

## WHAT'S NEW IN ....

# Psychiatry

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### Introduction

Within psychiatry the vast majority of diagnostic labels describe syndromes, and not true disease entities. The World Health Organisation (WHO) (1), and the American Psychiatric Association (APA) (2) have both produced, and continue to update, manuals defining the different types of psychological presentation. Both documents are consensus statements outlining what experts in the field believe to be rational divisions between disease entities. The chapter within the WHO's International Classification of Diseases (ICD-10) dealing with psychiatric diagnoses and the APA's Diagnostic Schedule Manual (DSM IV), whilst broadly similar, have significant differences within most categories. This demonstrates the difficulties that all psychiatrists face. Namely most psychiatric illnesses are not disease entities, but syndromes with neither conclusive aetiology or pathology, nor definitive treatments.

Schizophrenia (which is classified differently in both documents) is a good example of this. Schizophrenia as a disease entity is still no more than a hypothesis. Argument continues as to whether it is one syndrome or many. Argument also continues as to the overlap between schizophrenia and affective disorders, with some patients achieving diagnoses of Bipolar Affective Disorder, Schizoaffective disorder, or Schizophrenia, all over short periods of time. Argument continues as to exactly how antipsychotic drugs work, why some patients fail to respond to medication, and which medications are most effective.

### *Tantalus' Grapes*

Tantalus is a mythological greek character who was chained beneath a fruit tree with low branches. Each time he reached for the grapes the branch moved *tantalisingly* out of reach. So it is with our investigations into psychosis. In 1899 Kraepelin(3) revolutionised psychiatric classification suggesting two distinct diagnostic categories for the majority of the psychoses, dementia praecox (now labelled schizophrenia) and manic-depressive illness. In 1906 one of his acolytes Alzheimer (4) was able to demonstrate specific brain tissue changes in elderly dementing patients. Perhaps with more powerful microscopes the pathological changes of dementia praecox would be discovered and a cure become apparent. Later in the century the first antipsychotic agents were discovered (5). The importance of the dopamine receptor in psychosis was clearly demonstrated (6), and again we stood on the brink of discovering what was different about the dopamine system in the brains of psychotic patients. Decades of twin and adoption studies had shown a significant genetic component of the aetiology of schizophrenia; (7-9); so in the 1990s it seemed certain that the

use of novel DNA technology and gene linkage would identify specific genes responsible for schizophrenia, and new methods of treating this illness.

### *The branch moves*

So where are we now? In 2005 Craddock *et al* (10) argue that there is no neat distinction between schizophrenia and bipolar affective disorder. In 2004 Cotter *et al* (11) have demonstrated no difference in the glial cell densities in cortical layers 3 and 5 of Heschl's gyrus "an important negative finding" in the search for the pathology of schizophrenia. Argument continues about which neurotransmitters are key in psychosis; in 2006 Pomarol-Clotet *et al* (12) exposed a group of healthy volunteers to ketamine to further investigate the glutamate hypothesis of schizophrenia and the role of the NMDA receptor. In January 2007 Crow (13) analysed the results of several meta-analysis of schizophrenia gene-linkage studies, concluding that no single gene-locus has been agreed upon. Instead he suggests a novel theory that an epigenetic variation, occurring at the time of the speciation event, and directly relating to the evolution of language in humans, is the answer to the aetiology of schizophrenia.

So '*What's new in psychiatry*' is not necessarily vastly different from '*what is a century old in psychiatry*'. We are still striving to define distinct disease entities; investigate the aetiology and pathology of mental illness; understand why our interventions work; and identify which individuals will best respond to which intervention. In this article I will focus on recent changes to service provision; a recent advance in the study of psychosis; an upcoming but important aspect of the affective disorders; and a single area within the anxiety spectrum disorders which has a particular application to the military setting.

### Changes to Service Provision The Mental Capacity Act

The Mental Capacity Act 2005 (MCA 2005) (14) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Until this act comes into force later in 2007 such decisions have been based on case law. Frequently patients with mental illness do lack capacity; however whilst this act is not specific to psychiatry, psychiatrists have traditionally been called upon to assist in the judgement of general hospital patients capacity to make decisions about health and social issues. It is important for all health-care professionals to familiarise themselves with this act as they are "*legally required to 'have regard to' relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and they should be able to explain how they have had regard to the Code when acting or making decisions.*"(15) The MCA 2005 clearly explains what is meant by the terms 'lacks capacity' and 'acting in the best interests', and provides clear guidance how to assess

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these. It also for the first time makes 'advanced directives' legally binding.

