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From the Editor's desk

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Unity and memory: the pathways to true research for better mental health

This week has seen memorials to war heroes in Europe. For a limited time, a visually powerful red sea of poppies surrounds the Tower of London as reminder of each of the 888 246 British fatalities in the First World War. The sea of red flowing throughout the moat is a moving reminder of lost soldiers but also of the impact of war on bereaved families. The *BJPsych* has published much research on veterans and their health, and the impact of conflict on population mental health. Sadly, such conflicts continue in some parts of the world and many of our publications include studies in conflict zones. The proceeds from the sale of the poppies from the display will go to six charities that provide financial support to veterans with a variety of life challenges and disabilities and poor mental health (poppies.hrp.org.uk/about-the-charities).[1–3] Although a very sad time for many, the history and memories of the past unite European nations in a commitment to peace and prosperity for all. In the UK, charities are an essential component of society and they support the provision of mental healthcare to meet the needs of socially excluded and marginalised groups. Charities also helpfully ground the efforts of public services and commissioners in human stories and the stark realities of living with mental illness. The exhibition is a visual symbol that has galvanised people from diverse backgrounds as they visit and remember. Charities try to fill the funding gap in the face of underinvestment and when public health spending is reduced.

Despite mental illness accounting for 23% of the burden of disease, a freedom of information request recently revealed that, among the 72 of 142 responding clinical commissioning groups in England less than 10% of their budgets are spent on mental health (www.mind.org.uk/news-campaigns/news/new-data-shows-profoundly-worrying-picture-of-underinvestment-in-mental-health). Similar concerns are expressed in other areas of the world, that there is underinvestment and a lack of early diagnosis and intervention.[4–6] As we approach a general election in the UK, party leaders recognise the importance of mental health to the economy and to society and there are promises of more funding despite the recession. And at this politically receptive time, mental health charities are leading through a coalition of organisations calling for mental health research to be a priority (www.amhrf.org.uk). This recognition of the importance of research is of pivotal significance as, historically, charities have been preoccupied by service delivery, more recently in driving policy and parity of esteem, often seeing research as a distraction. We still do not understand how to improve the quality of life of children of parents with severe mental illness.[7] Early intervention research still needs more investment to address new frontiers and research questions.[8] More research should focus on interventions to reduce premature mortality in people with mental illness.[9] And research in some fields, such as autism, is predominantly in high-income countries.[10] Human rights and ethical concerns abound in mental health research,[11] and the breadth of psychiatric research is exciting but methodologically challenging, with calls to form new movements in social neuroscience to integrate diverse disciplinary perspectives.[12] Yet there are real concerns about how research might actually influence the care of patients and public mental health. What role does scientific publishing play in this process? Worryingly, most published research turns out to not be true despite the tenacity and depth of the peer-review process.[13] A culture of replication and collaboration is among the solutions moving towards true research. The placebo effect is a powerful methodological concern that has not been sufficiently considered in trials (see Leuchter *et al*, pp. 443–449, this issue). And using citations as an indicator of impact and quality reveals that biomedicine and psychiatry are not among the top 100 publications,[14] and impact as measured by citations may not occur in the discipline from which research emerges but in other fields of study.

Facing a recession and diminishing health budgets has united the charities, mental health providers and research institutions. Research must also benefit high- and low-income countries and provide new, definitive evidence of more cost-effective interventions and systems of care that are robust to economic, cultural and geographical variations. *BJPsych* publications aim to meet this standard. Studies of vitamin supplementation in treatments for depression and for resolving vitamin D deficiency in patients with intellectual disabilities show significant benefit (Almeida *et al*, pp. 450–457, this issue, and Frighi *et al*, pp. 458–464, this issue). Livingstone *et al*'s review of dementia care (pp. 436–442, this issue) finds that person-centred care, communication skills training and dementia care mapping decreased symptomatic and severe agitation in care homes immediately and for up to 6 months; activities and music therapy decreased overall agitation; and sensory intervention decreased agitation immediately. A European study shows that recession alone does not explain higher suicide rates (Fountoulakis *et al*, pp. 486–496, this issue). Despite a strong correlation between suicide rates and most economic indices in men, there was only a correlation with unemployment in women, and the increase in suicide rates occurred several months before the economic crisis emerged. What might be driving both trends? Medical illnesses are more common in those with bipolar disorder (Forty *et al*, pp. 465–472, this issue). Partially explaining the premature mortality of people with mental illness, Mitchell and colleagues (pp. 428–435, this issue) show that mammography is less often provided for screening in women with mental illness, mood disorders and severe mental illness, with no evidence of disparity among women with distress alone. Savić & Belkić (pp. 425–427, this issue) show that organisational and individual cultural practices shape and determine the natural course of illness and offer potential interventions for work stress. Stigma continues to challenge political, social and health-spending decisions, yet never has there been a time when evidence is essential. We must remind the public, commissioners and politicians what is already known, and ensure that future research answers critical questions that have maximum impact on patient experience, outcomes and public mental health.

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