From the Editor's desk

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APOLITICAL PSYCHIATRY

Recently at a national conference I created a storm by saying that 'good psychiatry is apolitical' and that we were generally lucky in the UK in being allowed to practise the way we thought was best. My critics claimed I was living in some distorted false utopia and one went so far as to suggest that I be prevented from practising in psychiatric services until I came to my senses. My arguments are simple; good practice is based on evidence, and in the end, the softly spoken voice of good data will drown the foghorns of opinion and dogma, however loudly they are blasted from the rooftops. The trouble is that the voice of good data is distorted more in psychiatry than in other disciplines. Singh & Burns (2006), for example, point out that nobody seems to suggest that the excess of diabetes in South Asians is a consequence of institutional racism yet, despite contradictory evidence (Arseneault *et al*, 2004; Gudjonsson *et al*, 2004; Morgan *et al*, 2005*a*,*b*), many are very keen to promote this explanation for the higher proportion of African–Caribbeans who are compulsorily admitted to psychiatric hospitals and subjected to restraint. Politics fills the gap when evidence is poor, and it is our task at the *Journal* to keep politics out by getting the unequivocal evidence in, and allowing all hypotheses to have acceptable status (including ones such as institutional racism) until the good data are collected and indicate a clear path forward.

Some of the difficulties in getting good evidence are illustrated well in this issue. Adams *et al* (pp. 391–392) suggest an unusual paradox, that rich countries may practise less evidence-based treatment than poor ones. The evidence is collected mainly in rich countries and becomes widely disseminated but, whereas economic exigencies force poor countries into better practice (e.g. Chisholm *et al*, 2004), richer ones are blinded by 'clouds of dust from marketing' and have less clear vision. Impartial head-to-head comparisons of different drugs are often lacking and so we are pleased to note that the study of McCue *et al* (pp. 433–440), finding clear differences between the effects of five antipsychotic drugs in schizophreniform disorders, was free of pharmaceutical company influence. But this does not mean that good evidence from company-funded studies should be ignored, and I support absolutely the statement by Thase (2002) that 'although the funding source of a research finding should be considered when reviewing and interpreting the results of a study, hopefully our field has not become so jaded or cynical that all such work is rejected out of hand'.

The influence of selective reporting of drug effects has become a *cause célèbre* in the case of SSRIs in the treatment of child and adolescent depression. The clouds of unreported dust are now settling and Dubicka *et al* (pp. 393–398) suggest that drug-induced suicidal ideation is indeed present in this population but not to a large degree – I think we are getting close to a good final evidence base here. Other subjects are still in the early days of evidence gathering, often the most exciting phase, and it is good to report both the suggestion of the positive value of music therapy in schizophrenia (Talwar *et al*, pp. 405–409) and the caution the authors have exercised in extrapolating from one significant finding (p. 408), the sophisticated handling by Busse *et al* (pp. 399–404) of data suggesting that the progression of mild cognitive impairment to dementia is anything but an inexorable straight line, and two very different facets of the fuzzy polyhedron called the schizophrenia spectrum (Cannon *et al*, pp. 463–464; Van Rijn *et al*, pp. 459–460). These all illustrate the need to keep evidence floating in a transparent equilibrium oscillating between doubt and certainty, and free of political interference. We hope that this message will also be noted in the corridors of power when the value of crisis resolution teams is being discussed. The data of Glover *et al* (pp. 441–445) give some support to this initiative but their conclusions are hedged in provisos. It is puzzling that the greatest effect on admissions was in women aged between 35 and 64; is this the first independent evidence of the value of 'a right good natter'?

PODCASTS FOR THE *BRITISH JOURNAL OF PSYCHIATRY*

I am keen on growing broad beans but often miss the early crop that grows close to the ground and gets covered in splashings of earth. I have always thought of these as podcasts but now understand that the word has been hijacked as 'non-music audio broadcasts that have been converted to an MP3 file or other audio file format for playback in a digital music player'. The excitement of this new technology is now available on the Royal College of Psychiatrists' website (see 'what's new' on http://www.rcpsych.ac.uk), where selected authors are interviewed by Dr Raj Persaud about their work as it is published in the *Journal*. Why not try it?

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