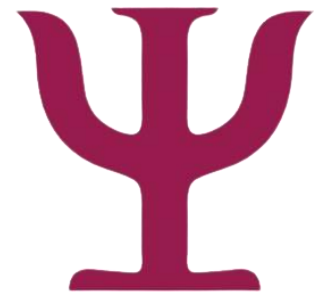


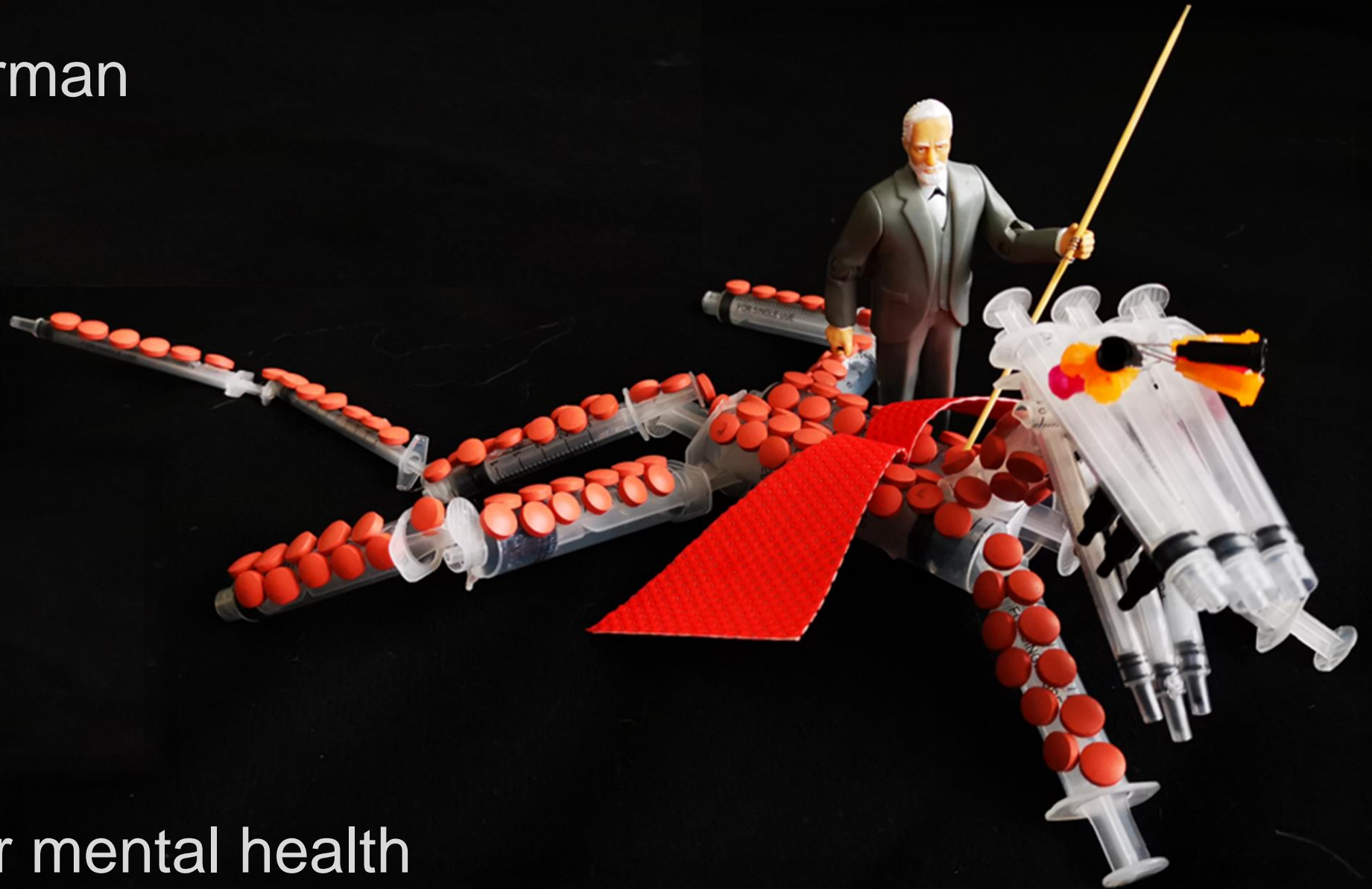
**Keynote Presentation:
A Manifesto for Mental Health**

Professor Peter Kinderman

University of Liverpool



@peterkinderman



a manifesto for mental health

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Additional

Particulars.

Sadness was brought on in this case by the loss of her child who accidentally fell into a well near her dwelling she saw the lock pulled out not knowing that it was

General Features

of the

Mental Malady.

that of her own child - Ever since then she has been insane at first the affection manifested itself as melancholia but however she has become at times subject to fits of violence and occasionally has refused her food

On admission was sent to No 12. took her food very freely when seen in the evening was found to be restless and noisy apparently, alarmed, a powerful opiate - some good wine & water was administered ^{with this quantity which} she passed a ~~very~~ ^{rather quiet} night

Jan 25

was very noisy & unmanageable yesterday so much so that about 3 o'clock PM it was found necessary to put her in her bed & she has not had time to sleep yesterday the

Aetiological Factors. (Symbols only, as scheduled by the Board of Control.)	
Principal.	Associated.
(One entry and one only to be made for each case in this column.)	(As many associated factors as may be ascertained are to be entered here.)

AND TWENTIES OF A YEAR.)

Instances of Epilepsy



INDY/PULSE

ANTI-DEPRESSANT PRESCRIPTIONS IN BRITAIN HAVE DOUBLED IN PAST 10 YEARS

The number of Britons on anti-depressants has almost doubled in the past 10 years / PA

Doctors issued 55 million prescriptions in 2014 alone

ROISIN O'CONNOR

@Roisin_OConnor

Monday 5 January 2015 12:09 GMT

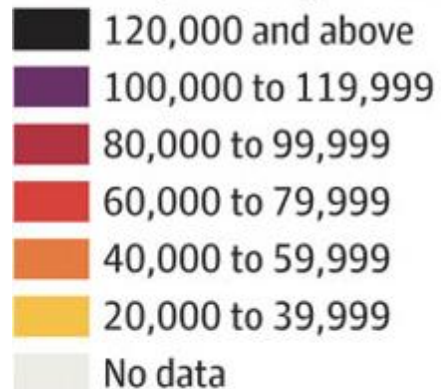


The number of Britons on anti-depressants has almost doubled in the past 10 years, an investigation has revealed.

