using data from the ENRICHD trial. In the MIND–IT study we recently confirmed that non-response to mirtazapine and citalopram was associated with more cardiovascular events compared with responders and even untreated controls, a finding that remained after controlling for several confounders, including early cardiovascular events (de Jonge *et al*, 2007). However, as it is unclear what factors are related to response to antidepressive medication (these may well include the presence of somatic symptoms of depression; Tylee & Gandhi, 2005), it also remains uncertain whether it might be an improved state of the heart disease that influences depression or reversely that treatment of depression results in an improved cardiovascular prognosis. However, although causality remains unproven it suggests that more effective treatments may have cardiovascular effects as well. We are not yet convinced that this will be ECT but we encourage researchers to explore this possibility.

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Substance misuse disguised as ADHD?

Attention-deficit hyperactivity disorder (ADHD) is a rather novel disease in adults. It has drawn increasing attention and at present there is no deficit of studies of ADHD in adults (Fayyad *et al*, 2007). Several studies have shown a considerable risk of co-occurring substance misuse in adults given the diagnosis of ADHD (Aanonsen, 1999; Wilson, 2007). Symptoms of ADHD seem to hamper success in methadone maintenance treatment (Kolpe & Carlson, 2007). Fayyad *et al* indicate in Table 5 that in 99% of cases adult ADHD occurs first in patients with a co-occurring substance use disorder but this is not commented upon in the discussion part of their paper. Respondents were classified retrospectively as having met full ADHD criteria in childhood. To ascertain the presence of ADHD in adulthood respondents were asked a single question only, whether they continued to have problems with attention or hyperactivity.

In Norway we have an impression that people with substance misuse tend to ask for a diagnosis of ADHD, as this may lead to better treatment within the psychiatric care system. The finding of Fayyad *et al* of higher prevalences in high-income countries, with purportedly better services for the treatment of ADHD, may be an indication of common presenting symptoms in substance use disorder and ADHD. Could the authors have observed symptoms and behaviour related to substance misuse and not ADHD?

Aanonsen, N. O. (1999) Sentralstimulerende legemidler og misbrukspotensial ved hyperkinetisk forstyrrelse. *Tidsskrift for den Norske Lægeforening*, **119**, 4040–4042.

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Kolpe, M. & Carlson, G. (2007) Influence of attention-deficit/hyperactivity disorder symptoms on methadone treatment outcome. *American Journal of Addiction*, **16**, 46–48.

Wilson, J. (2007) ADHD and substance use disorders: developmental aspects and the impact of stimulant treatment. *American Journal on Addictions*, **16** (suppl. 1), 5–11.

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Authors' reply Dr Berg raises the possibility that respondents in our surveys who reported persistence of ADHD in adulthood might actually have had symptoms caused by some other disorders, such as alcoholism, that are more stigmatising and less likely to be treated than ADHD. Such respondents might consciously have provided incorrect information in an effort to avoid stigma and to increase their chances of receiving treatment. Dr Berg states that such machinations occur in his country. This is an important point in view of the stigma associated with mental disorders and the fact that some healthcare systems discriminate against certain diagnoses. Mental health professionals need to increase their efforts to raise awareness and address these problems.

That said, it strikes us as implausible that our findings are importantly affected by the sort of bias proposed by Dr Berg. First, the World Mental Health surveys are community epidemiological surveys in which no treatment is provided. Second, in a number of the participating countries ADHD is not commonly recognised as an illness, making it unlikely that community respondents would have the sophistication to seek out this diagnosis. Third, we carried out in-depth clinical reappraisal interviews with a probability sub-sample of respondents who reported adult persistence of ADHD. We excluded respondents if concerns existed that another diagnosis might be primary. Although it is possible that some respondents were so familiar with ADHD that they tricked our experienced clinical interviewers, we consider it unlikely that this was widespread. Fourth, treatment-seeking was low in most World Mental Health surveys. When it occurred, the reason for seeking treatment was not ADHD but a comorbid disorder.

Irrespective of whether the type of bias Dr Berg suggested exists in epidemiological surveys, our results imply that clinicians should look more seriously for ADHD in their adult patients than they have before. As more physicians screen for ADHD among adults presenting for treatment of other psychiatric disorders, the extent to which untreated adult ADHD exists among help-seekers will become apparent.

