The data on atypical antipsychotic drugs, weight gain and metabolic dysregulation come from a heterogeneous collection of largely uncontrolled studies, but there is no doubt that these drugs induce weight gain and that some are worse than others. 'First do no harm'. There can be no justification for continuing to prescribe particular atypical antipsychotic drugs which cause serious weight gain to a population who are already at high risk of cardiovascular disease. Equally effective alternatives are readily available and are no more expensive. Obesity increases cardiovascular mortality by 50% (McGee, 2005). We must stop regarding weight gain as an acceptable price to pay for control of psychiatric symptoms.

Declaration of interest

S.B. has attended many educational functions supported by pharmaceutical companies but has no other links with the pharmaceutical industry.

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Akathisia as a risk factor for suicide

Hawton *et al* (2005) have produced a comprehensive, systematic review of risk factors for suicide in schizophrenia. The study questions the fundamental procedures that are an integral part of our clinical assessment of this vulnerable group of patients. Suicide is notoriously difficult to predict because of the rarity of the event, the obvious ethical problems of designing informative studies and the uncertainty about risk factors. However, although there is no study of akathisia and suicide that fulfils their strict inclusion criteria, there is more research available than the case reports mentioned (for example, Chow *et al*, 1997; Hansen, 2001; Hansen *et al*, 2004). We found no association between akathisia and suicidality in a group of 90 patients with treatment-resistant schizophrenia (Hansen *et al*, 2004). Akathisia may, however, have a very different impact on patients at different stages of their illness and according to the duration of treatment. Akathisia emerging early in treatment or after increases in dosages may be the more malignant in terms of distress.

Hawton *et al* also identified agitation (motor restlessness), impulsivity and depression as risk factors but not akathisia. However, akathisia could contribute to or be confused with any of these three identified risk factors.

There is also evidence that akathisia can occur as a consequence of antidepressant treatment, which is common in patients with schizophrenia (Muller-Oerlinghausen & Berghofer, 1999; Hansen & Wilkinson, 2001). Whether there is an additive effect of antipsychotic and antidepressant medication on the intensity and duration of akathisia is not yet known. None the less, in our opinion, it would be premature to exclude akathisia from a role in the complex web of factors that lead to suicide in schizophrenia and perhaps also in other conditions.

Chow, L. Y., Chung, D., Leung, V., *et al* (1997) Suicide attempt due to metoclopramide-induced akathisia. *International Journal of Clinical Practice*, **51**, 330–331.

Hansen, L. (2001) A critical review of akathisia – and its possible association with suicidal behaviour. *Human Psychopharmacology*, **16**, 495–505.

Hansen, L. & Wilkinson, D. (2001) Drug induced akathisia, suicidal ideation and its treatment in the elderly. *International Journal of Geriatric Psychiatry*, **9**, 231–233.

Hansen, L., Jones, R. & Kingdon, D. (2004) No association between akathisia or parkinsonism and suicidality in treatment resistant schizophrenia. *Journal of Psychopharmacology*, **18**, 384–387.

Hawton, K., Sutton, L., Haw, C., *et al* (2005) Schizophrenia and suicide: systematic review of risk factors. *British Journal of Psychiatry*, **187**, 9–20.

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Brief psychotherapy for Alzheimer's disease

I read with interest the paper by Burns *et al* (2005). This study into an under-researched and important matter is welcome. However, I would like to comment on the conclusions.

The authors quite appropriately comment that the lack of any *quantifiable* effect of their psychotherapy could result from the small sample size or the relative insensitivity of the outcome measures. They present qualitative data on participants' experience of the psychotherapy which show the therapy in a positive light. The collection of these data was highly biased, since participants in the 'standard care' arm of the trial were not asked about *their* experience of their treatment. In addition, these patients were not followed-up in the same way as those receiving the therapy. I suspect that if multidisciplinary, holistic care were being provided as it should, these patients would have made equally positive comments about their community psychiatric nurse, social worker, psychiatrist or general practitioner.

The authors of this study have neither devised the adapted therapy (this was described by Brierley *et al*, 2003), nor have they shown that the therapy works. Hence I disagree with the authors' main conclusion that 'this study shows it is possible to adapt a model of psychotherapy for those with Alzheimer's disease'. They have none the less presented some interesting preliminary data, suggesting a potential benefit of the therapy. I look forward to further research in this area.

Brierley, E., Guthrie, E., Busby, C., *et al* (2003) Psychodynamic interpersonal therapy for early Alzheimer's disease. *British Journal of Psychotherapy*, **19**, 435–446.

