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Highlights of this issue

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Bipolar disorder, substance misuse and specialist treatment

Bipolar disorder and substance misuse often occur together and complicate the treatment of either disorder. Post & Kalivas (pp. 172–176) review the role of stress in the co-occurrence of these disorders, demonstrating cross-sensitisation between, and increased reactivity to, recurrent stressors, episodes of illness and substance misuse. They suggest that the logical implication of their findings is a need for greater therapeutic focus on long-term prophylaxis, including stress immunisation and coping techniques, in younger people at risk of substance misuse or bipolar disorder. This should effect a reduction in the cross-sensitisation caused by any stress, episode of illness or substance misuse. The treatment of bipolar disorder at an earlier stage may improve the course of illness and the outcome. Given the devastating nature of the remitting and relapsing characteristic course of this illness, Kessing and colleagues (pp. 212–219) report the results of a trial comparing early specialist intervention with standard care. The specialist out-patient care included group psychoeducation and pharmacological treatment based on British Association of Psychopharmacology treatment guidelines. They found that the time to readmission was significantly increased in the specialised care group, compared with routine care, over a 6-year follow-up period. There was also a lower readmission rate for the specialised treatment group over this time. The authors conclude that early and sustained pharmacological and psychological treatment in a specialist clinic improves the long-term course of bipolar illness. An associated editorial by Vieta (pp. 170–171) advocates the integration of such specialist approaches within existing psychiatric services, for example by training community staff in specialist techniques.

Depression, dementia, social determinants and behavioural activation

Both affective disorder and dementia affect cognition and daily functioning. Meta-analyses have suggested that depressive illness doubles the risk of developing subsequent dementia. da Silva and colleagues (pp. 177–186) performed a systematic review to examine this relationship, confirming an increased risk of developing dementia in patients with affective disorders. Furthermore, they found that this association was modulated by the number of disease episodes, the severity of the depressive symptoms and the patient's gender. Interestingly, there was evidence that depressive illness may be both a prodromal state and also a risk factor for dementia; they highlight the need for a more detailed investigation of the shared pathophysiology of these disorders. The prevalence of depressive illness varies between different countries, and income inequalities have been suggested to contribute to these differences. Rai and colleagues (pp. 195–203) examined the socioeconomic determinants of depression in 53 different countries; the prevalence of depression varied between 0.4% in Vietnam and 15% in Morocco, but individual-level variables explained most of this variation. Female gender, being divorced, separated or widowed were associated with increased depression, and the risk of women being depressed was greater in higher-income countries. The latter finding could be interpreted in various ways, possibly reflecting an increased acknowledgement of the presence of depressive symptoms in more affluent countries, or reflecting changes secondary to traditional gender roles. The authors note that while country-level income was not related to depression, greater assets were protective against depression in all analyses; however, greater household spending was not protective, reflecting subtle differences in the indexing of affluence by these different measures. If there is variability in prevalence, could there also be potential variability in treatment response across different countries? Moradveisi *et al* (pp. 204–211) describe a comparative study of behavioural activation and standard treatment in Iran. They found that the behavioural activation demonstrated superior effectiveness compared with antidepressant therapy, especially in severe depression. The authors highlight the fact that this relatively simple intervention achieved results in routine practice settings in Iran analagous to those observed in Western countries.

Reducing readmissions and cost-effectiveness of IAPT

Admission to hospital for psychiatric illness is an intrusive and costly intervention; a rapid readmission after discharge from a period of in-patient care is a very negative outcome. Vigod *et al* (pp. 187–194) review interventions to prevent such early readmission and conclude that psychoeducation focused on disease management, and structured needs assessment prior to discharge were significantly likely to reduce readmission. Similarly, pre-discharge medication education, post-discharge telephone follow-up, timely liaison between in-patient and community staff, and peer support were also found to be effective components of care. The authors suggest that structured implementation of appropriate pre-discharge, post-discharge and bridging interventions are likely to reduce readmission rates. The Improving Access to Psychological Therapies (IAPT) initiative for common mental health disorders such as anxiety and depression has been implemented across England over the past few years. Mukuria *et al* (pp. 220–227) report that there were no significant differences in patient outcomes between their IAPT site and the comparator sites at 4- and 8-month follow-up. The IAPT site costs were greater than the other sites, but not significantly so, and the authors suggest that cost–benefit analyses from other sites would be necessary to clarify the debate about cost-effectiveness of such services.

Psychiatry recruitment

Over the past few years there has been a perception that fewer doctors are attracted to psychiatry as a career. Goldacre *et al* (pp. 228–234) report that the number of doctors choosing psychiatry as a career has remained relatively stable around 4% over the past few decades. Experience of psychiatry as a student and during early medical training were important determinants of making this career choice. They also highlight a relative decrease in the proportion of women choosing psychiatry as a career over this time. An accompanying editorial by Davies (pp. 163–165) reviews the wider implications for the imbalance in the workplace, if a stable proportion of medical graduates continues to select psychiatry as a career, but in the context of an expansion of consultant posts over the past few years. He suggests that rather than increasing recruitment at the cost of quality, the future may lie in actually raising the entry threshold to a smaller number of training posts, allied to an enhanced focus on core values based on delivering the biomedical component of specialist mental healthcare.