that half a century of studies of limited quality, duration and clinical utility left much scope for well-planned, conducted and reported trials. The consistently poor quality of reporting is likely to have resulted in an overoptimistic estimation of the effects of drug treatments for the condition. So much for good-quality research in the professional evidence base. What about bias?

The editors of our leading medical journals are clearly concerned about bias in research, particularly that which originates in conflicts of financial interest. Stelfox *et al* (1998) studied papers published in the *New England Journal of Medicine* on the use of calcium-channel antagonists in the treatment of cardiovascular disorders. They found that 96% of the authors of positive studies have received financial support from drug companies, compared with 37% of authors of negative studies. In a recent editorial in the *New England Journal of Medicine*, Marcia Angell (2000: p. 1516) has described the intertwining of academic medicine and the pharmaceutical industry in America, which extends far beyond grant support for research to include:

> '. . . a host of other financial arrangements. Researchers serve as consultants to companies whose products they are studying, join advisory boards and speakers' bureaus, enter into patent and royalty arrangements, agree to be the listed authors of articles ghostwritten by interested companies, promote drugs and devices at company-sponsored symposiums, and allow themselves to be plied with expensive gifts and trips to luxurious settings. Many also have equity interest in the companies.'

She argues that these links are less to do with the transfer of technology across from academia to industry, than they are to do with marketing and profit. This influence also extends to guidelines on clinical practice. In a recent survey (Choudhry *et al*, 2002), 87% of 200 authors of clinical guidelines had financial links with at least one drug company, including companies whose products they endorsed. Over half of the authors had been paid to conduct research.

Of course user-led research is biased, but so is most research. Some psychiatric research is of high quality and undertaken out of the highest ideals. Equally, much of it has a murky, less idealistic pedigree, driven by commercial interest. User groups certainly have their own 'political agendas', but to pretend that psychiatry does not is either extremely naïve or dishonest. It is time for us to reflect on the need for a little honesty and humility, and for us to acknowledge that there are serious doubts about the independence and integrity of much of what we, as psychiatrists, consider to be 'evidence'. To begin with, we need a debate about the influence that the drug companies have on our academic institutions, at our conferences, in our journals and in our consulting rooms.

Angell, M. (2000) Is academic medicine for sale? *New England Journal of Medicine*, **342**, 1516–1518.

Choudhry, N., Stelfox, H. & Detsky, A. (2002) Relationships between authors of clinical practice guidelines and the pharmaceutical industry. *JAMA*, **287**, 612–617.

Stelfox, H., Chua, G., O'Rourke, K., *et al* (1998) Conflict of interest in the debate over calcium channel antagonists. *New England Journal of Medicine*, **338**, 101–105.

Thornley, B. & Adams, C. (1998) Content and quality of 2000 controlled trials in schizophrenia over 50 years. *BMJ*, **317**, 1181–1184.

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Perceived failure of community care

In his editorial on care in the community, Julian Leff (2001) describes processes comparable with those in The Netherlands, resulting in a call for 'increasing restrictive mental health legislation enacted by governments pandering to public misperceptions'. This may be an indication that this process is more universal and not restricted to the situation in the UK. A few points may lead to more 'perceived failure' if not addressed.

Dr Leff states that 'there is substantial evidence of considerable success . . . of the 130 psychiatric hospitals . . . in 1975, only 14 remain open, with fewer than 200 patients in each'. Does this imply that it would have been a failure if it were 25 hospitals with 300 patients each? Closing hospitals should not be a goal as such, but a means to provide better services to patients. That a new generation of psychiatrists 'not only have never worked in a psychiatric hospital but have never seen one!' may not be such a desired development. In the coming decades in-patient facilities will still be needed and the number of them may fluctuate because of new treatment modalities and the capacity of society to harbour patients. An increase or decrease should not be an indicator of success or failure at all.

The 'invisibility of a community service' as grounds for 'perceived failure' is interesting in relation to the statement that 'the architectural presence of the asylums has been replaced by an apparent absence'. Were many asylums not tucked away at the outskirts of the city, if not further away? Mental health care should make itself, and its diversity of services, more visible. Could it be that professionals, patients and relatives have a somewhat defensive stance regarding the public and the media? In The Hague after the merger in 1999 of all psychiatric hospitals, community mental health organisations and addiction organisations, posters were put on trams and bus stops leading to a high visibility, which was well perceived.

Would 'a comprehensive community psychiatric service catering to all the needs of the catchment area population' enhance the perception of success? In The Netherlands in recent years this development has started in some areas owing to large-scale mergers of mental health organisations. This has lead to a disappearance of administrative and financial boundaries between in-, out- and day-care patient services. In The Hague there are indications that the needs of patients, family, general practitioners and police are better identified and addressed, leading to a visible profile and higher perceived success.

If we want to know what our targets are in 'a public relations job of this kind', we are at the brink of a more fundamental shift of defining and positioning the concept of (community) mental health. Who can identify him or herself with a psychiatric patient? Are there not fundamental differences between a patient with schizophrenia, agoraphobia or bipolar disorder? In The Netherlands generalisation and stereotyping lead to the situation that the acts of one person with an addiction and personality disorder may damage the positive image of mental health in general for a certain period.

