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Highlights of this issue

Edited by Derek K Tracy

E lucevan le stelle

Lithium. Is there anything it can't do? It has excellent effectiveness data and a range of other potential benefits including reducing rates of suicide, yet it seems forever in terminal decline in actual usage. De Picker et al (pp. 425–427) take a very novel approach in looking at the association between serum lithium levels and incidence of COVID-19 infection. This isn't as pie-in-sky as it sounds: there are data showing that lithium has antiviral properties, potentially via inhibiting RNA replication, and *in vivo* studies have shown that it can inhibit replication of coronaviruses. Taking electronic patient records of over 26 000 patients with documented drug levels during the pandemic, 6 month infection rates were explored. Lower rates of COVID-19 infection were seen in those on lithium compared with those on valproate; moreover, in the lithium group, those at therapeutic levels did better than those at sub-therapeutic levels. The findings held for both new diagnoses and positive PCR tests and were independent of diagnosis and vaccination status. The lithium miracle continues…

Of course, vaccinations still matter. We're all aware of the greater overall vulnerabilities of many with mental illnesses to COVID-19 and the concerns about a reduced access to an appropriate vaccination schedule. Murphy et al (pp. 417–424) give us more detail on this, in a cross-sectional analysis of a prospective cohort in Northern Ireland. Overall, those who had been in receipt of psychotropic medication had reduced odds of being vaccinated, though sub-analyses showed that this finding only held for anxiolytics, hypnotics and antipsychotics, not antidepressants. Sticking with vaccines, Kaleidoscope (pp. 434–435) discusses a putative one for Alzheimer's disease (and yes, #JustSaysInMice), before shifting gear to explore the impact of environmental lead on neurodevelopment, and asks whether there has been any improvement in the gender disparity of publishing in the world's top journals.

L'ora è fuggita, e muoio disperato

A couple of papers this month look at the associations between mental illness and physical health outcomes. Dementia is about twice as common in those with a history of depression, but the nature of this link has been tricky to tease out. This is particularly the case when trying to account for sociodemographic confounders and how upbringing might play a part in the strong familial aggregation of both conditions. Korhonen et al (pp. 410–416) control for this in a national cohort study of over one and a half million individuals aged 65 or older in Finland. The authors looked at a history of depression 15–30 years before baseline assessment to minimise any affective disorder being part of an early prodromal neurodegenerative process. Overall, they found an adjusted hazard ratio of 1.27 for dementia, rising to 1.55 in a sibling-fixed model that controlled for unobserved shared early-life experiences and genetic factors. Their interpretation of the latter finding is that this association does not arise from familial factors but is driven by depression. Education levels did not seem to affect this, but the association was weaker for the widowed than the married, and stronger for men than women. The data support depression as an aetiological risk for dementia.

Fleetwood et al (pp. 394–401) note how severe mental illness (SMI) is associated with an increased stroke rate and explore what that means in terms of actual care received and subsequent prognosis. Taking Scottish data over 23 years, 30 day mortality was significantly higher for those with schizophrenia, bipolar affective disorder and depression, as well as higher rates of subsequent cardiovascular events and mortality at 1 and 5 year time points for such individuals. Interestingly, there were no clear differences in provided care, which takes us to the paper by Wang et al (pp. 402–409) on healthcare resource use and costs for people with type 2 diabetes mellitus (T2DM). Compared with those who only had T2DM, individuals with a comorbid SMI had annual average costs £1930 higher; this increase was driven primarily by greater use of secondary care, with more mental health and non-mental health hospital admissions.

E non ho amato mai tanto la vita

The nature of psychiatry means that we often get drawn into complex areas on decision-making. Kam Bhui and Gin Malhi (pp. 374–376) discuss the proposed UK Assisted Dying Bill. The background is one all reasonable people will sympathise with: the autonomy and dignity of those with a terminal illness potentially facing increasing pain and distress, and loss of function and cognitive capabilities. Indeed, debate in the House of Lords was marked by moving revelations by Lord Field on his own terminal illness, and Baroness Meacher, who proposed the Bill, confessing that she had broken the law to help a friend to die. The legislation sets out how professionals might support individuals in such situations who wish to end their life. A summary is that it would require two doctors, independent of each other and one not involved in care, to confirm that: the person is terminally ill; they have the capacity to make decisions to end their life and understand alternatives; and that such intention is clear and settled. Should either doctor question this capacity, a psychiatrist will assist. Bhui and Malhi don't doubt the intent of the legislation as being benign at heart, but they question both the practicalities of how such issues are implemented – with challenges of appropriate oversight and risks of coercion – as well as the inadequately tested aspects around those with mental illness. In my opinion, the 'slippery slope' argument has been misused in many societal debates, but here the authors draw out examples from other jurisdictions where euthanasia has been extended to non-terminal 'unbearable suffering'. They express concern that this might be taken to include many instances of mental illness.

Peter McGovern (pp. 428–430) comments on the QualityRights initiative of the World Health Organization (WHO). The aims of this WHO drive are to reduce coercion, respect human rights and promote recovery-orientated community-based practice. Hard to imagine there's any disagreement in the room on such principles, so where's the beef? Well, last year, an article in the *BJPsych*[1] unpicked this in some detail to say good intention couldn't hide a rather negative portrayal of our profession, with unrealistic proposals to completely abolish involuntary treatment. McGovern – who helped develop the material – says this is to fundamentally misunderstand the WHO intent, and that we have nothing to fear. Two papers to debate in a continuing professional development group or journal club, I would suggest. Finally, McCowan et al (pp. 371–373) set out what I found to be a really thoughtful piece on the often unconsidered issue of autistic psychiatrists and the strengths and values they bring to the workplace. Better recognition of this, and joint learning, are called for – I couldn't agree more.

Reference

1 Hoare F, Duffy RM. The World Health Organization's QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry. *BJPsych* 2021; **218**(5): 240–42.

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