Highlights of this issue

By Kimberlie Dean

Suicide prediction and potential opportunities for prevention

Several papers address the topic of suicide, particularly issues of prediction and prevention, in the *Journal* this month. Kleiman & Liu (pp. 262–266) investigated the link between religiousness and suicidality by undertaking a prospective analysis of data from a nationally representative US sample. Those individuals reporting frequent attendance at religious services were found to be less likely to die by suicide over the follow-up period, even after other relevant factors were taken into account. In a linked editorial, Cook (pp. 254–255) highlights the importance of a study which moves beyond cross-sectional findings, and comments on the potential utility and appropriateness of considering spirituality and religion when assessing suicide risk in clinical settings.

In aiming to contribute to the literature on suicide prevention, Dougall *et al* (pp. 267–273) undertook a linkage analysis of hospital contact data, both psychiatric and general, for a sample of individuals who died by suicide in Scotland during the period 1981 to 2010. Last discharge data indicated that individuals who died by suicide were more likely to have had contact with general rather than psychiatric hospitals. The authors comment on the opportunities for prevention given that timing of suicide was relatively short following discharge from both settings. They also note the potential for improving recognition of prior psychiatric diagnosis for those presenting to general hospitals if access to electronic health records, including primary care records, were more available to health professionals.

Some of the most successful suicide prevention strategies have focused on targeting access to particular methods of suicide at a population level. Suicide by charcoal burning has been noted to be an exception to the general rule that the main methods of suicide in a population tend to change very slowly over time, with epidemics of such suicides being identified in Hong Kong and Taiwan. Yoshioka *et al* (pp. 274–282) present the results of an analysis of method-specific suicide rates in Japan between 1998 and 2007, indicating that such an epidemic appears to have occurred in the country, particularly among young men and women. An increase in overall suicide rates was also seen without a reduction in suicide by other methods, indicating that affected individuals might not have otherwise chosen such a lethal method of self-harm. The authors comment on the need to consider community-level interventions such as restricting access to charcoal in order to address the epidemic.

Mental health interventions: feasibility of translation, and focusing on resources

Observations of the gap between the accumulation of evidence for new interventions and their uptake by mental health services are oft made. Bird *et al* (pp. 316–321) assert that while evidence-based guidelines and approaches tend to focus on evidence of efficacy and cost-effectiveness, feasibility of implementation may well be the key to successful translation into practice. Undertaking a review of studies assessing implementation of interventions, the authors utilised outcomes from the review to develop a standardised measure for evaluating the feasibility of complex mental health interventions – the Structured Assessment of Feasibility or SAFE. The instrument includes 16 items organised into three categories – intervention, resource consequences and evaluation.

In contrast to therapeutic models based on addressing deficits, those focused on utilising the personal and social resources of the patient may have distinct advantages. Priebe *et al* (pp. 256–261) undertook a conceptual review of resource-oriented therapeutic models in psychiatry in order to identify any shared characteristics. Ten models targeting six different types of resources were identified, with social relationships being identified as a key resource in all models. The authors suggest that further research to improve understanding of the way in which social relationships affect mental health and can be harnessed in the context of effective interventions is sorely needed.

Brain imaging studies of working memory and vulnerability to depression

The overlap between schizophrenia and bipolar disorder is known to extend to the presence of cognitive impairments. Brandt *et al* (pp. 290–298) investigated the brain networks associated with working memory in three groups – patients with schizophrenia, patients with bipolar disorder and healthy controls – to establish whether deficits in such networks also overlap. While the same networks were found to be activated during working memory tasks in all three groups, some networks demonstrated graded hyperactivation in the two clinical groups, with the schizophrenia group showing greatest activation. Among those with bipolar disorder, hyperactivation in these networks was also associated with a history of psychosis and current mood elevation.

Vulnerability to recurrence following an episode of major depressive disorder is known to be associated with a range of clinical and other factors but biological markers of such risk are less well established. Nixon *et al* (pp. 283–289) investigated the default mode network, previously implicated in such vulnerability, in a sample of recovered-state patients compared with controls, using multimodal structural and functional magnetic resonance imaging. The authors report that the group with prior history of major depressive disorder did show significant functional hyperconnectivity in the default mode network and that this was associated with hypogyrification in relevant regions.