### **Advanced Directives**

An advanced decision enables someone aged over 18 to refuse specific medical treatment for a time in the future when they may lack capacity. This need not be in writing unless it is to refuse life-sustaining treatment in which case the directive needs to be signed and witnessed and clearly state that the decision applies even if life is at risk. Under the MCA 2005 an advanced directive is now recognised for the first time as part of statute law, indeed are legally binding. Health-care professionals now have a specific duty to enquire about the presence of an advanced directive, and also to use it to inform management decisions.

### **Lasting Power of Attorney**

Under the MCA 2005 'Enduring Power of Attorney' has been replaced by 'Lasting Power of Attorney'. An attorney with enduring powers of attorney could make decisions on behalf of a donor, but only relating to decisions about property and financial affairs. With the MCA 2005, attorneys with lasting power of attorney can now be given the legal right to make decisions about a far greater range of issues by the donor. As well as financial affairs attorneys can decide upon welfare issues including healthcare and provide consent to medical treatment.

### **Important implications for the military**

With the introduction of new medical information systems, it is conceivable that a serviceman's medical records could be available even as far forward as the point of wounding. It would therefore be possible (although not always practicable) for a medic to enquire whether a wounded serviceman has made an advanced directive. Of course if serving abroad the MCA 2005 may not be legally binding. Certainly if a serviceman is wounded whilst on exercise in the UK, or is repatriated, and is deemed to lack capacity, then those treating him will be legally obliged to comply with any binding advanced directives, and also to consult with any person holding lasting power of attorney, if an attorney has been appointed. The Code of Practice for the Mental Capacity Act 2005 is now available at <http://www.dca.gov.uk/menincap/legis.htm#codeofpractice> and is important reading for all those who might come into contact with persons lacking capacity (which includes all unconscious patients).

### **New Ways of Working**

New Ways of Working (NWOW) is a Department of Health document published in October 2005 (16). In the words of the report 'This is about a big culture change, it is not just tinkering at the edges of service improvement.' In essence the report recognises that it is not possible for consultant psychiatrists to be directly involved with every patient. NWOW outlines a vision of how work can be distributed amongst the multidisciplinary team. Under NWOW consultants would have smaller caseloads focusing on the most complex cases. Meanwhile other professions such as nurses, psychologists, and occupational therapists will be encouraged to manage case-loads independently, and assume enhanced roles such as prescribing medication. It is anticipated that pharmacists might also begin to prescribe, or take on a mentoring role to non-medical members of the MDT about medicinal issues.

A stumbling block to this has been that the consultant carries clinical responsibility for all patients in secondary and tertiary care. Particularly sensitive are issues of non-medical staff prescribing. Under NWOW consultants will retain oversight of a group of patients who are on their case-load, and be responsible for providing advice and support to the team, without being responsible for the actions of other clinicians within the team. NWOW addresses concerns that medical staff might have over

clinical responsibility and accountability and the GMC have clarified how Good Medical Practice applies to these new ways of working. In producing NWOW the Department of Health undertook a lengthy service user consultation process. Based on this Ten Essential Shared Capabilities are defined, which all mental health workers should be practicing (see Table 1). These focus on empowering mentally ill patients to make independent choices about their healthcare, and focusing on health and wellbeing rather than simply illness. These shared capabilities reflect perhaps the biggest changes within psychiatry over recent decades: that patients are increasingly becoming 'expert patients' by for example consulting the internet; that mental illness no longer carries such stigma in society; an increasing focus within society on individual rights; and the degrading of the doctor within society.

