Highlights of this issue

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YOUNG PEOPLE WITH INTELLECTUAL IMPAIRMENT

Johnstone *et al* (pp. 484–492) hypothesised that among young people with mild intellectual disability, the cognitive difficulties of a subgroup might reflect an underlying psychotic illness yet to be manifest. In a cohort of young people receiving special educational support, they found that it was possible to detect vulnerability for schizophrenia using relatively simple screening methods and concluded that such an at-risk group might well benefit from early identification and intervention. Emerson & Hatton (pp. 493–499) analysed data from the 1999 and 2004 Office for National Statistics survey of the mental health of British children and adolescents and, employing formal diagnostic criteria, determined that the prevalence of psychiatric disorder was 36% among those with intellectual disability (cf. 8% among children without intellectual disability). They also found evidence of an increased rate of exposure to psychosocial disadvantage among children with intellectual disability, which appeared to explain at least some of the increased risk of psychiatric disorder in that group.

ECONOMIC EVALUATIONS

Two papers in the *Journal* this month consider the costs associated with mental health treatments. Byford *et al* (pp. 521–527) assessed the short-term cost-effectiveness of selective serotonin reuptake inhibitors (SSRIs) and cognitive–behavioural therapy (CBT) given together with routine clinical care compared with SSRIs and clinical care alone in the treatment of adolescent depression. They did not find evidence of superior cost-effectiveness for the combination of SSRIs and CBT. In an economic study of 12 low- and middle-income countries, Chisholm *et al* (pp. 528–535) estimated that scaling up mental healthcare provision over a 10-year period to achieve the standard of a defined core package would require an additional investment of US$0.20 per capita each year for low-income and US$0.30 for lower middle-income countries. The authors argue that mental health needs for those in low- and middle-income countries are too often ignored by development agencies and that, on the basis of their predictions, the absolute amount of resources required would not be large.

COMMUNICATION WITH PATIENTS AND THERAPEUTIC ALLIANCE

Two trials focusing on very different methods of service–patient communication are published this month. Carter *et al* (pp. 548–553) found that the rate of repetition of hospital-treated self-poisoning was lowered over 2 years among those sent a series of postcards during the year following an index presentation. However, the proportion who presented with repeat self-poisoning was not reduced by the postcard intervention. Morriss *et al* (pp. 536–542) conducted a cluster randomised controlled trial of reattribution training for general practioners treating patients with medically unexplained symptoms. They found that, while doctor–patient communication changed, no improvement in patient outcome was seen. The authors warn that effective management of medically unexplained symptoms in primary care is likely to require a range of interventions tailored to the individual. Junghan *et al* (pp. 543–547) evaluated the relationship between unmet need and perceptions of therapeutic alliance using data from a longitudinal study involving eight community mental health teams in Croydon, south London. Patient-rated unmet need was associated negatively with both patient- and staff-rated therapeutic alliance. When the association was examined longitudinally, the authors found that improvements in patient-rated therapeutic alliance were achieved when patient-rated, rather than staff-rated, needs were targeted and reduced.

CHILDHOOD ADVERSITY, RESIDENTIAL QUALITY AND MENTAL HEALTH

Only a minority of military personnel exposed to trauma develop psychological problems. Iversen *et al* (pp. 506–511) found that among males in the regular UK armed forces, pre-enlistment vulnerability was relatively common and was associated with negative health outcomes. Two factors were identified as particularly important predictors of ill health: a 'family relationships' factor and an 'externalising behaviour' factor. Despite emerging evidence for a relationship between neighbourhood characteristics and mental health, Thomas *et al* (pp. 500–505) found that unexplained variation in rates of symptoms was much greater at the household than at the postcode level. They did not find evidence of independent associations between symptoms and either the quality of residential environment or the geographical accessibility of local facilities. The authors concluded that the psychosocial rather than physical environment may have a greater impact on mental health.

EARLY LIFE GROWTH IN SCHIZOPHRENIA AND SCREENING FOR AUTISM

Perrin *et al* (pp. 512–520) found an association between slowed growth in early life and schizophrenia among women. No effect was seen for measures of growth in later childhood and no associations were found when men with schizophrenia were considered. The authors postulate that among women, factors responsible for regulating growth might play a role in the development of schizophrenia. Charman *et al* (pp. 554–559) compared three autistic-spectrum disorder screening instruments in a sample of children with special educational needs. The Social Communication Questionnaire performed better (area under the receiver operating characteristic curve AUC=0.90) than the Social Responsiveness Scale (AUC=0.77) or the Children's Communication Checklist (AUC=0.79). Instrument performance was found to be influenced by the individual's IQ and the presence of behavioural problems.