

## Correspondence

---

### DAY HOSPITALS: STATISTICAL RETURNS

DEAR SIR,

Recently when analysing data from a census of psychiatric day-patients in South Glamorgan I looked at the official statistics on day-patients and found them rather confusing (DHSS, 1980; Welsh Office, 1981). The main problem is that the numbers of 'places allocated' at day hospitals in general bear little relationship to the numbers 'attending on the last full working day of the year' or to the average daily attendance calculated by dividing the total annual attendance by 250 (assuming a 5-day week and allowing 10 days for holidays). The figures for day places are suspiciously rounded and substantially larger than those for daily attendance, which on the face of it seems to suggest that day hospitals are much under-used.

The problem probably lies with the ambiguous notion of a 'day place'. The number of places a day hospital can offer during a week will of course vary according to the frequency with which patients attend, e.g. for a unit offering a maximum of 20 places a day it could vary from 20, if each patient attended on all 5 days of a working week to 100, if each attended only once, and the official statistics are probably meant to take account of this. At any rate they refer to places allocated on "the last full working day of the year" (presumably intended to be the same number as on any other day) i.e. to the *daily* allocation of places. Even so this may not be a very accurate notion in the minds of day hospital staff who have to make the returns. For example, the Tegfan Day Hospital in Cardiff was built to take 200 patients and does take 200–230 a week. However, since the frequency of patients' daily attendance varies so does the daily total vary and the daily average is somewhere around 155; to take a maximum of 200 a day would be well beyond our resources. The statistic we have in fact returned to the Welsh Office for the last working day of 1979 is 200 and in this we are doubtless at fault; in mitigation we would say that only a notional figure could have been given, while admitting that a figure around 150 would have been less erroneous. Judging from published statistics, determining what is meant

by 'places allocated' has been a problem to other hospitals as well, and it may be that the average daily attendance would be a better estimate of the daily number of places actually available.

In addition I wonder whether the choice of 'the last full working day of the year' is a good one. Day attendances around Christmas and the New Year are probably not as good as at other times. The figures for most regions for the last day are in fact substantially less than those for the average daily attendance for the whole year.

I. G. PRYCE

*Whitchurch Hospital,  
Whitchurch,  
Cardiff CF4 7XB*

### References

- DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1980) *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England 1976. Statistical and Research Report Series No 21*. London: HMSO.  
WELSH OFFICE (1981) *Mental Health Statistics for Wales 1979*. Welsh Office, Cardiff.

### ABNORMAL INVOLUNTARY MOVEMENTS IN THE ELDERLY

DEAR SIR,

Following an earlier pilot study in elderly patients in a mental handicap hospital (Bicknell and Blowers, 1980), we have recently carried out a prevalence study of abnormal involuntary movements in 12 local authority residential homes for the elderly. A total of 500 subjects, 138 males and 362 females were included in the study. They were rated individually for abnormal movements using a modification of the AIMS examination (NIMH, 1975).

Abnormal involuntary movements were observed in 179 (35.8 per cent) of the 500 subjects. These movements were mostly mild in severity, but orofacial involvement was present in 140 (28 per cent).

In the 122 (24.4 per cent) subjects who had received antipsychotic drugs for a minimum period of three months, abnormal involuntary movements were present in 59 (48.4 per cent), and in the 378 (75.6 per

cent) subjects who had no recorded history of anti-psychotic medication, abnormal movements were present in 120 (31.7 per cent). The Chi square test (Kirkwood, 1981), indicated that the difference in prevalence of abnormal movements between subjects who had received antipsychotics and those who had never been exposed to these compounds, was statistically significant ( $P < 0.001$ ), thus confirming the association of dyskinetic movements with antipsychotic medication.

The presence of spontaneous dyskinesia in 120 (31.7 per cent) of the 378 subjects who had never received antipsychotic medication confirms an earlier study in which 38 (18 per cent) of 211 residents who had never been treated with an antipsychotic drug showed dyskinetic movements (Bourgeois *et al.*, 1980).