- Working in Partnership
- Respecting Diversity
- Practicing Ethically
- Challenging Inequality
- Promoting Recovery
- Identifying People's Needs and Strengths
- Providing Service User Centred Care
- Making a Difference
- Promoting Safety and Positive Risk Taking
- Personal Development and Learning

Table 1: The Ten Essential Shared Capabilities  
From: *New Ways of Working for psychiatrists* (DoH)

## **Psychosis Schizophrenia and Cannabis**

The evidence is becoming increasingly convincing that cannabis has a causal role, and is not simply a confounding factor, in the aetiology of schizophrenia (17,18). Large prospective cohort studies of 50,000 Swedish conscripts (19), and 5000 young Dutch (20) found those who smoked cannabis in adolescence were up to 7 times as likely to suffer from psychotic symptoms as controls. These and other studies, whilst providing strong evidence that cannabis use is linked to schizophrenia, fail to show a causal link. It remained possible that any link is simply a confounding factor, that people may self-medicate with cannabis, or alternatively that cannabis use causes psychosis to present at a younger age rather than causing it *per se*.

The 2002 Dunedin study (21) followed just over one thousand individuals in New Zealand from birth to age 26. It found that use of cannabis by age 15 gave a 4.5 times increase in the likelihood of developing a schizophreniform illness by age 26. Looking at users of cannabis by 18 there was also an increased rate of schizophreniform disorders, but this result was not significant. In addition this study used a regression analyses to control for the presence of psychotic symptoms at age 11. When this factor was included the use of cannabis before age 15 still resulted in a large increase in schizophreniform disorders by the age of 26, however the results were no longer significant.

More recently a study by Caspi *et al* (22) looked into a specific gene, known as COMT (Catechol-O-methyl transferase). Individuals homozygous for the COMT methionine<sup>158</sup> allele displayed no increased risk of psychotic symptoms following exposure to cannabis in adolescence, whereas those carrying two copies of the COMT valine<sup>158</sup> allele who smoked cannabis as teenagers increased their likelihood of psychosis by ten-fold. This is strong evidence that cannabis does indeed cause psychosis, at least in susceptible individuals. In this study the groups did not differ in the consumption patterns of cannabis. This lends weight to the argument that this is a true causal phenomena, and not simply a confounding factor where those individuals most likely to develop

psychosis would be the most likely to seek out and consume cannabis. It is thought that 25% of the UK population are homozygous for the COMT valine<sup>158</sup> allele. A recent review has suggested that eliminating cannabis could prevent 8% of all schizophrenia cases (17). It also appears that the link is both dose dependant, and that the younger the age of use the higher the risk of psychosis. This increasing evidence of a causal link between cannabis and psychotic illness continues to inform the debate over the legal status of this illegal drug.

## Bipolar Affective Disorder

### *One disease or many?*

Bipolar Affective Disorder refers to a syndrome where the mood of an individual will vary from euthymia, to periods of depression, and to periods of elation. Again it is improbable that Bipolar Affective Disorder represents one true disease entity. The phenomenology is widely debated in the literature, and the current vogue is to refer to two sub-types of Bipolar Affective Disorder: Bipolar I and Bipolar II. Within the DSM IV classification system Cyclothymic Disorder, where the elevated and depressed moods are not sufficiently severe to reach diagnostic criteria, is also classified along with Bipolar Disorder; whereas within the ICD-10 classification system this is treated as a separate and unrelated condition. Any patient who has experienced at least one manic or mixed episode can be given a diagnosis of Bipolar I. Patients who have experienced at least one depressive episode, together with at least one hypomanic episode (a less severe form of elated mood, certainly without psychotic features) meet the criteria for a diagnosis of Bipolar II. Other suggested classification systems for Bipolar disorder have sub-divided it in up to seven different categories including a Bipolar I ½ (23) or a Bipolar III, IV, V and VI (24). Further sub-divisions of this syndrome include the concept of whether somebody displays 'rapid cycling' (Table 2). This refers to a group of patients who have four or more distinct mood swings in a single year (2). In fact it seems that the concepts of Bipolar I, Bipolar II, and rapid cycling do have important and evidence based implications in the management of individual patients.

Sub-Type	Definition
Bipolar I	A patient has experienced at least one manic, or mixed episode, of mood disorder. Episodes of major depressive disorder or hypomania can also have occurred.
Bipolar II	Presence of one or more major depressive episodes. In addition the presence of at least one hypomanic episode. The patient has never experienced a manic or a mixed episode of mood disorder. (Between 5% and 15% of Bipolar II patients will go onto receive a diagnosis of Bipolar I.)
Rapid Cycling	Rapid cycling is defined as the occurrence of at least four major depressive, manic, hypomanic, or mixed episodes during the previous year. New episodes occur when there is a switch to an episode of a different polarity, or following a period of remission lasting at least 2 months.

