drug and alcohol misuse and other predictors of negative outcome (Vestergaard *et al*, 1998) select themselves to the non-compliant patient group. Therefore, a finding that non-compliant patients fare worse than compliant patients may testify only to the existence of negative predictor variables among patients who were non-compliant, instead of supporting the efficacy of lithium treatment. Neither our study nor Kallner *et al*'s allow conclusions as to whether or not lithium has specific antisuicidal effects exceeding what can be inferred from its ability to prevent recurrent illness episodes in affective disorder patients.

The efficacy of long-term prophylactic treatment with lithium has been questioned frequently (Moncrieff, 1995). We believe, as apparently do Gracious & Falodun, that despite its shortcomings lithium is a very helpful tool in the psychiatric armamentarium. Arguments that support the efficacy (or inefficacy) of long-term lithium treatment should, however, rest on sound scientific evidence.

Brodersen, A., Licht, R. W., Vestergaard, P., *et al* (2000) Sixteen-year mortality in patients with affective disorder commenced on lithium. *British Journal of Psychiatry*, **176**, 429–433.

Kallner, G., Lindellius, R., Petterson, U., *et al* (2000) Mortality in 497 patients with affective disorders attending a lithium clinic or after having left it. *Pharmacopsychiatry*, **33**, 8–13.

Moncrieff, J. (1995) Lithium revisited. A re-examination of the placebo-controlled trials of lithium prophylaxis in manic–depressive disorder. *British Journal of Psychiatry*, **167**, 569–574.

Vestergaard, P., Licht, R. W., Brodersen, A., *et al* (1998) Outcome of lithium prophylaxis: a prospective follow-up of affective disorder patients assigned to high and low serum lithium levels. *Acta Psychiatrica Scandinavica*, **98**, 310–315.

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Finding the evidence in forensic rehabilitation

Cure & Adams (2000) suggest that we managed to overlook 22 000 potential references including 2000 which apparently contain data relevant to our inquiries. Contrary to our belief, they also claim that the randomised trial is the preferred research methodology in forensic psychiatric rehabilitation.

These criticisms are, in our view, based on a poor understanding of the process of rehabilitating mentally disordered offenders, and reveal a blinkered approach to novel research strategies which may be of value in such atypical settings.

Cure & Adams cited three examples of the many quality studies they allege we overlooked in our review. All were published after the final submission of our paper, but are presumably presented as examples of the treatment and rehabilitation of mentally disordered offenders. Two of the cited reviews examine antipsychotic treatment (in people with learning disabilities and with acute schizophrenia) and the other is a review of sex offender treatment. These studies are, without doubt, most relevant to clinical forensic psychiatric practice. They do not, however, target the process of rehabilitation in a more general sense, as outlined in our paper. There is more to forensic work than drugs and specific programmes for certain offender groups.

Apparently, Cure & Adams fail to appreciate the difference between psychiatric work among forensic and non-forensic populations. That difference is the rationale for our remark that a randomised trial is not the method of choice in evaluating the outcome of forensic psychiatric rehabilitation. The crucial point is that allocation to forensic psychiatric treatment is not controlled by medical professionals but by legal authorities, refractory to the systematic and premeditated manipulation that some research requires. Although mentally disordered offenders, delivered by the courts to the hospitals, can be diverted into different treatment schemes, it is not feasible to maintain a predetermined course of rehabilitation. Important factors such as the length of incarceration, number and duration of leaves as well as external support by non-forensic caregivers, are not possible to randomise and control.

Randomised trials do not provide the only source of data on treatment efficacy, although where these trials are possible, valid and important data may be presented. Our paper did not pretend to review all articles related to the field of forensic psychiatric practice. Such magnificent and ambitious endeavours can only be embarked upon by the privileged few who are provided with considerable support from national funding institutions. Their reports may prove invaluable in guiding clinicians, assuming that the issues are correctly presented – a considerable responsibility. One obvious risk of the rapid growth of evidence-based medicine is its inhibiting effect on the advancement of the theory of clinical practice and its potentially discouraging effects on active contributors and reviewers of articles to medical journals.

Cure, S. J. & Adams, C. E. (2000) Forensic trials inform the present and future (letter). *British Journal of Psychiatry*, **177**, 182.

Lindqvist, P. & Skipworth, J. (2000) Evidence-based rehabilitation in forensic psychiatry. *British Journal of Psychiatry*, **176**, 320–323.

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Arachnophobia: a practical management device

While not wishing to endorse a particular product or brand, I would like to report the effectiveness of a cheap and readily available device in the management of insect and spider phobia (the 'Bug Katcha', from Betterware). The device consists of a clear Perspex box with a sliding door mounted on a long handle, allowing the offending insect to be entrapped from a distance and released without manual contact.

Having in jest presented a severely spider-phobic psychiatrist friend with such an item, I was pleased to hear that its use had provided effective exposure *in vivo* and led to a marked reduction in symptoms of anxiety. She became able to talk about and to be in a room with spiders without displaying visible signs of arousal. As many non-arachnophobes prefer not to handle spiders directly, her functioning seems to have been restored to an acceptable level.

This device may provide a practical and cost-effective way to reduce the manifestations of simple insect and spider phobias.

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Thrombocytosis due to clozapine treatment: working towards an early marker for clozapine-induced agranulocytosis

Recently, Hampson (2000) reported thrombocytosis with clozapine, and serious consideration must be given to reports that

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