Britain is fourth in Europe when it comes to countries consuming the most antidepressants, with just Sweden, Denmark and Portugal taking more.

Anti-depressant prescriptions, 2009/10, per 100,000 population

Prescriptions per 100,000 pop.



Redcar & Cleveland PCT

120,137

159,655

11.3%

Ealing PCT

37,980

123,383

12.7%

Brent Teaching PCT

35,914

100,390

8.5%

Blackpool PCT

133,829 prescriptions per 100,000

186,623 2009/10 total prescriptions

10.1% Increase from 2008/09

Kensington & Chelsea PCT

35,845

69,373

12.2%

Salford PCT

121,293

272,279

9.5%

UK ► UK politics Education Media Society Law Scotland Wales Northern Ireland

Attention deficit hyperactivity disorder

The Observer

Daniel Boffey *Policy editor*

Sat 15 Aug 2015 22.01 BST



839

333

This article is over 2 years old

Prescriptions for Ritalin and other ADHD drugs double in a decade

Specialists fear cuts to mental health services have led to children being inappropriately prescribed drugs

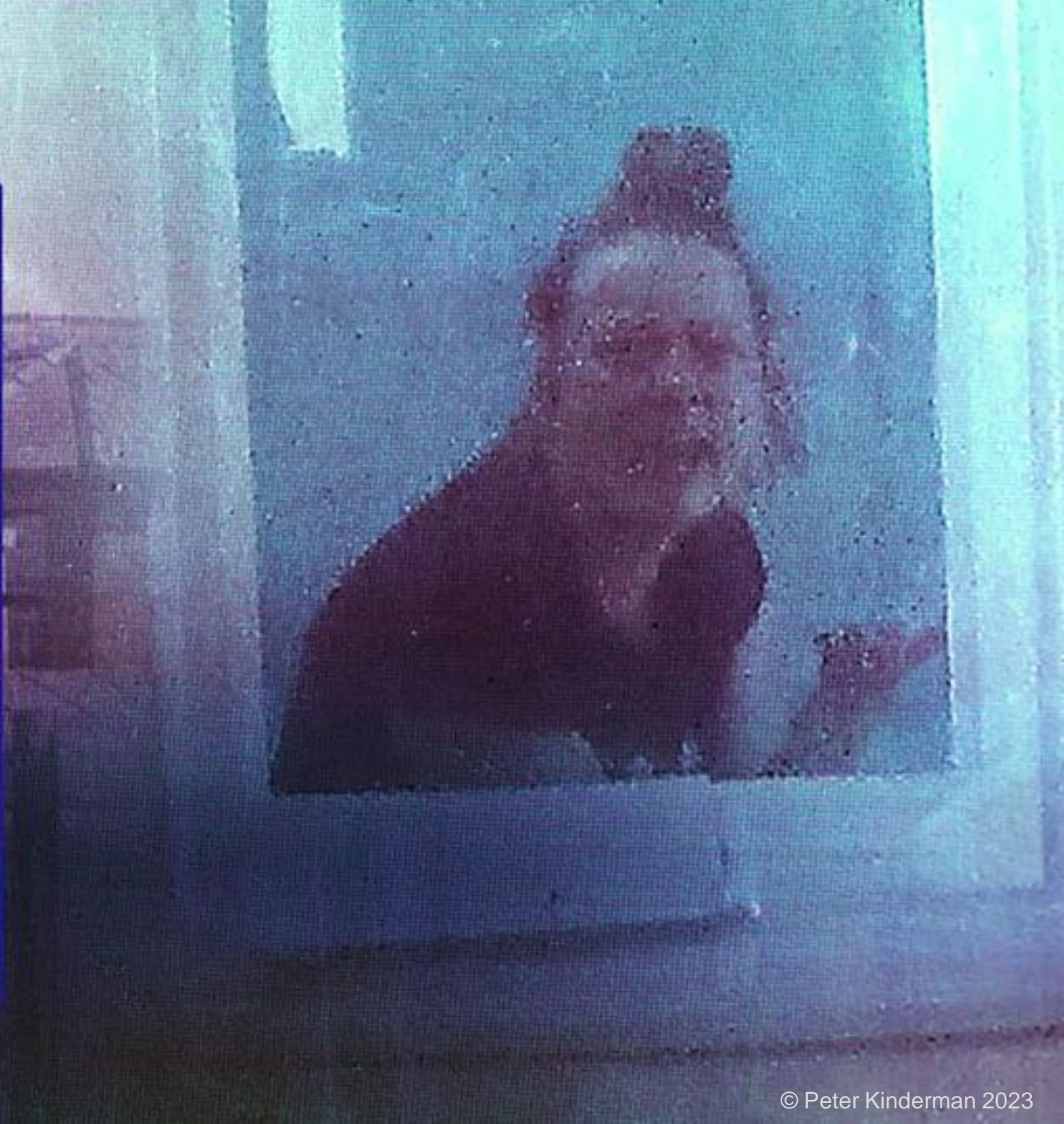
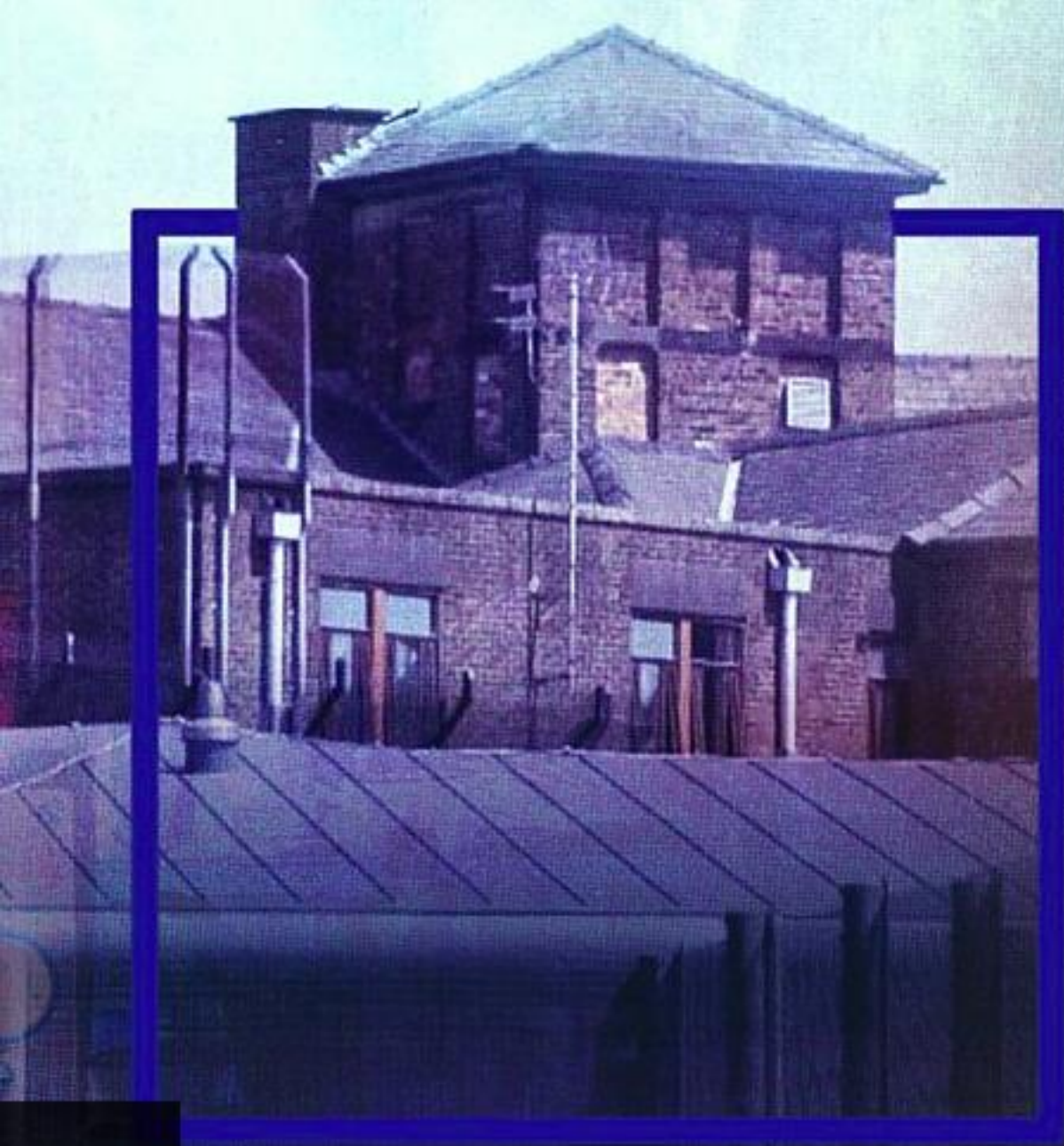


