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Left frontal activation

We read with considerable interest the paper by Shergill et al (2004) about the temporal course of brain activity associated with auditory verbal hallucinations. The researchers used functional magnetic resonance imaging to reveal those brain regions activated before, during and after such hallucinations (the occurrence of which was indicated by patients pressing a button). They concluded that activation of the left inferior frontal gyrus some 9 seconds prior to button pressing supports the theory that hallucinations originate in brain areas involved in the generation of ‘inner speech’. Given the importance of this question for future paradigm development, we wish to offer constructive comment.

There is a difficulty associated with the experimental method as described. Because no control condition was included (in which, for example, subjects might self-initiate button presses, unrelated to the timing of hallucinations) we cannot ascertain whether the frontal activation was attributable to the auditory verbal hallucinations or the procedure of button pressing itself; this problem emerged in the interpretation of an earlier, similar study (McGuire et al, 1993; Krams et al, 1996). In healthy individuals we have observed that the left frontal cortex also activates 9 seconds prior to simple, self-initiated button pressing (Hunter et al, 2004). Obviously, in healthy individuals this has no relationship to auditory verbal hallucinations (it is a feature of the temporal evolution of normal voluntary motor behaviour). During such behaviour, maximal frontal activity is seen in the middle and inferior frontal gyri (9 s prior to button pressing). The temporal sequence of frontal activation observed by Shergill et al (2004) could be related to the hallucinations or be attributed to the self-initiation of motor action (button pressing). This methodological consideration radically constrains the authors’ conclusions. The techniques of functional neuroimaging are complex and unfamiliar to most general readers. We hope that the concern we raise is helpful in elucidating the methodological issues inherent in studies such as these.


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Confounding factors for depression in adults with mild learning disability

The point prevalence of a major depressive illness in people with learning disability is between 2 and 7%, which means that depression can be twice as common in this group as in the general population (Prasher, 1999).

Collishaw et al (2004) present strong evidence for directing strategies of primary prevention towards socio-economic depri-vation and ill health in people with mild learning disabilities. However, these results should be viewed with caution as the study did not control for certain important factors. Certain groups of people with learning disability are shown to be at a risk of developing a depressive illness, for example those with Down’s syndrome, fragile-X syndrome or epilepsy (Prasher, 1999).

Down’s syndrome and fragile-X syndrome are among the most common genetic causes of learning disabilities, and epilepsy is 10 times more common in people with mild learning disability than in the general population (Bird, 1997). This implies that factors other than socio-economic deprivation could have contributed to the depressed mood in those with mild learning disability.


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Authors’ reply: We investigated the extent to which adult social adversity and ill health contributed to an elevated risk for depressed mood among adults with mild learning disability (Collishaw et al, 2004). The study used data from the 1958 National Child Development Study (NCDS), a nationally representative cohort followed from birth to age 43 years.

Dr Feroz-Nairn makes the point that epilepsy, fragile-X syndrome and Down’s syndrome are among the biological/genetic causes and correlates of learning disabilities and raises the question whether these factors contributed to the higher rate of depressed affect associated with mild learning disability.

A previous report on the NCDS birth cohort confirms that epilepsy and other neurological abnormalities were indeed more common for individuals with mild learning disabilities than for controls. However, the majority of individuals with mild learning disability had no known neuro-epileptic abnormalities and mild learning disability was more commonly associated with childhood social and family adversity (Maughan et al, 1999).

To investigate the possibility that group differences in depressed affect were due to biological factors such as epilepsy in those with mild learning disabilities, we re-analysed the statistical models...
reported in our recent paper (Collishaw et al., 2004). Controlling for childhood epilepsy/neurological problems did not reduce group differences in adult depressed affect (model adjusted only for gender: OR=2.84, 95% CI 1.7–4.9, P<0.001; model adjusted for gender and childhood neurological problems/epilepsy: OR=2.79, 95% CI 1.6–4.8, P<0.001). This is in contrast to the partial mediating effect of controlling for childhood social adversity (Maughan et al., 1999; Collishaw et al., 2004) and the almost complete mediating effect of additional controls for adult ill health and adult social adversity (Collishaw et al., 2004).

We cannot rule out completely the possibility that some other unmeasured third factor is confounded with social adversity and could explain our findings. We also acknowledge that specific biological factors may be of particular importance for understanding affective problems in some individuals with mild learning disability. Nevertheless, when assessed in an unselected general population cohort such as the NCDS, social factors and adult health do appear to have an important contribution to depressed mood among people with mild learning disability.

We identified 55 cases of dementia among 327 people who scored at or below the cut-off on the MMSE. The one case identified from the 10% of the negatively screened population was counted as one among the ten cases in the negatively screened population of 1607 (i.e. 65 cases in 1934 people aged 65 years and above).

The assessment of risk factors based on retrospective accounts of the carers and an inadequate number of controls for calculating the odds ratios can be considered methodological limitations of the study. The prevalence of dementia increases proportionately with age ($\chi^2=40.29$, d.f.=5, $P<0.001$). This $\chi^2$ value was not given in the text. The number of patients with Alzheimer’s disease was 30. The error in the article is regretted.


