatry* 2014; **204**: 20–9.

5 Lui SSY, Liu ACY, Chui WWH, Li Z, Geng F, Wang Y, et al. The nature of anhedonia and avolition in patients with first-episode schizophrenia. *Psychol Med* 2016; **46**: 437–47.

6 Crump C, Winkleby M A, Sundquist K, Sundquist J. Comorbidities and mortality in persons with schizophrenia: a Swedish national cohort study. *Am J Psychiatry* 2013; **170**: 324–33.

Mukesh Kripalani, Consultant Psychiatrist, Barnet, Enfield and Haringey Mental Health NHS Trust, London, UK. Email: drmukesh@doctors.org.uk

doi: 10.1192/bjp.208.4.398

Authors' reply: We thank Dr Kripalani for his interest in our editorial and we share his aspiration to improve the physical health of people who use mental health services. We would like to respond to some of the issues he has raised and note the following.

We believe our editorial demonstrated that this continuing health inequality represents a systems failure of primary care, secondary care and public health to coordinate to prevent premature mortality through implementation of evidence-based interventions. Our proposed systems solution was reflected in a recent editorial by Mitchell & De Hert '. . . there is much more we can do to help promote physical health in our patients with schizophrenia. We should be doing this early, at first contact by proactively attempting to minimise the accrual of cardiometabolic risk factors. In the long-term, this will prove a more effective strategy than responding only once the complication is established'.[1]

Our editorial highlighted the importance of evidence-based interventions that include antipsychotics. Our call for careful antipsychotic prescribing, well-balanced with psychological interventions and promotion of physical health, resonates with views of others, including major guidelines, particularly in the critical early treatment phase of psychosis:

- National Institute for Health and Care Excellence (NICE) guidelines (www.nice.org.uk/guidance/cg178) explicitly recommend that people experiencing first-episode psychosis (FEP) should access an early intervention service and be offered a range of evidence-based interventions that include pharmacological, psychological and physical health-promoting approaches.

- NICE recently endorsed the Lester UK Adaptation of the Positive Cardiometabolic Health Resource supporting systematic monitoring of those receiving antipsychotics (www.rcpsych.ac.uk/quality/NAS/resources).

- The British Association of Psychopharmacologists recommend specific prescribing considerations for treatment-naive individuals with FEP; for example antipsychotic choice based on relative side-effect liability, patient preference, low-dose initiation and titration within *British National Formulary* range, systematic side-effects monitoring following initiation, etc.[2]

- Dixon & Stroup recently highlighted, 'Because medication experiences for individuals at the beginning of treatment may have a lasting impact on their attitudes toward medication and course of illness, this is a critical time to optimise prescribing.'[3]

https://doi.org/10.1192/bjp.208.4.398a Published online by Cambridge University Press

A Swedish national database study concluded that mortality risks were highest in those untreated with antipsychotics.[4] However, this conclusion maybe an oversimplification and we suggest 'untreated' here describes being poorly engaged, lacking care and support rather than simply 'untreated with antipsychotics'; indeed, 'treated with antipsychotics' could be a proxy for well engaged, supported and receiving a range of interventions comparable to those recommended by NICE. Another anomaly was the study's reported average age of 36 years for its FEP subgroup, much older than usually reported.[5] Thus the study may have missed substantial numbers of younger people, a particularly vulnerable group for antipsychotic-induced weight gain and metabolic disturbance, limiting its applicability to more typically aged FEP populations.[6] Nevertheless the finding that lower mortality correlated with low and moderate antipsychotic dosing supports the importance of good prescribing.

Our simple collective view in providing this editorial as general practitioner, nurse and psychiatrist together, is that health inequality could be reduced by healthcare systems collaboratively embracing a more preventive approach in relation to the physical health of this vulnerable group from the earliest opportunity.

1 Mitchell AJ, De Hert M. Promotion of physical health in persons with schizophrenia: can we prevent cardiometabolic problems before they begin? *Acta Psychiatr Scand* 2015; **132**: 83–5.

2 Barnes TR. Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2011; **25**: 567–620.

3 Dixon LB, Stroup ST. Medications for first-episode psychosis: making a good start. *Am J Psychiatry* 2015; **172**: 209–11.

4 Tiihonen J, Mittendorfer-Rutz E, Torniainen M, Alexanderson K, Tanskanen A. Mortality and cumulative exposure to antipsychotics, antidepressants, and benzodiazepines in patients with schizophrenia: an observational follow-up study. *Am J Psychiatry* 7 Dec 2015 (doi: 10.1176/appi.ajp.2015.15050618).

