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Highlights of this issue

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The impact of mental healthcare policies and practices

Despite the shift from hospital to community-based mental healthcare provision in the decades following deinstitutionalisation, increasing rates of involuntary detention have been observed. Comparing data from two time periods in England (1984/85 and 2015/16), Keown *et al* (pp. 595–599) found that the rate of detention rose from 21.5 per 100 000 to 85.0 per 100 000 in the three decades since the introduction of the 1983 Mental Health Act. The increasing rate of detention was found to be predominantly as a result of a rise in civil detentions over the period; rates of detention under forensic provisions did not see a sustained increase, with court orders decreasing and prison transfers increasing. The authors also found evidence of an increase in private hospital involuntary admissions, with the chances of being detained in a private rather than a National Health Service hospital having increased fivefold. The authors consider a range of possible explanations for their findings, including the likelihood of increased rates of case finding as a result of increased or improved community services, and caution against an approach to mental health legislation review that focuses on the legal framework at the expense of considering the role of mental health service resourcing. In a short report, also published in the *Journal* this month, Paton & Tiffin (pp. 615–616) report on drivers of out-of-area (OOA) admission rates, using real-world data to model a 'virtual mental health ward'. Length of stay and referral rates were found to have a similar impact of OOA admissions, supporting the need to target both factors if OOA admission rates are to be reduced in the absence of an increase in in-patient capacity.

Pay-for-performance schemes, such as the quality and outcomes framework (QOF – focused on primary care) in the UK, aim to financially incentivise quality healthcare in order to improve population health, but evidence of the impact of such approaches, across a broad range of relevant outcomes, is limited. In a spatial cohort study, Grigoroglou (pp. 600–608) found no association between practice performance on the relevant QOF mental health indicators and suicide incidence in practice localities. Area-level socioeconomic factors were found to be more strongly associated with suicide rates in this study. The authors comment on the likelihood that the complex phenomenon of suicide may be influenced by a wide range of factors outside the influence of primary care, highlighting the need for a multiagency approach to suicide prevention.

Finally, Bhui *et al* (pp. 574–578) provide an analysis of the persistent problem of ethnic inequalities in severe mental illness and in the experience of care, considering the underlying causes, barriers to progress and new paradigms required to bring about change. The authors call for the voices of patients to be heard and considered alongside the implications of high-quality research.

Exposure to adversity: childhood sexual abuse, famine and a trial of post-traumatic stress disorder (PTSD) treatment

In an editorial in the *Journal* this month, Ingrassia (pp. 571–573) highlights the work of the Independent Inquiry into Child Sexual Abuse in the UK and, in particular, the implications for mental health services and mental health clinicians with regard to addressing the needs of victims and survivors of childhood sexual abuse. The author comments on the importance of improving the confidence and, often as a result, sensitivity of clinicians in routinely enquiring about sexual abuse during mental health assessments.

In China, the burden of mental illness in the population, particularly of depression, is high. Prenatal exposure to starvation during the Chinese Great Famine of 1959–1961 has been linked to higher rates of schizophrenia in adulthood, and has been postulated as a possible contributor to the burden of other mental illnesses in the country. Using data from the China Health and Retirement Longitudinal Survey of adults aged at least 45 years, Li *et al* (pp. 579–586) found that those who had experienced severe famine during fetal, mid-childhood, young teenage or early adulthood, but not other developmental periods, were more likely to experience symptoms of depression in later adulthood. Famine was estimated to have accounted for 13.6% of depressive symptoms in the population.

On the basis of the high rates of trauma exposure and subsequent PTSD in South African adolescents, Rossouw *et al* (pp. 587–594) trialled prolonged exposure therapy in comparison with supportive counselling, with the interventions delivered by non-specialist health workers, reflecting the scarcity of mental health specialists in low- and middle-income country settings. Those in the prolonged exposure group showed greater improvement in PTSD symptom severity levels at the post-intervention, 3-month and 6-month follow-up points, although both groups demonstrated improvement. Despite the superior improvement seen in symptom levels for the prolonged exposure intervention, measures of general functioning did not differ between the groups.

Targeting modifiable risk factors to prevent interpersonal violence

Fazel *et al* (pp. 609–614) conducted an umbrella review of meta-analyses focused on risk factors for interpersonal violence in general population samples, considering both absolute and relative measures of effect. Strong associations were found for neuropsychiatric disorders, particularly substance use disorders, and the most important historical factor identified was witnessing or being a victim of violence in childhood.

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