

Highlights of this issue

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Trauma, PTSD and support at home

Traumatic brain injury during military conflict is associated with neuropsychological deficits and functional impairment. In its milder form, as concussion, it is not clear whether, or how, this might overlap with depressive illness and post-traumatic stress disorder (PTSD). Vasterling *et al* (pp. 186–192) demonstrate that depressive illness and PTSD in US military personnel are related to enduring cognitive compromise, while milder traumatic brain injury is associated with much more limited neuropsychological consequences. They conclude that there should be a greater focus on treating depression and PTSD in returning veterans – which should not only serve to reduce emotional distress but also the related neuropsychological deficits. In an accompanying editorial, Rona (pp. 172–174) reviews the nature and consequences of traumatic brain injury in military personnel and suggests that they can be reassured that mild, blast-related traumatic brain injury has a good longer-term prognosis. A UK study examined the influence of perceived difficulties at home on the mental health of military personnel stationed abroad. In these soldiers, Mulligan *et al* (pp. 193–198) found a prevalence of common mental disorder of 18% and PTSD of 3%, with a higher rate of these illnesses associated with perceptions of poor support for the family back at home, and a perception of negative events in the home environment. They suggest that both increasing support to families and increasing the awareness of this support, may have a positive impact on the mental health of personnel deployed abroad.

Psychotic remission and function; antipsychotics and dementia

Remission in psychotic illness has been largely defined as an improvement in signs and symptoms such that they do not interfere with function or behaviour. However, it is not clear how well this maps onto the real-life experience of patients. Oorschot and colleagues (pp. 215–220) use an experience sampling approach, applied during day-to-day functioning, to demonstrate that patients fulfilling these remission criteria did experience lower levels of symptoms and a modest increase in hedonistic experiences; but this did not extend to superior functional improvement. There is ample evidence of increased rates of morbidity and mortality associated with the use of antipsychotic medication in the treatment of patients with dementia. Barnes and colleagues (pp. 221–226) use data from a large UK audit to show that 16% of patients with dementia were being treated with antipsychotics; variations in this figure related to both clinical settings and profiles. There were higher rates of antipsychotic prescribing in in-patient services, care homes and with patients with more severe dementia or dementia related to Parkinson's disease. They suggest that areas of good practice include clear consideration of alternative treatment approaches

and documentation of clear target symptoms, with a planned review of these targets.

Depression and exercise; suicide prevention

There are mixed data on the efficacy of exercise in improving depressive symptoms in older people. Bridle and colleagues (pp. 180–185) demonstrate a robust effect of structured exercise in reducing depressive symptoms in this population. Their systematic review and meta-analysis suggested that participating in an exercise programme could reduce depressive symptoms by 20% – equivalent to that seen in antidepressant and psychotherapy studies in depression. Interestingly, they found that the evidence for mixed exercise, comprising individualised strength and endurance training, was more robust than that available for more generalised movement training such as Tai Chi. The risks of self-harm and suicide are extremely high in the period immediately following discharge from in-patient care. Gunnell and colleagues (pp. 233–238) examined the effects of implementing a national strategy that introduced a formal intensive programme of care for discharged patients at risk of self-harm. They found no evidence for a reduced risk of suicide in the post-discharge period, but did find lower rates of non-fatal self-harm following the introduction of this initiative. The authors also highlight the necessity for, and the practical difficulty in, the evaluation of policy implementation of this nature. A related editorial by Pitman & Caine (pp. 175–177) provides a useful review of the levels at which suicide prevention interventions can be implemented. They highlight the fact that population-level social approaches, such as lowering unemployment, may have a much greater impact than strategies focused on interventions in high-risk target groups. They suggest that in order to be able unambiguously to evaluate the outcomes of any intervention, there needs to be a clearer understanding of the differences between these two approaches.

Morale in mental health and hypotheses

A survey of the mental health workforce in the UK showed that personnel were generally satisfied with both their work and their colleagues. There were variations in the responses, with acute general ward staff being above threshold for emotional burnout, along with staff working in community mental health teams, while crisis resolution teams had better morale. Johnson and colleagues (pp. 239–246) report that their data fit with the contemporary demand–support–control model of job satisfaction, with greater satisfaction linked with higher levels of engagement and job demands, and with high levels of control and support. They suggest that morale could be improved through increased attention to strategies which serve to increase autonomy and reduce job demand. In a related editorial, Burns (pp. 178–179) agrees that low morale is a serious problem but puts forward an eloquent argument that more targeted hypotheses are necessary to make sense of such broad data-sets. He suggests that rather than focusing on the demand–support–control model, the answer may lie in a clear declaration of what the functions and duties are of mental health working in community teams and acute in-patient units, and to desist from constant criticism and reorganisation in these services for a significant period of time.