BJPsych The British Journal of Psychiatry (2018)
212, A11. doi: 10.1192/bjp.2018.26

Highlights of this issue

By Derek K. Tracy

Hate to say I told you so

Would it surprise you to know that psychotic major depression has a similar point prevalence to schizophrenia? Figures vary between studies, but Margaret Heslin & Allan Young argue (pp. 131–133) that psychotic major depression is both underidentified and underresearched, particularly longer-term outcomes. The mood congruent nature of psychotic symptoms (for example delusional guilt) and individuals downplaying what they may recognise to be irrational thoughts can make psychotic major depression harder to detect, but there are data to show that it is associated with higher rates of attempted suicide than schizophrenia. Guidelines support treatment augmentation with antipsychotic medication, but the underpinning evidence base is weak, with little hard further data on dosages or duration.

van den Berg *et al* (pp. 180–182) consider post-traumatic stress disorder (PTSD) in those with psychotic illness. They present positive 1-year follow-up data on such individuals randomised to receive one of two active interventions – eye-movement desensitisation and reprocessing or prolonged exposure therapy – compared with waiting list. Although no gain was seen in terms of social functioning, the authors argue the long-term reduction in PTSD symptoms support the application of generic PTSD guidelines to those who also have psychoses.

From diagnostic breadth to narrowing: average changes in broad-symptom scales have been proposed to mask important individual symptom alterations, hindering the interpretation of trial data. Näslund and colleagues report (pp. 148–154) a patient-level mega-analysis on the critical and always controversial issue of the impact of selective serotonin reuptake inhibitor (SSRI) antidepressants on suicidality. They focus solely on changes in the suicidality item of the Hamilton Rating Scale for Depression (HRSD), using all Food and Drug Administration registered industry-sponsored placebo-controlled trials that used the HRSD – encapsulating over 8000 patients. This strategy is interesting as it overcomes a core challenge of retrospectively interpreting relatively infrequent but catastrophic events with multiple confounders, and SSRIs as a class had not previously been subjected to such an approach. Compared with placebo, SSRIs reduced suicidal ratings in those over the age of 24; in those under that age, there was no difference between the active and placebo interventions. Paddy McLaughlin & Rina Dutta discuss this further in this month's Mental Elf blog: https://elfi.sh/bjp-me12.

Main offender

Prison populations of women and girls are rising, currently estimated at almost three-quarters of a million globally. However, gender-sensitive understanding of their needs, including mental health, is commonly inadequate, especially as many have significant histories of past vulnerabilities and trauma, and prisons risk being retraumatising environments. Annie Bartlett & Sheila Hollins' editorial (pp. 134–136) notes how women have greater rates of mental illness, self-harm and suicide than male counterparts, accounting for about 5% of the UK prison population, but 50% of total incidents of self-harm. Given the demographics, prison estates are typically designed around men but the authors note how isolation from external social support is a particular risk factor for women. Positive initiatives to promote trauma-informed prisons and enhance prison staff training are noted, such as the 'One Small Thing' package.

Discussion on community treatment orders (CTOs) always attracts lively debate. The influential OCTET trial has published several data-sets arguing that they do not reduce readmission, although Tom Burn's talk at the 2016 International Congress labelling CTOs as 'ineffective but popular' captured a second aspect – some clinicians seem to like them. Trevithick *et al* (pp. 175–179) explore their usage in England in the 5 years following their introduction in 2009. Year on year their use increased from an initial figure of 6.4/100 000 population to 10.0/100 000 population. This equates to about 4000 uses per annum, or roughly 10% of those detained in hospital; interestingly local culture is crucial with a sixfold variation in CTO use across different hospitals. An independent review of the Mental Health Act is currently progressing, chaired by our past President, Sir Simon Wessely – I suspect both usage and effectiveness data will be on their radar.

Perhaps even more controversial is the issue of restraint in mental health settings. Analysis by Faisil Sethi and colleagues (pp. 137–141) notes how practice here has also been driven by local culture rather than any particular evidence, and they discuss the current international drive to minimise and limit use to the least restrictive form. In the UK, several sets of recent guidelines have called for a reduction or elimination of face-down prone restraint, but examination of National Health Service benchmarking data once again shows considerable national variation in practice. The authors note how there can be times when restraint is necessary, but the risk for causing direct harm and damaging therapeutic relationships means it must be considered an emergency intervention and subsequently adequately documented.

Well, well, well

Challenging behaviour occurs in an estimated 10–15% of adults with intellectual disability, and it is associated with adverse outcomes including longer in-patient admissions and – echoing the work of Sethi *et al* – more restrictive care. Hassiotis *et al* (pp. 161–168) undertook a multicentre cluster randomised controlled trial of the impact of staff training in positive behaviour support in community intellectual disability services. Compared with treatment as usual, positive behaviour support did not alter challenging behaviour over the 12-month follow-up period. Negative trial data can be disappointing but are crucial to informing our evidence base and practice; Kaleidoscope further reports (pp. 189–190) on two such negative outcome trials – one on stimulant medication in bipolar affective disorder and one on multisystemic therapy in adolescent antisocial behaviour.

Life expectancy in those with Down syndrome has significantly increased in recent years, but this comes with a considerable risk of developing Alzheimer's disease. As with the earlier mentioned challenge of antipsychotics in psychotic major depression, we have a limited evidence base on medication management of Alzheimer's disease in adults with Down syndrome. Eady *et al* (pp. 155–160) collected a naturalistic longitudinal follow-up data-set of over 300 such individuals in England. Median survival time was significantly greater for those on medication (both cholinesterase inhibitors and memantine), and pharmacological intervention showed an early gain in maintaining cognitive function. The data are promising, and appear comparable with the wider general population – the authors call for prospective work on early-phase illness.

Finally, Kaleidoscope weighs up the scientific literature, Horace's *Odes* and guidance from the Beatles, to at last answer the hoary question as to whether or not money brings happiness…

https://doi.org/10.1192/bjp.2018.26 Published online by Cambridge University Press