

for psychiatric illness. Furthermore, our use of random-effects regression models controlled for further unmeasured individual characteristics that are stable over time. Our finding of a modest but robust effect is meaningful and therefore clinically important, especially when combined with other small effects. Further research into determinants of quality of life will provide other levers of change for improvement, which are unlikely to be staff-rated symptomatology (Lasalvia *et al*, 2002).

We agree that interventions to improve mental health will have an impact on patient-rated unmet need, which in turn (as we demonstrate) will improve quality of life. However, the advantage of identifying a modest but robust causal relationship is that it highlights the importance of a more comprehensive approach to meeting needs. Mental healthcare that focuses exclusively on treating psychiatric illness can risk neglecting the importance of other consequences of mental ill health, such as discrimination in travel (Driver and Vehicle Licensing Agency, 2005), insurance (Association of British Insurers, 2003) and debt (Meltzer *et al*, 2002). Mental health services that also address a wide range of health and social needs (as, for example, assessed in our study by the Camberwell Assessment of Need) are more likely to improve quality of life.

Declaration of interest

The Health Services Research Department, where this study was based, receives royalties from sales of the *Camberwell Assessment of Need* published by Gaskell.

Association of British Insurers (2003) *An Insurer's Guide to the Disability Discrimination Act 1995*. London: Association of British Insurers.

Driver and Vehicle Licensing Agency (2005) *Psychiatric Disorders*, Chapter 4. Swansea: DVLA.

Lasalvia, A., Ruggeri, M., Santolini, N. (2002) Subjective quality of life: its relationship with clinician-rated and patient-rated psychopathology. The South-Verona Outcome Project 6. *Psychotherapy and Psychosomatics*, **71**, 275–284.

Meltzer, H., Singleton, N., Lee, A., et al (2002) *The Social and Economic Consequences of Adults with Mental Disorders*. London: Stationery Office.

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Abstinence-oriented treatment for opiate addiction

Smyth *et al* (2005) reported outcomes of abstinence-oriented in-patient treatment for opiate users at 2–3 years and found that 23% of patients were abstinent for the preceding 30 days according to self-report without methadone maintenance. At the start of the treatment 49% had injected heroin. There was, however, a group of patients who were truly abstinent: those who had died.

Of the 109 patients who had been located out of the original 149, 5 had died. The total expected number of deaths from the original sample would therefore be closer to 7, but would perhaps be even higher if we assume that those lost to follow-up led more 'chaotic' lifestyles. The authors rightly note that abstinence-oriented treatment is associated with accidental overdose (Strang *et al*, 2003).

In Glasgow, before the advent of supervised consumption, rates of methadone-related overdose were around 2.5 per 100 treatment-years. This rate fell to less than 0.5 per 100 treatment-years (Advisory Committee on the Misuse of Drugs, 2000) after the supervised consumption of methadone was introduced. Supervised methadone consumption is known to be effective in reducing the risk of overdose and there is a dose-related effect in reducing mortality, with doses over 75 mg being more effective than doses below 55 mg (van Ameijden *et al*, 1999). Methadone also reduces the risk of injecting; this in turn reduces viral transmission, which is the other significant risk of increased mortality among drug users (Dolan *et al*, 1998).

However, the attitude of treatment agencies towards extended maintenance is changing in the direction of delineated treatment episodes (National Treatment Agency for Substance Misuse, 2005). In these days of crack cocaine, the belief that methadone treatment works (Gossop *et al*, 2003) and saves money (Godfrey *et al*, 2004) has diminished. This is despite evidence for interventions such as contingency management and cognitive-behavioural therapy using substitute prescribing (Rowan-Szal *et al*, 2004).

Of course, abstinence should be a potential goal of drug treatment. Deciding those patients for whom abstinence-oriented treatment is appropriate, and the risk of such treatment, is more difficult. There is no reliable evidence for matching

patients to optimal treatments in addiction. However, those who inject, isolated users and alcohol/benzodiazepine co-users are all over-represented in the morgue (Warner-Smith *et al*, 2001). Risk awareness might well be a reasonable first step and for many abstinence might be more dangerous than desirable.

