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# Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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## Preventive psychiatry within public health

Thank you, *BJPsych*, for your timely editorial on population mental health.[1] It is a pity that the authors did not mention the strategy for England entitled No Health without Mental Health, launched in February (before their final submission) as this strategy did involve precisely the teamwork of psychiatrists, public health specialists and economists that they see as 'the challenge'. Their 'must list' for psychiatry begins with help 'to remedy the consequences of adversity and vulnerabilities'.

A key weakness of UK attempts to address health inequalities has been a failure of leadership[2] – and the common mental disorders show a steeper social gradient than common physical illnesses such as heart disease. Can the Royal College of Psychiatrists take a lead in addressing the antecedents of adversity and vulnerability, not just the 'consequences'? Desolate, impoverished neighbourhoods spawn childhood mental illness[3] and rising unemployment breeds desperate drinking and suicidal despair.[4] In the original National Health Service Act 1946, maternity services were the exemplar of planning equitable care on the basis of population health needs . . . but in England today many maternity services are at breaking point, with antenatal care services widely sacrificed to maintain staffing for deliveries. The College could speak with unique authority on the need for better antenatal care, to prevent a generation blighted by neurodevelopmental problems.[5]

I suspect that consultant psychiatrists are, on average, better educated, more articulate and able to reflect than, say, Members of Parliament. Urban degeneration, unemployment and the breakdown of comprehensive health services need to be linked explicitly to escalating economic and social costs of mental illness. Only the College could 'join up the dots' convincingly for MPs to respond to urgent population mental health needs.

There is a timely opportunity to test such specialist influence on national policy. Thanks to heroic lobbying by thousands of women before the last election, the training and deployment of 4200 extra health visitors became one of the goverment's top 10 priorities.[6] The editorial on preventive psychiatry describes 'opportunities to break the intergenerational transmission of risk'. Can psychiatric expertise now permeate into the skill set and effective practice of these 4200 public health practitioners?

### Declaration of interest

W.C. is Editor of the *Journal of Public Mental Health* and currently involved with the national demonstration site for a Victims and Vulnerable Persons Index in North Lincolnshire.


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6 Policy Watch. Re-energising health visiting. *NMC Review* 2011; **1**: 30–1.


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**Authors' reply:** We are indebted to Caan for an opportunity to further debate the potential of preventive psychiatry within a public health context. A failure to address inequalities reflects not only a failure of leadership but also lack of commitment by all sectors to recognise potential benefits in human capital and economic savings over the next decades. The Royal College of Psychiatrists' position statement,[1] which informed the Department of Health strategy No Health without Mental Health, sets out the evidence base and the need for further research. Recognising the role of psychiatrists and specialists in primary, secondary and tertiary prevention as well as the need for further development to include a role for specialists with appropriate training and accreditation processes is vital.

Preventive psychiatry is not new and remedying the consequences of adversity and vulnerabilities are but one of a number of preventive activities that already take place within existing psychiatric practice. The editorial sets this out alongside the new challenges facing specialists but also the wider public health community.[2] The prevention of violence and hostility between adults and young people has been long recognised as a core task of preventive psychiatry.[3] As set out in the College's position statement,[1] protecting and promoting health and optimal maturation of young people while taking account of complex interactions between biology and the environment are key objectives and are also at the heart of more complex approaches to medicine in general;[4] preventing gender violence, sexual exploitation and abuse, promoting best parenting, nutrition, exercise, and education, protecting mental capital and physical health, and delivering interventions that develop mature adults who enjoy the responsibilities of adulthood while still enjoying the pleasures of life over the life-course are clearly important objectives. These policy priorities, although challenged by the need for more evidence and related research questions, are as important in low- and middle-income countries as in their higher-income neighbours.[5]

These ambitious frameworks require local adaptations and actions, which incorporate an understanding of people's lifestyle, attitudes, beliefs, cultures and status reflected in the delivery of interventions.[5] Existing universal and global policies are being challenged by socially excluded groups and by people with multiple health problems, as well as those presenting with novel phenotypes.[4] There is a role for specialists to be central to both policy and delivery, and to inform other stakeholders of the many varieties of personal distress and illness that are often lumped together under the title of mental health; an approach that would not be acceptable, say, for infectious diseases (see Lemkau[6]). Inclusive and progressive policies and practices must protect the health and well-being of the population as a whole but also of the most vulnerable, including those victim to inequalities and social exclusion or those with complex needs that do not conform to unitary concepts of what constitutes mental health, illness and mental disorder;[7] these opportunities must be seized while also



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dealing with economic and financial crises that have an adverse impact on population mental health.


