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Highlights of this issue

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The coronavirus disease 2019 (COVID-19) pandemic has clearly had an impact on mental health, but it is fortunate that there is still an abundance of high-quality research in psychiatry. This month's Highlights is testament to this and encompasses new dimensions in research, all with considerable relevance to everyday clinical practice.

Our intentions are good but misunderstood

We start these Highlights with a perspective on psychiatry. In 2012, The World Health Organization developed its QualityRights initiative, together with an accompanying Tool Kit. It sought to translate international human right standards – in particular, the Convention on the Rights of Persons with Disabilities (CRPD) – into practice. In 2019, training material was published to support the initiative, but the negative portrayal of psychiatry is a cause of concern raised in an editorial by Hoare and Duffy (pp. 240–242). They argue that psychiatrists implement coercive practices as a last resort, after a careful weighing of the risks and benefits and extensive discussion with the individual receiving treatment and their family. Although the QualityRights initiative has a lot going for it, the finer points may need to be more subtly nuanced.

Pull together

Psychiatry is, by its nature, both holistic and complex. Mental disorders often overlap, with multiple aetiological factors and outcomes. The layers that influence onset and natural history may be stifled by research that has little external validity. That is where mental health-related multimorbidity (MHRM) steps into the frame. In an editorial by de la Torre et al (pp. 237–239), the authors talk us though the advantages of real-world data – observational data that captures healthcare outcomes in real-world settings, from different populations and from different data sources. The opportunities are immense, with the possibility of including outcomes for patients who may not have been included in research studies, the ability to examine multiple mental and accompanying physical disorders; and the ability to explore the interplay with a range of sociodemographic and other clinical data. There is clearly much more to be done for an approach that can provide early intervention for MHRM.

Building up reserves

At first glance, the observation made by Almeida-Meza el al (pp. 243–251) that increased levels of cognitive reserve are negatively and independently associated with dementia incidence when compared with the lowest level, may not surprise us. But whereas previous studies have focused on educational attainment, their study used a multifaceted index that included occupation and leisure activities as part of a large population-based longitudinal study. Apart from educational attainment, both occupation and leisure activities also independently predicted a reduced risk of dementia. What is more, participants who engaged in leisure activities showed a 26% reduced risk of dementia when compared with those who did not engage, especially in those aged between 50 and 84 years. There is a clear message here for the importance of the maintenance of life-long learning, social networks and leisure activities in the prevention of dementia.

New horizons in dementia

With a brief return to real-world data, the study by Vaci et al (pp. 261–267) used the UK-Clinical Record Interactive Search system (UK-CRIS) to analyse de-identified secondary care clinical case records from two National Health Service trusts. This method extracted diagnostic free-text information on current and past diagnostic clinical information using a natural language processing model to include information on medication and scores on two rating scales – the Mini-Mental State Examination (MMSE) and Montreal Cognitive Assessment (MoCA). Their main finding was that medication prescription for dementia treatment stabilised cognitive performance for between 2 and 6 months in 68% of patients. Findings of note were a more marked improvement in both MMSE and MoCA scores for people living with both moderate and severe dementia. Perhaps even more striking was the that improvements were more significant with scores on the MoCA, emphasising the role of improvement in frontal lobe function with cholinesterase inhibitors and memantine.

We finish with a truly elegant study by Roberts et al (pp. 276–282). The authors used single-photon emission computerised tomography (SPECT) to examine a biomarker for Lewy body dementia and apply this to differentiation between mild cognitive impairment (MCI) in Lewy body dementia and MCI in Alzheimer's disease. The finding of a five times greater likelihood of an abnormal scan in probable MCI in Lewy body dementia than MCI due to Alzheimer's disease has implications for showing SPECT to be a useful at the MCI stage where there is high index of suspicion for Lewy body disease.

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