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**Measures for mental health outcomes**

I was very interested to read the article by Salvi et al. (2005) on choosing the measure for mental health outcome assessments. Readers might be interested in a comparison of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS; Phelan et al., 1995) and Health of the Nation Outcome Scale (HoNOS; Wing et al., 1998) scores. One thousand pairs of HoNOS and CANSAS scores were recorded by four trainees and myself. Figure 1 shows the means with standard errors of the HoNOS values associated with each CANSAS score.

The higher CANSAS scores (13–22) were not encountered very often and accounted for only 3.5% of scores. The large standard errors are because some of the CANSAS scores occurred infrequently. HoNOS and CANSAS scores are related in the lower CANSAS range of 1–8, the most common range, accounting for 79% of the scores. Up to a CANSAS score of 12 ($n=955$) there is a reasonably close correlation with the HoNOS scores. The Spearman coefficient is 0.564, indicating that the correlation is significant at the 0.01 level (two-tailed).

The use of CANSAS is becoming established in Lothian mental health services. CANSAS is very useful as a needs assessment tool for individual patients. Its face
validity as an outcome measure is not as good as that of the Threshold Assessment Grid (Slade et al, 2000), Global Assessment of Functioning (Jones et al, 1995) or HoNOS. This correlation exercise confirms that it can be used as an outcome measure with reasonable validity. It is useful in terms of consultant appraisal discussions, evaluation of workload of community and ward mental health teams and local and regional assessment of outcomes in different patient groups. Given the above correlation, benchmarking is also possible with other services, especially in England, where HoNOS is established. The conclusions of Salvi et al (2005) in the last paragraph of their article are absolutely valid.

Given the great difficulty in implementing and coordinating any single outcome assessment, I hope that the above comparison of CANAS and HoNOS scores, in combination with the results of Salvi et al (2005), will assist those running mental health services.


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Publication of case reports

Several letters advocating the reinstatement of case reports in the Journal have been published recently (Williams, 2004; Enoch, 2005). I believe that it would be useful to make a distinction between two substantially different kinds of such reports. The first group includes discussions of challenging cases with difficult clinical implications and interesting phenomenological descriptions, with the only aim to improve the readers’ diagnostic and therapeutic skills. Typical examples are the ‘Grand Rounds’ that used to be published in the BMJ. I agree with Dr Enoch and Dr Williams’ point of view and I would personally welcome the publication of these case reports in the Journal.

However, another group of reports have a substantially different objective. Their aim is to allow clinicians to share their anecdotal experience of unusual outcomes in clinical practice. These reports are a self-selected group of unlikely cases because only ‘man bites dog’ stories reach publication. The conclusions of sophisticated randomised trials with good statistical analyses are difficult enough to interpret because of biases such as unmasking, file drawer problems, etc. Anecdotal care reports can be confusing and misleading because the subjective data are often interpreted as objective, creating even more noise where the signal is already faint. The publication of a one-off case report of an adverse effect can profoundly influence clinical practice on the basis of a freak event. Infamous examples include the widely followed recommendation not to use haloperidol and lithium in combination (Cohen & Cohen, 1974) and the reluctance to use intravenous thiamine for the prevention of Korsakoff syndrome on the basis of a few reports of adverse reactions (Thomson & Cook, 1997). The cases of the hundreds of thousands of people who have been safely and successfully treated with these medications are not published because no one wants to state the obvious. I believe that the past editor’s decision to move on from publishing this latter group of case reports was extremely wise.


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Editor’s response: We do publish case reports if they have, or could have, important general implications. The paper by Boddart and her colleagues in this issue (Boddart et al, 1995) is a good example of this.


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ECT for acute mania

In his excellent review of the management of acute mania, Professor Keck does not mention an additional form of available treatment, no doubt because it is archaic and anecdotal.

In the early 1950s, when the only drugs available to treat mania were para-derine and barbiturates, patients were ill for months, and sometimes even died of exhaustion. In those days ‘electroplexy’ was given for everything, but a standard course of treatment of seven sessions of electro-convulsive therapy (ECT) over 3 weeks proved ineffective in manic patients. However, it became apparent that ECT applied twice daily, over 3 or at the most 4 days, usually brought the manic attack to an end.

I last used this treatment over 20 years ago, in circumstances where prompt restoration to health was vital. It was completely successful. The real difficulty was in obtaining anaesthetic cover twice daily. In drug-resistant cases such an approach might still have a place, with considerable savings in the time spent in hospital.


