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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The trial was generally well done and the procedures reasonably described. However, the researchers did not, from a cognitive–behavioural perspective, treat maternal depression. Cooper *et al* describe that treatment used cognitive–behavioural techniques but focused not on depression but on the management of mother–infant interactions.

Several randomised placebo-controlled trials have shown that CBT – when done properly – is an effective treatment for post-partum depression (Holden *et al*, 1989; Appleby *et al*, 1997; Chabrol *et al*, 2002) and for major depressive disorders (Hollon *et al*, 2002). There is an important relationship between post-partum depression and mother–infant interactions but it is not, by any means, the entirety or even the essence of post-partum depression. Although it is advisable to customise CBT to patients' circumstances, exclusive use of one focus, such as mother–child interactions, is not a test of the therapy. If the goal is to change depression, one should treat depression. Thus, the title is inaccurate and the discussion of the lack of effect of CBT for maternal depression is misleading.

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Authors' reply: There are many cognitive–behavioural therapies, with the precise form of the CBT shaped to the nature and context of the particular disorder. So, for example, CBT for panic disorder and CBT for bulimia nervosa (Hawton *et al*, 1989), although sharing a basic orientation and broad therapeutic principles, are very different from one another. The form of CBT in which we were interested had as its principal focus the mother–infant relationship and aspects of infant management. The reason for this was quite clear. It is well established that many forms of treatment for post-partum depression, including counselling (Holden *et al*, 1989), interpersonal psychotherapy (O'Hara *et al*, 2000), 'cognitive–behavioural counselling' (Appleby *et al*, 1997) and fluoxetine (Appleby *et al*, 1997), have significant antidepressant effects, but it has not been established that any of these interventions has an impact on the quality of the mother–infant relationship and child developmental progress, both known to be compromised in the context of post-partum depression. (The evidence for the efficacy of CBT in this context is, incidentally, less certain. Indeed, none of the three studies cited by Professor McGrath and colleagues in support of this form of treatment delivered an orthodox CBT; and one, in fact, was not a study of CBT at all, but of non-directive counselling.) We were interested in determining whether treatment that addressed the maternal role, as part of a wider supportive therapeutic relationship, would have wider benefits. The form of CBT we investigated was shaped by these concerns, and the discussion refers explicitly to this treatment and is, therefore, wholly apposite.

In several respects the findings of our trial were not what we had expected and were, to us, disappointing. However, the data were what they were, and it was our job to try to understand them. When the first trials comparing CBT with interpersonal psychotherapy for major depression were published in the 1980s, British clinical psychology reverberated with the chunterings of the CBT faithful whose instinctive reaction to the equivalence conclusion was to query the probity of the trial CBT therapists. With time, a more mature position was evolved. The findings of our study, along with the broad failure of the trials of preventive treatments for post-partum depression, would seem to us to be cause for pause and reflection, rather than instinctive defensiveness.

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Cognitive–behavioural therapy as a treatment for psychosis

McKenna (2003) comments that Sensky *et al* (2000), in their trial of cognitive–behavioural therapy (CBT) *v.* befriending for the treatment of schizophrenia, found no advantage of CBT over befriending at the end of the 9-month intervention period. In his view, they were therefore not justified in making the claim that CBT is effective in treating negative as well as positive symptoms in schizophrenia. This assertion fails to recognise the different mechanisms by which CBT and drugs may benefit psychotic symptoms. While drugs are likely to produce a (relatively) immediate effect in altering neurotransmitter pathways, CBT (as is the case with other psychological therapies) is postulated to alter attachment-related memory (Gabbard, 2000) and develop an understanding of the illness. Cognitive–behavioural therapy utilises skills which, if successful, can be maintained by the patient long after therapy has ended. This would explain why Sensky *et al* (2000) witnessed a non-significant difference between the control and intervention groups at the end of the intervention period but a significant continued improvement in those receiving CBT (and not in those receiving befriending) at 9-month follow-up. It would not be expected that drugs would maintain a benefit 9 months after being stopped. Preliminary results of a 5-year follow-up of the cohort of patients in this study indicate that these gains in the CBT group have been maintained (D. Turkington, personal communication, 2001).

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