Table 2: Current classification system for Bipolar affective disorder. (Adapted from DSM IV)

### The morbidity due to depression within bipolar disorder

Now that the concept of bipolar II is widely accepted the prevalence of bipolar disorder has increased to around 3% of the population (25). It is thought that up to one third of patients with a diagnosis of major depressive disorder will go on to receive a

diagnosis of bipolar disorder. It is therefore always important to carefully question all patients presenting with depression for previous episodes of hypomania. Recent studies have shown that for both bipolar I and bipolar II patients are symptomatic for around 50% of the time. For bipolar I patients 2/3 of this time is spent with predominantly depressive symptoms (26); for bipolar II at least 90% of the episodes are predominantly depressive (27). Patients with bipolar disorder will spend on average 9 years of their lives with depression. Although it has becoming increasingly recognised that the majority of morbidity in bipolar disorder is associated with depression, and not manic or hypomanic episodes, a systematic review of treatments for bipolar depression by Gijnsman *et al* in 2004 (28) was only able to include 12 randomised, controlled trials (RCTs), and only 5 RCTs compared the use of antidepressants with a placebo. That such little research has been conducted in such an important illness has been described as scandalous. He concluded that *"the gap between practice and theory should make us all uncomfortable"*.

### Treatments in bipolar depression

The National Institute for Health and Clinical Excellence (NICE) published a full guideline in the management of bipolar disorder in July 2006 (29). This comprehensive guideline is evidence based and in broad agreement with the other commonly used guideline in the UK, produced by the British Association for Psychopharmacology (30). There is a growing evidence base for the use of atypical antipsychotics as the first line intervention for acute manic episodes, and this is the strategy suggested by the NICE guideline. Atypical antipsychotics are increasingly also being used for long term prophylaxis in bipolar disorder, although currently only Olanzapine has a UK licence for this. For bipolar depression it seems that antidepressants are effective (28). The NICE guideline suggests caution, and indeed stopping antidepressant medication after successful response (29), as there is a risk that antidepressant medication may cause switching from a depressive episode to a manic or hypomanic episode. Gijnsman's systematic review found that overall antidepressants did not induce switching to mania (with switching rates for antidepressants 3.8%, compared to 4.7% for placebo); however tricyclic antidepressants did cause a higher switching rate at 10%. An RCT published last year (31) found that the antidepressant Venlafaxine was much more likely to cause switching in bipolar depression than the antidepressants sertraline or bupropion, but in this study the increased risk of switching appeared to be limited to the 'rapid cycling' sub-group. Following a trial by Calabrese *et al* published in 1999 (32), there has been considerable interest in the use of Lamotrigine as an antidepressant agent for bipolar depression, and is a suggested treatment for bipolar depression in those who are rapid cyclers, or have recently had a hypomanic episode (29). There is also growing interest in the use of Quetiapine, an atypical antipsychotic, in the treatment of bipolar depression with evidence from an RCT (33) suggesting it to be both effective and well tolerated when used as a monotherapy compared to placebo. Both of these agents also have growing support of having additional benefit over other anticonvulsants or antipsychotics in preventing depressive relapses (34).

### Post Traumatic Stress Disorder

#### The Role of Screening in Preventing and Detecting PTSD in Military Populations

At face value it would appear that it would be beneficial for the military if they could predict which soldiers would become psychological casualties. However it has been assessed that between 20% and 30% of the soldiers screened would be case positive on the screening process and require a subsequent assessment by their medical officer (35). Very few of these

would actually have a psychiatric diagnosis and require input from mental health services (36). Even so, in the run up to operational deployment, this would cause the absence of soldiers from their units and other logistical difficulties. The search for mental health symptoms might focus soldiers minds on this issue, create personal doubts where none previously existed. Meanwhile soldiers and NCOs might lose faith in the reliability of all positively screened soldiers (whether true or false-positives), and so adversely affect morale in the lead up to combat. Such screening programmes have been assessed in a UK serviceman population (37-39). This research found that such screening had little support amongst servicemen. Take up rates for appointments with medical officers were less than 30%; this take up rate dropping further amongst case-positive soldiers, and also during the build up to operational deployment. Reasons for soldiers refusing to take up offers of appointments following psychological screening include the social withdrawal of unwell soldiers, a fear of stigma, and a lack of confidence in the military health-care system (38). Following a deployment attempts to screen troops might mean that unwell soldiers might "answer questions in a way that reduces any chance of delaying their well-deserved leave" (35).

