

Highlights of this issue

By Sukhwinder S. Shergill

Public mental health: is well-being keeping well?

The Annual Report of the Chief Medical Officer on *Public Mental Health Priorities* was published in September 2014. An editorial co-authored by Dame Sally Davies, the Chief Medical Officer, is one of four linked editorials in this month's *BJPsych* that comment on the state of public mental health in the UK. Mehta & Davies (pp. 187–188) suggest that the focus on 'well-being' that has been in vogue over the past few years lacked any significant evidence base to support it; they suggest that the way forward is to adopt a biopsychosocial model focused on mental health promotion, mental illness prevention, treatment and rehabilitation. The background to the concept of well-being is reviewed in more detail by de Cates and colleagues (pp. 195–197) and their editorial highlights the lack of empirical data in general and specifically of validated assessments of well-being in people suffering from mental illness, with the consequent difficulties in monitoring outcomes of any interventions designed to improve well-being. They advocate for improved measures to assess well-being in mental illness rather than an absolute move away from well-being being used as part of clinical commissioning. The urgent need for psychiatrists to have improved training in relevant methodologies, such as logical framework matrix analyses, and to acquire and make use of local health intelligence information is raised in an editorial by Foreman (pp. 189–191). He makes the point that without these tools, it is difficult for psychiatrists to collaborate with their public health colleagues. He points out that psychiatrists are trained in assessment and treatment of symptoms and signs presenting in individuals, while assessment of local population informatics and multiagency intervention is the public health equivalent. Foreman uses the example of school-based interventions for childhood aggressive behaviour to illustrate the key advantage of public mental health approaches; an intervention that results in small effect sizes by individual clinical outcome standards can still yield a very worthwhile impact on population prevalence. Finally, the lack of a public health expert contribution to the Annual Report is raised as a relative failing in an editorial by Stewart-Brown (pp. 192–194); she uses one chapter on applying neuroimaging techniques to identify individuals at high risk of developing psychosis as an illustration – from a public health perspective this is clearly a form of screening – and points to a wealth of existing data showing that any screening programme for symptoms that occur on a continuum in the population is unlikely to meet criteria for effectiveness, however sophisticated the technology being applied to the task. This editorial concludes by commending the Annual Report as essential reading – and echoing the call for greater public health training in psychiatry and mental health training in public health.

Depression and exercise

There are physiological changes associated with physical exercise that could counteract key biological alterations conventionally associated with depressive illness. These include increased levels of brain-derived neurotrophic factor and lowered inflammatory markers, in addition to an improved psychological evaluation. The optimal type of exercise and whether it should be used along with medication remains less clear. Belvederi Murri and colleagues

(pp. 235–242) found that physical exercise enhanced both the remission rates and the speed of remission when added to treatment with sertraline in elderly patients with depression. There were no significant differences in outcomes of the patients that were allocated to progressive aerobic exercise or non-progressive exercise, as both were superior to the sertraline-alone group. The authors commend this as a safe, adjunctive treatment for elderly patients with depressive illness. A similar result was demonstrated in a Swedish primary care study comparing exercise, internet-based cognitive-behavioural therapy (CBT), and treatment as usual in adult patients with mild-to-moderate depression. Both the physical exercise and internet CBT were more effective than standard clinical management of depression – the authors suggest that exercise should be more widely recommended.

Maternal depression, child maltreatment and suicide in Rwandan children

There is an enormous personal, economic and societal cost associated with suicide and self-harm. Increased psychosocial stressors, such as those associated with HIV, and a lack of support may contribute to suicidality. Ng and colleagues (pp. 262–268) report that over 20% of HIV-positive children in Rwanda reported suicidal behaviour compared with 13% of non-affected children. Suicidality was associated with the presence of depression and poor parenting. The authors advocate for an increased focus on tackling child and adult mental health concerns and supporting positive parenting, in addition to wider initiatives to address poverty and improve social support. Plant and colleagues (pp. 213–220) examined the impact of maternal depression during pregnancy on adult offspring, finding a 3.4-times increased risk of depressive disorder in the adult offspring. They found that childhood maltreatment mediated the association between maternal depression and the development of depression in adulthood. The authors suggest that all pregnant women should be screened for depression, and psychological interventions offered to those at higher risk.

Psychological coping after coronary syndrome, partner violence and mental illness

Depressive symptoms are common after a myocardial infarction – and are associated with a greater risk of subsequent cardiac events. Could variations in coping style change the longer-term risk of a recurrence of cardiac events? Messerli-Bürgy *et al* (pp. 256–261) report that patients with a task-oriented coping style had a lower incidence of adverse cardiac events, and the combination of low task-oriented coping and high depressive symptoms showed the strongest association with adverse cardiac outcomes. Given that changing coping styles is a target of many psychological interventions, CBT may be useful in supporting some patients after coronary syndromes. Intimate partner violence is reported in approximately 20% of women in their lifetime, with the presence of consequent depression, post-traumatic stress disorder and suicide. Khalifeh and colleagues (pp. 207–212) demonstrate increased rates of intimate partner violence in patients with chronic mental illness, with higher rates of suicide, and less help-seeking from informal networks but greater help-seeking from health professionals. Recent NICE guidelines on domestic violence emphasise the need for an appropriate response to the presence of such violence in patients with mental illness – and for professionals to be aware of the need to respond within defined care pathways.