We welcome the recognition of the importance of evidence-based practice by the *Journal*. However, we think that articles described as evidence-based should at least meet basic evidence-based criteria, which are widely available (Sackett *et al*, 1997). Otherwise, there is a danger that the term 'evidence-based' will simply become a fashionable label to lend undue authority to old-style articles.

Cookson, J. (1997) Lithium: balancing risks and benefits. *British Journal of Psychiatry*, **171**, 120–124.

Moncrieff, J. (1997) Lithium: evidence reconsidered. *British Journal of Psychiatry*, **171**, 113–119.

Oxman, A. D., Cook, D. J. & Guyatt, G. H. (1994) Users' guides to the medical literature. VI. How to use an overview. *Journal of the American Medical Association*, **272**, 1367–1371.

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., *et al* (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal*, **312**, 71–72.

—, Richardson, W. S., Rosenberg, W. M. C., *et al* (1997) *Evidence-based Medicine. How to Practice and Teach EBM*. Edinburgh: Churchill Livingstone.

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Clinical trials: severe mental illness and substance misuse

Sir: In her editorial on severe mental illness and substance misuse, Johnson (1997) commented on the paucity of studies with control groups, large enough numbers of subjects and adequate length of follow-up. We have also been looking at this area of significant clinical need and believe a major difficulty is the longitudinal perspective required in terms of outcome, as experience suggests clinical improvements take several years to be realised (Drake *et al*, 1993). This makes planning and financing randomised controlled trials in an area with many potential confounding factors and a population notoriously non-compliant very difficult indeed.

In light of recent calls for the development of high-quality clinical databases (Black, 1997), surely it is more realistic to develop case registers of patients with severe mental illness and substance misuse and seek to use these to follow people over a long time period. While randomised controlled trials should remain as the gold standard in testing specific interventions for specific populations, the complexities of managing patients (including those often excluded from randomised controlled trials) over many years in an area where progress is often slow might be better measured by a more naturalistic methodology.

Black, N. (1997) Developing high quality clinical databases. *British Medical Journal*, **315**, 381–382.

Drake, R. E., Bartels, S. J., Teague, G. B., *et al* (1993) The treatment of substance abuse in severely mentally ill patients. *Journal of Nervous and Mental Disease*, **18**, 606–611.

Johnson, S. (1997) Dual diagnosis of severe mental illness and substance misuse: a case for specialist services? *British Journal of Psychiatry*, **171**, 205–208.

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Subjective quality of life and drug treatment for schizophrenia

Sir: Quality of life of people with schizophrenia receiving drug treatment is a poorly researched area. The study by Franz *et al* (1997) concludes that the significantly better quality of life they reported in people receiving atypical neuroleptics was independent of both psychopathology and the side-effects of the drugs. Instead, the difference in subjective quality of life was related to the differences in the intrinsic properties of the two classes of drugs, that is pharmacogenic or akinetic depression due to conventional antipsychotics and improvement in mood and drive with the atypical neuroleptics. The fact that these effects indicate nothing other than negative and extrapyramidal symptoms immediately makes the above conclusion contradictory.

The concept of quality of life in people with schizophrenia is not well understood. According to the model proposed by Awad & Hogan (1994), the most important factors that bring about a change in quality of life (including subjective quality of life) are changes in symptoms and in the side-effects of the drugs. Surprisingly, Franz *et al* (1997) could not demonstrate any influence of these two critical factors on the ratings of quality of life they reported. It is possible that the cross-sectional design of their study as well as a certain arbitrariness in changing neuroleptic (from conventional to atypical and from one type of atypical neuroleptic to another within a period as short as 10 days) may have interfered with the expected negative correlation between scores of psychopathology and quality of life. Furthermore, time of administration of the Positive And Negative Syndrome Scale is not known, and no standardised instrument was used to measure the extrapyramidal symptoms. Thus, the effect of atypical neuroleptics on subjective quality of life need not be independent of symptoms and of the side-effects of the drugs.

Awad, A. G. & Hogan, T. P. (1994) Subjective response to neuroleptics and quality of life: implications for treatment outcome. *Acta Psychiatrica Scandinavica*, **89** (suppl. 380), 27–32.

Franz, M., Lis, S., Plüddemann, K., *et al* (1997) Conventional versus atypical neuroleptics: subjective quality of like in schizophrenic patients. *British Journal of Psychiatry*, **170**, 422–425.

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One hundred years ago

Mental Disease Out-Patients

We have pleasure in drawing attention to the fact that an out-patient department for mental disease has now been established for upwards of two years at Sheffield, under Dr. Crochley Clapham.

Dr. Clapham reports that it has been successful in attracting a considerable number of patients, in a fair proportion of whom he believes that the necessity of asylum treatment has been avoided, therein confirming the experience of a similar department at St. Thomas' Hospital.

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Dr. Clapham is also of opinion that his department has exemplified the greater readiness of such patients to be associated in treatment with other diseases rather than to attend as out-patients to an asylum or lunatic hospital. Those patients who will go to the latter are mostly cases who have been in-patients or are already qualified to become so.

That Dr. Clapham may soon be imitated in other large towns is a wish that will occur to everyone interested in the prevention of insanity.

REFERENCE

Journal of Mental Science, **XLIII**, April 1897, 328.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Seoane, A., Carrasco, G., Carbré, L., *et al*, *BJP*, 171, 340–345. In the description of the procedure of rapid detoxification in heroin addicts using clonidine (p. 341, second column, third paragraph), the dosage of clonidine used was printed incorrectly. The relevant sentence should read: "Every four hours 3 μg/kg clonidine was administered subcutaneously to attenuate adrenergic hyperactivity and 0.7 mg/kg metoclopramide was injected endovenously to increase gastric emptying."

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