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Highlights of this issue

By Derek K. Tracy

Tinker, Tailor, Soldier, Spy

Those of you, like me, who waste far too much time on Twitter might have noticed recent online faux-outrage at an apparent discovery that our College library in Prescott Street had blocked the purchase of several psychology-focused or psychiatry-critiquing textbooks by well-known contemporary British authors. The story was, well, #fake-news, but, my woke brethren, I have uncovered a more disturbing conspiracy: I cannot find any pharmacological, genetic or neuroimaging papers in this month's *BJPsych*. Instead we have a plethora of psychology and health policy focused papers. I will investigate more on this evident deep-state fifth column undermining of our patriarchal biological medical model, and report back shortly.

In the meantime, we start with a couple of outstanding, provocative and thoughtful editorials. Owen Bowden-Jones, Julia Sinclair and Anne Lingford-Hughes start us off (pp. 178–179) with a primer on the global drugs debate, a complex area often awkwardly interfacing healthcare, politics and wider society. We grapple with the conflict that some who use drugs are not significantly adversely affected, but many are – often profoundly – while several of these compounds also have emerging therapeutic potential. Further, legal frameworks are highly variable between jurisdictions and can reflect societal mores rather than clear evidence. The authors call for prioritising better understanding of drug policies on the most vulnerable, and the longer-term impact of adolescent substance use. In the UK, the challenge is magnified by the cuts to substance-use service spend, which is controlled by a social care system with uncertain, and historically pessimistic, funding forecasts.

There has been a welcomed growth in perinatal mental health services, but Catalao et al (pp. 180–181) push it earlier, debating the less discussed issue of preconception care. Their editorial takes us right back, noting how perinatal problems can be preceded by difficulties from adolescence. Mental health problems are linked with poorer use of contraception and higher rates of unintended pregnancies. Besides the important point that this is clearly a concern for all society and not 'just' a 'women's issue', the authors note it can also be a direct biological and psychosocial issue for men through mental ill health having an impact on offspring via epigenetic changes and impaired parenting. The authors propose that our growing perinatal and increasingly integrating services offer a mechanism through which preconception advice and care might be disseminated.

The 39 Steps

NICE, the National Institute for Health and Care Excellence, is, well, nice, right? Perhaps a little pedestrian at times, but solid, reliable and always beyond reproach – like a dull best friend. McPherson & Sunkin (pp. 231–234) challenge our preconceptions and ask if its independence from government, intended to protect guidelines from commercial lobbying, might actually make it legally and scientifically unaccountable. They note how the few legal challenges that have been made to NICE rulings have been quashed, with the courts typically determining that it was not their role to contravene findings, even where experts strongly disagree, unless it was 'obvious that the public body, consciously or unconsciously, are acting perversely'. However, while outreaching to various stakeholders, NICE is not obligated to take on any of their comments or advice, and the current debate and controversy about the consultation of the planned revised guidelines on depression are given as an exemplar. Fascinating stuff, and who would have guessed it: your boring bestie might be harbouring a dirty secret.

Cognitive–behavioural therapy (CBT) and interpersonal psychotherapy (IPT) are well established treatments for depression – and recommended by NICE – but the *frequency* of sessions is based more on custom and practice than clear evidence. There are some data to support intensity being more important than duration, but these works have typically been methodologically weaker, for example observational studies and retrospective analyses. Bruijniks et al (pp. 222–230) prospectively randomised about 200 individuals to one of these two interventions, and participants were further stratified to receive this either once or twice a week. Those getting the more intense input had lower drop-out rates and did significantly clinically better, with no differences between the two therapy types. Jack Kerwin from King's College London writes more in this month's Mental Elf blog: https://elfi.sh/bjp-me21. As all participants received the same total number of sessions (up to 20) there would appear to be no extra service cost to such a model as twice-weekly treatment only lasts half as long; however, cost analysis was not part of the study. Dennis et al (pp. 189–196) return us to IPT, demonstrating the superiority of a telephone-based, nurse-delivered variant over TAU in those with postpartum depression. The relationally and affect-focused aspects of IPT are argued by the authors to have particular resonance for a postnatal cohort. Their work covered a diverse urban and rural population, but it might have a special appeal in the latter or in geographically dispersed populations.

The Ipcress File

An 'over controlled personality' has been argued to often form a part of refractory depression. This putatively opens it up to dialectical behavioural therapy (DBT) that has traditionally been used in the management of personality disorder. Lynch et al (pp. 204–212) report on a randomised controlled trial of a novel transdiagnostic therapy form – 'radically open' (RO) DBT that seeks to tackle rigid coping styles. The 162 participants with refractory depression allocated to the RO BDT did better upon completion of the 6 months of 29 therapy sessions and 27 skills classes than those who received TAU, but gains dissipated by about 7 months and there were no differences by the primary 12-month end point.

Tamsin Ford and colleagues ask (pp. 175–177) if a mindfulness-based cognitive therapy early in adolescence might protectively alter the trajectory of depression and anxiety across the lifespan. Their editorial argues that theoretical reasoning as well as some of their promising pilot data on the topic lend weight to the argument, but they note the clear need for some prospective trials. Their call to understand any potential mediators of change – beyond 'just' outcomes – is especially welcome. CBT has been shown to help manage depression in individuals with cancer, but it has been less explored in the more advanced forms of illness. Serfaty et al (pp. 213–221) undertook a multicentre trial of 230 such individuals who were randomised in a single-blind manner to 12 sessions of this intervention via an IAPT (Improving Access to Psychological Therapy) model or TAU. No gains were seen, and the authors consider that IAPT's delivery, although practically viable, is not an optimal mechanism to deliver psychological interventions for this vulnerable group with often significant need.

Finally, Kaleidoscope (pp. 237–238) updates us reviewing new research on the risk of committing, or being subjected to violence if one has a psychiatric diagnosis (the findings of which may surprise you), and discusses the global shift in legislation on involuntary detention that might have an impact on us all in the near future.

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