A comprehensive review of this subject has recently been published in the Journal of the American Medical Association (35). This review reminds readers that just as any other screening programme, the costs and potential adverse effects of screening need to be assessed, and that there are well established principles for any new screening intervention (40). The authors conclude that there is currently no evidence that psychological screening is beneficial, could in fact cause harm, and might divert resources away from more useful programmes to support the psychological well being of combat troops.

### Psychological Debriefing

Following a traumatic event, it is natural that those caring for the 'victim' will want to do everything possible to prevent any ongoing psychological damage. For many years mental health professionals have been instigating debriefing sessions for those exposed to trauma, and in some organisations such debriefing sessions have been compulsory (41,42). In the last month the author has been taught by some enthusiastic psychotherapists, as a compulsory part of his psychiatry training programme, the value in holding group emotional debriefing sessions following traumatic events. There has also been pressure on organisations to conduct debriefing after employees have been exposed to trauma, in order to reduce any subsequent litigation. Indeed in a class action involving over 2000 British Military Personnel, the failure to provide such debriefing was one of the charges made against the MOD (43,44).

As admirable as these motives are, psychological debriefing is an intervention, and like any other intervention needs to demonstrate an evidence base. Although there are a large number of people who have found such debriefing sessions helpful, repeated systematic reviews have found that there is no evidence to support improved outcomes following psychological debriefing (45,46). Even more worryingly there is some evidence from RCTs that psychological debriefing can in fact cause harm (47,48). Several hypotheses for how debriefing can lead to harm have been postulated. It has been suggested that those offered debriefing might not then go onto use their own natural support networks that might have promoted recovery. Another suggestion is that where, in a process of debriefing, individuals express their emotions, the sympathetic nervous system becomes activated interfering with the normal encoding of the traumatic memory, or causing a state of hyperarousal causing symptoms of PTSD to escalate. This second suggestion is supported by an RCT published in the

British Journal of Psychiatry in 2006 which showed that individuals with baseline hyperarousal were damaged by an emotional debriefing model, but not an educational model (49).

The current NICE guideline for PTSD (50) makes the clear recommendation that the systematic provision of 'single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services'. In a review article following the judgement on the previously mentioned court case Colonel Palmer arrives at the same conclusion based on first principles, and places the sociological and psychological issues of trauma neatly within a military framework (51).

This subject remains a contentious issue and there are still dissenting voices who strongly advocate the use of debriefing following traumatic events (41), and it certainly remains important to remember that individuals do need emotional support following a traumatic event, and some will go onto need medical support. Indeed there is increasing evidence that both medication, and trauma-focused therapies are effective in managing PTSD (50,52). However until evidence, based on ethically approved trials, demonstrates a role for this type of intervention, psychological debriefing should have no place within military organisations.

### Computerised Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is the current in-vogue psychotherapy. There is an established tradition that CBT can be delivered in a brief, time limited, fashion consisting of approximately 8-20 weekly, structured, one hour, sessions. In this format CBT has a demonstrable efficacy for the treatment of depression, agoraphobia, social phobia, PTSD, bulimia, obsessive-compulsive disorder, and schizophrenia (53). It is also a relatively cheap intervention as far as psychotherapies are concerned. Even so the availability of CBT in the UK is restricted by the relative expense and scarcity of clinical psychologists, which in many areas leads to long waiting lists for this form of intervention.

One way of increasing the availability of cognitive and behavioural focused therapies is in the use of 'self help therapies'. The rather grand title of 'bibliotherapy' has been given to the practice of using books to increase psychological well being. Many self-help books adopt cognitive behavioural methods in a written format. These are available in high-street book shops, and similar booklets are often handed out in psychiatric out-patient clinics. There is good evidence that bibliotherapy is an efficacious intervention (54), and can be as effective as therapist led CBT (55).

