

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

- '1 in 4' prevalence for psychiatric disorder...or should that really be '1 in 3'? Parity of esteem in statistical headlines
- Further evidence for a role for the locus coeruleus in the aetiopathogenesis of dementia
- Sarcosine in the management of schizophrenia
- Author's reply
- Comment on 'The vulnerability paradox in global mental health and its applicability to suicide'

'1 in 4' prevalence for psychiatric disorder...or should that really be '1 in 3'? Parity of esteem in statistical headlines

Bebbington & McManus are to be thanked and congratulated for keeping this important and popular, but slippery, statistic under regular review and close-examination.¹ Their summary is likely to lead most readers to continue using the now well-known and oft-quoted '1 in 4' headline statistic for the overall prevalence of psychiatric disorders. They also rightly point out the twin dangers of over- and under-egging the statistic, risking lack of credibility and lack of impact, respectively.

However, I would suggest that the data presented comfortably allows for a new, revised '1 in 3' headline. This would not be overstating the case, but would simply accurately describe their findings. Their current '1 in 4' summary headline explicitly excludes 'personality and other disorders', as well as 'substance use disorders' and 'developmental disorders'...including them takes the true statistic to (very nearly) '1 in 3' (31.6%, to be precise).

There is now a long history of evidence and campaigning to have personality disorders recognised as 'bona-fide' mental disorders, with services developed and provided to match. Calls range from the 2003 National Institute for Mental Health in England 'Personality Disorder: no longer a diagnosis of exclusion',² through to the more recent 2018 consensus statement on personality disorder³ and the freshly released 2020 Royal College of Psychiatrists Position statement, 'Services for People Diagnosable with Personality Disorder'.⁴ They have always been in the ICD-10. Similar arguments and evidence could be made (ethically, on the grounds of stigma/parity, and scientifically) for the inclusion of the substance use disorders and developmental disorders that bring the final statistic to 1 in 3.

Presenting a new '1 in 3' headline would not be over-egging the evidence, but simply presenting the full findings of carefully conducted up-to-date research, thus promoting accurate, evidence-based societal perceptions of mental disorder, and subsequent policy decision-making. This is especially important given the limited traction so far gained in closing the gap between rhetoric and action with regard to 'parity of esteem for mental health'.⁵ The NHS Long Term Plan for Mental Health⁶ carries the potential for hope, but nothing should be taken for granted until it materialises.

In the meantime, we should advocate not excluding people with personality disorder (or substance use and developmental

disorders) from the headline statistics generated by good-quality research; statistical parity of esteem for all those with mental disorders would justify a new, revised, evidence-based and accurate '1 in 3' summary headline, which would be neither under-egged, nor over-egged, but 'just(-ly) right'.

Declaration of interest

I am an elected member of the Executive Committee of the General Adult Faculty, Royal College of Psychiatrists, and also work in an NHS general adult community mental health team that treats and supports people with a range of mental health problems, including personality disorders.

- 1 Bebbington P, McManus S. Revisiting the one in four: the prevalence of psychiatric disorder in the population of England 2000–2014. *Br J Psychiatry* 2020; **216**: 55–7.
- 2 National Institute for Mental Health in England. *Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder*. Department of Health, 2003.
- 3 Mind and others. "Shining lights in dark corners of people's lives" The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder. Mind, 2018. Availability from: <https://www.mind.org.uk/media-a/4408/consensus-statement-final.pdf>.
- 4 Royal College of Psychiatrists. *Services for People Diagnosable with Personality Disorder. PS01/20*. Royal College of Psychiatrists, 2020. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2
- 5 Moore A. The forgotten foundations: in core mental health services, no one can hear you scream. *BJPsych Bull* 2018; **42**: 225–8.
- 6 NHS England. *NHS Mental Health Implementation Plan 2019/20–2023/24*. NHS England, 2019. Available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf>

Andrew Moore, Consultant Psychiatrist, Devon Partnership Trust, UK. Email: andrew.moore7@nhs.net

doi:10.1192/bjp.2020.174

Further evidence for a role for the locus coeruleus in the aetiopathogenesis of dementia

We read with great interest the article by Peters et al, which provides a systematic review of changes in blood pressure, body mass index (BMI) and cholesterol levels in individuals that go on to develop all-cause dementia.¹ The authors find that a decrease in BMI and, in turn, blood pressure occurs well before the onset of dementia.¹ This finding, based on 13 longitudinal studies, adds to a confluence of evidence indicating that the locus coeruleus (meaning 'blue place' in Latin) plays a key role in the aetiopathogenesis of dementia.

The locus coeruleus serves as the major noradrenaline supplier to the brain. Via a ubiquitous network of projections, the locus coeruleus critically influences cognitive and affective processes together with physiological parameters such as heart rate, blood pressure, pupil size, sleep pattern, inflammation and stress. Neuropathologically, locus coeruleus degeneration is a hallmark of dementia, especially of those subtypes that are characterised by prion-like protein aggregates such as Alzheimer's disease, Down syndrome and Lewy body dementia, but not typically vascular dementia.² Importantly, neurofibrillary degeneration of locus coeruleus neurons seems to be an early event, and is closely linked to mild cognitive impairment and its progression to Alzheimer's disease.³ It is easy to envisage how cytopathology in the locus coeruleus might affect sympathetic output to the cardiovascular system via coeruleus-vasomotor and coeruleus-spinal pathways and, thus, cause a decrease in blood pressure.

Placing the findings of Peters et al¹ in the context of the neuropathology of neurodegenerative diseases raises several interesting issues. If the decrease in blood pressure is a risk factor and/or precursor for dementia, should we monitor blood pressure in our