diagnostic criteria,[3,4] with comments such as: 'Well, there's definitely a bit of depression there' or 'She says she feels depressed'.

In a similar vein, 'paranoia' and 'paranoid' are often used by clinicians in their lay meaning of 'intense suspicion',[2] when the true psychiatric definition is 'delusional';[6] such ideation might involve purely grandiose or somatic themes. Despite this, one often sees 'paranoid' and 'persecutory' used synonymously. The subjective complaint of 'paranoia' is common in patients with neurotic presentations and personality disorders, and its inappropriate use in case notes without careful use of inverted commas, to signify a verbatim quote, risks inappropriate labelling of patients as psychotic and overtreatment with antipsychotics.

Next, the term 'psychosis' is increasingly used as a diagnosis – as if it were a singular disease for which specific treatments were indicated[7] – rather than the syndrome that it is. It can occur in organic, substance-induced or affective disorders, yet I contend that 'psychosis' is often used, lazily, as a euphemism for schizophrenia, by psychiatrists either ignorant of established diagnostic criteria[3,4] or wary of stigmatising their patients (as if one would happily tell guests at a dinner party that one was 'psychotic').

Most concerning, though, is the jargon that Timms includes in his own title: 'mental health'.[1] The assumption that 'mental health' and the oxymoronic 'mental health disorder' are synonymous with psychiatry and its diseases is quite erroneous. Psychiatry, as practised by psychiatric nurses and psychiatrists, was once charged with the management of patients with psychiatric diseases. But our colleagues are now mental health nurses and our departments mental health services. Far from relating to recognised diseases, the doublespeak 'mental health' has become synonymous with a vague and unattainable concept of complete emotional well-being. Consequently, an increasing fraction of our population, even a majority according to some reports,[8] young and old, are reported to have 'mental health problems'. The jargon underlying this explosion has set us and our entire healthcare system up to fail, through unrealistic public expectations and ever unmet need.

Let us be psychiatrists and psychiatric nurses once more; let us work in psychiatric services. Let us diagnose schizophrenia and depressive episodes using recognised criteria and be judicious in our use of potentially hazardous and costly treatments; most of all, let us avoid terms steeped in ambiguity.

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1 Timms P. A Devil's dictionary for mental health. *BJPsych Bull* 2017; **41**(5): 244–246.

2 Chambers Harrap. *The Chambers Dictionary* (13th edn). Chambers Harrap Publishers Ltd, 2014.

3 World Health Organization. *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. WHO, 1992.

4 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th edn). American Psychiatric Publishing, 2013.

5 Braithwaite R. Evidence suggests massive overdiagnosis and, by extrapolation, overprescription of antidepressants. *BMJ* 2014; **348**: g1436.

6 Hamilton M (ed). *Fish's Clinical Psychopathology* (2nd edn). Butterworth-Heinemann, 1985.

7 NHS Choices. *Psychosis – Treatment*. NHS Choices, 2016. Available at http://www.nhs.uk/Conditions/Psychosis/Pages/Treatment.aspx (accessed 3 October 2017).

8 Arie S. Simon Wessely: "Every time we have a mental health awareness week my spirits sink". *BMJ* 2017; **358**: j4305.

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Sharing quality and safety improvement work in the field of mental health

I welcome the findings of D'Lima, Crawford, Darzi and Archer[1] on the relative scarcity of publications related to mental health quality and safety improvement within reputable quality and safety journals.

I agree with the authors' proposition that there is increasing interest in the application of improvement science within the mental health field. A large number of providers of mental health services in the UK and beyond are now starting to apply quality improvement methods at scale. The Royal College of Psychiatrists has established a quality improvement committee over the past year, and has recently appointed its first quality improvement lead. There is also an organically growing global mental health improvement network (#MHimprove), which meets twice a year and has begun to present and share knowledge at large international conferences.

As both the College quality improvement lead and the lead for quality at East London NHS Foundation Trust (ELFT), with perhaps one of the largest improvement programmes in the world within mental health services, my experience agrees with the conclusion of the authors that publishing mental health improvement work within reputable quality and safety journals is a struggle. Our efforts to share real-world improvement work have largely been unsuccessful in the high-quality journals within this field. My theory, both as a submitting author and a reader of these journals, is that the journals are still focusing more on the research and evaluation end of the spectrum, as opposed to real-world, messy improvement work in mental health services.

As an example, the use of Shewhart (control) charts to demonstrate improvement over time, which is seen as best practice by improvers across the globe, is still frowned upon by journals (both subject-matter specialist journals and quality and safety journals), who prefer enumerative statistics in the form of pre- and post-comparison of averages. This jars with the real world of applied science, where there is no pre- and post-state, but a gradual and iterative transition, fuelled by multiple tests of change with increasing degree of belief and reliability in the change package.

Despite these challenges, ELFT has published approximately 15 peer-reviewed articles over the past 4 years and has

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3–4 articles continuously in the process of submission. All published papers are made available transparently to everyone through the ELFT quality improvement website (https://qi.elft.nhs.uk), which has now had over half a million hits in the past 3.5 years. Going even further, ELFT aims to share learning from all completed projects on its website, in acknowledgement of the fact that practising improvers and clinicians will always struggle to find time to publish all completed improvement work in peer-reviewed journals.

This brings me to the question: are journals still relevant in a world of fast-paced knowledge-sharing and acquisition, and with increasingly digital and connected networks? More than 500 leaders and clinicians from more than 50 different provider organisations have now been to visit ELFT to find out more first-hand about the quality improvement work taking place. At ELFT, we are also using the web and social media to share knowledge in real time and transparently with everyone, as we recognise our responsibility in helping to grow the field of knowledge within mental health improvement, and also to foster confidence in the use of quality improvement.

So, while my personal experience leads me to agree with the authors that publishing mental health improvement in journals remains challenging and often puts people off from even submitting, I would also suggest that there is much more active improvement work taking place and being shared by mental health services globally than might be apparent from looking at high-quality peer-reviewed journals alone.

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1 D'Lima D, Crawford M, Darzi A, Archer S 2017; Patient safety and quality of care in mental health: a world of its own? *BJPsych Bull* 2017. **41**(5): 241–243.

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