

Highlights of this issue

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Mental healthcare in general health settings

Two studies in the *Journal* this month examine mental health interventions delivered in general health settings – one in a general hospital and one in an occupational healthcare setting. A cognitive behavioural group treatment for a range of functional somatic syndromes was tested in a study by Schröder *et al* (pp. 499–507). Compared with enhanced usual care, those receiving the intervention showed greater improvements in self-reported physical functioning, bodily pain and vitality, and, indeed, on most secondary outcomes. The authors highlight in particular the benefit demonstrated for those receiving the intervention despite the severity of health impairment typical of their sample and the novelty of including participants with a wide range of functional somatic syndromes. In an editorial, Morriss (pp. 444–445) comments that the burden of providing care to those with functional somatic syndromes lies predominantly with primary care and that, given the reluctance of affected individuals to accept referral to mental health services, the main role of mental health professionals may well be the provision of training, support and advice to primary care colleagues rather than direct patient care.

Collaborative care as an intervention for major depressive disorder was the subject of investigation by Vlasveld *et al* (pp. 510–511) in a randomised controlled trial based in an occupational healthcare setting, with the occupational health physician operating as the care manager. Workers on sick leave for between 4 and 12 weeks were screened for depression and those meeting criteria for major depressive disorder on subsequent assessment were approached for inclusion. Symptom reduction ($\geq 50\%$ on the PHQ-9) was seen more often in the treated group at 3 months but no effect was seen when the PHQ-9 was considered as a continuous measure of outcome. Gilbody *et al* (pp. 442–443) comment in a linked editorial that mental health services have a potentially important role in reducing the impact of depression on the workforce in the UK and consequently on the economy. Examining the impact of mental and physical disorder on partial rather than total disability (inability to perform some, but not full-role, functions in daily life) in a large international sample, Bruffaerts *et al* (pp. 454–461) found that those with disorders reported 1.58 additional disability days per month. At

an individual level, mental health disorders such as post-traumatic stress disorder, depression and bipolar disorder yielded the highest number of days with disability, whereas physical disorders had the greatest impact at a societal level.

Longitudinal studies – mortality, course of common mental disorder and maltreatment

Page *et al* (pp. 485–490) utilised data from the UK General Practice Database to test the hypothesis that individuals with severe and enduring mental disorders are at elevated risk of heat-related mortality. Among those with psychosis, dementia and substance misuse disorders, risk was highest for those of younger age, those with a primary diagnosis of alcohol or other substance misuse, and among those prescribed hypnotics or antipsychotics. Individuals with alcohol use disorders are also known to be at elevated risk of depressive and anxiety disorders. Boschloo *et al* (pp. 476–484) found that the persistence of depressive and/or anxiety symptoms can be influenced by the co-occurrence of alcohol use disorders – in a 2-year follow-up study, such persistence was predicted by DSM-IV alcohol dependence but not by abuse.

The extent to which maltreatment in childhood is associated with later development of mental ill health has been difficult to determine because ascertainment of information about childhood maltreatment has often been undertaken retrospectively. In a study comparing the impact of prospective and retrospective data ascertainment, Scott *et al* (pp. 469–475) found that childhood maltreatment was associated with elevated risk of mood, anxiety and drug disorders under both study conditions, with no difference found between the comparison groups.

Cognitive decline in childhood and deterioration in later life

In a longitudinal study of children with 22q11.2 deletion syndrome, a group known to have substantially elevated risk of schizophrenia, Duijff *et al* (pp. 462–468) found evidence of cognitive decline observed between the ages of 5.5 and 9.5 years. The authors suggest that further study of genes at the 22q11.2 locus might aid understanding of the aetiology of early cognitive deterioration. Taylor *et al* (pp. 491–498) conducted a magnetic resonance imaging study to examine the visual cortex of individuals diagnosed with dementia with Lewy bodies. Visual cortex abnormalities were identified in higher visual areas but function appeared preserved in lower visual areas.