

## Highlights of this issue

Edited by Derek K. Tracy

### I feel the need, the need for speed

Every scientific paper on coronavirus disease 2019 (COVID-19) reminds me of the factoid that there were an estimated 200 000 papers published on the topic by December 2020 (one being the paper evaluating the number of papers). We feel the need, the need for speed, as Maverick might encourage, but we also want quality, never mind the width, especially with selection-biased pop-surveys often showing outlandish 'statistics' that only serve to panic. Three high-quality data-sets can be found in this month's issue, all of which wisely avoid the word 'tsunami' (although one let slip in an 'unprecedented'). Kwong et al (pp. 334–343) tap into the Avon Longitudinal Study of Parents and Children that has been following up over 5000 children and parents for many years, and the almost equally large Generation Scotland cohort. The real gains here are that we have big numbers, and participants who have been tracked from long before we ever heard the word 'furlough'. Rates of depression were largely unchanged, but anxiety levels had almost doubled to 24%. These findings are echoed by work by O'Connor et al from the longitudinal UK COVID-19 Mental Health & Wellbeing study (pp. 326–333). Here, 3000 representative adults across the UK were followed-up during the first waves of the pandemic across 6 weeks in March and April 2020. Again, there were no significant changes in depressive symptomatology (or loneliness), but suicidal ideation increased over time. Interestingly, anxiety and levels of defeat and entrapment decreased after an initial spike. It is argued that the 'illness differential' in these papers might involve depression relating to loss whereas anxiety can be more in response to ongoing threat, and further, a sense of global community might protect against depressive guilt and blame. In both of these pieces younger people, women, and those from socially disadvantaged backgrounds seemed to bear the biggest brunt. Lockdown, isolation, loss of employment, child care and other social pressures, as always, do not distribute equitably.

Jeon et al (pp. 344–351) explored a Korean patient database, incorporating everyone who received a mental or behavioural disorder diagnosis in the 6 months prior to having an initial COVID-19 test, matching them by age and gender with up to four individuals without a mental health diagnosis. Across the 230 000 or so included they found no association between receiving a mental health disorder and subsequently being infected with COVID-19, except for one subgroup: people with schizophrenia. However, those with a mental illness had significantly greater mortality rates once infected. Once again, COVID-19 is a social disease, hitting the more disadvantaged harder.

### Sorry Goose, but it is time to buzz the tower

Some areas in mental health deserve particular support and research funding. Rates of depression are almost twice as high in children and adolescents with intellectual disabilities and autism spectrum disorders (ASD). As for everyone else, guidelines recommend talking therapies as an initial intervention: the problems are that the specific evidence base for this is far sparser for these populations, and historical practice has relied more on medication. Cameron et al (pp. 305–314) systematically review the best current data, identifying ten relevant studies. However, 'best current data' are not as good as we might hope for: four were case reports, and six were quasi-experimental – all had moderate to high risk of bias. The authors rightly

note that we need randomised controlled trials in these more vulnerable groups of young people, particularly evaluating any adaptations and specific tailoring of therapy. They also highlighted the current lack of exploration of the experiences of those with intellectual disabilities and ASD undergoing therapy, as well as those of their families and therapists. This leads to the paper by Murray et al (pp. 323–325), who evaluated the utility of the freely available parent-reported Strengths and Difficulties Questionnaire (SDQ) for detecting emotional and behavioural difficulties in young people with intellectual disabilities. The authors note that although the prevalence of such difficulties is high, their accurate identification can at times be challenging, and the SDQ has primarily been tested in more general young populations. Taking data from 626 individuals, they found the measure to be an effective screen in both milder and more severe intellectual disability, and their results indicate it can be used with the same standard cut-off points.

To turn this around, between one in 20 and one in 50 families have a child with an intellectual disability, and this can have an impact in complex ways, from caring commitments through financial challenges to sociocultural factors. Baker et al (pp. 315–322) explored this in the largest such work to date, with parents from the IMAGINE-ID study, where children had an intellectual disability from one of a diverse range of genetic causes. The parents had considerably greater emotional distress than the general population: the child's age, physical disability, autistic characteristics and other behavioural difficulties particularly had an impact, as did difficulties because of a copy number variant (CNV) diagnosis. This last point is a particularly novel finding, and the authors note that it is not yet clear why it is the case that a CNV diagnosis disproportionately has an impact on parents, although they speculate it might be linked to a greater likelihood of also having an oppositional defiant or conduct disorder. It is hard to resist their call for better recognition and support of these parents, or their reminder of the great capacity for adaptation and resilience of so many. Charlie Lynch writes more in this month's Mental Elf blog: <https://elfi.sh/bjp-me29>.

### You can be my wingman any time

Are there 'COVID gains'? For me, these will be by a hybrid work future (some flexibly from home but regularly back to the office for National Health Service instant 'coffee' and gossip) and the renewed emphasis on staff well-being. Regarding the latter, we were stressed in 2018 and we will be stretched in 2022 whatever happens to the virus; can we retain better looking after of healthcare professionals? I am optimistic, but that is my personality. Strydom et al (pp. 302–304) say a third change is last orders for poor care of people with neurodevelopmental disorders. They echo the earlier mentioned findings that the virus has a disproportionate impact on the most vulnerable: for example, those with Down syndrome were three times more likely to die if infected. A complex range of issues are likely to interplay, from the environmental and care settings, through individual constitutional or genetic factors, to inequity in securing any needed healthcare provision. 'Long COVID' may present a particular future challenge. Pamela Taylor and colleagues (pp. 299–301) finish off by updating us on the new Sentencing Council Guideline for offenders with mental illness, which goes live in October. If you give evidence in court, you will need to read it; it is a very terse summary of key points from a lengthy but important new document. As a general adult psychiatrist, I was particularly captured by the description of, and discussion on, 'assessing culpability' and the lack of clinical research underpinning judicial decisions when passing sentence and disposal to either prison or hospital. Finally, Kaleidoscope (pp. 355–356) discusses practical steps at reducing racial inequality in the workplace and asks if Twitter is good for more than cat videos.