Correspondence

EDITED BY KHALIDA ISMAIL

Success of community care?

There is debate regarding the success or otherwise of community care. The evidence deriving from the closure of Friern Hospital on which the Team for the Assessment of Psychiatric Services project is based, discussed by Leff (2001), cannot be generalised because, in contrast to typical hospital closures, in the region of £100 million was allocated to ensure the 'success' of the project. Despite this expenditure, the following points should be considered.

At the time of the closure of Friern Hospital an internal audit found that only 14 long-stay patients were there by compulsion and 11 of those were under court orders (Weller, 1989).

After closure, high wire netting was erected and 24-hour guard-dog patrols were instituted because of attempted returns by patients to the hospital.

Many of the patients offered 'a home for life' were subsequently moved.

Many have become 'revolving-door' patients.

The hospital building, of listed architectural merit (but which drew inexplicable opprobrium at the time), and spacious grounds are now luxury flats, and a £400 million deal has been struck for many more on other hospital sites (*The Times*, 12 September 2002: p. 3).

Twenty patients committed suicide in the first year after closure (further details available from the author upon request). This figure stands in contrast to the findings of Powell *et al* (2000), who showed that even within the high-risk group of in-patients, 100 patients would need to be detained unnecessarily in order to prevent one suicide.

Leff, J. (2001) Why is care in the community perceived as a failure? *British Journal of Psychiatry*, **179**, 381–383.

Powell, J., Geddes, J., Hawton, K., *et al* (2000) Suicide in psychiatric hospital in-patients. Risk factors and their predictive power. *British Journal of Psychiatry*, **176**, 266–272.

Weller, M. P. I. (1989) Mental illness – who cares? *Nature* **399**, 249–252.

Declaration of interest

Grant from the Regional Health Authority and the National Schizophrenia Fellowship to compile the suicide statistics.

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Telephone support and suicide prevention

We read with interest the paper by De Leo *et al* (2002), which implied that needs assessment telephone calls and 24-hour emergency services had proved effective for elderly females, with a reported significant reduction in suicide rate.

In our study of 216 elderly suicides in Cheshire and Birmingham over a 5-year period (1994–1998; Salib *et al*, 2001), 30% of suicide victims were not known to psychiatric services. Surprisingly, 38% of the men and 16% of the women among those elderly suicide victims unknown to services were found to have had some defined, albeit untreated, psychiatric morbidity.

Evidence of psychiatric morbidity was extracted from coroner's records of statements provided by families and friends of the deceased. Men were less likely to be known to local services but more likely to be living alone and to harbour undetected psychiatric morbidity, hence the high risk of succeeding in their first suicide attempt.

Elderly male suicide victims do not tend to ask for help, whether face to face or over the telephone, so we must find a way to take the help to them, particularly at their moment of despair.

The findings of De Leo *et al* are hardly surprising. However, there is an obvious risk that we may evaluate our services based on 'total' decline in numbers of suicides, in which women may be over-represented, thus giving a false impression of the actual reduction in suicide rate.

De Leo, D., Buono, M. D. & Dwyer, J. (2002) Suicide among the elderly: the long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry*, **181**, 226–229.

Salib, E., Tadros, G. & Cawley, S. (2001) Elderly suicide and attempted suicide: one syndrome. *Medicine Science and the Law*, **41**, 250–255.

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Qigong and suicide prevention

De Leo *et al*'s study (2002) confirmed that a TeleHelp–TeleCheck service reduced suicides among elderly service users in northern Italy. The authors comment that the highest suicide rates in almost every country (including Hong Kong and China) are among those aged more than 75 years. The literature suggests that considerable numbers of suicides among the elderly are due to depression. Conwell (1996) reported that 60–75% of those who committed suicide had a diagnosis of depression among patients aged ⩾75 years. This is particularly relevant in elderly people with chronic physical conditions such as stroke and Parkinson's disease. My colleagues and I (Tsang *et al*, 2002) recently hypothesised, after a comprehensive literature review, that depression in elderly people with chronic physical illnesses results from disability and a reduction in psychosocial resources. If depression is left untreated, suicide may be a consequence.

In view of the high prevalence rates and seriousness of the consequences of the co-occurrence of depression and physical illnesses in later life, various approaches have been developed to counteract the effect of depressed mood. De Leo *et al*'s study reports one such approach, using a telephone helpline and emergency response service. We (Tsang *et al*, 2002) proposed *qigong* as a psychosocial intervention to help elderly people with depression and chronic physical illnesses. *Qigong* has a long history with diverse schools in China. It can be seen as a method to regulate the body, breathing and mind. In China, health and longevity are believed to be determined by strength, balance and cultivation of the three treasures: *jing* (essence),

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