who developed 'irreversible oro-facial dyskinesia', (Jancur, 1970): "Tranquillisers and anti-depressive drugs were stopped in 1966 and she was given calcium (Sandoz), which we found to be very helpful in some cases in the treatment of drug-induced 'irreversible oro-facial dyskinesia'; however, in her case there was no marked improvement and her dyskinesia is getting progressively worse as the years go by. It appears to be part of a degenerative process".

Due to inconsistent results of treatment and lack of knowledge of the role of calcium in treatment of EPS, we discontinued the use of calcium and replaced it with the latest anti-parkinsonian drugs.

The suggestion by Drs Fernando and Manchanda – that further work needs to be done to see if a relatively innocuous drug like calcium can relieve patients of the distress of EPS – is commendable and should be pursued.

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Significant Results in Tables

SIR: The article by Rust *et al* (*Journal*, May 1988, **152**, 629–631) illustrates the ultimate folly in that irritating habit of 'starring' significant results. In Table I of the paper, correlations are given from one to five stars (!) according to their significance level. As Sprent has remarked, such a practice has no place in a serious scientific paper although it may be useful in a hotel guide book. Please try to advise your authors against such excesses.

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SIR: Firstly, I should point out that the authors did not put any stars against the correlations in the paper in question; we have your corporate editorial selves to thank for this, as you kindly translated raw significance values into what I assume is your preferred format. Secondly, may I add that I really had no objection to your doing this. It seems to me that the proper use of icons in a table or figure do indeed make interpretation easier, and I'm afraid that I fail to see the point Professor Everitt is making. Personally, I find the use of stars in hotel guide books quite helpful, and I cannot see why ease of readability and interpretation should not also be the aim of a serious scientific paper.

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Progress Towards DHSS Targets for Community Care

SIR: Dr Forster's overview of community psychiatry (*Journal*, April 1988, **152**, 582–584) usefully restates current DHSS policies that promote local, non-institutional forms of psychiatric care (House of Commons Social Service Committee, 1984). In 1975 a target of 47 900 in-patient psychiatric places in England was set (HMSO, 1975; HMSO, 1984), after a maximum national in-patient census of 148 000 in 1954. I report a survey which describes progress at the national level towards these goals.

Postal questionnaires were sent to the Planning Departments of the 14 Regional Health Authorities in England. Questions asked concerned the present and planned levels of provision of in-patient and day-patient services for all psychiatric patients. The data exclude services for the mentally handicapped, and describe place availability rather than usage.

The total number of psychiatric in-patient places in England in July 1987 was given as 69 787. The number of free-standing psychiatric hospitals in each Region varied between 4 in Mersey and 21 in North East Thames. There were 19 239 places at the 273 day hospitals. Wide regional variations in current day hospital provisions were revealed, with 33 in the Wessex Region and 9 each in the Oxford and North Western Regions. There was a six-fold difference between the number of day hospital places in the East Anglia Region (526) and the North Western Region (3173).

Regional plans for service provision by the middle of the next decade were recorded. Each Region had plans to definitely or possibly close at least one psychiatric hospital during this period, and the Trent Region intends to close eight. Thirty-three hospitals were specified for definite closure, and a further 30 for possible closure. The net expected bed reduction for all except the four Thames Regions (whose figures were not available) was 10 741 (22% of current levels). Extrapolating this to the whole of England gives an estimated 54 140 remaining in-patient places after the completion of the currently

planned reductions of 15 647 beds by 1996. Day hospital places are expected to rise by 6499 over the same period to a total of 34 231. Wide Regional differences in day hospital services are expected to persist: there is a five-fold difference between the 828 places planned by the Northern Region and the 4116 in the North Western Region.

The results of this survey demonstrate a continuation of the long-standing decrease in the number of psychiatric in-patient beds. No acceleration in the rate of discharge of patients in England is expected over the next decade: it will remain about 2300 patients per year. The present total number of both in-patient and day-patient places is 89 126. These results suggest an estimated 78 400 total places after the planned closures: a shortfall of approximately 10 000 places from the current level of service provided by the Regions. The estimated 54 140 in-patient places after closures remains over 6000 places short of the long-standing government target of 47 900 (HMSO, 1984). The Audit Commission (1986) found that Health Authorities have been more successful in planning hospital closures than in implementing successor services. These figures suggest that this will continue to hold throughout the next 5–10 years. Given this, local government authorities may be expected to play an increasingly active role in providing for deinstitutionalised patients (Griffiths, 1988).

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Therapy-Resistant Depression

SIR: We read Professor Leonard's article (*Journal*, April 1988, **152**, 453–459) on the biochemistry of resistant depression with interest. We would like to ask him how his serotonergic hypothesis of resistant depression explains certain experimental findings that are at variance. Most antidepressants enhance electrophysiological responsiveness of cells to iontophoretically applied 5HT (de Montigny & Aghajanian, 1978), yet this is in conflict with receptor binding and behavioural evidence for down-regulation of 5HT function following antidepressant therapy (Peroutka & Snyder, 1980; Goodwin *et al*, 1984). Neither is it explained why ECT would appear to have to have the opposite effect to antidepressants by increasing 5HT mediated behaviour and $5HT_2$ receptor binding (Green *et al*, 1983). It would thus appear that, as yet, no one hypothesis can link together the various mechanisms of actions of the antidepressant therapies on 5HT function.

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PEROUTKA, S. J. & SNYDER, S. H. (1980) Long-term antidepressant treatment decreases spiroperidol-labelled serotonin binding. *Science*, **212**, 827–829.

SIR: While I agree entirely with the views of Drs O'Shea and Mathews that no one hypothesis can link the various mechanisms of action of antidepressants to changes in 5HT function, I feel that their letter ignores the fact that the healthy, genetically pure laboratory rat differs from a depressed patient. The apparent differences between the biochemical and electrophysiological changes initiated by antidepressants and ECT in rat brain would not appear to apply to the depressed patient. In my annotation, I commented on the similarity of action of antidepressants and ECT on platelet 5HT transport in depressed patients. Thus all antidepressants so far examined normalised the decreased $5HT_2$ receptor function (as shown by reduced platelet aggregation) in those patients responding to treatment; qualitatively similar changes occur in ^{3}H-5HT uptake into platelets from these patients. Such findings suggest that there is a 5HT sub-normality in depression