▲ The National Institute for Health and Care Excellence says drugs should only be used as a last resort for ADHD.
Photograph: Murdo Macleod/The Guardian

Nearly a million prescriptions for Ritalin and related drugs for attention deficit hyperactivity disorder (ADHD) were dispensed last year - more than double the number of a decade ago.

The figures have prompted a damning indictment of the system from experts who claim that the running down of mental health services has led to children being misdiagnosed and inappropriately prescribed drugs.







RESEARCH

Suicides associated with the 2008-10 economic recession in England: time trend analysis

OPEN ACCESS

Ben Barr *NIHR research fellow*¹, David Taylor-Robinson *MRC research fellow*¹, Alex Scott-Samuel *senior clinical lecturer in public health*¹, Martin McKee *professor*², David Stuckler *lecturer*^{2,3}¹Department of Public Health and Policy, University of Liverpool, Liverpool L69 3GB UK; ²London School of Hygiene and Tropical Medicine, London, UK; ³Department of Sociology, Cambridge University, Cambridge, UK**Abstract****Objective** To determine whether English regions worst affected by the economic recession in the United Kingdom in 2008-10 have had the greatest increases in suicides.**Design** Time trend analysis comparing the actual number of suicides with those that would be expected if pre-recession trends had continued. Multivariate regression models quantified the association between changes in unemployment (based on claimant data) and suicides (based on data from the National Clinical Health Outcomes Database).**Setting** 93 English regions, based on the Nomenclature of Territorial Units Statistics level 3 groupings of local authorities at county level and groups of unitary local authorities.**Participants** Men and women with a record of death from suicide or injury of undetermined cause in 2000-10.**Main outcome measure** Number of excess suicides during the economic recession (2008-10).**Results** Between 2008 and 2010, we found 846 (95% confidence interval 818 to 877) more suicides among men than would have been expected based on historical trends, and 155 (121 to 189) more suicides among women. Historically, short term yearly fluctuations in unemployment have been associated with annual changes in suicides among men but not among women. We estimated that each 10% increase in the number of unemployed men was significantly associated with a 1.4% (0.5% to 2.3%) increase in male suicides. These findings suggest that about two fifths of the recent increase in suicides among men (increase of 329 suicides, 126 to 532) during the 2008-10 recession can be attributed to rising unemployment.**Conclusion** The study provides evidence linking the recent increase in suicides in England with the financial crisis that began in 2008. English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men.**Introduction**

Few would contest that the UK government's austerity policy has increased job losses, and indeed, one of its core aims has been to achieve large scale reductions in public sector employment. But what are the implications for health?

This is an important question. A recent report commissioned by the government called for measures that would make dismissing employees easier than it is now, conceding that "some people will be dismissed simply because their employer doesn't like them," but arguing that this is a "price worth paying."¹ Although the wording of the report was unusually blunt, it reflected a widely held view among many of the government's supporters that the answer to the current financial problems was to deregulate labour markets further, with so-called "supply-side" policies that weaken employment protection and obligations in areas such as health and safety.² But if these policies are to be pursued, what is the price that must be paid by those who will lose their jobs? Such knowledge is essential before deciding whether this price is worth paying.A growing number of people may be paying the ultimate price. In 2008, suicides began to rise in England, from a 20 year low,^{3,4} increasing by 7% among men and 8% among women from the previous year (fig 1). Although suicides began to fall again in 2010, they are currently still above corresponding values in 2007.But can these recent increases in suicide be attributed to the current financial crisis?⁵ Commentators on an observed increase in suicides in Greece argued that it was a "premature over-interpretation" to attribute this increase to the crisis, since the changes were within the range of annual statistical fluctuations, owing to the small numbers involved.⁶ Whether health ministers hold the same views about the trends in the UK is unclear since, as far as we know, they have been entirely

"... The study provides evidence linking the recent increase in suicides in England with the financial crisis that began in 2008. English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men... We estimated that each 10% increase in the number of unemployed men was significantly associated with a 1.4% increase in male suicides. These findings suggest that about two fifths of the recent increase in suicides among men during the 2008-10 recession can be attributed to rising unemployment..."

