

Highlights of this issue

BY ELIZABETH WALSH

SUICIDE . . .

Previous self-harm is a major predictor of non-fatal repetition and subsequent suicide. Owens *et al* (pp. 193–199), in a systematic review, estimate the rates of these outcomes following self-harm and find the link between self-harm and suicide to be a strong one. Non-fatal repetition occurred in around 15% of people in the year after an attempt, with up to 2% committing suicide over this time. Although self-harm increases an individual's risk greatly, because of the low incidence of suicide in the population the authors suggest that to reduce suicide rates at a population level an intervention aimed at all patients who harm themselves is required. Suicide in those aged over 75 is a frequent event.

. . . AND TELECOMMUNICATIONS

De Leo *et al* (pp. 226–229) examine the long-term effects on suicide of a broad public health intervention providing twice-weekly telephone support and emergency response to elderly persons in Italy. Despite those at increased risk of suicide being offered the intervention, significantly fewer suicides occurred among this group compared with general population suicide rates. Jones (pp. 191–192), in an accompanying editorial, explores the use of telecommunications to expand education, support, detection and treatment of mental illness suggesting that it should be a key component of health services planning.

MENTAL HEALTH NEEDS AND SERVICE PLANNING

Since the closure of large hospitals little attention has been paid to the changing expenditure requirements across different regions of England for people with learning disabilities. Forsyth & Winterbottom (pp.

200–207) explore this and highlight the widespread discrepancies. Similarly, de Girolamo *et al* (pp. 220–225) investigate provision of residential care for people with mental illness across regions of Italy since the phasing-out of mental hospitals and find marked variability. McConnell *et al* (pp. 214–219) describe a high prevalence of psychiatric disorder and poorly met needs for treatment in Derry, Northern Ireland, an area of high social deprivation and civil conflict. Burns *et al* (pp. 236–241), as part of the UK700 study, confirm that low case-load size alone is not significantly associated with a reduced need for hospitalisation. They suggest that by identifying patients who are most likely to require protracted hospitalisation, we may focus intensive case management services on those most likely to benefit in the community.

OUTCOME IN CHRONIC FATIGUE SYNDROME (CFS)

Psychological interventions that encourage exercise are effective treatments for CFS. Bental *et al* (pp. 248–252) find poor predictors of response to such treatment to be variables that indicate resistance to accepting the therapeutic rationale, poor motivation to treatment adherence or secondary gains from illness. The severity and chronicity of symptoms did not predict response to psychological treatment and it is thus suggested that this kind of treatment be available to all patients.

SELF-HELP FOR BULIMIA

Palmer *et al* (pp. 230–235), in a randomised controlled trial, find self-help based upon a book combined with a few sessions of professional guidance to be an effective treatment for bulimia nervosa and binge eating disorder. Three different forms of self-help were compared with a waiting-list comparison group and, although there was

no significant difference in the final clinical outcome between the groups after they had progressed through a stepped care programme, guided self-help was found to be a worthwhile initial response. Although face-to-face guidance was most useful, there was some evidence that telephone guidance may be beneficial. When waiting-lists for full treatment are long, this may be a useful initial response which could also be adapted to primary care and other non-specialist settings.

NEUROLEPTIC-RESISTANT DOES NOT MEAN TREATMENT-RESISTANT

Williams *et al* (pp. 184–187) question the term 'treatment-resistant' in psychosis, as it implies that little further can be done, generating therapeutic nihilism. They suggest the term 'neuroleptic-resistant schizophrenia' and outline various management options that may be tried when clozapine monotherapy has failed. Suggested pharmacological approaches are discussed and with promising results for psychosocial treatments, it is suggested that these may be adapted to clozapine-resistant patients.

DURATION OF MAJOR DEPRESSIVE EPISODES

Spijker *et al* (pp. 208–213) report the results of a Dutch epidemiological study examining the duration of major depressive episodes in the general population. The median duration of episodes was 3 months, with 50% of participants recovering within this time. Within a year about 25% had not recovered, with this figure falling to only 20% at 2 years. This high rate of chronicity in the general population was unexpected, with clinical characteristics such as severity of the initial episode and the presence of comorbid dysthymia predicting a longer duration. Üstün & Kessler (pp. 181–183), in an accompanying editorial, point out that because the majority of the epidemiological findings of depressive disorders relate to North America and Europe, data are needed from other areas of the world to enable us to deal with the global burden of depression.

EUROPEAN FIRST-EPISODE SCHIZOPHRENIA NETWORK

. . . is the subject of an extensive supplement accompanying this month's *Journal*.