

## Highlights of this issue

By Kimberlie Dean

### Outcomes for those with severe mental illness: crime victimisation, mortality and gender differences

Several papers in the *BJPsych* this month examine risks and outcomes for those suffering severe mental illness (SMI). Khalifeh *et al* (pp. 275–282) found strikingly elevated risks of past-year crime victimisation, including violent crime, among individuals with SMI compared with the general population. Women with SMI were at particularly high risk of domestic, community and sexual violence, with four- to ten-fold higher odds of reporting such experiences compared with women surveyed in the general population. The psychosocial morbidity following experience of violent victimisation was also greater in the SMI group in this study. In a study based in rural Ethiopia, the rate of excess mortality for those with SMI was found to be twice that of the general population, over 10 years of follow-up (Fekadu *et al*, pp. 289–296). Those with SMI died approximately three decades prematurely, mainly from infectious causes. The authors comment on the need to include both premature death and mortality due to self-harm in the estimation of the global burden of disease for SMI, an issue which is particularly important in low-income country settings where healthcare investment decisions are based on prioritisation informed by estimates of disease burden. In a 14-year follow-up study based in rural China, Ran *et al* (pp. 283–288) found that males with schizophrenia were significantly younger, had significantly higher rates of mortality, suicide and homelessness, and lower levels of support than females with schizophrenia. A range of other outcomes, including symptom scores, suicide attempts and inability to work, did not appear to differ by gender. The authors comment on the need to consider gender-specific factors when developing and implementing interventions for schizophrenia.

### Intervention outcomes: gains in employment, mortality, carer experience and preventing depression

Data from a randomised trial comparing cognitive therapy with paroxetine treatment for depression was used by Fournier *et al* (pp. 332–338) to examine relative gains in employment for treatment responders in relation to treatment type. At the end of 28 months of follow-up higher rates of full-time employment were found in the cognitive therapy group, although effects were not seen earlier in the study following acute treatment. The authors comment on the broader economic implications of their findings and argue that cognitive therapy should be considered

the treatment of choice for those with depression who are unemployed. Krivoy *et al* (pp. 297–301) examined the relationship between adherence to antidepressant therapy and mortality rates in a sample of patients with ischaemic heart disease and found that those with moderate and good adherence had significantly reduced adjusted mortality rates compared with the non-adherent group, over a 4-year follow-up period. Interestingly, the unadjusted results indicated the opposite association between adherence and mortality, with adherence actually being associated with having more risk factors for mortality such as older age and comorbid physical disease.

A systematic review and meta-analysis undertaken by Yesufu-Udechuku *et al* (pp. 268–274) found evidence to support the hypotheses that carer-focused interventions can improve the caring experience, improve quality of life and reduce psychological distress for those caring for individuals with SMI, with psycho-education and support-based interventions being the focus of most studies included. Overall, however, the authors found the quality of evidence to be mainly low and very low.

Given the prevalence, treatment difficulties and poor associated outcomes, prevention of late-life depression is an important health priority. In a large sample of women with either prior history of cardiovascular disease or multiple risk factors, Okereke *et al* (pp. 324–331) found that long-term folic acid and B vitamin supplementation did not reduce the risk of depression in mid-life and older women, despite the significant reduction in homocysteine levels achieved in the trial. Similarly, no significant differences between the treatment and placebo groups were found when high-risk subgroup or sensitivity analyses were undertaken.

### Physical ill health as a cause and consequence of mental disorder

Allan *et al* (pp. 308–315) used data from the Whitehall II study to examine the relationship between lifetime hypertension and brain structure in older adulthood and found evidence for an association both longitudinally and cross-sectionally. Poorly controlled hypertension and hypertension of greater duration were found to be associated with greater white matter hyperintensities, supporting a dose–response relationship. The authors call for a greater focus on improving treatment and treatment response for those with poorly controlled hypertension.

In a nationwide longitudinal study based in Taiwan, Chen *et al* (pp. 302–307) found that individuals with post-traumatic stress disorder (PTSD) had an increased risk of developing stroke, including ischaemic stroke, even after adjustment for potential confounding factors. The relative risk was higher for young adults with PTSD and the association persisted even when the first year of observation was excluded. The authors comment on potential biological mechanisms which might explain the observation, including dysregulation of the hypothalamic–pituitary–adrenal axis, and call for more research to investigate such mechanisms.