Highlights of this issue

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CONSEQUENCES OF SUBSTANCE MISUSE

Although there is much evidence to link cannabis use with later development of psychotic disorders, little is known about the outcomes for those presenting with 'cannabis-induced' psychosis. Arendt *et al* (pp. 510–515) report that 44.5% of those treated for cannabis-induced psychosis in a Danish sample later developed a schizophrenia-spectrum disorder, with the risk being higher for men. Alcohol consumption has been linked to depression and anxiety in cross-sectional samples but longitudinal studies have not consistently confirmed the association. Such a longitudinal study was carried out in the UK by Haynes *et al* (pp. 544–551) based on an 18-month follow-up of participants in the Psychiatric Morbidity Among Adults Living in Private Households, 2000 survey. Although those who had not consumed any alcohol in the 12 months before baseline had reduced odds of developing depression and anxiety by follow-up, hazardous and dependent drinkers were not found to have an increased risk. Binge-drinking did appear to increase risk but this finding did not reach significance.

PATIENT PERCEPTIONS: IN-PATIENT SAFETY AND OUTCOME PRIORITIES

In a qualitative study of staff and patient perceptions of safety for women in medium secure units, Mezey *et al* (pp. 579–582) found only partial support for the notion that women in such units would feel safer if they were segregated from male patients. The women in single-sex units did report less sexual abuse and serious physical assault than those in mixed-sex units but many stated a preference for being treated in a mixed-sex environment. Rosenheck *et al* (pp. 529–536) have tested a method of quantifying patient outcome preferences in a sample of people with schizophrenia originally enrolled in a large, multisite clinical trial. Across the sample, the highest priorities were placed on reducing confusion and increasing energy; the lowest priority was given to social life and reducing side-effects.

COGNITIVE HETEROGENEITY, EMOTION PERCEPTION AND MEMORY IN SCHIZOPHRENIA

Joyce *et al* (pp. 516–522) sought to determine whether subgroups of those with first-episode schizophrenia present with different profiles of cognitive impairment, as is known to be the case in chronic schizophrenia. In their patient sample, half demonstrated normal-range IQ preservation, 40% showed a decline and the remainder showed low but preserved IQ. Across IQ subgroups, however, working memory was consistently found to be impaired, leading the authors to suggest that executive dysfunction may be a pervasive abnormality intrinsic to schizophrenia. Impairments in facial and vocal emotion perception were found to be associated with illness duration in a study by Kucharska-Pietura *et al* (pp. 523–528). Although perception of both positive and negative emotion was impaired, the latter was found to be impaired to a greater extent. In a meta-analysis of 18 studies examining abnormal brain activity elicited by an episodic memory task in people with schizophrenia, Achim & Lepage (pp. 500–509) identified a number of regions of consistent differential activation, including the left inferior prefrontal cortex, medial temporal cortex bilaterally, left cerebellum, and other prefrontal and temporal lobe regions.

TRAIT MEASUREMENT AND DIAGNOSTIC STABILITY

Establishing the boundaries of the autistic spectrum has been hampered by the inadequacies of screening instruments. The Social and Communication Disorders Checklist (SCDC) is reported by Skuse *et al* (pp. 568–572) to be an efficient first-level screening instrument suitable for use in large population surveys. In a study of women with eating disorders followed for 30 months, Milos *et al* (pp. 573–578) found that although the diagnostic category of eating disorder was relatively stable, there was considerable instability between the three specific eating disorder diagnoses over time. The authors argue for further trans-diagnostic research given the likely common biological and psychological underpinnings of the specific eating disorders.

WEIGHT GAIN, MORTALITY AND GLOBAL BURDEN OF DISEASE

Olanzapine was associated with significantly greater weight gain than haloperidol in an analysis based on data from a multicentre randomised double-blind clinical trial conducted over 2 years (Zipursky *et al*, pp. 537–543). When an observed-cases methodology was employed, olanzapine was associated with a mean 2 year weight gain of 15.4 kg compared with 7.5 kg for those randomised to haloperidol. In a population-based study in Nova Scotia, Kisely *et al* (pp. 552–558) found that the overall mortality rate ratio was 1.74 for people with psychiatric disorders receiving treatment in public, private, in-patient, out-patient and primary care settings. Mortality was higher among men, those with lower incomes, those receiving treatment in specialist settings and those with dementia or psychosis. In an economic modelling study, Chisholm *et al* (pp. 559–567) conclude that community-based interventions for bipolar disorder are more efficient than in-patient services at the global level. Lithium appeared to be no more costly yet more effective than valproic acid while the most cost-effective interventions were combination strategies involving a mood stabiliser together with psychosocial treatment.

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