BJPsych The British Journal of Psychiatry (2023)
222, A19–A20. doi: 10.1192/bjp.2023.35

Highlights of this issue

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Viking, North Utsire, Forties, Cromarty, Tyne, Dogger, Fisher, German Bight, Lundy, Fastnet, Rockall, Malin

Lots on forecasts this month. There is much interest in how depression and anxiety predict later trajectories in young people. Two papers in this month's journal explore this, both taking data from the longitudinal UK ALSPAC cohort. One looked at how early symptomatology manifests in functioning into young adulthood, the other at how parental difficulties change children's well-being. In the former, Morales-Muñoz et al (pp. 212–220) explored clinical data of over 8000 participants at ages 8, 10 and 13 years and followed up their subsequent psychosocial well-being at age 24. There were differences in illness patterns, with anxiety generally decreasing from childhood to adolescence and depression doing the opposite. Earlier occurrence of anxiety, depression or their combination was significantly associated with worse outcomes, including mental illness and difficulties with education and employment. Having both these problems as a child had the greatest adverse impact, including the additional likelihood of later substance misuse. Martin et al (pp. 204–211) tackle the question of how parental postnatal depression might affect children by the time they reach early adolescence. Taking a little under 5000 mother–father–child triads, the authors initially looked for associations between depression symptoms and so-called 'bridge symptoms' that might reinforce illness during infancy. Subsequently, a network model was used to explore associations between these and adolescent outcomes. Specific symptoms were indeed linked to those late childhood problems, notably guilt, anhedonia, panic and sadness in mothers, and, for fathers, feelings of being overwhelmed. The work is particularly interesting in terms of moving beyond a binary presence or absence of illness or scale cut-off scores to begin to explore the underlying mechanisms that might be causal in reinforcing depression networks between parents. Dr Lisa Lloyd from Coventry and Warwickshire Partnership NHS Trust writes more in this month's Mental Elf blog at: https://elfi.sh/bjp-me34.

Northwesterly 3 to 5, veering northeasterly 5 to 7. Moderate or rough. Snow showers. Good, occasionally very poor

Two interesting articles on people with intellectual disability (PwID), with Sam Tromans and colleagues (pp. 188–190) exploring the pending reform of the Mental Health Act and an analysis by Branford et al (pp. 191–195) on anti-seizure medication (ASM). The draft Mental Health Bill, which will amend England and Wales's 1983 Act, has proposed protections for PwID and people with autism to ensure that they are not involuntarily detained without the presence of a mental illness. So far, so good. But Tromans et al invoke the law of unintended consequences and challenge us that good intentions might nevertheless create harm. They note the greater complexity of assessing those with intellectual disability and autism on psychiatric in-patient admission, a process that can take a considerable amount of time owing to varying issues around communication, capacity assessments, behavioural difficulties, and atypicality of symptoms and presentation. There are dangers that altered legislation will lead to people being discharged unduly rapidly, without time for provision of suitable accommodation or adequate packages of care (including via the 'protection' of section 117 aftercare) and with community healthcare staff unable to appropriately manage any behavioural challenges. The focus of any policy change, they argue, should be the provision of timely, high-quality community care packages, and alternative and acceptable legal frameworks need to be in place. A strengthening of the Mental Capacity Act is one suggestion, but with a need for better safeguards such as those provided by the Mental Health Act.

I must confess I hadn't realised that ASMs are the second most widely used medication class in PwID – indeed, their use is on the rise – and that in many cases they are part of a polypharmacy regime involving two or more ASMs. It's usually assumed that instigation of ASMs is due to a history of epilepsy, but this can be a legacy issue from childhood; it may be due to concomitant psychiatric comorbidity or an attempt to manage challenging behaviour. The authors note how much of this is off-label. Interestingly, the seemingly obvious potential link between seizure activity and post-ictal challenging behaviour is not clearly borne out by more recent reviews of the rather mixed literature, so controlling seizures to control problematic behaviour doesn't appear to be as logical as it might have seemed. Overall, it's disappointing to learn how limited the national data are on this issue, though it's probably no worse than any other area one might drill down into. However, given the concerning mortality data from the national Learning Disability Mortality Review Programme, Branford et al are right to call for all stakeholders to come together to address this issue, to have better education and adherence to evidence-based prescribing guidelines, and to have clear rationales and monitoring when medications are commenced.

Great Orme Head to the Mull of Galloway – strong wind warning. West or northwest 3 to 5, becoming variable 2 to 4

Post-traumatic stress disorder (PTSD) can clearly arise from any number of traumas. One would not wish to seemingly uncaringly 'rank' pains, but we can recognise how they can vary from, for example, an awful but random road traffic accident to very targeted physical or emotional abuse, and, further, how such incidents could be a one-off or part of a pattern of complex trauma over years. Although most people might anticipate a form of imperfect dose–response relationship, less research has unpicked how this affects treatment success. Hoppen et al (pp. 196–203) systematically reviewed and meta-analysed data on the efficacy of psychological treatments in children and adolescents exposed to single or multiple traumas. Their work encompassed 57 randomised controlled trials with over 4000 participants. As one might expect, treatment had better outcomes than passive and active control conditions more generally (though a lack of adequate trials ($N = 1$) meant no firm conclusions could be drawn for active controls in single-event PTSD). And in terms of the number of traumata? Efficacy did not differ by exposure frequency. This is reassuring for clinicians.

We wrap up this month with Ian Kelleher's editorial (pp. 185–187) on moving psychosis predictive work to child and adolescent services. He reasons that the current clinical high risk approach is evidently only catching a very small percentage of future cases of psychosis, and – critically – interventions in the area are not clearly working. Taking animal models of schizophrenia, Kelleher persuasively argues that we need to move the needle back and catch people at earlier stages of brain development, when there are greater opportunities to limit pathological synaptic arborisation and pruning, functional connectivity and dopaminergic maturation. Although psychoses are clearly very rare in child and adolescent mental health services (CAMHS), those

who attend for any reason have considerably greater risks of later developing them. CAMHS are put forward as a 'high-capacity, high-risk system for future psychosis prediction' with enormous and as yet untapped potential. Finally, finishing our shipping forecast for the month, Kaleidoscope (pp. 224–225) tackles, among other issues, the hoary question of whether a little alcohol, occasionally taken, might be protective against the future development of depression.

https://doi.org/10.1192/bjp.2023.35 Published online by Cambridge University Press