Burns, A., Guthrie, E., Marino-Francis, F., *et al* (2005) Brief psychotherapy in Alzheimer's disease. Randomised controlled trial. *British Journal of Psychiatry*, **187**, 143–147.

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Author's reply: Dr White has raised some important points. The qualitative data on the participants' experience was only a tiny part of the study and, although agreeing with the points made, I feel they are hardly relevant to the main thrust of the work. Dr White is correct that we did not devise

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the adapted therapy, but we did adapt the devised therapy, and superficial scrutiny of the authors on both the papers cited will attest to this. We stand by our conclusion that the model can be adapted and that, at least in part, it works. This is more than anyone else has ever done in this field, and one could only agree with Dr White's comment about future research in this area.

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Call for a European Guidelines Institute

The guideline assessment by Gaebel *et al* (2005) has been long overdue. Whereas there was originally quite a bit of scepticism about guidelines in psychiatry, there now appears to be a sort of 'guidelines mania', as each European national association tries to produce its own guidelines. We have recently completed an assessment of even more (n=61) guidelines, which was not limited to schizophrenia but focused on European psychiatric guidelines. Although our results were similar – the general quality of the guidelines was medium grade, although there were some of outstanding quality – we arrived at somewhat different conclusions.

By amending the AGREE instrument (AGREE Collaboration, 2003) with an additional item, we found that national particularities were very rarely considered by European psychiatric guidelines (18%), and then only very vaguely. This is not surprising, since the evidence available for guidelines is almost always of an international nature. There are hardly any treatment studies focusing specifically on national subgroups. Therefore the evidence underlying the guidelines must always be the same *per se*. Given the enormous expenditure of time and money that is necessary to develop a methodologically sound guideline, we strongly advocate the establishment of a European Guidelines Institute. It could then be the task of the national associations to adapt guidelines to the specific conditions of their own countries. Such a procedure could improve the quality of most national guidelines and foster the ongoing standardisation of European medical care.

AGREE Collaboration (2003) Development and validation of an international guidelines appraisal instrument for assessing the quality of clinical practice guidelines: the AGREE project. *Quality and Safety in Health Care*, **12**, 18–23.

Gaebel, W., Weinmann, S., Sartorius, N., *et al* (2005) Schizophrenia practice guidelines: international survey and comparison. *British Journal of Psychiatry*, **187**, 248–255.

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Authors' reply: Leucht *et al* agree with us that specific national conditions are rarely considered by practice guidelines. This is not surprising because the evidence available for guidelines is almost always of an international nature. However, in our view not all guidelines share or should share the same evidence. Those developing guidelines may ask different clinical questions and may consider different interventions or outcomes as relevant. This is not a methodological problem of guidelines.

Furthermore, methodologically sound qualitative evidence such as consumer preference studies may be used by guideline developers; this may be restricted to certain regions or nations. It is certainly of concern, however, that the external validity of the available study evidence is rarely evaluated. There are also few efforts to analyse minority ethnic or other subgroups within multicentre studies or to run effectiveness studies in non-Western countries. Of the 5000 randomised controlled trials (RCTs) in the database of the Cochrane Schizophrenia Group, 80% are from Western countries (Moll *et al*, 2003). The American Psychiatric Association's 1997 clinical practice guideline for schizophrenia does not provide any information regarding potentially different outcomes for minority ethnic groups included in the RCTs from the USA (U.S. Department of Health & Human Services, 2001).

It is not obvious to us that a European Guidelines Institute would be of great help or would be accepted as a legitimate developer of guidelines. During the development of guidelines many decisions must be made at an early stage by national consensus groups with the contribution of key stakeholders. In our survey most respondents preferred to develop national guidelines with the help of international experts or to share experiences or data with other guideline developers. In our view, evidence concerning efficacy and risk of specific interventions could be reviewed by an international group in order to develop core recommendations that could be adapted by those developing national or local guidelines. For this purpose activities have been started within the World Psychiatric Association (WPA). However, the adaptation of available evidence to local circumstances is an important national or regional duty in guideline development.

Declaration of interest

W.G. is Chairman of the Section on Schizophrenia of the WPA and Chairman of the Section on Guideline Development of the German Society of Psychiatry, Psychotherapy and Nervous Diseases (DGPPN). S.W. is involved in the revision of the schizophrenia practice guideline of the DGPPN.

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U.S. Department of Health & Human Services (2001) *Mental Health: Culture, Race, Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services. http://www.mentalhealth.samhsa.gov/cre/default.asp

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