in reducing suicide, especially in those age groups whose members are less likely to attend the accident and emergency department at times of crisis, such as children and the elderly.

Duckworth & McBride (1996) have reported that 80% of elderly suicide victims received no psychiatric referrals, and according to Harwood *et al* (2001), only 15% of elderly people who died by suicide were under psychiatric care at the time of death.

In our study, analysing coroners' inquests of 200 cases of suicide in old age in Cheshire, 1989–2001 (Salib & El-Nimr, 2003), the role of primary care was emphasised. Interestingly, even those victims who were known to psychiatric services still preferred to contact their general practitioners (GPs) in the last few weeks before the fatal act.

One conclusion might be that people whose GPs acknowledged their mental health problems and cared to refer them to a specialist service were able to build a more meaningful therapeutic relationship with their doctors and readily contacted them as a final desperate act in the last period of their lives. A well-trained GP can act not only as an effective first point of contact but also a final one!

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Assertive outreach in Tyneside

Priebe *et al* (2003) have questioned whether the findings of the Pan-London Assertive Outreach Study can be generalised to assertive outreach services in the rest of the UK. Cornwall & Haveman (2003) evaluated the Newcastle and North Tyneside assertive outreach service using the same research instruments as those in the Pan-London study, so direct comparisons can be made.

After 17 months of operation, the Newcastle and North Tyneside team was similar in size to the London mean (n=56) with a score on the Dartmouth Assertive Community Treatment Scale (Teague *et al*, 1998) of 3.5 (medium fidelity to the model). The team has care programme approach (CPA) responsibility and small case-loads, operates out of office hours but without dedicated in-patient beds and, at the time of evaluation, no consultant psychiatrist. It thus corresponds to a Cluster B team in the Pan-London study (Wright *et al*, 2003).

Patient contact frequency and duration was higher than the London mean with an average face-to-face contact of 94 minutes per week. There was also a greater focus on patient engagement, with this being the primary focus in 33.1% of contacts. Engagement with the service in assertive outreach patients was compared with a random sample of community mental health team (CMHT) patients on enhanced CPA. There was no difference in the level of engagement, raising the possibility that the focus on engagement was having an impact in a previously hard-to-engage patient group.

Similar to the London study (Billings *et al*, 2003), team members were fairly satisfied with their jobs and most were not experiencing high levels of burnout. Compared with two local CMHTs, assertive outreach staff reported a higher level of personal accomplishment, replicating the Pan-London study finding. Another common finding was that the assertive outreach staff rated lack of support from senior staff in the service as a greater source of stress than did CMHT staff. Team members also identified dual diagnosis as an unmet training need.

Newcastle and North Tyneside patients were more likely than London patients to be White (86% *v.* 45%) or living alone (68% *v.* 52%). More surprisingly, they had significantly higher levels of alcohol misuse or dependency (31% *v.* 16%) and drug misuse or dependency (40% *v.* 20%). This reflects the fact that the Newcastle and North Tyneside service may be managing a more severely ill patient group, with 93% having experience of compulsory admission and 70% having had an in-patient admission lasting more than 6 months. Using the mean MARC severity score (Huxley *et al*, 2000), assertive outreach patients in Newcastle and North Tyneside had significantly more severe problems than the sample of local CMHT patients on enhanced CPA (7.4 *v.* 3.4; t=6.35, d.f.=83, P<0.01; mean difference=4.0, 95% CI 2.7–5.3).

Wright *et al* (2003) have suggested that the London teams are assertive community treatment-like teams, but that the US assertive community treatment model may not easily translate to the UK context. The Newcastle and North Tyneside data contrast with both the London data and data from the UK700 study (Burns *et al*, 1999) in terms of the strong focus on patient engagement. Longitudinal studies are needed to determine whether this will actually enhance engagement and whether that improves outcome.

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Treating maternal depression?

Cooper *et al* (2003) reported a randomised trial with mothers with post-partum depression that compared routine primary care, non-directive counselling, cognitive–behavioural therapy (CBT) and psychodynamic therapy and found that psychological therapy improved maternal mood in the short term but the long-term effect was no better than spontaneous remission.

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