Correspondence to: B Barr b.barr@liverpool.ac.ukExtra material supplied by the author (see <http://www.bmj.com/content/345/bmj.e5142/tab-related-files>)**Web appendix:** Supplementary material (web appendices 1-5)No commercial reuse. See rights and reprints <http://www.bmj.com/page/permissions>Subscribe <http://www.bmj.com/subscribe>



Interaction Between the Serotonin Transporter Gene (5-HTTLPR), Stressful Life Events, and Risk of Depression A Meta-analysis

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Richard Herrell, PhD
Thomas Lehner, PhD
Kung-Yee Liang, PhD
Lindon Eaves, PhD
Josephine Hoh, PhD
Andrea Griem, BS
Maria Kovacs, PhD
Jurg Ott, PhD
Kathleen Ries Merikangas, PhD

THE SUCCESSFUL STATISTICAL identification and independent replication of numerous genetic markers in association studies have confirmed the utility of the genome-wide approach for the detection of genetic markers for complex disorders.^{1,2} However, recent genome-wide association studies have also indicated that most common genetic risks, at least when studied individually, are modest in magnitude, with relative risks in the range of 1.3 or less.³ This suggests that complex disorders result from the combination of numerous individual genetic and environmental contributors, with the potential for interactions among them. However, there is a lack of consensus regarding whether gene × gene or gene × environment interactions should be examined at the stage of gene detection or only after a gene effect has been clearly identified and replicated.³

Context Substantial resources are being devoted to identify candidate genes for complex mental and behavioral disorders through inclusion of environmental exposures following the report of an interaction between the serotonin transporter linked polymorphic region (5-HTTLPR) and stressful life events on an increased risk of major depression.

Objective To conduct a meta-analysis of the interaction between the serotonin transporter gene and stressful life events on depression using both published data and individual-level original data.

Data Sources Search of PubMed, EMBASE, and PsycINFO databases through March 2009 yielded 26 studies of which 14 met criteria for the meta-analysis.

Study Selection Criteria for studies for the meta-analyses included published data on the association between 5-HTTLPR genotype (SS, SL, or LL), number of stressful life events (0, 1, 2, ≥3) or equivalent, and a categorical measure of depression defined by the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) or the *International Statistical Classification of Diseases, 10th Revision* (ICD-10) or use of a cut point to define depression from standardized rating scales. To maximize our ability to use a common framework for variable definition, we also requested original data from all studies published prior to 2008 that met inclusion criteria. Of the 14 studies included in the meta-analysis, 10 were also included in a second sex-specific meta-analysis of original individual-level data.

Data Extraction Logistic regression was used to estimate the effects of the number of short alleles at 5-HTTLPR, the number of stressful life events, and their interaction on depression. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated separately for each study and then weighted averages of the individual estimates were obtained using random-effects meta-analysis. Both sex-combined and sex-specific meta-analyses were conducted. Of a total of 14 250 participants, 1769 were classified as having depression; 12 481 as not having depression.

Results In the meta-analysis of published data, the number of stressful life events was significantly associated with depression (OR, 1.41; 95% CI, 1.25-1.57). No association was found between 5-HTTLPR genotype and depression in any of the individual studies nor in the weighted average (OR, 1.05; 95% CI, 0.98-1.13) and no interaction effect between genotype and stressful life events on depression was observed (OR, 1.01; 95% CI, 0.94-1.10). Comparable results were found in the sex-specific meta-analysis of individual-level data.

Conclusion This meta-analysis yielded no evidence that the serotonin transporter genotype alone or in interaction with stressful life events is associated with an elevated risk of depression in men alone, women alone, or in both sexes combined.

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“... the number of stressful life events was significantly associated with depression ...

No association was found between 5-HTTLPR genotype and depression ... and no interaction effect between genotype and stressful life events on depression was observed ... no evidence that the serotonin transporter genotype alone or in interaction with stressful life events is associated with an elevated risk of depression...”

Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies

Filippo Varese^{1,3,7}, Feikje Smeets^{1,3}, Marjan Drukker³, Ritsaert Lieveise³, Tineke Lataster³, Wolfgang Viechtbauer³, John Read², Jim van Os^{2,3,4}, and Richard P. Bentall¹

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Evidence suggests that adverse experiences in childhood are associated with psychosis. To examine the association between childhood adversity and trauma (sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) and psychosis outcome, MEDLINE, EMBASE, PsychINFO, and Web of Science were searched from January 1980 through November 2011. We included prospective cohort studies, large-scale cross-sectional studies investigating the association between childhood adversity and psychotic symptoms or illness, case-control studies comparing the prevalence of adverse events between psychotic patients and controls using dichotomous or continuous measures, and case-control studies comparing the prevalence of psychotic symptoms between exposed and nonexposed subjects using dichotomous or continuous measures of adversity and psychosis. The analysis included 18 case-control studies ($n = 2048$ psychotic patients and 1856 nonpsychiatric controls), 10 prospective and quasi-prospective studies ($n = 41\ 803$) and 8 population-based cross-sectional studies ($n = 35\ 546$). There were significant associations between adversity and psychosis across all research designs, with an overall effect of $OR = 2.78$ (95% $CI = 2.34-3.31$). The integration of the case-control studies indicated that patients with psychosis were 2.72 times more likely to have been exposed to childhood adversity than controls (95% $CI = 1.90-3.88$). The association between childhood adversity and psychosis was also significant in population-based cross-sectional studies ($OR = 2.99$ [95% $CI = 2.12-4.20$]) as well as in prospective and quasi-prospective studies ($OR = 2.75$ [95% $CI = 2.17-3.47$]). The estimated population attributable risk was 33% (16%-47%). These findings indicate that childhood adversity is strongly associated with increased risk for psychosis.

Key words: psychosis/adversity/trauma/meta-analysis/abuse/neglect

Introduction

Adverse childhood events including trauma is a common experience worldwide, with some estimates suggesting that about a third of the general population may be affected.¹ Evidence suggests that its effects in adulthood may include a range of negative social outcomes, including higher criminality,² a lower educational level³ and lower general health and well-being. Adverse childhood events have also been related to a greater risk of psychiatric disorder^{1,4,5} and, especially given its high prevalence, it is likely that it is an important determinant of mental ill-health.⁶

A growing number of methodologically sound studies have examined child maltreatment (eg, sexual abuse, physical abuse, emotional/psychological abuse and neglect), peer victimization (eg, bullying), and experiences of parental loss and separation as risk factors for psychosis and schizophrenia. Nevertheless, the association between adverse childhood events and psychosis has been a topic of enduring controversy. Only narrative reviews have so far attempted to synthesize these findings, with inconsistent conclusions.⁷⁻⁹ Therefore, a systematic quantitative synthesis of the existing data is required.

