We calculated a 95% CI for the reported prevalence from Bangalore, which was 11.6–21.2%. This suggested that it was unlikely that the differences in prevalence between Scotland and Bangalore were simply because of sampling error. Other possible explanations include variations in ECT technique, anaesthesia, or the methodology of EEG recording. These topics merit further research and may inform the debate about the importance of routine EEG monitoring.

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Mental health and Irish ethnicity

Sir: Given Bracken *et al*'s (1998) use of mental hospital admissions data of the 1971 and 1981 Mental Health Enquiries to argue that the Irish have the poorest record of mental health of all ethnic minorities in Britain, it is surprising that the investigators offer no explanation of why reliance was placed on such outdated information.

The Hospital Episode Statistics (HES) system was introduced in April 1987 to replace the Hospital Inpatient Enquiry (HIPE) and the Mental Health Enquiry (MHE). HIPE ceased to exist in 1985 and the MHE in 1986, these changes resulting in major deficiencies in HES data until the early 1990s. Routine hospital activity data did not record any measure of ethnicity until the mandatory collection of ethnic group data for National Health Service (NHS) hospital in-patients was introduced in April 1995. However, the use of a national standard for collecting the data – the 1991 Census classification without provision for free-text responses – meant the only options for the majority self-identifying as 'Irish' were to tick 'White' or 'Any other ethnic group'. Although the NHS offered a detailed set of local codes, including 'Irish', scarcely any trusts have used these (Aspinall 1998*a*). Also, the continuing high level of incompleteness of ethnic coding (44% invalid in 1996/97) means that HES is unlikely to provide in the near future the data needed to establish current levels of admission for psychiatric and other specialities among the Irish. This is unfortunate in view of the Commission for Racial Equality's efforts in 1995–96 to get NHS trusts to include an 'Irish' monitoring category and the reported wish of the trusts themselves to see the national standard 'White' category broken down to include groups like the Irish (Aspinall, 1998*b*).

What is needed is some measure of psychiatric morbidity in the community, including those in communal establishments. Clearly with health and lifestyle surveys collecting data on up to 25 000 residents (South East Institute of Public Health, 1993), there is scope to accrue basic data on the mental health of the Irish (through the use of, for example, the generic instrument SF–36 and associated three-item depression screen, or the General Health Questionnaire (GHQ–12)). However, the regular inclusion of an 'Irish' category among the population groups used in such surveys will depend upon its widespread recognition as a legitimate ethnic group. Perhaps that has been brought a step nearer with the recently announced decision to include an 'Irish' category in the 2001 Census (Her Majesty's Treasury *et al*, 1999).

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One hundred years ago

Morphine habit of long-standing cured by bromide poisoning

Dr. Neil Macleod, *Brit. Med. Journ.*, July 10th, 1897. – Two very interesting cases of treatment, to say the least heroic, are here recorded. The first case, a lady aged 32, had been the victim of the morphine habit for seven years. The extent to which she had taken this drug is not given, but when she came under treatment with symptoms of great nervous irritability she had reduced her morphine to the, for her, very small dose of 10 minims of Majendie's solution (gr. $\frac{1}{3}$ rd) every four hours. She was ordered bromide of sodium in 30-grain doses every four hours, but must have trebled this dosage, for in two days 18 drachms had been consumed. She was removed to hospital, and for four days received hypodermically $1\frac{1}{2}$ grains of morphine per diem. On the