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Heroin-assisted treatment: no difference in treatment retention

Haasen *et al* (2007) report highly significant findings from their trial of heroin plus methadone maintenance. A small problem is that the heroin plus methadone group were, to a large extent, self-selected, with only 2.3% failing to initiate treatment in this group *v.* 28.8% in the methadone only arms. They state that this 'limiting effect . . . is minimised' by randomisation and intention-to-treat analysis. Intention-to-treat analysis makes their already significant findings even more impressive, but randomisation is limited by the unavoidable self-selection in a trial which is necessarily not masked. The paper goes on to say that 'retention was higher in the heroin group, with 67.2% completing the 12-month treatment compared with 40% of the methadone group', but later this is given as 56.3% for the methadone only group when the 28.8% who did not initiate treatment were excluded. The retention rate would rise again if the drop-out ('discontinued') rate was calculated using the same reduced denominator, and therefore retention rates would possibly differ insignificantly. Taking this into consideration would also explain the almost equal numbers of 'discontinued' participants in the two main arms of the trial.

The findings of this aspect of the trial are not surprising and without doubt it would be difficult to devise a control with the reinforcing power of heroin. Injectable methadone, financial incentives or pleasurable activities might approximate a substitute and produce more accurate retention figures. With the high cost of freeze-dried heroin, as used in the UK, adding these incentives might attract funding for a suitably modified study conducted here. Given that high retention rates are today's centrally defined most desirable outcome in the UK, this sort of study might be even more attractive here.

Haasen, C., Verthein, U., Degkwitz, P., *et al* (2007) Heroin-assisted treatment for opioid dependence: randomised controlled trial. *British Journal of Psychiatry*, **191**, 55–62.

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Author's reply Drs Al-Adwani & Nahata raise an important issue when evaluating the outcome of maintenance treatment, namely how to evaluate the retention rate in an unmasked trial. The special incentive for patients randomised to methadone treatment was the option to switch to the heroin group after completing 1 year of treatment. Since retention is considered one of the main outcome measures for maintenance treatment, our trial shows that heroin-assisted treatment has two advantages: it reaches a higher number of potential patients (percentage initiating treatment) and the retention rate of those initiating treatment is significantly higher (68.3 *v.* 56.3%, log rank $\chi^2=14.1$, $P<0.001$). Therefore, it is incorrect to say that 'retention rates would possibly differ insignificantly': the difference is certainly less, but still significant.

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Factors in those who repeatedly self-harm

We read with interest the article on young people who self-harm (Young *et al*, 2007) but feel the outcome of factors considered would have been more viable if a further subgroup analysis was performed in those patients who repeatedly self-harm. A significant amount of our time is taken up by people who self-harm repeatedly. This subset of clients are often entrenched in their behaviour patterns and use services disproportionately. Existing studies have not adequately analysed factors responsible for repetition of self-harm and we feel that Young *et al* missed an excellent opportunity to investigate this, albeit in a younger age-group.

An analysis of our data from the Integrated Care Pathway (Rajwal & Gash, 2006) showed repetition rates of 40% for 2004, 42% for 2005 and 43% for 2006 of all our referrals each year. This means that 18% of our patients in 2004, 18.9% in 2005 and 19.2% in 2006 were responsible for the above statistics year on year. These data are from adults of working age and only include repetition in the same calendar year. About 13% of our referrals are under 21, and 18% of those are for repetitions of self-harm. Hence a small proportion of our clients are responsible for a large proportion of our work.

Our data support Young *et al* on the lack of a gender bias in the prevalence of self-harm. Females comprised 50.2% of our referrals in 2006 but only 49.0% of those repeating self-harm. The old myth of a higher proportion of females self-harming was not borne out by our statistics, although we considered the entire adult age-group.

We would be interested to know whether the results of Young *et al* would be different in the subgroup with repeated self-harm.

Rajwal, M. & Gash, A. (2006) Risk assessment in self-harm. *Psychiatric Bulletin*, **30**, 436.

Young, R., Van Beinum, M., Sweeting, H., *et al* (2007) Young people who self-harm. *British Journal of Psychiatry*, **191**, 44–49.

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Authors' reply: Kripalani *et al* raise an important issue by suggesting that those who repeatedly self-harm may constitute a distinctive clinical subgroup. We initially avoided including this group in our study because there remains considerable uncertainty about an appropriate definition. However, following discussion with Dr