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reporting bias in treatment rankings. However, network meta-analysis does not make multiple comparisons that can be corrected in this way, and the study concerned<sup>5</sup> does not in fact demonstrate any bias, but only shows that the posterior distribution of rankings is sensitive to the pattern of data—hardly a surprising result.

In any case, conclusions on which treatment is best are never based on the posterior distribution of the ranks, which are notoriously unstable, but on the posterior expected effect size, which is what is reported in our study. Decisions based on imperfect evidence can always be wrong, but network meta-analysis is a method that helps identify the optimum decision in view of the evidence.

DMC is the developer of one of the versions of individual CBT that was shown to be efficacious. All other authors declare no competing interests.

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## Protecting the human rights of people who use psychedelics

In a recent Comment Ben Sessa<sup>1</sup> explained how the War on the Drugs worldwide has impeded development of psychiatric treatment with psychedelics such as LSD (lysergic acid diethylamide) and psilocybin (found in magic mushrooms). Prohibition also had negative outcomes for the millions of individuals who find it worthwhile to use psychedelics in various cultural settings outside of those in the clinic.

People have used psychedelics in spiritual practice for at least 5700 years, pre-dating all major organised religions.<sup>2</sup> 100 years ago, members of rival religious groups campaigned against Native American use of psychedelic peyote cactus.<sup>2</sup> However in the 1950s, concerned scientists used evidence and human rights arguments to defend peyote users, leading to legal exemptions for specific groups.<sup>2</sup> When psychedelics spread to the wider society in the 1960s, this was also acknowledged by religious scholars and governments as a spiritual movement (eg, the UK Home Office<sup>3</sup>).

Under the UN 1971 Convention on Psychotropic Substances, WHO has responsibility to evaluate international policy for psychedelic substances. The original WHO assessment said that psychedelics “are usually taken in the hope of inducing a mystical experience leading to a greater understanding of the users’ personal problems and of the universe”.<sup>4</sup> The WHO assessment did not cite a single example of harm from naturally-occurring psychedelics such as psilocybin or peyote, and cited only a handful of anecdotes related to LSD.<sup>4</sup> This was in no way an evidence-based harm assessment.

In the past 50 years, people are thought to have used at least half a

billion doses of psychedelic drugs. Psilocybin mushrooms and other psychedelics are legally sold in The Netherlands. Based on extensive human experience, it is generally acknowledged that psychedelics do not elicit addiction or compulsive use and that there is little evidence for an association between psychedelic use and birth defects, chromosome damage, lasting mental illness, or toxic effects to the brain or other body organs.<sup>2</sup> Although psychedelics can induce temporary confusion and emotional turmoil, hospitalisations and serious injuries are extremely rare.<sup>2</sup> Overall psychedelics are not particularly dangerous when compared with other common activities.<sup>2</sup>

In 2016 the UN will have a special meeting in New York to set the future for international drug policy. Former UN Secretary General Kofi Annan and the Global Commission on Drug Policy say that we must “Ensure that the international conventions are interpreted and/or revised to accommodate...decriminalisation and legal regulatory policies.”<sup>5</sup> National and international policies should respect the human rights of individuals who chose to use psychedelics as a spiritual, personal development, or cultural activity.

I am board leader of EmmaSofia, a non-profit organisation based in Oslo, Norway, working to increase access to quality-controlled MDMA (4-methylenedioxymethamphetamine) and psychedelics. I have received funding from the Research Council of Norway (grant 185924).

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For more on **EmmaSofia** see  
[www.emmasofia.org](http://www.emmasofia.org)

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## Why moving more should be promoted for severe mental illness

In their August 2014 Editorial, *The Lancet Psychiatry*<sup>1</sup> called for investigation into the best way to deliver exercise interventions in the multidisciplinary management of people with severe mental illness. We concur that the most important challenge to the effectiveness of exercise is adherence. We therefore advocate that the focus in this debate should not be on the most ideal dose–response (ie, efficacy), but on how people with severe mental illness might include such changes in their daily lives (ie, effectiveness).

Exercise is not a one-size-fits-all intervention.<sup>2</sup> Symptoms, previous exercise history, motivation, and access to services all effect the modality and intensity of exercise that individuals will undertake.<sup>3</sup> Inexperience with intense physical effort, associated fatigue and discomfort, increased risk of physical injuries, poor availability of exercise facilities and specialised equipment, and cost associated with access to facilities or training can all act as barriers for moderate to vigorous exercise.<sup>3</sup> For others, this type of activity might be ideal, supporting the need for access to trained clinicians

with expertise in exercise prescription and psychopathology.

We advocate that individuals who are unable or unwilling to meet the goal of 150 min of moderate physical activity could still benefit from engaging in some physical activity. Findings of a 2013 meta-analysis<sup>4</sup> of studies of the general population suggested that risk for premature mortality significantly increases when adults sit for more than 7 h a day, indicating that recommendations should be as broad as possible. Therefore, people with severe mental illness should be advised to sit less and to break up sitting time throughout the day rather than focusing on compliance with general population guidelines. Health-care professionals should take immediate action and advise patients to sit less and move more. For example, people with severe mental illness might be advised to reduce prolonged sitting by standing or strolling for 1–2 min at least once an hour. Advice on how to accumulate time spent in light physical activity could include getting up from the chair and moving around during television commercial breaks, or adding 5 min walks throughout the day, for example walking short distances rather than using motorised transport.

Although seemingly trivial, adopting small, incremental lifestyle changes can better position sedentary people with severe mental illness to transition to brief bouts of moderate intensity exercise.<sup>5</sup> Such an approach will not be constrained by socioeconomic, environmental, and organisational barriers. Implementation of such interventions requires a shift in culture and system reform, from the design

of mental health facilities through to changing staff attitudes. At a minimum, mental health professionals should briefly assess current exercise behaviours at every consultation, and discuss realistic and specific goals that could be adopted, with support and follow-up. Changes in physical and mental health parameters can then be monitored.

Health recommendations for the general population should not be discarded, but reframed as aspirational goals. Small incremental improvements—sitting less and moving more—constitute real-world interventions to improve the health of people with severe mental illness.

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