Advisory Committee on the Misuse of Drugs (2000) *Reducing Drug Related Deaths*. London: Stationery Office.

Dolan, K., Wodak, A. D. & Hall, W. D. (1998) Methadone maintenance treatment reduces heroin injection in New South Wales prisons. *Drug and Alcohol Review*, **17**, 153–158.

Gossop, M., Marsden, J., Stewart, D., et al (2003) The National Treatment Outcome Research Study (NTORS): 4–5 year follow-up results. *Addiction*, **98**, 291–303.

Godfrey, C., Stewart, D. & Gossop, M. (2004) Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS). *Addiction*, **99**, 697–707.

National Treatment Agency for Substance Misuse (2005) *Business Plan 2005/6. Towards Treatment Effectiveness*. London: NTA. <http://www.nta.nhs.uk/publications/Businessplan05.pdf>

Rowan-Szal, G. A., Bartholomew, N. G., Chatham, L. R., et al (2004) A combined cognitive and behavioural intervention for cocaine-using methadone clients. *Journal of Psychoactive Drugs*, **37**, 75–84.

Smyth, B. P., Barry, J., Lane, A., et al (2005) In-patient treatment of opiate dependence: medium-term follow-up outcomes. *British Journal of Psychiatry*, **187**, 360–365.

Strang, J., McCambridge, J., Best, D., et al (2003) Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *BMJ*, **326**, 959–960.

van Ameijden, E. J., Langendam, M. W. & Coutinho, R. A. (1999) Dose-effect relationship between overdose mortality and prescribed methadone dosage in low-threshold maintenance programs. *Addictive Behaviors*, **24**, 559–563.

Warner-Smith, M., Darke, S., Lynskey, M., et al (2001) Heroin overdose: causes and consequences. *Addiction*, **96**, 1113–1125.

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Author's reply: I agree with Critchlow & Nadeem that abstinence-based treatment may only be appropriate for a minority of opiate-dependent patients and that risk awareness is an essential first step for both patient and treatment provider. There is an increased risk of accidental overdose in the

weeks following discharge from abstinence-oriented residential treatment.

In common with centres in Britain and Australia, addiction treatment services in Dublin are oriented towards harm reduction. However, there is no conflict between a goal of harm reduction yet continuing to provide patients with the option of an abstinence-based treatment such as that examined in our study. In all medical specialties, doctors are charged with the responsibility of weighing up the advantages and disadvantages of various treatment options. There are many circumstances in which patients will have to choose between a more conservative treatment option and a more aggressive approach with a higher risk but a greater reward.

In the case of opiate dependence, both clinicians and patients in Dublin are fortunate to have the option of both methadone maintenance and abstinence-based treatments. Although there are real risks of accidental overdose associated with the latter, we believe that in a therapeutic relationship that is collaborative and respectful, the patient should be given the choice. Denying them the choice of an abstinence-based treatment would represent a retreat to a paternalistic approach to medicine which was so commonplace a generation ago and which is criticised by patient groups today. At the other end of the spectrum, there are many countries where patients are denied, or have very restricted access to, methadone maintenance treatment (Kakko *et al*, 2003; World Health Organization, 2004). This has occurred when treatment options have been determined by politicians instead of clinicians and decisions have unfortunately been driven by ideology rather than evidence.

Kakko, J., Svanborg, K. D., Kreek, M. J., et al (2003) 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. *Lancet*, **361**, 662–668.

World Health Organization (2004) *The Practice and Context of Pharmacotherapy of Opioid Dependence in Central and Eastern Europe*. Geneva: WHO.

