

## Highlights of this issue

By Kimberlie Dean

### Prescribing practices under the microscope

Two papers in the *Journal* this month examine patterns of prescribing practice. With established clinical guidelines for the management of individuals with treatment-resistant schizophrenia in mind, Howes *et al* (pp. 481–485) reviewed prescribing practices prior to commencement of clozapine for a sample of patients managed within one mental health service. The authors found evidence of a significant theoretical delay in initiation (mean 47.7 months). Antipsychotic polypharmacy and high-dose antipsychotic treatment were also identified as common in the pre-initiation period. In a linked editorial, Patel (pp. 425–427) argues that clinician hesitation to commence clozapine when indicated for those with treatment-resistant schizophrenia is often driven more by clinicians' knowledge, attitudes and preferences than by good clinical reasoning. Of relevance to discussions about a need to change prescribing practices in the light of evidence-based clinical guidelines, the quality improvement programmes (QIPs) initiated by the UK Prescribing Observatory for Mental Health (POMH-UK), have thus far focused primarily on areas of practice related to antipsychotic prescribing (e.g. metabolic monitoring, polypharmacy). Evidence that positive change in clinical practice can be achieved as a result of such programmes is emerging but, as Barnes & Paton argue (pp. 428–429), progress is gradual, variable and moderate. On the basis of concern about individuals with mental illness receiving inferior treatment for physical conditions, Mitchell *et al* (pp. 435–443) conducted a meta-analysis focusing on prescribing practices. The authors found evidence that patients with severe mental illness were more likely to be prescribed lower quantities of several common medications for the treatment of physical conditions, particularly cardiovascular ill health or risk. The authors call for research focused on understanding patient and provider influences on received medication and a greater focus, both at a clinician and clinical organisational level, on optimising treatment of physical health comorbidities for those with mental illness.

### Mental health service capacity and treatment outcomes in LAMI settings

Treatment coverage for mental disorders is known to vary widely across low- and middle-income (LAMI) countries. McBain *et al* (pp. 444–450) have examined the potential role of Group 1 disease burden (i.e. unrelated communicable, maternal/perinatal and nutritional diseases) on mental health service capacity. At a country level, higher Group 1 disease burden was found to be associated with indicators of reduced service capacity – fewer mental health practitioners, fewer out-patient facilities and a reduced number of psychiatric beds. Rahman *et al* (pp. 451–457) found that an intervention based on the principles of cognitive-behavioural therapy, involving family members and local health workers as 'agents of change', was an effective treatment for perinatal depression when tested in two rural subdistricts of Rawalpindi, Pakistan, even for those women who reported being in debt and/or not being financially empowered. These latter two factors were additionally found to moderate the effect of treatment, with effect sizes for depression improvement being greater for those women reporting debt and/or a lack of financial empowerment. Although no evidence for mediation of the intervention on depression outcomes was found, indicators of poverty were also found to be improved by the intervention.

### Challenging the current paradigm in psychiatry and academic psychiatry

In response to a number of editorials previously published in the *Journal* alerting readers to a crisis in psychiatry and calling for a strengthening of the biomedical approach to practice, Bracken *et al* (pp. 430–434) argue that psychiatry needs to move beyond the current technological paradigm and focus instead on the non-technical dimensions of practice such as engagement with relationships, meanings and values. The authors contend that such an approach better reflects current evidence about what is needed to achieve positive outcomes, and call for clinicians to collaborate with the service user movement to pursue shared goals. Similarly, Kleinman (pp. 421–422) argues that academic psychiatry has lost its way in pursuit of an increasingly narrow, biologically focused research agenda which, it is proposed, has become of decreasing relevance to both clinical practice and global health needs. In Kleinman's view, academic psychiatry has not only failed to benefit people with mental illness, but is becoming the author of its own demise, with numbers of young clinicians and researchers attracted to the field ever dwindling.