Highlights of this issue

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ASSERTIVE OUTREACH TEAMS – COMPOSITION AND CHARACTERISTICS

Recent mental health policy in England has mandated the provision of assertive outreach teams as an adjunct to community mental health teams. Teams are based on the assertive community treatment (ACT) model developed in the USA. Based on surveys of the 24 dedicated assertive outreach teams established within Greater London by 2001, a series of papers in this issue characterise the components of these teams, staff experiences and perceptions and profile the patients receiving these services. Wright *et al* (pp. 132–138) found wide variation in practice and fidelity to the ACT model. They suggest that although such heterogeneity in practice represents a clinical challenge, it also provides a research opportunity to distinguish effective from redundant components of the approach. Billings *et al* (pp. 139–147) found staff to be fairly satisfied with their jobs and not experiencing high levels of burn-out. Teams served a wide range of patients with significant rates of substance misuse and violent behaviour, reflecting a need for assertive outreach expertise in forensic mental health and dual diagnosis (Priebe *et al*, pp. 148–154). Even in established assertive outreach patients, more than 20% can be expected to be admitted compulsorily and more than 30% to be hospitalised within a 9-month period.

SCHIZOPHRENIA . . . BRAIN ABNORMALITIES

Using a case–control design, Collinson *et al* (pp. 114–120) report early-onset schizophrenia to be associated with an average 4.5% reduction in brain volume and significant impairment in intellectual abilities. Findings from the study also indicated that the nature and extent of changes in cerebral volume, asymmetry and IQ differ between men and women.

. . . CLOZAPINE

Although clozapine is thought to be superior to conventional antipsychotics in the treatment of schizophrenia, most recent trials have not replicated the dramatic superiority shown in earlier trials. Moncrieff (pp. 161–166), in a fresh meta-analysis, demonstrates substantial variation between the results of different studies and suggests that it may be inappropriate to combine the studies in a meta-analysis given the degree of heterogeneity between their findings. Shorter duration of trial, higher levels of baseline symptoms, commercial support and possibly earlier year of publication predicted greater superiority of clozapine over conventional antipsychotics.

. . . AND COGNITIVE–BEHAVIOURAL THERAPY

Recent reviews support the efficacy of cognitive–behavioural therapy (CBT) in the management of schizophrenia. Just as schizophrenia as a diagnosis pulls together people who vary considerably in presentation, CBT as a descriptor is similarly imprecise. Turkington *et al* (pp. 98–99) encourage a move away from efficacy studies to the exploration of the active effective ingredients of the CBT process for managing psychosis.

ETHNIC DIFFERENCES IN RISK

Hunt *et al* (pp. 155–160), in a national clinical survey of patient suicides in England and Wales, suggest that different suicide prevention measures are needed for different ethnic groups. For example, diagnostically, three-quarters of Black Caribbean patients had schizophrenia whereas patients from South Asia were most likely to be suffering from affective disorder. With a male preponderance almost universal in suicide research this study reports a higher number of female suicides in Chinese patients, a finding in line with reports from China. McKenzie *et al* (pp. 100–101), in an accompanying editorial, encourage further clarification of risk factors in individual ethnic groups to aid prevention strategies.

DEPRESSION – AN EXPENSIVE ILLNESS

In the National Health Service the cost of treating depression exceeds the cost of treating both hypertension and diabetes. Chisholm *et al* (pp. 121–131) explore the relationship between depression status, work loss and health care costs from a multi-national study of depression in primary care. The economic consequences of currently untreated depression were considerable, both in terms of health care consumption and work days lost. Medical comorbidity was associated with a 17–46% increase in health care costs and had at least as much influence as symptom severity on the costs of depression. Scott & Dickey (pp. 92–94), in an accompanying editorial, suggest the crucial next step in research is to identify similarities and differences in the costs and long-term prognosis of depression.

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