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Highlights of this issue

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Rates of involuntary in-patient treatment

Rates of involuntary psychiatric in-patient treatment are known to vary across settings and over time. Keown *et al* (pp. 157–161) conducted an ecological study to investigate the impact of sociodemographic factors such as age, ethnicity and deprivation on rates in urban and rural settings in England in 2010/11. Compulsory in-patient treatment rates were found to be higher in urban areas and were associated with ethnic density. Areas with higher levels of deprivation had higher rates of in-patient treatment while areas with a higher proportion of adults aged 20–39 years had higher rates of compulsion. In a linked editorial, Burns & Rugkåsa (pp. 97–98) welcome the ecological approach taken to the research and comment on the way in which research in the field has developed from simple descriptive studies of admission rates to explorations of the complexity underlying their patterns. The authors highlight the importance of considering both area-level and individual factors. In a related short report by Petros *et al* (pp. 169–170), the impact of childhood trauma on psychosis relapse requiring hospital admission is considered. The report reviews the findings of seven studies and concludes that there is a lack of consensus with regard to this potential association.

In another editorial in the *BJPsych* this month, the ethical issues central to understanding the implications of compulsory treatment rates are considered by Lepping *et al* (pp. 95–96). The authors argue that autonomy should not be considered to have automatic priority over other ethical values such as beneficence, non-maleficence and justice.

Rates and predictors of mortality among people with mental illness

Four papers in the *BJPsych* this month focus on factors associated with mortality – mortality in relation to depression, parenting style in childhood and bipolar disorder. Holwerda *et al* (pp. 127–134) explored loneliness and depression in later life together in order to assess their potential joint effect on mortality. After 19 years of follow-up in a Dutch sample of individuals aged 55–85 years, both factors were found to be associated with excess mortality in bivariate but not multivariate analyses. Severe depression was also found to have an impact on mortality in men who were also lonely, a result the authors describe as a 'lethal combination'. In another study of depression and mortality, Nefs *et al* (pp. 142–149) studied the impact of individual symptoms and potential mechanisms in a sample of people with type 2 diabetes. Anhedonia (but not dysphoria or anxiety) was found to be associated with mortality, and physical activity was revealed to be a potential mediator of the former effect. The authors argue that while studies of treatments for depression have so far failed to demonstrate a subsequent benefit on mortality risk, considering the role of individual symptoms and their associated mechanisms may represent a more fruitful approach.

Parenting style is known to have an impact on offspring health and well-being in early life, leading Demakakos *et al* (pp. 135–141) to examine the later impact on mortality risk at older ages. Using data from the English Longitudinal Study of Ageing, a graded inverse relationship between parenting style and mortality was identified even after adjustment for age, gender and a range of potential covariates. The authors also highlight a finding that parenting style was specifically associated with cancer mortality, but not cardiovascular mortality, and call for their novel findings to be replicated in other samples. In a study of outcomes for older men with bipolar disorder, Almeida *et al* (pp. 121–126) found evidence of an increased risk of both dementia and mortality. The authors comment on the potential for mechanisms underlying these associations to be amenable to intervention and thus to have relevance for preventive strategies.

Overlap between schizophrenia and bipolar disorder

Encouraged by the accumulating evidence of shared genetic and environmental factors contributing to the development of schizophrenia and bipolar disorder, Reininghaus *et al* (pp. 107–113) present the results of an evaluation of a transdiagnostic psychosis dimension encompassing features of both disorders. Using multidimensional item-response modelling of OPCRIT symptom ratings, the authors identified one transdiagnostic dimension and five specific dimensions, providing the best model fit. They also found evidence to support the diagnostic utility of the dimensions identified with respect to predicting categorical diagnoses.

Interestingly, another paper in the *BJPsych* this month presents evidence for a genetic factor that was differentially associated with schizophrenia but not bipolar disorder – *VRK2* gene expression levels (Tesli *et al*, pp. 114–120). In an editorial also focused on schizophrenia genetics, Curtis (pp. 93–94) comments on the implications of recent findings that, for the first time, identify specific coding variations directly affecting schizophrenia risk. Two genes have been implicated – one, a common variation in *C4* which codes for complement component 4 and has been shown to have a modest effect on risk, and two, rare disruptive mutations of *SETD1A* coding for a histone methylase which has been shown to have a large impact on risk.