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Kemp, R., Kirov, G., Everitt, B., et al (1998) Randomised controlled trial of compliance therapy. 18-month follow-up. *British Journal of Psychiatry*, **172**, 413–419.

Lewin, R., Ingleton, R., Newens, A., et al (1998) Adherence to cardiac rehabilitation guidelines: a survey of rehabilitation programmes in the United Kingdom. *British Medical Journal*, **316**, 1354.

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Author's reply: There has been much discussion over the terminology of treatment compliance in recent decades (Kemp & David, 1997; McEvoy, 1998). I am not wedded to any particular term. Anyone who takes an interest in compliance therapy will see that the principles are based on the search for mutual understanding and collaboration between doctor (or therapist) and patient (or client or user). I agree that as psychiatrists we should be especially alert to such matters but we should also acknowledge that we alone are able to enforce treatment in circumstances where consensus is not possible but treatment essential. For some cases, over 50% of patients in the Kemp *et al* (1998) study, enforced compliance may be the first step towards adherence and later concordance (Kane *et al*, 1983; Kjellin *et al*, 1997).

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One hundred years ago

Wandering lunatics

The city coroner of Liverpool, Mr. Sampson, has lately drawn attention to the fact that there is no suitable provision for dealing with persons suffering from the milder forms of mental aberration, and who, while they show no definite marks of insanity, are unable to give any satisfactory account of themselves, and are clearly in a condition in which insane impulses might at any time arise with grave danger either to themselves or to others. Such persons are frequently found by the police wandering at large, and are then conveyed to the bridewell and examined by a medical man. If they are found to be unable to take care of themselves, and yet the medical man does not feel justified in certifying then and there that they are insane, it is manifest that, in the interests both of the sufferers themselves and of the public, they should be retained in some suitable place until the cause and nature of the mental aberration can be ascertained. Until recently no serious difficulty in dealing with such cases has arisen, since they have been received into the workhouse on a doctor's note, and there dealt with as the occasion demanded. Latterly, however, the authorities of Mill Road Infirmary have declined to receive them, owing, it is stated, to there being no accommodation in the workhouse for the alleged lunatics; and there has been no alternative but to take them back to the bridewell, where there is no proper provision for attending to them, and to bring them before the presiding magistrate the following day. As these persons are not charged with any offence for which they can be committed to goal [sic], there is no alternative but to discharge them.

It is high time that reception houses for all cases of supposed insanity were established in the great centres of population. The Barony Parish of Glasgow has set apart observation wards in the ordinary poorhouse to meet this difficulty, and we understand that good results have been obtained there, not only for the individuals, but also for the ratepayers.

REFERENCE

Journal of Mental Science, April 1898, 449–450.

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

Corrigenda

Harris, E. C. & Barraclough, B., *BJP*, 173, 11–53. The third sentence of the fifth paragraph under the subheading "Opioid dependence and abuse (DSM–III–R 304.00 and 305.50) (Tables *5a–e*)" (p. 19, third column) should read: "The all cause SMR for HIV+ abusers was sixty times the expected compared with 17 times the expected for HIV− abusers." Table *4b* (Alcohol dependence and abuse: males, p. 15): genito-urinary SMR of 169 should not have an asterisk (i.e. the figure is non-significant). Table 35*a* (Psychiatric illness, all treatments: both genders, p. 42): infectious SMR of 203 should not have an asterisk (i.e. the figure is non-significant).

Londborg, P. D., Wolkow, R., Smith, W. T., *et al*, *BJP*, 173, 54–60. The endpoint values on Fig. 1 (p. 57) and Fig. 2 (p. 58) were omitted. In Fig. 1 (mean weekly frequency of panic attacks by group, expressed as a per cent of frequency at baseline) the endpoint values are: placebo 0.61, pooled sertraline 0.35. In Fig. 2 (percentage time spent in anticipatory anxiety per week) the endpoint values are: placebo 15.2, pooled sertraline 10.8.