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 CANSAS and HoNOS scores, in combination with the results of Salvi *et al* (2005), will assist those running mental health services.

Jones, S. H., Thornicroft, G., Coffey, M., *et al* (1995) A brief mental health outcome scale: reliability and validity of the Global Assessment of Functioning (GAF). *British Journal of Psychiatry*, **166**, 654–659.

Phelan, M, Slade, M., Thornicroft, G., *et al* (1995) The Camberwell Assessment of Need (CAN): the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, **167**, 589–595.

Salvi, G., Leese, M. & Slade, M. (2005) Routine use of mental health outcome assessments: choosing the measure. *British Journal of Psychiatry*, **186**, 146–152.

Slade, M., Powell, R., Rosen, A., *et al* (2000) Threshold Assessment Grid (TAG): the development of a valid and brief scale to assess the severity of mental illness. *Social Psychiatry and Psychiatric Epidemiology*, **35**, 78–85.

Wing, J. K., Beevor, A. S., Curtis, R. H., *et al* (1998) Health of the Nation Outcome Scales (HoNOS): research and development. *British Journal of Psychiatry*, **172**, 11–18.

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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.

Cohen, W. J. & Cohen, N. H. (1974) Lithium carbonate, haloperidol, and irreversible brain damage. *JAMA*, **230**, 1283–1287.

Enoch, M. D. (2005) Case reports (letter). *British Journal of Psychiatry*, **186**, 169.

Thomson, A. D. & Cook, C. C. (1997) Parenteral thiamine and Wernicke's encephalopathy: the balance of risks and perception of concern. *Alcohol and Alcoholism*, **32**, 207–209.

Williams, D. D. R. (2004) In defence of the case report (letter). *British Journal of Psychiatry*, **184**, 84.

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

Boddaert, N., Barthélémy, C., Poline, J.-B., *et al* (2005) Autism: functional brain mapping of exceptional calendar capacity. *British Journal of Psychiatry*, **187**, 83–86.

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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 paraldehyde 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 electroconvulsive 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.

Keck, P. E. Jr (2003) The management of acute mania. *BMJ*, **327**, 1002–1003.

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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

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(Salize *et al*, 2002). However, data on the effectiveness of coercion measures are lacking and there is no evidence base for involuntary commitment. The few studies have focused mainly on out-patient commitment and show mixed results (Swanson *et al*, 2000; Steadman *et al*, 2001; Swanson *et al*, 2003).

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 trails. 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 cerocion 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 *v.* 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.

Salize, H. J., Dressing, H. (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry*, **184**, 163–168.

Salize, H. J., Dressing, H. & Peitz, M. (2002) *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States. Final Report*. Mannheim: Central Institute of Mental Health. Available at http://europa.eu.int/comm/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf

Steadman, H. J., Gounis, K., Dennis, D., *et al* (2001) Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatric Services*, **52**, 330–336.

Swanson, J. W., Swartz, M. S., Wagner, H. R., *et al* (2000) Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, **176**, 324–331.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., *et al* (2003) Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, **21**, 473–491.

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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 Marušič (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.

Marušič, A. (2004) Mental health in the enlarged European Union: need for relevant public mental health action. *British Journal of Psychiatry*, **184**, 450–451.

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E. Gruber, S. M. Biocina, J. Andelic Croatia

R. Dinolova Bulgaria

J. van Os The Netherlands

M. Lambert Germany

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

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