

Highlights of this issue

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SUICIDE AND VIOLENCE

There is a lot of concern about whether psychiatrists can predict suicide and violence in their patients, therefore any research that provides guidance, usually at an epidemiological level, is useful. In this issue, Lorant *et al* (pp. 49–54) found that men were at higher risk of suicide when they had a low level of educational attainment. This study, across ten European countries, did not find the same to be true for women, and found an increased risk of suicide to be associated with greater socio-economic disadvantage. The authors suggest that psychiatric disorders seem to be an important pathway between socio-economic status and suicide; thus, improving the access of people within lower socio-economic groups to psychiatric services may contribute to reducing socio-economic inequalities in suicide. Patients with schizophrenia have a significantly increased lifetime risk of suicide. In a systematic review of the risk factors of suicide in schizophrenia, Hawton *et al* (pp. 9–20) found that higher risk was associated with previous depressive or suicidal episodes, recent loss, drug misuse, non-adherence with treatment and increased agitation and fear of mental disintegration. Somewhat unexpectedly, lower risk was associated with the presence of auditory hallucinations. They propose that more attention should be focused on the treatment of affective symptoms, high-risk periods such as those following loss events and improving adherence, rather than core symptoms of schizophrenia per se. Psychiatrists should be aware of the Zero Tolerance Zone Campaign launched by the British government to reduce the number of violent episodes occurring in the National Health Service. An integral part of the initiative makes the case for withdrawing the duty of care from patients who are persistently violent. However, there is a caveat that this should not be applied to

anyone who is mentally ill or under the influence of alcohol and drugs. Behr *et al* (pp. 7–8) examine the issues raised by this policy for both the care of psychiatric patients and the safety of the staff caring for them. They question why being under the influence of drugs or alcohol is an exclusion criterion for this policy, but an offence such as drinking and driving, committed under the influence of alcohol, is treated entirely differently. They discuss the role of competence in mental illness and the impact of accepting responsibility for behaviour, suggesting that clinical ethics committees may be in a position to help frame more appropriate guidance, at a local level, for patients in contact with mental health services.

OUTCOME RELATED TO CRISIS TEAMS AND SELF-HELP INFORMATION

Community care has become the mainstay of psychiatric service provision in the UK. However, the optimal mix of services remains contentious. Johnson *et al* (pp. 68–75) examine the effects of introduction of a crisis resolution team (CRT). Such teams are dedicated to providing short-term intensive home treatment and are being deployed nationally as part of current policy. In a comparison of data before and after the introduction of a CRT, admission rates fell significantly in the 6 weeks following introduction of the team and patients reported better satisfaction with services. There were no differences with respect to the numbers of involuntary admissions, levels of clinical symptoms or social functioning. The authors suggest that some admissions were prevented by the CRT, although this effect was largely restricted to voluntary patients. Providing more information to patients with psychiatric disorders, and their carers, is actively

encouraged but the role of information in preventing subsequent psychological symptoms is less well established. Turpin *et al* (pp. 76–82) provided self-help information to patients attending the accident and emergency department with trauma. At 1-year follow-up, they found no decrease in the rates of post-traumatic stress disorder (PTSD), anxiety or depression in the group given information compared with the control group. Intriguingly, rates of depression and PTSD were lower in the control group, suggesting that providing self-help information, certainly in this area, may be counterproductive. A case of more research needed.

BIRTH, MARRIAGE AND PROTEOMICS IN MENTAL HEALTH

The association between low birth weight and subsequent risk of schizophrenia is well recognised. Increasingly, it is becoming apparent that this may also be a risk factor for many other disorders including affective disorders. Wiles and colleagues (pp. 21–28) show that low birth weight babies born at full term were more likely to experience psychological distress in adulthood, and that this did not appear to be mediated by other childhood factors. They propose that a neurodevelopmental pathway may be implicated in the development of affective disorder. One way of examining genetic and environmental interactions, applied to psychiatric disorders, is through analysing the protein products of genes, or proteomics. Pennington *et al* (pp. 4–6) describe the techniques used in proteomics research and review significant recent findings. Domestic violence is surprisingly common, both in the Western world and elsewhere, and has significant psychological sequelae. In a population-based study, Kumar *et al* (pp. 62–67) demonstrate the link between domestic violence and increased risk of poor mental health in India. Poor mental health was also linked with other risk factors such as witnessing or having been the victim of parental violence during childhood, and more general factors such as lower socio-economic status and less education. The authors calculate that an effective programme that eliminated domestic violence would reduce the prevalence of poor mental health by 41%.