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Pandora searches the world literature for evidence, news and other sources on matters of interest (doesn't shy away from controversy) to bring to the reader. She welcomes comments and suggestions (via [ip@rcpsych.ac.uk](mailto:ip@rcpsych.ac.uk))



### *Antidepressants – the trendy panacea but how safe are they?*

According to the Health and Social Care Information Centre (HSCIC), antidepressant drugs are among the three most prescribed drug groups in the UK, alongside the statins and analgesics. One in 10 women, mostly of mature age and from deprived areas, are on antidepressant drugs. But let's not assume that these are all prescribed for the treatment of depression. A recent study by Wong *et al* in Canada, using data from electronic prescribing records by primary care physicians in Quebec, found that for only 55% of the prescriptions was the indication depressive disorder; among the rest the indications included anxiety, insomnia or pain, but also off-label indications such as migraine, menopausal vasomotor symptoms, attention-deficit/hyperactivity disorder and digestive disorders.

There are understandable concerns about the outcomes of off-label prescribing and the evidence shows that there is an association with an increased risk of adverse events. Another study in Quebec, by Equale *et al* and published in January this year, found that off-label prescribing was associated with higher rates of adverse events than on-label prescribing. Interestingly, off-label prescribing where there was strong scientific evidence was associated with the same risk of adverse events as on-label prescribing! So let's not give up on off-label prescribing as yet but make sure the reasoning behind this has a good scientific basis.

Equale, T., Buckeridge, D. L., Verma, A., et al (2016) Association of off-label drug use and adverse drug events in an adult population. *JAMA Internal Medicine*, 176, 55–63. doi:10.1001/jamainternmed.2015.6058.

Wong, J., Motulsky, A., Buckeridge, D. L., et al (2016) Treatment indications for antidepressants prescribed in primary care in Quebec, Canada, 2006–2015. *JAMA*, 315, 2230–2232. doi:10.1001/jama.2016.3445.PMID:27218634.

### *One suicide is too many*

My local newspaper in London reports on average one suicide every 4–6 weeks; okay, it is a high-risk area, but is this acceptable? The UK's Office for National Statistics (ONS) reported a 2% reduction in suicide rates in 2014 but it should be noted that the year before there had been a 4% increase!

At the recent annual meeting of the American Psychiatric Association (APA), the issue of suicide was given special attention. Drs Shareh Ghani and Karen Chaney presented the Magellan programme, which they claimed brought suicide down to zero in the first 3 months and significantly reduced suicide rates in Arizona by 67% in the general population and by 42% among people with serious mental illness. They adopted Applied Suicide Intervention Skills Training (ASIST) to train staff in 12 out-patient centres. They claimed that their programme 'looks at suicide differently, as a systems issue, not a one therapist, one doctor issue. That's a big culture change.' The programme is 'quite laborious, but it is very effective'. They trained over 90% of the targeted workforce in ASIST and found a significant increase in the number of providers who 'felt strongly' they could engage and assist those with suicidal desire or intent. Key components of the programme include standardised suicide risk screening; if the screening is positive, a full assessment of suicide risk is conducted, and appropriate interventions are made to ensure safety, treatment, ongoing care and close follow-up. As part of the programme, a comprehensive clinical decision support tool is implemented in the electronic medical record.

The incoming APA President, Maria A. Oquendo, said, 'all suicides should be preventable,

and the strategy for that is early intervention and early identification of individuals at risk. When you have an integrated health system, you have a much better opportunity to do that, because all members of the care team have a way of communicating, for example, using the electronic health record.'

The National Health Service in the UK has had all these systems in place for some time – where do we go wrong?

Magellan Health – Suicide Prevention Programme. Presentation at the annual meeting of the American Psychiatric Association, 15 May 2016.

### ***Magic mushrooms for depression?***

**L**SD and other hallucinogenic drugs were investigated as potential therapeutic agents in the 1960s, but interest declined over the following decades, only to resurge in the past few years. Psilocybin, a component of some species of magic mushrooms, is a 5HT<sub>2A</sub> serotonin receptor agonist and a hallucinogenic agent. It was given to patients with treatment-resistant unipolar depression in an open-label study of 6 men and 6 women, and an improvement in symptoms was noted at 1 week and at up to 3 months after treatment.

