

Highlights of this issue

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Pathways between waking and sleep

Care pathways for mental health are becoming a more obvious piece of the regulatory landscape. Theoretically, they encompass a sequence of steps for clinical care of a particular group of patients, which can then be used to calculate typical costs for an episode of treatment. Evans-Lacko and colleagues (pp.4–5) discuss their evolution from within managed care settings in the USA to their current incarnation as potential indicators suitable for use in the 'payment by results' scheme in the UK. Their benefits are suggested to include improvements in the efficiency and quality of care, although there appears to be limited evidence to support this view. Of particular interest is that when applied in the UK, the optimal care pathway has been more costly than the actual costs associated with using services.

A call for the psychiatric profession to wake up has been sounded by a special article which highlights the perceived downgrading of the importance of medical aspects of psychiatric care, particularly in the context of an improved focus on psychosocial care for people with mental illness. Craddock *et al* (pp.6–9) distinguish between the mild psychiatric symptoms which can be managed by general services, perhaps by professionals outside psychiatry, and those severe mental illnesses which require a medical assessment, formal diagnosis, the implementation of evidence-based treatment and monitoring of mental state and physical morbidity. They argue that where the general practitioner is unclear about diagnosis or treatment, the patient should always be seen by a psychiatrist. They contrast this approach with the model proposed in *New Ways of Working*, advocated by the National Institute for Mental Health in England and the Royal College of Psychiatrists, which permits a patient to enter secondary care without necessarily having been seen by a psychiatrist, or being seen only if concerns are identified by another team member. They invoke Reil's original suggestion when first using the term 'psychiatry' (the basis of an editorial by Marneros, pp.1–3) that psychiatry is the only specialty where the doctors are fully trained – incorporating an awareness of psychological and sociological aspects of the person into their medical knowledge. In concluding, they welcome the advent of multidisciplinary care in managing psychiatric illness, but caution against the risks of moving away from biomedical approaches: the possible marginalisation of patients, and a failure to translate neuroscientific knowledge into benefits for patients. One example of the latter is a study of brain dopamine in response to opioid administration. Although opioids are addictive, they are sedative rather than arousing, unlike stimulant drugs. It has been suggested that all drugs of abuse may act through cortical reward systems, particularly the dopamine system. However, Daghli *et al* (pp.65–72) found that although opioid injection enhanced subjective pleasure and produced physiological changes, these were not associated with any change in dopamine binding. They conclude that dopamine may not have the same role in heroin addiction as it does in stimulant use.

Structured assessment of risk and CBT

Risk assessment has become a routine part of clinical assessment. Aberhalden and colleagues (pp.44–50) demonstrate the benefits of frequent risk assessment during the early phase of acute psychiatric admission in producing a 41% reduction in aggressive incidents and a 27% reduction in the use of coercive measures. They suggest that the use of a structured assessment, yielding a simple risk classification system and allied to discussion and implementation of preventive measures and plans, is simple to implement and effective in reducing violence on in-patient units. Sumathipala *et al* (pp.51–59) used cognitive-behavioural therapy (CBT) in patients with medically unexplained symptoms, compared with structured care, to examine the specificity of an earlier pilot CBT study showing positive results. They found no differences between their groups, with both showing improvement from baseline measures. They conclude that some element of the structured care also provides the beneficial aspect evident in the CBT. This leads on to the testing question: what is the optimal method of assessing the quality of clinical skills or competencies? Keen & Freeston (pp.60–64) examined the reliability of three different tools – essays, case studies and videotapes – in assessing CBT competencies in trainees attending a diploma course. Intriguingly, they found the essays, the least obvious practical demonstration of skills, to be the most reliable, followed by case studies; assessment of videotapes was the least reliable. They conclude that standard examination procedures used by universities for such postgraduate courses have low reliability, thus reducing their validity. One way forward may be to implement the approach adopted by medical schools who favour the use of objective structured clinical examinations, which have been shown to improve reliability.

Tourette syndrome; ethnicity and psychosis

Tourette syndrome is a perplexing, heterogeneous disorder characterised by multiple tics and considerable comorbidity with both attention-deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD). Robertson *et al* (pp.31–36) performed a factor analysis of the symptoms and signs in 410 patients with Tourette syndrome to clarify the phenotype. They observed five main factors, with socially inappropriate behaviours (including coprophenomena, echophenomena and paliphenomena), complex vocal tics and simple tics co-occurring with ADHD, whereas OCD was associated with these and with complex motor tics and compulsive behaviours. The conclusion is that better characterisation of the phenotype may help clarify any susceptibility genes for the disorder. There is an established association between increased prevalence of psychosis and minority ethnicity. Kirkbride *et al* (pp.18–24) demonstrated that this association remained significant even after covarying for the effects of age, gender and socio-economic status. They found that the rates of psychosis were higher in White minority ethnic groups, as well as Black Caribbean, Black African and Indian groups. They suggest that schizophrenia does not occur equally among all people and in all places, and increased resources may be needed to cope with an increased incidence of psychosis in the UK, which has recently experienced elevated levels of migration from the new European Union entrants.