Computerised CBT (CCBT) takes the concept of self-help therapies one stage further. In its simplest format it is just the provision of a 'soft copy' of traditional bibliotherapies. At its most advanced CCBT can provide an interactive experience for the patient, with the computer responding in an appropriate fashion to their input. CBT is to some extent a didactic treatment, and therapists will explain the cognitive and behavioural models of illness to patients. Many therapists using CBT will also use protocols, and well-established session-by-session treatment plans as interventions for particular presentations (56). These elements can easily be incorporated into an interactive computer programme. In fact CCBT has been around for over 20 years (57); NICE produced their first technology appraisal of this area back in 2002.

Many people have expressed great reservation about CCBT. Clinicians themselves may feel supplanted by this technology, and many express frank disbelief that such an approach can be effective. CCBT is of only limited use in people who are not

computer literate; most packages also rely heavily on text, so require the client to be literate, normally with a minimum reading age of 11 years. CCBT can lead to concerns for patient safety, with the possibility of patients reporting thoughts of self-harm to the computer, with little or no supervision in place from a clinician. Even IT literate clients can find the CCBT approach impersonal. Certainly drop out rates for CCBT are of the order of 30% (58). Lastly a consideration needs to be made for patient confidentiality

Many of these concerns about CCBT can be redressed. As the programmes become increasingly sophisticated the interactive feel is improving; many programmes now incorporate video graphics, and audio feeds. Some of the CCBT programmes are designed to be used either in a clinic, or at a GP surgery. This allays some concerns about suitable supervision and confidentiality. Programmes delivered in the routine care setting do not require patients to have personal access to a computer. Some require no previous IT experience on behalf of the user. CCBT can have considerable advantages over bibliotherapy, it is possible that the use of IT conveys a considerable placebo effect over the written word. In addition where the package is delivered in a structured fashion, with homework to be completed between weekly sessions, there is an increased onus on the client to actually work through the material compared with traditional bibliotherapy. CCBT also has an application in particular niche markets such as an internet delivered package for housebound patients with severe agoraphobia or social phobia, and perhaps for severely ill patients who might be unable to tolerate interaction on a 1:1 basis with a therapist. CCBT can be viewed as a supplementary intervention to therapist led CBT, for example as part of a stepped care approach, or to be used as an 'add on' to therapist centred CBT (59).

There are some free-of-charge CCBT packages available over the internet [for example [www.livinglifetothefull.com](http://www.livinglifetothefull.com) or [www.moodgym.anu.edu.au](http://www.moodgym.anu.edu.au)]. The five packages included in the most recent NICE guideline (60) are commercial packages. The NICE guideline assesses the available evidence and is equivocal on three of these; but recommends the package 'Beating the Blues' as an option for delivering CBT in the management of mild and moderate depression, and 'FearFigher' as an option for delivering CBT in the management of panic and phobia. There are a number of problems with assessing the evidence base of CCBT. Technology in this area is advancing rapidly and hence by the time evidence is available the software can be out of date and seem archaic. Also companies with a commercial interest in this area are able to race ahead and demonstrate an evidence base, whilst not necessarily offering an advantage over free resources openly available on the internet.

Currently it is certainly fair to say that some CCBT packages are efficacious. CCBT will become increasingly acceptable to the new generations brought up in the internet age. There is a considerable amount of research into CCBT currently being conducted. This allows the possibility that the evidence base supporting the use of various types of CCBT will increase in the near future. A paradigm shift whereby patients with mild to moderate depression or anxiety will access a course of CCBT via the NHS Direct website, before they even consider presenting to their GP, may not be too far in the future.

## Conclusion

The evidence base in psychiatry is rapidly changing, with constant advances in the understanding of mental illness. The way that services are provided, and the legal context surrounding the mentally ill and mentally incapacitated are also undergoing a period of review. Treatments, both psychological and physical, continue to emerge that will help in alleviating the distress of psychological illness.

Take home messages:

- All healthcare professionals should familiarise themselves with the new Mental Capacity Act by looking at the code of conduct (15).
- Cannabis is a harmful substance.
- All patients presenting with depression should be carefully questioned for previous episodes of hypomania.
- Psychological screening has at best a limited role within the military.
- There is no evidence base for psychological de-briefing, and it may in fact be harmful.
- Computerised CBT is here to stay, and will become an increasingly important intervention.

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