This is a very small study with several limitations and no conclusions can be drawn about the potential usefulness of such agents in the treatment of depression or indeed about its safety. Perhaps the emphasis should be on using such hallucinogenic agents to try to develop a better understanding of the workings of the brain and the mechanisms involved in the genesis of symptoms, before going on to clinical trials with patients?

Carhart-Harris, R. L., Bolstridge, M., Rucke, J., *et al* (2016) Psilocybin with psychological support for treatment-resistant depression: an open-label feasibility study. *Lancet Psychiatry*. doi: 10.1016/S2215-0366(16)30065-7.

### ***There is light at the end of the tunnel!***

**P**hototherapy has established itself as an effective treatment for seasonal affective disorder and it is popular with patients. Although it has been considered also in the treatment of non-seasonal depression, there hasn't been sufficient interest in this. In a recently reported study, patients with major depressive disorder of moderate severity were randomised to treatment over 8 weeks with: (1) light monotherapy (30 minutes) plus placebo pill; (2) antidepressant monotherapy (20 mg fluoxetine) plus an inactive negative ion generator (30 minutes); (3) light plus fluoxetine; and (4) placebo light and placebo pill. Light therapy alone or in combination was effective, although the combination treatment had the most consistent results.

Lam, R. W., Levitt, A. J., Levitan, R. D., *et al* (2016) Efficacy of bright light treatment, fluoxetine, and the combination in patients with non-seasonal major depressive disorder. A randomized clinical trial. *JAMA Psychiatry*, 73, 56–63. doi: 10.1001/jamapsychiatry.2015.2235.

### ***Agitation and psychosis in dementia – to treat or not to treat?***

**T**here has been increasing concern for some years about the use of second-generation antipsychotic drugs (SGAs) in people with dementia, with evidence emerging that these are associated with an increased risk of strokes in this population. In October 2009, a report for the Minister of State for Care Services by Professor Sube Bannerjee, commissioned and funded by the Department of Health, recommended a drastic reduction in their use, based on existing research evidence.

A recently published study disputes previous findings. The authors conducted a meta-analysis of population-based studies to assess the risk of stroke in dementia patients prescribed SGAs rather than the FGAs (first-generation antipsychotics). They found no differences in the risk of stroke between the SGAs and FGAs. This doesn't mean there is no risk!

The reader may be interested in the new practice guidelines on the use of antipsychotics in dementia issued by the American Psychiatric Association (<http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426807>).

Rao, A., Suliman, A., Story, G., *et al* (2016) Meta-analysis of population-based studies comparing risk of cerebrovascular accident associated with first- and second-generation antipsychotic prescribing in dementia. *International Journal of Methods in Psychiatric Research*. doi: 10.1002/mpr.1509. [Epub ahead of print]

### ***Watch too much television at your peril!***

**A**lot has been said about sedentary life and obesity and heart disease, but what about brain health? The authors of a prospective study of over 3000 adults (aged 18–30 years) who had enrolled in the Coronary Artery Risk Development in Young Adults (CARDIA) Study (1985–2011) investigated a possible association between patterns of TV viewing and physical activity and mid-life cognition. They visited participants and carried out at least three assessments over 25 years. A high level of television viewing was defined as over 3 hours per day for over two-thirds of the visits. At baseline and at year 25, they assessed cognitive function using the Digit Symbol Substitution Test, Stroop Test and Rey Auditory Verbal Learning Test. The high television viewers with low physical activity were two times more likely to have poor cognitive performance.

You have been warned!

Hoang, T. D., Reis, J., Zhu, N., *et al* (2016) Effect of early adult patterns of physical activity and television viewing on midlife cognitive function. *JAMA Psychiatry*, 73, 73–79. doi:10.1001/jamapsychiatry.2015.2468.