The present study presents a quantitative review and meta-analysis of the available empirical literature, examining the magnitude and consistency of the effects of different, widely-examined types of adversity and trauma observed in: (i) prospective cohort studies, (ii) large population-based cross-sectional studies, and (iii) case-control studies.

“...There were significant associations between adversity and psychosis ... with an overall effect of [an odds ratio of] = 2.78

... These findings indicate that childhood adversity is strongly associated with increased risk for psychosis...”

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Special article

Wake-up call for British psychiatry

Nick Craddock, Danny Arntel, Mary-jane Attenburrow, Anthony Bailey, Alan Carson, Phil Cowen, Bridget Craddock, John Eagles, Klaus Ebmeier, Annie Farmer, Seena Fazel, Nicol Ferrier, John Geddes, Guy Goodwin, Paul Harrison, Keith Hawton, Stephen Hunter, Robin Jacoby, Ian Jones, Paul Keedwell, Mike Kerr, Paul Mackin, Peter McGuffin, Donald J. MacIntyre, Pauline McConville, Deborah Mountain, Michael C. O'Donovan, Michael J. Owen, Ferni Oyebode, Mary Phillips, Jonathan Price, Prem Shah, Darryl J. Smith, James Walters, Peter Woodruff, Allan Young and Stan Zammit

Summary

The recent drive within the UK National Health Service to improve psychosocial care for people with mental illness is both understandable and welcome: evidence-based psychological and social interventions are extremely important in managing psychiatric illness. Nevertheless, the accompanying downgrading of medical aspects of care has resulted in services that often are better suited to offering non-specific psychosocial support, rather than thorough, broad-based diagnostic assessment leading to specific treatments to optimise well-being and functioning. In part, these changes have been politically driven, but they could not have occurred without the collusion, or at least the acquiescence, of psychiatrists. This creeping devaluation of medicine disadvantages patients and is very

damaging to both the standing and the understanding of psychiatry in the minds of the public, fellow professionals and the medical students who will be responsible for the specialty's future. On the 200th birthday of psychiatry, it is fitting to reconsider the specialty's core values and renew efforts to use psychiatric skills for the maximum benefit of patients.

Declaration of interest

All authors are members or fellows of the Royal College of Psychiatrists and currently work within, or have recently worked within, the UK National Health Service. We hope that both of these organisations will be influenced by this paper.

British psychiatry faces an identity crisis. A major contributory factor has been the recent trend to downgrade the importance of the core aspects of medical care. In many instances, this has resulted in services that are better suited to delivering non-specific, psychosocial support rather than a process of thorough, broad-based diagnostic assessment with formulation of aetiology, diagnosis and prognosis followed by specific treatments aimed at recovery with maintenance of functioning. These changes have been driven in part by government, but there has been both active collusion and passive acquiescence by psychiatrists themselves. Our contention is that this creeping devaluation of medicine is damaging our ability to deliver excellent psychiatric care. It is imperative that we specify clearly the key role of psychiatrists in the management of people with mental illnesses.

Psychiatric illness and 'mental health'

How many of us have, in clinical discussions, been aware of uneasiness in colleagues in defending 'the medical model of care' or been the only one using the word 'patient' when discussing service delivery or planning? However, despite the recent misguided tendency by many to caricature a medical psychiatric approach as being narrow, biological and reductionist, we are struck by how keen other members of staff are for themselves or their relatives to be seen by an experienced psychiatrist when mental illness affects them. Moreover, when patients were asked how they would prefer to be described by a psychiatrist, 67% preferred 'patient' and only 9% preferred 'service user'.² This disjunction cannot be a healthy state of affairs and aggravates public and health professionals' difficulties understanding psychiatric illness and the psychiatrist's role.

One key issue is that the concept of mental illness has broadened considerably since Reil first coined the term psychiatry 200 years ago.^{3,4} As a result, many people with mild psychiatric

symptoms have developed exaggerated and unrealistic expectations of psychiatry. Indeed, psychiatric services may not be best placed to manage the majority of individuals with such mild symptoms, who would be better served by other more general services. It is probably in the best interest of such individuals to avoid medicalising both the terminology and the type of help that they may require or want.

Certain circumstances do, however, require professionals with medical training to diagnose and treat underlying psychiatric or non-psychiatric physical disorders. Further, those with severe mental disorders can and do benefit from the process of a medical psychiatric assessment, diagnosis and treatment.⁵⁻⁷ For those with severe mental illness, to avoid medicalisation is at best confusing and at worst damaging or even life-threatening. These individuals, the very people for whom Reil argued that psychiatry was needed,^{3,4} are being let down by the current state of affairs. These considerations about the nature and breadth of psychiatry bear upon the fundamental issue as to where its appropriate boundaries lie, and whether practitioners can and should continue to try to span such a broad spectrum of skills, knowledge and interests.⁸

We have spoken naturally about psychiatrists treating mental illness: use of the term 'mental health' to describe services for those with mental illness risks undermining the real importance and impact of these conditions on patients. The recent renaming of one Welsh trust's psychiatric out-patient clinic to 'Mental Health Well-Being Clinic' takes this confusion one step further. Using such terminologies may in turn undermine the priority of psychiatric illness for health commissioners and politicians. Psychiatry is more or less alone among medical specialties in the extent to which it has adopted this approach that so distorts its original purpose.

The influences that encourage demedicalising the care of those with severe mental illness are legion and apply in part to other fields of medicine. They probably include political drives to cut

Special article

Psychiatry beyond the current paradigm†

Pat Bracken, Philip Thomas, Sami Timimi, Esa Asen, Graham Behr, Carl Beuster, Seth Bhunoo, Nor Browne, Naviyati Chhina, Duncan Double, Simon Downer, Chris Evans, Suman Fernando, Malcolm R. Garland, William Hopkins, Rhodri Huws, Bob Johnson, Brian Martindale, Hugh Middleton, Daniel Moldavsky, Joanna Moncrieff, Simon Mullins, Julia Nelki, Matteo Pizzo, James Rodger, Marcelino Smyth, Derek Summerfield, Jeremy Wallace and David Yeomans

Summary

A series of editorials in this Journal have argued that psychiatry is in the midst of a crisis. The various solutions proposed would all involve a strengthening of psychiatry's identity as essentially 'applied neuroscience'. Although not discounting the importance of the brain sciences and psychopharmacology, we argue that psychiatry needs to move beyond the dominance of the current, technological

paradigm. This would be more in keeping with the evidence about how positive outcomes are achieved and could also serve to foster more meaningful collaboration with the growing service user movement.