5 Kirkbride JB, Fearon P, Morgan C, Dazzan P, Morgan K, Tarrant J, et al. Heterogeneity in incidence rates of schizophrenia and other psychotic syndromes: findings from the 3-center AeSOP study. *Arch Gen Psychiatry* 2006; **63**: 250–8.

6 Correll CU, Manu P, Olshanskiy V, Napolitano B, Kane JM, Malhotra AK. Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents. *JAMA* 2009; **302**: 1765–73.

David Shiers, MBChB, MRCGP, MRCP(UK), School of Psychological Sciences, University of Manchester, Manchester M13 9PL, UK. Email: david.shiers@doctors.org.uk; **Jonathan Campion**, MBBS, MRCPsych, South London and Maudsley NHS Foundation Trust, and Faculty of Brain Sciences, University College London, London; **Tim Bradshaw**, RMN, PhD, School of Nursing, Midwifery and Social Work, University of Manchester, Manchester, UK

doi: 10.1192/bjp.208.4.398a

'Lethal discrimination', ideology and social justice

Perhaps the journal risks accusations of hyperbole by adopting the slogan of 'lethal discrimination' in relation to the shockingly high standardised mortality ratios (SMRs) of people with severe mental illness (SMI). Other serious illnesses (cancer, etc.) have high SMRs but to suggest that this is due to lethal discrimination would attract criticism.

Taggart & Bailey[1] are right to draw attention to the high SMRs in people with SMI. This is consistent with accepted tenets of moral philosophy, particularly liberal political philosophy. Central to this are principles that citizens enjoy maximum liberty (subject to respect for the liberty of others) and, second, that social arrangements permit social inequality only to the degree that this improves the well-being of the least advantaged.[2] People with SMI are among the most disadvantaged.

Table 1 of the editorial indicates that those with SMI in contact with services fare better in the USA than in the UK. This will not surprise those who have expressed dismay about developments in mental health services in the UK.[3] However, the important question is whether the way US mental health services are funded, commissioned and managed may be better. Psychiatrists need to remain open minded about what systems deliver best results, if we are to achieve our aims effectively.[4]

International comparisons are notoriously difficult to make. A host of health and social indicators however suggest worse outcomes in more unequal societies. Because the USA is a more unequal society, Table 1 is counterintuitive. Perhaps Table 1 is misleading. Taggart & Bailey do not tell us whether the US data include outcomes of individuals with SMI receiving care in prison. In the past 40 years the proportion of people with SMI who are compulsorily detained in the USA has remained the same. However, whereas 40 years ago 75% were in mental hospitals and 25% in penal institutions, now the proportions are 5% and 95% respectively.[5] Table 1 will have validity only if the outcomes of imprisoned individuals with SMI are included.

Should further research confirm US superiority, another issue might arise: does more restrictive treatment (in prison) achieve better outcomes? If so, psychiatrists will have to face deeply uncomfortable questions. Could it be that enhanced incarceration leads to lesser freedom but a lower SMR? Would lower a SMR be the effect of more intensive psychopharmacological treatment or is there less psychopharmacological intervention in prison and the higher UK SMR is due to more psychopharmacological treatment in the community? What kind of societies lead to best outcomes for people with SMI?

Health outcomes do not depend only on healthcare. To participate constructively in debate and action aimed at reducing SMRs in those with SMI, psychiatrists need to become familiar with the complex issues addressed by political philosophy[2] as well as public mental health. They also need to be aware that although they may master evidence and political ethical reasoning, social ideology will sometimes prevail as to what happens on the ground.[6] Perhaps it is anxiety secondary to this that impelled invention of the concept of lethal discrimination in people with SMI.

Declaration of interest

G.I. is an NHS consultant psychiatrist, and Chairman and Director, London International Practice Ltd.

1 Taggart H, Bailey S. Ending lethal discrimination against people with serious mental illness. *Br J Psychiatry* 2015; **207**: 469–70.

2 Ikkos G. Fairness, liberty and psychiatry. *Int Psychiatry* 2009; **6**: 46–8.

3 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

4 Ikkos G, Sugarman P, Bouras N. Mental health services commissioning and provision: lessons from the UK? *Psychiatriki* 2015; **26**: 181–7.

5 Bark N. Prisoner mental health in the USA. *Int Psychiatry* 2014; **11**: 53–5.

6 Bouras N, Ikkos G. Ideology and psychiatry. *Psychiatriki* 2013; **24**: 17–27.

George Ikkos, Consultant Psychiatrist in Liaison Psychiatry, Royal National Orthopaedic Hospital NHS Trust, Stanmore, Middlesex, UK. Email: george.ikkos@nhs.net

doi: 10.1192/bjp.208.4.399