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Variations in involuntary commitment in the European Union

The recent article by Salize & Dressing (2004) reported that frequencies of compulsory admissions vary remarkably among countries in the European Union, from 6 per 100,000 citizens in Portugal to 218 per 100,000 in Finland. These findings are not surprising given the large differences in the laws, mental health acts, and legal instruments of the countries but they are astonishing given the much smaller differences in psychiatric morbidity. These differences show that the number of involuntary admissions is a result of a complex set of still poorly understood legal, political, economic, social and multiple other factors...
The absence of an evidence-based model for the use of coercion in psychiatry is partly due to ethical difficulties in studying coercion measures, for example, using randomised controlled trials. We need to find ways to overcome these difficulties, for example by assessing the effectiveness of involuntary admission in those who pose relatively little danger to themselves and others. Results of these studies need to be taken into account in the current debate on the use of coercion measures. It is likely that certain groups of patients benefit more from specific coercion measures than others. Patients with psychotic disorders with severe social breakdown and lack of motivation for treatment probably benefit more from coercion measures than those with personality disorders. International comparative studies are needed to assess the effects of different laws on outcomes, for example laws using criteria of danger versus those using need for treatment criteria. Valid and reliable instruments are needed when deciding to use coercion; these should include assessment of the severity of psychiatric disorder, danger to self or others and motivation for treatment. Researchers active in this field could form collaborative (inter)national working groups on pressure for treatment and coercion in psychiatry.


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Psychiatry in Europe

A group of psychiatrists and mental health staff from many of the new entrants to the European Community and from candidate countries as well as from the UK met in Luton, Bedfordshire on 17 and 18 September 2004 to discuss early intervention in psychotic illness. At the end of the conference, the delegates discussed the issues raised by Andrej Marušić (2004) in the Journal.

The delegates recognised that there were indeed many disparities in the mental health of the populations of the different member and candidate states of the European Union, and that mental health provision in the different states was very diverse. In particular, they noted that the research profile of many of the newer states of the European Union required improvement, and there was need for major development work and investment in many states if they were to provide adequate and effective community-based psychiatric services to all people of the Union.

The achievement of such goals will require much sharing of experience and ideas. The delegates were anxious to contribute to the development of modern community-based psychiatric services in Europe and have committed themselves to future cooperation in the development of such services. They are willing to form a network to support each other’s projects.

These endeavours could include collaboration through joint research projects, joint training schemes for both medical and non-medical staff, exchange schemes and visits, both long- and short-term, to share knowledge and expertise, developing joint protocols for the diagnosis of illness and patient management, twinning of services from different countries, developing psychosocial and family interventions for patients, sharing epidemiological information from case registers, and holding an annual conference, as well as joint meetings on particular issues of mutual interest. We hope that such activities could be funded by existing European Union programmes. It is proposed that this group of colleagues be known as the Luton group, after the place where the conference was held. A secretariat based at the Bedfordshire Centre for Mental Health Research in Association with the University of Cambridge will coordinate the group. We would welcome any communication from colleagues with similar interests.


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One hundred years ago

Asylum reports

London County Epileptic Colony, Ewell (Report for the year ending March 31st 1904). – The colony was formally opened under happy auspices on July 1st, 1903 [an account of the opening appeared in THE LANCET of July 11th, 1903, p. 110], when on the occasion of the visit of H.R.H. Princess Louise, Duchess of Fife, and in the presence of the chairman of the London County Council and a large...
assembly of visitors, the opening ceremony was performed by the Duke of Fife. A handsome brass tablet has been placed in the entrance hall to mark the occasion. This therefore is the first report. The colony owes its origin to the fact that the asylums committee of the London County Council was impressed with the knowledge that among the epileptics housed in its asylums there were some 300 patients whose disease was mild in character and who seemed suitable to enjoy the benefits of colony or farm life. Accordingly an estate of 112 acres was purchased near Ewell, Epsom, on which a system of villas and buildings of a suitable character were erected. All the villas are of a one-storeyed character and provide accommodation each for 38 patients. The warming and ventilation are on the latest approved pattern and the buildings are lighted throughout by electricity. Roads have been made and gardens planted, the gardens of the villas being separated by earth banks or belts of planted trees and shrubs, so that ingress and egress are found only by the paths. The total number of patients admitted during the year was 315, comprising 250 males and 65 females. During the year the death-rate was low; there being only 17 deaths (14 males and three females). The medical superintendent, Dr. C. H. Bond, states in his report that private cases are admitted but that as the number of such cases received has been small “there still remains one villa not yet in occupation.” The necessity of vigilance in regard to the class of patients is emphasised. Thus of the 315 cases sent to the colony 80, or 25 per cent., had at one time or another in their history been regarded as suicidal. The table of admissions shows a faulty (neurotic or insane) heredity in nearly 50 per cent. of cases, distributed as follows: 18 per cent. of cases of insane heredity, 17 per cent. of epileptic heredity, and 10 per cent. of alcoholic heredity. “A well-defined history of trauma, in the form of either injuries to the head or severe falls productive of shock, was found in as large a proportion as 14 per cent.” Arteriosclerosis was present in 14 per cent. of the admissions. Farm and garden work is systematically and daily taken part in by the patients, while the grounds are freely open for all to stroll about in during the intervals. “In a few instances the character of the men’s labour is really that of skilled workmen, in about a third it is of fair value, but in the case of the majority it is crude and that of men entirely unaccustomed to agricultural pursuits.” The patients are under regular medicinal treatment which includes bromide of strontium and a specially regulated diet. Cricket and other games are provided. The Commissioners in Lunacy state that the colony consists of able-bodied working epileptics, that the buildings are well constructed and suitable to their purpose, that the colonists were neatly clad and looked in good health, and that satisfactory progress has been made in the colony during the first year of its existence.

**REFERENCE**

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