Community-oriented care is a success for a subgroup of patients with psychiatric disorders. Perceived failure in one area should not lead to a situation that the whole of mental health services, including care in the community, is perceived as a failure.

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Leff, J. (2001) Why is care in the community perceived as a failure? *British Journal of Psychiatry*, **179**, 381–383.

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Author's reply: Regrettably, Dr Hoencamp has misinterpreted a number of phrases in my editorial. Rather than calling for increasingly restrictive legislation, I was warning the reader against this alarming consequence of public and governmental misperceptions of care in the community. On another point, I certainly did not mean to imply that closing psychiatric hospitals is itself an indication of a successful policy. The evidence of success to which I was referring consists of the growing body of research showing that the quality of life of discharged long-stay patients is improved by relocation in community homes (e.g. Leff & Trieman, 2000). Dr Hoencamp is of course right that in-patient facilities will continue to be needed, but there is no reason for them to be located in the outdated structures of the psychiatric hospitals. There are undoubtedly problems with admission wards in district general hospitals, but these can be remedied by improved architectural design and the provision of alternatives such as acute day hospitals (Creed *et al*, 1990).

Although many asylums were deliberately built outside of towns, urban expansion brought them within the ambit of residential areas. Even those that remained remote, engendered in the public mind the image of life-long incarceration. I agree with Dr Hoencamp that more should be done to publicise community mental health services. We should be proud of what has been achieved and promote a high visibility. He raises the issue of the diversity of psychiatric disorders and the difficulty the public and the media have in distinguishing them. This dilemma faces any organisation attempting to change public attitudes towards people with mental illness and the services they need. The Royal College of Psychiatrists' campaign 'Changing Minds: Every Family in the Land' addresses a wide range of psychiatric disorders, while the World Psychiatric Association's 'Global Campaign against the Stigma of Schizophrenia' focuses on that one condition. Hopefully the results of these programmes will indicate which is the more effective strategy. However, early results from the World Psychiatric Association campaign indicate that education aimed at teenagers in schools produces the most positive change in attitudes. A good strategy would seem to be the inclusion in the school curriculum of information about the diversity of disorders and treatment modalities in psychiatry.

Leff, J. & Trieman, N. (2000) Long-stay patients discharged from psychiatric hospitals. Social and clinical outcomes after five years in the community. The TAPS Project 46. *British Journal of Psychiatry*, **176**, 217–223.

Creed, F. H., Black, D. & Anthony, P. (1990) Randomised controlled trial comparing day and inpatient psychiatric treatment. *BMJ*, **300**, 1033–1037.

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Use of outcomes measures by psychiatrists

Gilbody *et al* (2002) highlight the poor adherence of psychiatrists to using instruments to measure clinical outcomes. Assessment tools and outcome measures have been in use among practitioners working with people with learning disability for many years. There are many validated tools and reliable measures available for use in clinical practice that are routinely used. The take-up of assessment tools and outcome measurements has perhaps been influenced by the proportion of this patient group who have poor verbal skills, making access to their mental state and internal world a challenge to the clinician.

Observation of behaviour is an important element of assessment of mental health problems in people with learning disabilities. The Mini Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS–ADD) is commonly used to detect psychopathology in people presenting with challenging behaviour that may be due to mental illness. It has been shown to have good reliability and validity (Prosser *et al*, 1998). The Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS–LD) is a useful tool to measure change over time to a therapeutic intervention (Roy *et al*, 2002). Clinical observations can be carried out by any clinician in the multi-disciplinary team trained in the application of these clinical tools.

It could be argued that the use of these instruments is reductionist and does not communicate the breadth of human experience and suffering of patients. Where language fails to express the impact of mental illness and social distress, I would hold that the use of rating scales can objectively indicate the nature of the suffering and the effectiveness of interventions made in patient care.

I believe the key to the use of tools in the future will depend on educating trainees to use these instruments and allowing them to be freely available in clinical practice. Of course they would gain greater prominence in practice were they to form part of assessment in the MRCPsych examinations!

Gilbody, S. M., House, A. O. & Sheldon, T. A. (2002) Psychiatrists in the UK do not use outcomes measures. National Survey. *British Journal of Psychiatry*, **180**, 101–103.

Prosser, H., Moss, S., Costello, H., *et al* (1998) Reliability and validity of the Mini PAS–ADD for assessing psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research*, **42**, 264–272.

Roy, A., Matthews, H., Clifford, P., *et al* (2002) Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS–LD). *British Journal of Psychiatry*, **180**, 61–66.

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Dissent as a symptom: why China has questions to answer

In his letter taking issue with our claim that psychiatry is abused by the Chinese authorities for political control purposes, Dr Sing Lee (2001) cites his own experience in examining patients there suffering from '*qigong*-related mental disorder'. He concludes that this culture-bound syndrome both exists and can be a serious condition, and that the psychiatric detention of *Falun Gong* practitioners in China today is therefore not a sign of the political abuse of psychiatry. Without challenging the validity of Chinese psychiatrists' diagnoses of *qigong*-related mental disorder in particular cases, it should be stressed that the Chinese authorities themselves hardly ever mention this diagnosis when justifying the psychiatric detention of *Falun Gong* practitioners. Indeed, recent articles in the Chinese psychiatric literature have stated

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