Highlights of this issue

BY MARY CANNON

COUNSELLING WORKS . . .

Counselling is often underestimated as a treatment for depression. Bedi *et al* (pp. 312–318) show that counselling is just as effective as antidepressant medication in treating depression over an 8-week period in a primary care setting. This study uses an interesting design – a partially randomised preference trial – whereby patients were either randomised or assigned to the treatment of their choice, if they had a strong preference. Surprisingly, having a preference for a particular treatment did not appear to confer any extra benefit in response. The authors point out that no particular psychotherapeutic model was employed in this study. The highly trained and experienced counsellors were allowed to adopt whatever approach they believed was most suitable for their patient.

. . . BUT SHARED CARE RECORDS DON'T

Shared care, which is the joint participation of general practitioners and hospitals in the planned delivery of patient care, is a good idea in theory but has not been found to improve outcome for chronic medical conditions. Warner *et al* (pp. 319–324) report on a randomised controlled evaluation of patient-held shared care records for individuals with severe mental illness. They found that carrying a shared care record did not significantly improve mental health or satisfaction with psychiatric services. Uptake of the scheme was low among both patients and professionals, and 40% of the patients reported losing their (passport-sized) shared care record at least once during the course of the study.

PREDICTING VIOLENCE – DIFFICULT BUT NOT IMPOSSIBLE

Dolan & Doyle (pp. 303–311) review recent developments in systematic violence risk assessment and conclude that violence risk prediction is still an inexact science. However, they stress that clinicians should be able to demonstrate the rationale behind their decisions on violence risk, and should be aware of the benefits and limitations of current assessment tools.

RISK OF SUICIDE

Predicting suicide is also a difficult task, as many psychosocial, psychiatric and biological factors may be involved. Reporting on a psychological autopsy study from Taiwan, Cheng *et al* (pp. 360–365) find five risk factors for suicide: major depression, emotionally unstable personality disorder, substance dependence, family history of suicidal behaviour, and loss events (particularly loss of a cherished idea). Stressful life events that did not involve an element of loss were not associated with suicide. At least we can forget about seasonal variation as a risk factor for suicide. Yip *et al* (pp. 366–369) speculate that mobile phones, e-mail and the internet may be partly responsible for the disappearance of the seasonal effect.

BRIGHTER PROSPECTS FOR DEPRESSION

How long does an episode of unipolar major depression last after we begin to treat it? Only 3 months on average, according to Furukawa *et al* (pp. 331–335) who report results from a Japanese cohort of 78 first-episode patients presenting to both in-patient and out-patient settings. Freemantle *et al* (pp. 292–302) advocate keeping the treatment of depression simple. Their meta-analysis shows that antidepressants selective for serotonin reuptake are just as effective as drugs that act on more than one pharmacological site.

SCHIZOPHRENIA – DEVELOPMENTAL OR DEGENERATIVE?

In support of a neurodevelopmental model of schizophrenia, Fannon *et al* (pp. 354–359) find that developmental delay in childhood is associated with cerebral ventricular enlargement at illness onset. Others hold that degenerative processes are also important in schizophrenia. Kelly *et al* (pp. 348–353) report a very high level of cognitive dysfunction among a community-based sample of patients with schizophrenia in Nithsdale, Scotland, with 81% of patients showing evidence of memory impairment. Older patients had poorer performance than younger patients. The authors speculate that a premature ageing process in schizophrenia, due to a variety of factors, can lead to accelerated cognitive decline.

THE CZAR SPEAKS

Professor Louis Appleby (pp. 290–291), the new mental health 'czar' (although he considers this a 'ludicrous' term), presents his vision for the future of mental health services in the UK, in the light of the National Service Framework and the National Plan for the National Health Service. He hopes that the Royal College of Psychiatrists will lead a debate about the role of psychiatrists in a modernised mental health service. What special skills do we have to justify our position as clinical leaders? Are we prepared to give up some areas of responsibility to support new nurse consultant posts? Should we demand more involvement in service planning and resource allocation? It remains to be seen how psychiatrists will rise to these challenges.

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