The study was not done as a randomised clinical trial, which is a pity. As mentioned above, the control group is likely to have a better prognosis, and therefore the results of the study indicate that intensive case management is more effective than shown in the comparisons in the paper. Even though the results are convincing, it is not likely that they will be included in any future meta-analysis.

It can be discussed whether intensive case management should only be offered to the difficult-to-engage subgroup. The results presented indicate that a group deemed to be well-functioning might also need that kind of service. The NICE guidelines recommend specialised early intervention services to all young people with a first episode of psychosis, not only to the subgroup with the most complex problems.

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Investment in mental health: a battle for resources

In Description of the Retreat,1 Samuel Tuke observed that “of all the modes by which the patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious”. Being gainfully employed is a cherished goal of many people with mental disorders. Interventions such as individual placement and support can improve patients’ chances of being employed.2 In first-episode psychosis, staff training in motivational interviewing further enhances the effect of individual placement and support.1 Meaningful activity is not simply working; it gives meaning in more than one way to one’s being.

Despite the best available treatment, about 10% of people with schizophrenia will end up in a chronic, enduring, and seriously disabling state. At this severe end, patients have very low levels of meaningful activity, let alone paid employment. Evidence is scarce to guide clinicians on how to improve functional outcomes of this group. In The Lancet Psychiatry, Helen Killaspy and colleagues4 report findings of a cluster-randomised trial of an intervention designed to increase patients’ engagement in activities, which was set in 40 mental health rehabilitation units in England. 20 units were randomly allocated to receive the intervention, which consisted of a manual-based staff training programme delivered by a specific intervention team; the other 20 units continued to provide standard care. Despite rigorous efforts to ensure intervention fidelity, 12 months after randomisation, no improvement was seen in patients’ engagement in activities or functioning, compared with standard care (coefficient 1.44, 95% CI –1.35 to 4.24). Killaspy and colleagues postulate that the absence of clinical effect might be because the staff training did not lead to sustained change in practice, that current turbulence in the NHS prevented staff from delivering the intervention consistently, or that patients were impaired too severely to benefit from the intervention.
The last possibility gives food for thought. In all chronic medical disorders, a subset of individuals exist who will have a poor outcome despite the best possible care. We accept this effect as natural heterogeneity in the course and outcome of diseases. The population under study by Killaspy and colleagues represents such a subset. Patients were being managed in small community-based units, many of which are under threat of closure (as happened to one unit during the study). One rationale for deinstitutionalisation was the erroneous attribution of the impoverished lives of patients to the institution, rather than—as we later discovered—negative symptoms and cognitive deficits inherent in the disorder. So what should we do for this population?

First, we should acknowledge that this group exists, has complex needs, and currently ends up in virtual asylums that have developed in an unplanned manner, without any long-term strategy or investment, and are typically supplemented by very expensive private sector provision. Second, we need to alter the nature of debate in psychiatry, from polarised to complementary. Debates in mental health invariably end up polarised: hospital bad, community good; medication bad, psychotherapy good; biomedical models are reductionistic and hence bad, psychosocial models are holistic and hence good. For policy makers and funders, such simple and divisive bifurcations make pitching one part of the service against another easy, shifting resources between them. Successful investment in community care has, at times, happened at the expense of inpatient care, thus leading to a self-fulfilling prophecy whereby underfunded inpatient units have become true to caricature: non-therapeutic and coercive rather than caring. In times of budget cuts, services further retreat into territorial battles, seeking to maintain their slice of a shrinking pie. The austerity era is already producing calls for functional teams to be subsumed into generic care, potentially undoing hard won new investment into specialist care. We are beginning to see the negative effect of such changes. Trusts that have merged their specialist community teams (eg, assertive outreach, early intervention) with generic community services have higher suicide rates. Cutting the number of psychiatric beds also leads to a corresponding increase in rates of detention in subsequent years. Shifting resources from one part of the mental health system to another strengthens one bit but weakens the other. We need the entire care pathway to be robust.

A third sobering lesson can be taken from the findings of Killaspy and colleagues’ negative trial: if even well-resourced units with determined input from dedicated teams do not improve patients’ functioning at the severe end of the disorder, perhaps we should shed our current orthodoxy that demonises the asylum function of psychiatric care, to provide a place of safety, refuge, and protection. Until we make a major therapeutic breakthrough, we should ensure that we do not keep cutting the number of long-stay beds in the hope that simply discharging patients into the community will improve outcomes. Good mental health care needs investment in all aspects. No amount of community investment will ever obviate the need for some hospital beds. If communities were all that therapeutic, people would not fall ill in the first place. In the current climate, a real threat exists that specialist and generic services will be too busy fighting over resources rather than jointly arguing for increased investment in all aspects of mental health care, from generic to highly specialised.

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Suicidal behaviour: identifying the best preventive interventions

The search for effective interventions for suicidal behaviour is hampered by the rarity of its occurrence, even in high-risk samples. Randomised controlled trials, in which suicide or suicide attempt is the outcome of interest are rare, and most of these studies have small sample sizes. One strategy to address the low base-rate challenge is to use extant national or regional databases that contain treatment information to estimate the effects of a specific intervention. These designs can yield large sample sizes that are crucial to study interventions for suicidal behaviour, and with propensity scoring, some of the inherent biases that plague treatment assignment in clinical settings can be addressed. Linking these two strategies—the use of observational data and propensity scoring—has several advantages: the hypothesis can be tested in an ecologically valid, heterogeneous, real-world sample, rather than in a narrowly defined or convenient sample; observation can occur over long periods of time, typically prohibitively expensive in randomised controlled trials; and the intervention can be tested as it is applied in the clinic, rather than by highly trained experts. Thus, although randomised controlled trials remain the gold standard for assessment of interventions, propensity scoring of observational treatment data can be of great utility.

In a large naturalistic, ecological study by Erlangsen and colleagues published in The Lancet Psychiatry, the authors examine the effect of a panoply of brief (eight to ten sessions) psychosocial therapies offered to patients who presented for care at a suicide prevention clinic after deliberate self-harm, compared with treatment as usual that ranged from psychiatric inpatient treatment to no treatment. Using propensity scoring to match patients and controls for 31 variables shown in this dataset to be associated with the treatment received and to match factors known to be linked to suicide risk, analyses suggest that psychosocial therapies were associated with a lower risk of future deliberate self-harm and death by any cause. The number needed to treat was 44 for 1 year and 34 for a longer observation period, suggesting that positive effects accrued and the effects seemed more pronounced in women, youth, and first attempters of suicide.

As is true for any study, several questions remain unanswered. Importantly, psychosocial therapies are very broadly defined, including therapies that are quite disparate (from psychoanalytically oriented to dialectical behavioural therapy) begging the question of what the so-called active ingredient is; this might simply be the provision of a safe, confidential place to talk for 8 to 10 hours. If so, such an inoculation, lasting for years should be easy to implement. However, the answer is probably more complex. Perhaps knowing that people will have a place (the suicide prevention clinic) to discuss distressing problems should the need arise is the active ingredient. Perhaps the very referral to a suicide prevention clinic has designated the patient as being at high risk, alerting the individual's support network to the need to attend to the emergence of acute suicide risk. Whatever the active ingredients are, to identify them specifically will translate to more efficient, cost-effective preventive treatments.


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