

From the Editor's desk

By Kamaldeep Bhui

**Disruptive transformations
to extend the reach and refine health systems**

The political climate has changed in the UK and USA following unanticipated results of two democratic votes by the public. Although there are fears about future prosperity, isolation, political extremism and the impact on healthcare, trade and collaborative ventures, there are also opportunities to re-examine assumptions and habits that have served us well. Political extremists express their opinions with greater confidence, but may not be unthinking in their decision-making.¹

So fears about resistance to new information should not be entertained or lead to reluctance to transform. The disruptive consequences may be harnessed for more successful patient outcomes if we can generate the necessary science and evidence to inform decisions. Indeed, some might argue that science that is motivated or delivered to aspire to more liberal values is not representative of the populations consuming the science, and that such a starting point may influence the methods, scientific questions and findings.² The message is that we should not fear new ideologies and propositions, no matter how radical they appear at first glance, but closely investigate their implications for developing more sustainable health, including mental health, care systems that are robust at times of recession and growing needs. Obama published an important paper on healthcare reforms in the USA.³ The starting point seemed like an impossible position of little comprehensive coverage, greater government spend on healthcare per head of population (compared with the UK), and seemingly expensive private healthcare plans for those wishing to exercise more choice than afforded them in publicly funded systems. This seemed like a radical and untenable solution to many. However, the impact reported between 2010 and 2015 tells a different story. Policy and legal reforms, despite opposition, skepticism and significant strain in health systems, led to greater coverage, quality and competition, which resulted in a reduction in costs of public-private health plans. A mixed economy of private and public-funded providers is now a reality in the UK. Might we use similar measures to drive down the costs and improve quality for the entire health system in the UK? One issue that deserves more action is premature mortality and a lack of parity in spend and policy. For example, although multiple reports on parity of esteem as a principle have influenced the Health and Social Care Act 2012, and the NHS Constitution and NHS Mandate 2014–15, concerns about a lack of evidence, political commitment, and resources in the short term mean there is no systems-wide action for more integrated training, services and policy.⁴ More disruptive innovation may be helpful.

In the UK, there are calls for a critical and radical rethink of health systems to ensure that their reach and coverage is

improved, while we refine and improve existing interventions, all at minimum, no or less cost. At the same time there are immediate concerns about insufficient medical, nursing and social care staff and a lack of appropriately resourced services, leading to rationing of non-urgent care and less choice than previously enjoyed. Several recent *BJPsych* research papers have responded to contemporary questions around proposed reforms and these should inform transformation plans in mental healthcare.^{5–9} Yet, much refinement of interventions is needed. This issue of the *BJPsych* reveals new findings that show the magnitude of the challenge and how we might improve the reach and refine existing mental health systems. For example, the coverage of mental health systems is inconsistent and very poor in some countries (Thornicroft *et al*, pp.119–124). Nutritional interventions appear to be helpful in reducing body mass index, and should be adopted, albeit there is a need for more pragmatic trials (Teasdale *et al*, pp.110–118). Heslin *et al* (pp.157–164) evaluate enhancements of care pathways including police contact; and depression screening and targeted feedback for cardiac patients improves depressive symptoms and self-management (Löwe *et al*, pp.132–139). New research includes evaluations of acceptance and commitment therapy for psychosis (Shawyer *et al*, pp.140–148) and democratic day hospitals for personality difficulties (Pearce *et al*, pp.149–156), and a new screening instrument for personality difficulties is tested by Zimmerman and colleagues (pp.165–166). Cortisol may be a good predictor of response to psychotherapy for depression (Fischer *et al*, pp.105–109), childhood maltreatment and emotional abuse are risks for chronic and treatment-resistant depression (Nelson *et al*, pp.96–104), and Andreas *et al* (pp.125–131) show that the prevalence of mental disorders among the elderly across Europe is much higher than previously reported, requiring better diagnostic processes and psychosocial interventions that accommodate variations of cognitive functions.

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BJPpsych

The British Journal of Psychiatry

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BJP 2017, 210:176.

Access the most recent version at DOI: [10.1192/bjp.210.2.176](https://doi.org/10.1192/bjp.210.2.176)

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