

## Correspondence

Editor: Greg Wilkinson

**Contents:** Elderly offenders/Calcium therapy for neuroleptic-induced extrapyramidal symptoms/Significant results in tables/Progress towards DHSS targets for community care/Therapy-resistant depression/The viral theory of schizophrenia/Psoriasis and lithium/General practice patients on long-term psychotropic drugs/P3 and CT scan in patients with chronic schizophrenia/Unilateral auditory hallucinations/Inadequate seizures with electroconvulsive therapy/Diethylpropion, bupropion, and psychoses/Self-inflicted eye injuries/Psychosomatic medicine and contemporary psychoanalysis/Vitamin B12 in psychotic depression/Clinical dementia rating/Delusional AIDS and depression/Mianserin and mania/Is castration too “barbarous” for rapists?

### Elderly Offenders

SIR: Dr Lynch's comments on our paper (*Journal*, July 1988, 153, 122) are most welcome. We had hoped to highlight a problem for which we believed too little appropriate management is available, and his letter provides further evidence that this is the case.

Dr Lynch is by no means the first to challenge the assumption that criminality decreases with age. Greenberg (1983) goes further still, and includes among the distorting factors the tendency of the young to commit crimes in groups, the improved skills in avoiding detection among the elderly, and annual cohort effects. Nevertheless, the overall discrepancy between the contribution to crime by people of 55 and over compared with those of, say, 15–25 is so great that it seems unlikely that these are sufficient explanations and that there must also be a real difference. Furthermore, a number of longitudinal studies within cohorts on both sides of the Atlantic (summarised by Cline, 1980), while not generally following the subjects beyond the age of 30, do all suggest a genuine decline with age with most types of offending. Drunkenness and drink-related offending seem the sole areas of important deviation from this position. While defending the generally accepted view of the changing patterns of criminal behaviour with age, none of this detracts from Dr

Lynch's point that almost certainly, more of the elderly are involved in offending than appear in official statistics.

Dr Lynch's concern about the poverty of psychiatric provision is in direct line with ours. The vast majority of our over-55 sample had a history of previous psychiatric treatment, and a bare majority had active symptoms of disorder on admission to prison; very few went on to treatment. Dr Lynch's figures are much more representative of the true levels of neglect, as he gives the proportion of all identified elderly offenders who receive a psychiatric opinion, and not just the minority on custodial remand as was the case in our sample. How many fewer still would have actually benefited from the opinion hardly bears thinking about. It would be valuable to hear from psychiatrists in areas that offer a more constructive approach to the elderly offender than Chester, Liverpool, and Greater London.

PAMELA TAYLOR

*Institute of Psychiatry  
Denmark Hill  
London SE5 8AF*

JANET PARROTT

*Bexley Hospital*

### References

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### Calcium Therapy for Neuroleptic-Induced Extrapyramidal Symptoms

SIR: I read with great interest the correspondence by Drs Fernando and Manchanda on calcium therapy for neuroleptic-induced extrapyramidal symptoms (EPS) and the report of successful treatment of two cases of EPS whose symptoms disappeared with calcium (*Journal*, May 1988, 152, 722–723).

We used calcium in the 1960s for drug-induced Parkinsonism, with mixed success. I reported a patient with retinitis pigmentosa and psychosis

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.

J. JANCUR

*Stoke Park Hospital  
Stapleton  
Bristol BS16 1QU*

#### Reference

JANCUR, J. (1970) Retinitis pigmentosa with mental retardation, deafness and XX/XO sex chromosomes. *Journal of Mental Deficiency Research*, 14, 269–273.

#### 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.

B. S. EVERITT

*Institute of Psychiatry  
Denmark Hill  
London SE5 8AF*

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.

JOHN RUST

*University of London Institute of Education  
25 Woburn Square  
London WC1H 0AA*

#### 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