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## Homicide rates and income inequality

There is evidence that psychosocial factors other than those discussed by Swinson *et al*[1] affect homicide rates and it is important to know whether these disproportionately affect individuals diagnosed as mentally ill. Specifically, there is evidence that income inequality strongly influences rates of violent crime, including homicide.[2] Wilkinson & Pickett have claimed that changes in inequality also influence rates of substance misuse.[3] It is thus important to know whether the increase in homicide rates described by Swinson *et al* could be caused by those with psychiatric problems being ‘left further behind’ in terms of income and/or social status.


1 Swinson N, Flynn SM, While D, Roscoe A, Kapur N, Appleby L, et al. Trends in rates of mental illness in homicide perpetrators. *Br J Psychiatry* 2011; **198**: 485–9.

2 Wilkinson R. Why is violence more common where inequality is greater? *Ann NY Acad Sci* 2004; **1036**: 1–12.

3 Wilkinson R, Picket K. *The Spirit Level: Why Equality is Better for Everyone*. Penguin, 2010.


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**Authors' reply:** We were looking for factors which corresponded to the overall rise in homicides in people with psychosis; factors which showed increases of a similar magnitude, over a similar timescale. This was the case for drug misuse, allowing us to infer an association. Evidence has been found linking income inequality to both violent crime[1] and rates of substance misuse,[2] although this has been disputed and there is controversy[3] over the validity of the association found between income inequality and mental illness.[4] There has been a marked increase in income inequality in recent years[5] but, from the data which we have available to us, we are unable to comment as to whether this is also the case among those with mental illness, and whether there is any causal association with homicide rates. In future research we hope to explore the data using deprivation indices which might provide further information on any association between income inequality, mental illness and homicide.


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## Observational BALANCE

We read with interest Kessing *et al*'s timely and welcome paper[1] supporting, by way of observational cohort study, the findings of BALANCE.[2] Lithium again is shown to be superior to valproate for the management of bipolar disorder. The strength in this case comes from bridging the gap between the relatively brief follow-up in randomised control trials (RCTs) and the real-life situation faced by clinicians managing a lifelong illness of unpredictable course. Although the enriched study design in BALANCE aimed to maximise the generalisability of the findings to a clinical population, limitations inevitably remained in terms of including patients who had shown a differential previous response to either lithium or valproate, diagnostic heterogeneity within the sample population, and frequency of comorbidity compared with the general population. The limitations of observational cohort studies are multiple and well documented. One key concern is confounding by indication, but more general problems exist with group biases and masking of cause and effect relationships.

Kessing *et al* used ‘switch to’ and ‘add on’ as proxy outcomes for the efficacy of mood stabilisers. It would have been interesting, if possible, to separate the ‘switch to’ group from the ‘add on’ groups. The ‘add on’ outcome probably represents a treatment failure; however ‘switch to’ is likely to be a combination of lack of efficacy and poor tolerability. Indeed, their findings suggest that the initial, very rapid increase in incidence of switch/add on is related to tolerability rather than efficacy, whereas in BALANCE this finding would have been lost by drop-out during the run-in period. This is unlikely, however, to explain the superiority of lithium that is clearly present in both outcome measures.

It was previously argued that observational studies would overestimate treatment effects and that they hold little value in assessing therapies; however, comparative studies with RCTs, across various branches of medicine have now dismissed this.[3] This sort of complementary approach, reconfirming findings from RCTs over long follow-up periods, is an important addition to the evidence base for treatment. This is especially true in areas where the disorder under investigation is chronic relapsing–remitting, and when the exclusion criteria of RCTs can often mean that external validity is low. If, as has been suggested, bipolar disorder is a heterogeneous condition with subtypes associated with preferential response to specific mood stabilisers[4] (which can be identified by symptoms, clinical course and family history), then the observational study carries even more weight when compared with the RCT as it ‘allocates’ patients to treatments on the basis of



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