development that can be monitored and facilitates team learning and performance enhancement in multi-disciplinary setting (Young, 1996). What is needed is a system that evaluates medical performance rather than doctors' attendance of 'points-generating meetings', which perhaps have more value to those who organise them and to those who collect signatures.

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Transforming mental health legislation

There is an international precedent to the revolutionary change to mental health legislation proposed by Zigmond (*Psychiatric Bulletin*, November 1998, **22**, 657–658). In 1974 in Jamaica there was an Amendment to the 1930 Mental Hospital Act, which has achieved the predicted effect on the medical incapacity act proposed by Zigmond.

The 1974 Amendment provided the foundation for the establishment of community psychiatry in Jamaica (Hickling, 1993, 1994). The Amendment allowed mental health officers to become the agents of therapeutic intervention, replacing the police as the designated officer for the apprehension and removal of the acutely ill patient to a place of treatment. The law Amendment also allowed any medical facility to replace the asylum as the sole place of assessment and treatment of the mentally ill.

This legislative amendment has allowed mentally ill people to be admitted to medical wards in general hospitals and treated under the legislation governing the physically ill. There has been no need for the development of expensive and unwieldy systems of mental health tribunals for the protection of the civil liberties of patients. The 1974 Amendment has encouraged a benevolent and syncretic relationship to develop between mentally ill people, their families, the mental treatment services, the police and the legal system.

In the years since the introduction of the 1974 Amendment, a remarkable system of community mental health care has developed around the island. Admissions to the Mental Hospital have fallen by 80%, and there has also been a reduction on the total number of psychiatric hospital admissions island-wide of nearly 50% (Hickling, 1991, 1994). By 1993 merely 5% of the total psychiatric admissions were by compulsory detention under the statutes of the 1930 Mental Hospital Law.

The openness and the flexibility of the 1974 Amendment has allowed the families of patients to take the legal responsibility for the admission of their mentally ill relative with incapacity in the same way that they would if their relative with incapacity had suffered from a non-psychiatric illness requiring their admission to hospital, but which prevented the patient from personally giving their permission for admission. There have been no negative medico-legal sequelae to these practices in the 25 years of operation of the legislative amendment.

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— (1994) Community psychiatry and deinstitutionalization in Jamaica. *Hospital and Community Psychiatry*, **45**, 1122–1126.

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New drugs and the NHS

Sir: May I applaud the paper by David Taylor (*Psychiatric Bulletin*, November 1998, **22**, 709–710) lamenting the conventional disgruntlement which seems to characterise our approach to new pharmacological remedies. This may reflect a general preference for social/psychotherapeutic strategies, or more sinisterly a willingness to devalue the needs of our patients. Many psychiatrists seem quite content to paralyse the non-verbal communication of people with schizophrenia to save a paltry £1000 per annum (by prescribing a conventional dopamine blocker). Similarly, we seem willing to regard Alzheimer's disease as untreatable, our patients not meriting six further months of good function. Our colleagues treating HIV infection have no qualms in spending £10 000 a year to treat their patients. Neurologists will have to decide whether to spend £10 000 per annum on beta interferon to reduce the relapse rate of multiple sclerosis (Goodkin, 1998). Paediatricians spend £5000 a year on growth hormone to restore growth, gastroenterologists spend £500 a year to prevent gastric bleeding in patients who need NSAIDs, all worthy objectives. However psychiatrists are prepared to accept that a patient with

Alzheimer's disease is not worth £800 per year (rivastigmine), even when it saves on institutional fees; a saving for the local authority but not for the NHS.

One accepts that the drugs budget has limitations, but when compared with the cost of other less effective interventions the price is relatively small. If we do not stand up for our patients the case will go by default as, for example, is typified by the lukewarm approach of the Alzheimer's Disease Society.

GOODKIN, D. E. (1998) Interferon beta therapy for multiple sclerosis. *Lancet*, **352**, 1486–1487.

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Rationale behind psychiatrists' choice of drugs

Sir: I read Johnson Dickson-Mulinga's survey (*Psychiatric Bulletin*, November 1998, **22**, 677–680) with considerable interest. However, why is the author so worried at half of his respondents quoting "personal experience" as the most important influence on their prescribing habit and why does he assume that such prescribing is not rational or not scientific and non-problem solving?

For that matter, what scientific evidence do we have to imply that prescribing habits should only be evidence based? Is it just another example of our rush to join the evidence-based medicine club without realising that not only is the process of evidence gathering at its infancy but more importantly that there are still some basic flaws in the very process of evidence collection and its implication and implementation in routine clinical practice (Sikdar, 1997; Thornley & Clive, 1998)?

Thus I feel it is unfair to be suspicious of or look down upon "personal experience"-based prescribing practice as second best, so long as it works for an individual patient and does not cause any harm.

SIKDAR, S. (1997) Evidence-based psychiatry: which evidence to believe? *British Journal of Psychiatry*, **171**, 483–484.

THORNLEY, B. & ADAMS, C. (1998) Content and quality of 2000 controlled trials in schizophrenia over 50 years. *British Medical Journal*, **317**, 1181–1184.

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Maximum output of ECT machines

Author's reply: The case report by Galloway *et al* (*Psychiatric Bulletin*, November 1998, **22**, 713–714) did not include a definition of what constitutes a "satisfactory fit", and no information was given about the techniques of anaesthesia and seizure monitoring. It was not possible therefore to distinguish intrinsic and extrinsic causes of a failure to induce adequate cerebral seizure activity. This distinction is not a theoretical nicety. If the induction of cerebral seizure activity was impossible because too much intravenous methohexitone had been administered, then I would suggest it was more appropriate to ask the anaesthetist to give less anaesthetic than look for a more powerful ECT machine.

Our suggestion, and this was the word we used, that the Ectron Series 5A ECT machine was not underpowered is only amenable to scientific disproof. We have not been able to do so locally. The Edinburgh protocol to measure the initial seizure threshold and our techniques of anaesthesia and seizure monitoring were described in our paper (Dykes & Scott, 1998). We now have data from 540 courses of ECT, 158 in people aged 65 years or older (Glen & Scott, 1999). The maximum initial seizure threshold was observed in a 72-year-old man with depression treated with bilateral ECT and who also took carbamazepine as a maintenance treatment of a bipolar affective disorder. His seizure threshold was 325 mC, the maximum output of the Ectron machine is 700 mC.

DYKES, S. R. & SCOTT, A. I. F. (1998) Initial seizure threshold in bilateral electroconvulsive therapy. *Psychiatric Bulletin*, **22**, 298–299.

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