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Diagnostic stability and status of acute and transient psychotic disorders

We read with interest the article by Pillmann & Marneros (2005). Acute and

transient psychosis is a common clinical presentation in the developing world. We retrieved medical records of all patients with psychotic disorders (F06.0–06.3, F20–29, F30.2, F31.2, F31.5, F32.3, F33.3) who attended our unit from 1 January to 30 September 2003. There were 87 patients (13.9%) with a diagnosis of acute psychosis (ICD–10 F23). The majority were young adults (mean age 29.75 years, s.d.=10.95), male (52%) and without a history of precipitating stress (71%) or similar illness (93%). The mean duration of follow-up was 13.2 months (s.d.=11.7). The diagnosis was revised to affective disorder in 8 patients (9.2%), schizophrenia in 23 (26.4%), and 10 patients (11.5%) presented with recurrent episodes of acute psychosis.

The high drop-out rate has been attributed to a good response to antipsychotic medication, spontaneous remission and/or preference for indigenous treatments (Raguram *et al*, 2002). Most studies of acute psychosis have small samples (Susser *et al*, 1998; Marneros *et al*, 2003; Pillmann & Marneros, 2003; Singh *et al*, 2004) and there are no large long-term follow-up studies of acute psychosis from the developing world.

The introduction of the categories acute and transient psychotic disorders in ICD–10 and brief psychotic disorder in DSM–IV has allowed for coding of patients with a single episode of illness. However, there is also a need to categorise people who present recurrently with such episodes. Future classification should consider such a category.

Acute psychotic presentations can be secondary to organic psychoses and substance dependence. Psychiatrists often subscribe to the Kraepelinian dichotomy and attempt to label all functional psychosis as schizophrenia or affective disorders. However, clinical presentations of acute psychosis challenge such categorisation. Although many patients recover, some relapse with similar acute psychotic presentations, and a significant proportion also develop classic schizophrenia and mood disorders. The difficulty in reaching a diagnosis at the time of the initial presentation is because it is often difficult to recognise the classic syndromes at the onset of the illness. However, these can be identified over time as they become more obvious. Thus, acute psychoses can be a presentation of organic psychoses, substance-induced disorders, schizophrenia, affective illness or may

be ‘micro-psychotic’ episodes that occur in some personality disorders. They can also be separate clinical entities. Clinicians working in the developing world are often aware of this distinction.

Marneros, A., Pillmann, F., Haring, A., et al (2003) What is schizophrenic in acute and transient psychotic disorder? *Schizophrenia Bulletin*, **29**, 311–323.

Pillmann, F. & Marneros, A. (2003) Brief and acute psychoses: the development of concepts. *History of Psychiatry*, **14**, 161–177.

Pillmann, F. & Marneros, A. (2005) Longitudinal follow-up in acute and transient psychotic disorders and schizophrenia. *British Journal of Psychiatry*, **187**, 286–287.

Raguram, R., Venkateswaran, A., Ramakrishna, J., et al (2002) Traditional community resources for mental health: a report of temple healing from India. *BMJ*, **325**, 38–40.

Singh, S. P., Burns, T., Amin, S., et al (2004) Acute and transient psychotic disorders: precursors, epidemiology, course and outcome. *British Journal of Psychiatry*, **185**, 452–459.

Susser, E., Varma, V. K., Mattoo, S. K., et al (1998) Long-term course of acute brief psychosis in a developing country setting. *British Journal of Psychiatry*, **173**, 226–230.

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White matter in liars

Yang *et al* (2005) propose a neurodevelopmental theory of pathological lying, finding increased prefrontal white matter and lower prefrontal gray/white ratios in pathological liars compared with antisocial and normal controls. Spence (2005) asks whether these findings represent cause or effect. Since lying is a criterion symptom for childhood conduct disorder, we re-examined a structural magnetic resonance imaging study of early-onset conduct disorders (Kruesi *et al*, 2004 plus unpublished data).

Youths had been classified as liars or not based upon structured interviews and collateral information when documenting criterion symptoms of conduct disorder. Liars ($n=6$) were compared with individuals with conduct disorder ($n=4$) and with healthy volunteers ($n=10$). The mean ages of the three groups (191.5, 195 and 190.8 months) were similar ($F(2,19)=0.015$). In accordance with developmental differences, ratios of prefrontal white volume to total