Declaration of interest

None.

What makes a good psychiatrist? What particular skills are needed to practice a 'medicine of the mind'? Although it is impossible to answer such questions fully we believe that there is mounting evidence that good practice in psychiatry primarily involves engagement with the non-technical dimensions of our work such as relationships, meanings and values. Psychiatry has thus far been guided by a technological paradigm that, although not ignoring these aspects of our work, has kept them as secondary concerns. The dominance of this paradigm can be seen in the importance we have attached to classification systems, causal models of understanding mental distress and the framing of psychiatric care as a series of discrete interventions that can be analysed and measured independent of context.¹

In recent years this Journal has published a series of editorials arguing that the profession should adopt an even more technological and biomedical identity, and that psychiatrists should focus on their mastery of technology to allow progress in the development of brain research, genetics, pharmacology and neuroimaging.²⁻⁴ These resonate with calls in North America for psychiatry to become simply a 'clinical neuroscience'.⁵ However, the promise of therapeutic gains from the brain sciences always seems to be for the future, leading some to interrogate their contribution to advances in our field.⁶ Indeed, neuroscientists themselves have become more cautious about the value of reductionist approaches to understanding the nature of human thought, emotion and behaviour.^{7,8} Furthermore, there is ample evidence that anti-stigma campaigns based on biogenetic models of serious mental illness have been counterproductive.⁹

The increasing focus on neuroscience has meant that other important developments in the provision of care and support for people with mental health problems over the course of the past century have been neglected. Historically, these have been driven mostly by non-technical changes that have fostered empowerment and social inclusion.¹⁰ It is generally agreed that the closure of the large Victorian asylums improved patients' quality of life. But this was mainly the result of economic imperatives combined with a growing realisation of the negative effects of institutionalisation, rather than, as frequently suggested, a consequence of the introduction of new drugs.^{11,12} Other positive developments have resulted from the establishment of multidisciplinary, community-based care and the rise of the service user movement and

voluntary sector supports. Many psychiatrists have worked hard to promote these developments but the increasing focus on technical and biomedical aspects of care have served to sideline such efforts.

The technological paradigm

Since its origins in the asylums of the 19th century,¹³ psychiatry has faced a fundamental question: can a medicine of the mind work with the same epistemology as a medicine of the tissues? Through the 19th and 20th centuries, psychiatry held fast to the idea that mental health problems are best understood through a biomedical idiom; that problems with feelings, thoughts, behaviours and relationships can be fully grasped with the same sort of scientific tools that we use to investigate problems with our livers and lungs. In more recent decades, models of cognitive psychology, such as 'information processing', have been developed that work with the same technical idiom.¹⁴ The 'technological paradigm' that now guides psychiatry incorporates these perspectives, works with a positivist orientation¹⁵ and involves the following assumptions.

- Mental health problems arise from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual.
- These mechanisms or processes can be modelled in causal terms. They are not context-dependent.
- Technological interventions are instrumental and can be designed and studied independently of relationships and values.

In the technological paradigm, mental health problems can be mapped and categorised with the same causal logic used in the rest of medicine, and our interventions can be understood as a series of discrete treatments targeted at specific syndromes or symptoms. Relationships, meanings, values, cultural beliefs and practices are not ignored but become secondary in importance. This order of priorities is reflected in our understanding of the training needs of future psychiatrists, what gets published in journals, what topics are selected for analysis at conferences, the types of research that are promoted and how we conceptualise our relationship with the service user movement.

We suggest that this paradigm has not served psychiatry well. Ignoring fundamental epistemological issues at the heart of our

†See editorial, pp. 421-422, this issue.



