columns

7 November 2002. The meeting was a call to football professionals to endorse the use of sports psychologists.

Psychologists have received a cautious reception from sports professionals (Martin *et al*, 1997). Countries like Australia and the USA have been using psychologists in sports for decades. In the UK, developments have been slower, with important changes, such as the accreditation of the British Association of Sports and Exercise Sciences, happening in the late 80s.

The involvement of psychiatrists in sports has been more anonymous, as psychiatry not only carries a stigma but is also the antithesis of *Mens sana in corpore sano* (Carranza, 1999). Society perpetuates the problem by seeing sportsmen as highly-skilled entities, rather than primarily as human beings with strengths and weaknesses. Because of this, sports professionals in need of psychiatric help usually approach services as a last resort, during the final stages of their problem.

The FA strategy should be made extensive to other sports and, ideally, implemented at all levels. It would also be desirable to consider the inclusion in the strategy of professionals such as psychiatrists, who could play not only a therapeutic (Begel, 1992) but, equally important, a preventative role. Psychiatry can also complement psychology providing clinical input, or working together in a wider strategy towards changing behaviour in the public, and attitudes related to sport in society in general.

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Combination therapy

Bains and Nielssen (2003) discourage the combined prescription of a (conventional) depot antipsychotic preparation with oral atypical medications, on the grounds that there is 'no published research to support such a combination on theoretical or practical grounds'. The authors considered that 'use of atypical antipsychotics may be seen as a way of minimising distressing side-effects and also reducing the risk of developing tardive dyskinesia (by allowing the use of lower net doses of depot antipsychotic)'. Ultimately, however, they appear not to accept this approach, stating that 'none of the treating psychiatrists [in their study] offered this rationale for treatment'.

Combination therapy with an atypical antipsychotic agent can, in some poorly-compliant patients, represent the most viable way of ensuring the delivery of an effective dose of antipsychotic medication, while at the same time limiting (especially extrapyramidal) side-effects.

Moreover, some patients, while rejecting varying doses of depot antipsychotic medication, are more accepting of a fixed dose of the injected preparation, with temporary addiction of an oral agent, the dose of which can be easily adjusted according to mental state and requirements.

The scientific literature and professional guidelines recommend antipsychotic monotherapy. However, while it is accepted that this should be a standard principle in antipsychotic prescribing, there seems to be a – perhaps substantial – minority of patients for whom the combination of oral atypical and depot conventional antipsychotic appears to be more appropriate. The authors' apparent espousal of a blanket rejection of combination therapy is therefore unfortunate.

BAINS, J. S. & NIELSSEN, O. B. (2003) Combining depot antipsychotics in forensic patients: a practice in search of a principle. *Psychiatric Bulletin*, **27**, 14–16.

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Prevention in Psychiatry CR104, February 2002, 94 pp, £7.50 Summary

It is a truism that prevention is better than cure, yet preventive activities generally have low priority among interventions undertaken by psychiatrists. This report aims to provide psychiatrists and others involved in the promotion of mental health and the care of people with mental illnesses with an evidence-based approach to preventive interventions.

It begins with a background section, introducing concepts related to mental health promotion and the prevention of psychiatric disorders. Prevention is then considered in relation to the different stages of the life cycle, beginning in the womb and ending with the approach of death. Life cycle chapters are provided for the prenatal period and infancy; childhood, puberty and early adolescence; late adolescence and young adulthood; adulthood; older people; and the stage of approaching death. Account is taken of the fact that the influences acting at one stage of the life cycle will impact on the rates of disorder in later stages. Further, traumatic events such as physical or sexual abuse will impact not only on the individual concerned throughout the life cycle, but on subsequent generations.

Preventive activities are then considered in relation to the different settings in which they can take place. Settings considered include the neighbourhood and the community; early years provision, school and higher education; the workplace; residential care settings; the criminal justice system and prisons; primary care settings; the general hospital; and specialist psychiatric settings. In all of these, preventive activities relevant to psychiatric disorders need to be placed and maintained on the agenda, and the report provides practical, evidence-based information on how this may be achieved.

The Working Party has tried to keep the report brief and clear. To make the material more accessible, some information has been summarised and presented in the form of bullet points. A small number of key references to each section are provided for those readers wishing to pursue the subject further.

Domestic Violence

Council Report CR102 April 2002, £7.50. 44 pp.

This policy statement on domestic violence was produced by a working group under the chairmanship of Dr Gill Mezey. The following are the key points:

- Psychiatrists need to have a working knowledge of the aetiology, effects and range of interventions available for victims of domestic violence.
- Domestic violence, that is the physical, sexual or emotional abuse of an adult victim by an adult perpetrator in the context of an intimate relationship, occurs in around 23% of women and 15% of men over their lifetime.
- Women are more likely to sustain physical injuries than male victims, they are more likely to experience repeated assaults and they are more likely to report emotional distress or fear as a result of the violence.
- Domestic violence is associated with psychiatric illness, including depressive

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