

## Highlights of this issue

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### CLINICAL PRACTICE AND CLINICAL SERVICES IN THE SPOTLIGHT

Kingdon & Young (pp.285–290) debate the impact of biological research on clinical psychiatry in the *Journal* this month. This is followed by a number of review and original research articles which have focused on clinical practice and mental health services. With a particular emphasis on ethnic variation, Raleigh *et al* (pp.304–312) examined data from two national surveys of service users' access to and experience of community mental health services. In addition to finding that ethnicity is poorly recorded by services, the authors found that a number of socio-demographic and clinical factors had a stronger independent impact on patient experience than did ethnicity. Compared with the White British group, the Asian but not the Black patient group responded negatively when asked about their experience of services.

Okai *et al* (pp.291–297) conducted a systematic review of research related to mental capacity to consent to treatment among psychiatric patients. Despite the heterogeneity of studies included, the authors found consistent evidence that capacity can be reliably assessed, that

mental incapacity is common, and that clinical rather than socio-demographic factors have the greatest impact on likelihood of incapacity. In another review, Gaskin *et al* (pp.298–303) found evidence to support interventions intended to reduce use of seclusion facilities in psychiatric units. The authors warn against ignoring the findings of pragmatic studies and argue that more reports of failed attempts to reduce seclusion are needed.

In an inner-city in-patient sample of individuals with severe mental illness, Hodgins *et al* (pp.343–350) found high rates of aggressive behaviour, violent victimisation and criminality. They argue that service providers need to recognise that general adult wards are now treating a subgroup of patients presenting with complex difficulties and that this necessitates consideration of specific treatment packages designed to improve outcomes for such groups.

### ADOLESCENTS, YOUNG ADULTS AND THOSE WITH INTELLECTUAL DISABILITY

On the basis of data from a birth cohort based in Christchurch, New Zealand,

Fergusson *et al* (pp.335–342) found that over one third of the sample met criteria for major depression on at least one occasion between ages 16 and 21 years, with 22.7% reporting two or more episodes. They also found that frequency of depression in adolescence and early adulthood predicted poorer psychiatric and life-course outcomes. In a prospective study of a sample with mild-to-profound intellectual disability, Smiley *et al* (pp.313–319) found a 2-year incidence of 16.3% for mental ill health. The authors identified a number of risk factors for future ill health, some of which appeared to differ from those found in the general population (e.g. type of accommodation and support, urinary incontinence, severity of intellectual disability and not having impaired mobility).

### SOCIAL AND BIOLOGICAL STUDIES OF SCHIZOPHRENIA

The mechanisms underlying the well-established association between urbanicity and increased risk of schizophrenia are not well understood. Weiser *et al* (pp.320–324) found evidence for an interaction between population density and poor premorbid social and cognitive functioning, in relation to later risk of schizophrenia. Théberge *et al* (pp.325–334) examined glutamatergic changes in a sample of individuals with schizophrenia during their first episode of illness in relation to grey matter volumetric reductions. Thalamic and anterior cingulate glutamine levels were noted to be higher than normal. The authors also noted a correlation between parietal and temporal grey matter loss and thalamic glutamine loss.