

Highlights of this issue

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REFERRAL, REHABILITATION AND TREATMENT RESPONSE

Over recent years it has become possible for general practitioners (GPs) to refer patients with common mental disorders to community mental health nurses and some previous studies have questioned the cost-effectiveness of this approach. Kendrick and colleagues (pp. 50–59) have demonstrated that there were no significant symptomatic benefits to patients referred to community mental health nurses. They used a randomised controlled trial with two different nursing interventions, a generic and a problem-solving technique, which were compared with a control arm (treatment as usual by the GP). They concluded that community mental health nurses should not be referred unselected patients with mental disorder and that problem-solving treatment should be reserved for patients with at least moderately severe depressive illness. At the other end of the patient journey, most people with severe mental illness would like to work, but very few actually do. Latimer *et al* (pp. 65–73) describe the advantages of implementing an individual placement and support model of supported employment. In a randomised controlled trial of supported employment compared with standard vocational training, they demonstrated that it was feasible to increase time spent in employment by using a dedicated employment specialist within the clinical service. Although the duration of untreated psychotic illness has been demonstrated to affect treatment outcome, this has not previously been confirmed for common mental disorders. Kisely and colleagues (pp. 79–80) report that a longer duration of untreated illness presenting to primary care, even in the case of anxiety and depressive disorders, is associated with poorer outcome and response to treatment. In patients presenting with their first episode of psychotic illness, response

to treatment is related to level of premorbid functioning. Rabinowitz *et al* (pp. 31–35) showed that good premorbid functioning was related not only to better outcome, but also to using lower doses of medication. They suggest that these features might be used in planning treatment, with earlier consideration of clozapine for patients with poor premorbid functioning.

BIPOLAR DISORDER, NEURODEVELOPMENT, IMAGING AND COMORBIDITY

While genetic factors are undoubtedly important in the aetiology of bipolar disorder, environmental factors may also be relevant. It has been suggested that exposure to obstetric complications may increase the risk of developing bipolar disorder; Scott *et al* (pp. 3–11) report that a systematic review of the literature does not support this hypothesis. However, they did find that some adversity *in utero*, especially during the second trimester, may increase the risk of adult unipolar mood disorder. A structural neuroimaging study of patients with bipolar disorder demonstrated decreased temporal lobe volumes compared with controls. El-Badri and colleagues (pp. 81–82) suggest that this could be associated with decreased grey matter density but was less likely to be due to decreased amygdala or hippocampal volume and was not related to a generalised cerebral atrophy or to significant enlargement of the lateral ventricles. They also reported a non-significant increase in white matter intensities in the patients. High rates of anxiety disorders have been noted among people with bipolar disorder and, over a 1-year follow-up, Otto *et al* (pp. 20–25) found that those with comorbid anxiety disorders had a poorer outcome. Even euthymic patients with anxiety disorders were more likely to relapse. They suggest that treatment of such

anxiety disorders may be useful in improving outcomes in these individuals.

PSYCHOLOGICAL THERAPY IN PSYCHOSIS AND PERSONALITY DISORDER

It is accepted that psychological treatment, particularly cognitive-behavioural therapy (CBT), is useful in treating the symptoms of schizophrenia. There is an unanswered question, common to many treatment studies, including those using pharmacological therapies, regarding the likely impact of the intervention in the real world, with less-selected patients and with non-specialist therapists. Turkington *et al* (pp. 36–40) demonstrated that it is possible to train community mental health nurses, within a short time, to provide brief CBT to good effect. Patients receiving CBT showed improvements in insight, negative symptoms and delayed time to admission and duration of admission. They note the lack of significant effects on psychotic symptoms or occupational recovery and the limitations of not having an active comparator and of the nurses not being members of local and community mental health teams. Following-up previous work on the usefulness of family therapy in schizophrenia, Chien *et al* (pp. 41–49) showed the benefits of mutual support groups for the families of patients with schizophrenia, which excluded the patients themselves. Interestingly, they had better outcomes than both the psychoeducation group, which included both patients and family members, and the usual care group. The mutual support groups were run by nurses and linked to the out-patient service; this model could easily be incorporated into current services and is already in use by some in the UK (e.g. the National Psychosis Unit). Emmelkamp and colleagues (pp. 60–64) compared CBT and brief dynamic psychotherapy in the out-patient treatment of people with avoidant personality disorder. They found CBT to be more effective than both dynamic therapy and the waiting-list control. Dynamic therapy did not differ from a waiting-list control on the primary outcome measures, although it did demonstrate some advantage on secondary measures. The benefits of treatment and the between-group effects were still present at 6-month follow-up.