General Assembly

Distr.: General
28 March 2017

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Human Rights Council

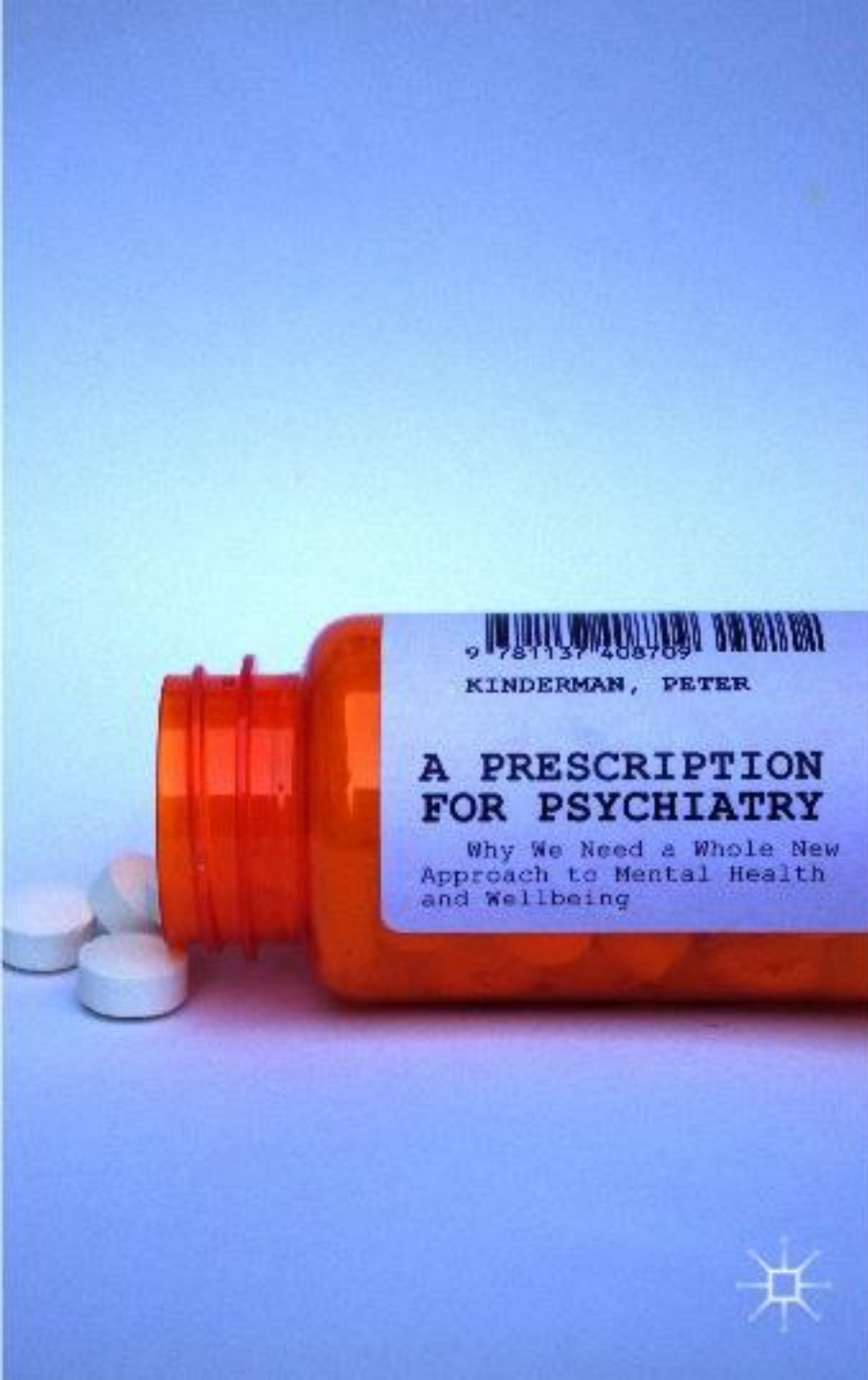
Thirty-fifth session

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

“The crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights. Mental health policies should address the “power imbalance” rather than “chemical imbalance”.

The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting “disorders”.





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Insight

Sarah Carpenter: cover artist 2018

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Non-diagnostic recording of mental health difficulties in ICD-11

In our previous Correspondence (Sept 1, 2017, p 664),¹ we recommended that mental health clinicians and policy makers routinely use ICD social codes to record psychosocial adversities known to be important determinants of our mental health. Despite arguments that traditional biomedical diagnoses ignore the social context and adversities survived by people who later report mental health problems,² supporters of diagnosis often suggest it is the only way to plan treatment and access services.³ Publication of the ICD-11, however, suggests that a more precise approach is within reach.

In addition to the social codes, ICD-11 contains the prototype of a system approximating the phenomenological approach to identifying mental health problems.⁴ Although offering a diagnosis of Moderate Personality Disorder (6D10.1) will remain possible, a clinician could instead record one or more adverse or traumatic experiences, and subsequent specific mental health difficulties. For example, personal history of sexual abuse (QE82.1), history of spouse or partner violence (QE51.1), and low income (QD51) leading (understandably) to anger (MB24.1), depressed mood (MB24.5), feelings of guilt (MB24.B), and non-suicidal self-injury (MB23.E). Any modern record system will use categorisation, but we can, and should, avoid unnecessary pathologisation and welcome methods that contribute to better clinical services. With clearer links to social inequity, this strategy would help establish a rights-based approach to care,⁵ and service users need not be given a diagnostic label, which many find unhelpful.

Although clinical formulation can be used to explore relationships between adversities and mental health difficulties, using ICD codes would allow national data capture of these links. Our understanding of these relationships is hampered

by focusing on heterogeneous diagnostic categories that correspond neither to biological nor psychosocial causal mechanisms.⁵ Capturing this data nationally would raise awareness of the specific impact of psychosocial adversities, and substantially develop the growing literature associating specific adversities with particular mental health difficulties, such as childhood sexual abuse and voice hearing. This data would improve clinical practice, particularly early intervention, by facilitating the development of care pathways that target particular trajectories of distress following specific adversities.

Such an approach meets the universal call for appropriate, internationally recognised, data collection and shared language use, and avoids the well known inadequacies of reliability and validity associated with traditional diagnoses. To extend, therefore, our earlier recommendation that clinicians use ICD social codes,¹ we further recommend that these phenomenological codes offer a constructive, radical way forwards.

We declare no competing interests.

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Health Policy

Child and adolescent mental health services in Europe

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A proposal to introduce formal recording of psychosocial adversities associated with mental health using ICD-10 codes

It is well known that poverty and social inequity are major determinants of our mental health,¹ and the United Nations Special Rapporteur² characterises mental health care not as a crisis of individual conditions, but as a crisis of social obstacles, which hinders individual rights.

It is important, therefore, that the circumstances that have given rise to distress should be formally recorded alongside the distress itself. Psychosocial codes, which are already part of both ICD-10 and DSM-5, incorporate descriptive information regarding adverse life experiences and living environments, but are almost never used or reported in clinical practice or academic publications. These quasi-diagnostic codes document neglect, abandonment, and other maltreatment (Y06 and Y07), homelessness, poverty, discrimination, and negative life events in childhood, including trauma (Z55-Z65), in ICD-10. DSM-5 includes V codes, mirroring ICD-10, including problems related to family upbringing, and housing and economic problems.

Broadening routine data capture within UK National Health Service records could establish more inclusive, social, systemic, and psychologically comprehensive patterns of difficulties, which could target information regarding established social determinants of mental health problems, such as inequality, poverty, and trauma. Imagine if it were as serious to fail to document extreme poverty as it would be for a clinician to fail to identify severe depression.

We do not expect that clinicians should resolve such difficulties; it is not the job of mental health professionals

to end poverty. Nevertheless, proper recording of psychosocial ICD and DSM codes in the context of psychiatric diagnoses is imperative because of the close relationship between the two. The UK government programme of reassessing disability benefits (relevant to codes Z59.7, insufficient social insurance and welfare support; and Z59.8, other problems related to housing and economic circumstances) using the Work Capability Assessment has been associated with an increase in suicides, mental health problems, and prescription of antidepressants.³ Transitions into poverty (relevant to codes Z59.1, inadequate housing; Z59.4, lack of adequate food; Z59.5, extreme poverty; and Z59.6, low income) have been associated with increased odds of children developing socioemotional behavioural difficulties,⁴ and individuals who have had an institutional upbringing (Z61.1, removal from home in childhood) are approximately 11 times more likely to experience paranoia compared with those with a less disrupted early history.⁵

As clinicians, we might be better able to serve our clients if we can use such data capture to apply more effective pressure on the political system and drive wider system reform. Such use of the existing and available psychosocial codes is presently very uncommon. We recommend it should become routine.

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ICD-11 (Mortality and Morbidity Statistics)

Search ?

Moderate Personality Disorder (6D10.1)

-

ICD-11 (Mortality and Morbidity Statistics)

Search



Moderate Personality Disorder (6D10.1)

Or...

Personal history of sexual abuse (QE82.1), History of spouse or partner violence (QE51.1), Low income (QD51), and Threat of job loss (QD82).