The Task Force of the American Psychiatric Association (1980) reporting on late neurological effects of antipsychotic drugs suggested that the ageing brain may have an increased likelihood of antipsychotic related dyskinesias, especially of the oral region, and also drew attention to the fact that in the elderly, studies had shown that the prevalence of spontaneous buccolinguomasticatory movement abnormalities, is close to that found in antipsychotic treated geriatric patients.

Our own study has shown that in a group of elderly subjects, age range 59–102 years (mean 82.7 years) there is a considerable prevalence of spontaneous dyskinesias, and that antipsychotic drugs do seem to increase the risk of developing dyskinesias during old age.

A. J. BLOWERS

*Department of Human Biology and Health,  
University of Surrey, Guildford, Surrey*

R. L. BORISON

*Medical College of Georgia,  
Atlanta, Georgia, USA*

C. M. BLOWERS

*Maudsley Hospital, London SE5*

D. J. BICKNELL

*St George's Hospital, London SW17*

#### References

- BICKNELL, D. J. & BLOWERS, A. J. (1980) Tardive dyskinesia and the mentally handicapped. *British Journal of Psychiatry*, **136**, 315–16.
- BOURGEAIS, M., BOUILH, P., TIGNOL, J. & YESAVAGE, J. (1980) Spontaneous dyskinesias vs neuroleptic induced dyskinesias in 270 elderly subjects. *Journal of Nervous and Mental Disease*, **168**, 177–8.
- KIRKWOOD, B. R. (1981) Statistics: Chi-square test for contingency tables. *British Journal of Hospital Medicine*, **25/3**, 291–2.

**TASK FORCE ON LATE NEUROLOGIC EFFECTS OF ANTI-PSYCHOTIC DRUGS.** Tardive dyskinesia: summary of a task force report of the American Psychiatric Association. *American Journal of Psychiatry*, 1980, **137**, 163–72.

#### HYPOALGESIA IN DEPRESSIVE ILLNESS

DEAR SIR,

In his comment on Ben-Tovim and Schwartz's paper (*Journal*, January 1981, **138**, 37–9) Professor Whitlock makes a didactic statement that "tricyclic and other types of antidepressant medication have pronounced analgesic properties" (*Journal*, May 1981, **138**, 437–8). Without qualification this statement could be quite misleading, as is evident from a careful look at the papers to which he makes reference.

Ward and his colleagues (1979) describe a study in patients who were depressed and who were also found to have chronic pain complaints. Turkington (1980) studied patients with leg pain secondary to diabetic neuropathy who were all found to have 'substantial degrees of depression'. In both studies treatment with tricyclic antidepressants produced improvement in both the pain symptoms and the depression. The obvious implication of these reports is that when chronic pain symptoms are associated with pathological depression, antidepressants are effective in relieving the pain at the same time as the depression. Indeed this is the conclusion reached by the authors: they do not suggest that antidepressants are 'analgesic'.

Antidepressants are now widely used in patients with chronic pain though it is not clear whether they have a specific therapeutic effect in such patients, or if they do, how they are working. When benefit is obtained there are three likely explanations: that it is purely secondary to their antidepressant activity; that it represents some sort of intrinsic 'analgesic' action as suggested by Whitlock; or that it is a reflection of their sedative effects whereby they modify the central perception of pain at the cortical level, or the psychological reaction to painful stimuli (Hanks, 1981). There is insufficient evidence at present to be confident which pharmacodynamic effect is most important.

In animal pharmacological models neither the tricyclics (Spencer, 1976) nor the more recent drugs such as mianserin, nomifensine or trazodone, exhibit any analgesic effects. A difficulty here is that these models are only predictive for acute pain and are generally not sufficiently sensitive to identify non-narcotic analgesics. No-one has suggested that antidepressants are effective in the treatment of acute pain, but their possible effects in chronic pain cannot be