Leading (understandably) to:

Anger (MB24.1),
Depressed mood (MB24.5),
Feelings of guilt (MB24.B),
Non-suicidal self-injury (MB23.E)

ICD-11 (Mortality and Morbidity Statistics)

Search



Dimensions of external causes



▶ Additional aspects of mechanism

▼ Activity when injured

- ▶ XE545 Paid work
- ▶ XE8VF Unpaid work
- ▶ XE729 Educational activity
- ▶ XE38D Sports, recreation or leisure activity
- ▶ XE0E5 Being taken care of
- ▶ XE9GU Unspecified type of activity when injured

▶ Aspects of place of injury occurrence

▶ Objects or living things involved in causing injury

- ▶ Alcohol use in injury event
- ▶ Psychoactive drug use in injury event
- ▶ Aspects of transport injury events
- ▶ Aspects of sports injury events
- ▶ Aspects of occupational injury events

Foundation Id : <http://id.who.int/icd/entity/722188140>

QE31 Insufficient social welfare support

Parent

[Problems associated with social insurance or welfare](#)

Show all ancestors

All Index Terms

- Insufficient social welfare support
- insufficient welfare support
- inadequate welfare support

Hide index terms

OPI03

Using formulation in general psychiatric care: good practice

Good Practice Guidelines on the use of
psychological formulation

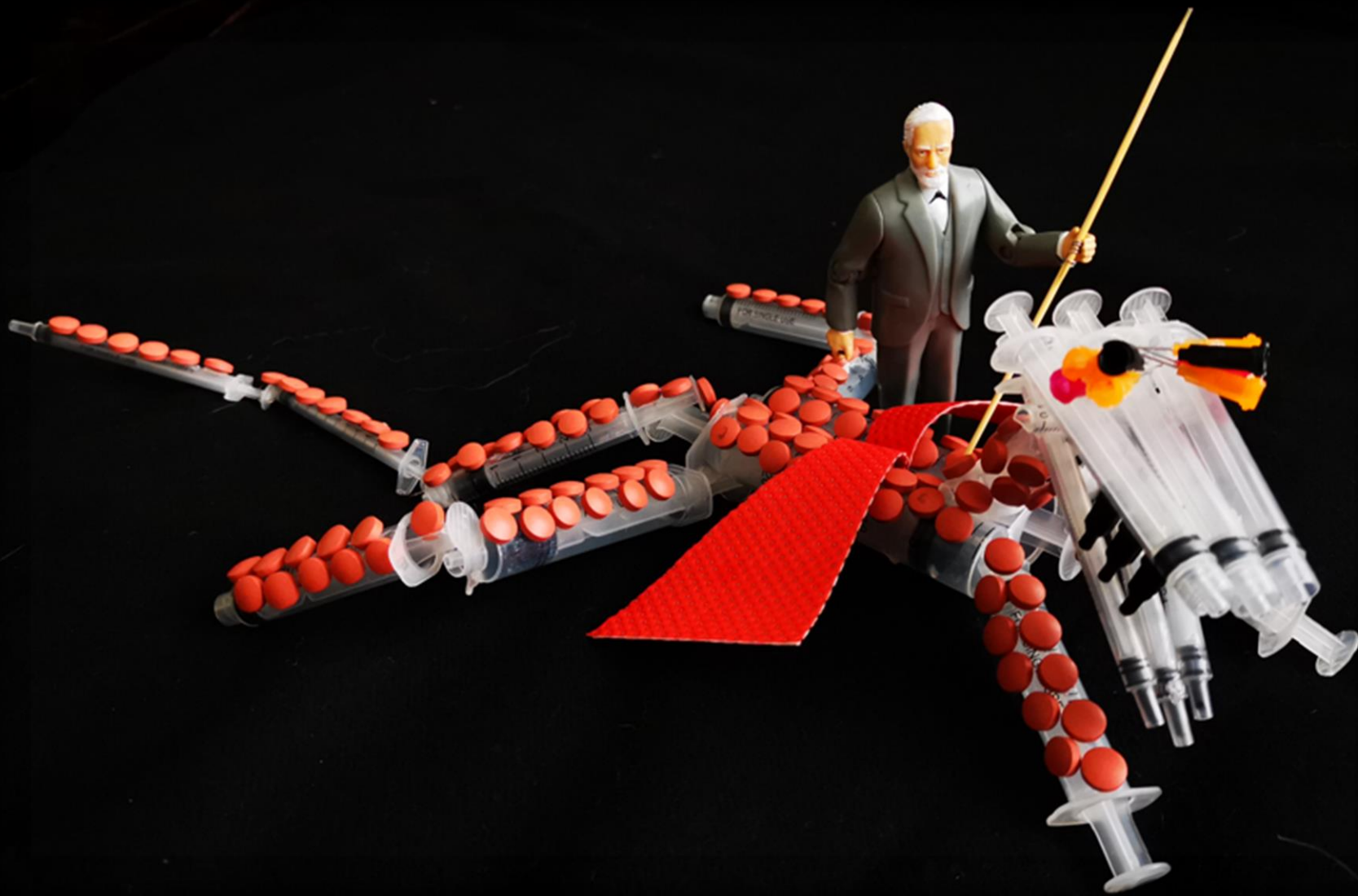
December 2011

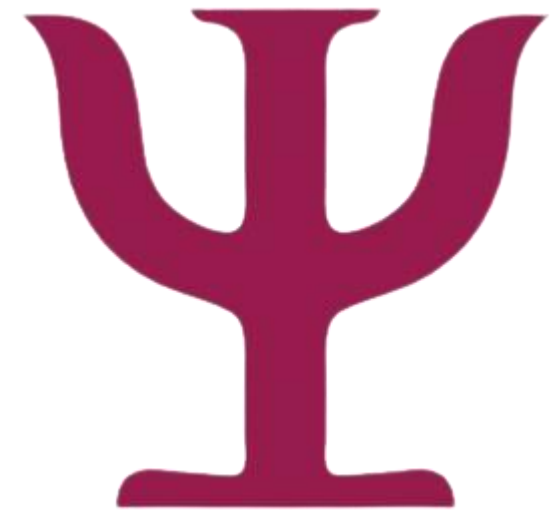
OCCASIONAL PAPER









A large, stylized maroon Greek letter Psi (Ψ) is centered in the lower right quadrant of the image. The background is split diagonally from the bottom-left to the top-right. The upper-left portion is a solid maroon color, while the lower-right portion is white. Two thin, parallel white lines run diagonally across the entire image, separating the maroon and white areas.