

Correspondence

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Costing community care

Sir: We strongly agree with the comment by Stanley & Macmillan (1996) made with reference to our article entitled 'The cost of comprehensive care of people with schizophrenia living in the community' (Salize & Rössler, 1996), that with cost studies in community health care only comparisons of like with like can gain full validity.

The aim of our study, however, was not to compare the community care cost of dehospitalised old long-stay patients with the costs these patients would have caused if they had been in full hospital care, as Stanley & Macmillan believe. Of course, the total community care costs of such a cohort would have been greater than those of 'new' long-stay patients, cared for in community-based mental health care since the onset of illness.

Against the assumption of Stanley & Macmillan our calculations do include costs for housing and food for all those patients of our cohort who had been cared for in residential care. Eighteen patients (27%) were living in sheltered homes for the mentally ill during the study period. The accommodation and food costs of the remaining patients were not taken into account as we only wanted to identify and calculate the direct care cost covered by the mental health care system and not the societal cost of care. If we were to add the average social welfare payment received by chronically mentally ill persons in Germany not in residential care, amounting to US\$ 330 per month, to our calculations for those patients of our cohort not accommodated in sheltered homes, the average cost of care for our total cohort would rise to \$21,257. This is only slightly higher than the figure we presented in our article (\$18,377) and still represents only 49.4% of the cost of a permanent stay in a state mental hospital.

Stanley & Macmillan point out that 'old' long-stay patients need sheltered accommodation to a much greater extent than the patients of our cohort. Our 18 patients cared

for in sheltered homes had a mean cost of \$36,452 per year for their comprehensive mental health care (including residential care, readmissions to psychiatric wards, crisis interventions, out-patient attendances, occupational therapy, drugs etc.). This is still only 84.7% of the lowest rate of an uninterrupted 12-month stay in a state mental hospital in Germany. Even when considering that dehospitalised 'old' long-stay patients probably would have more frequent or longer (and more expensive) readmissions, community-based mental health care in Germany seems to be the less costly alternative for these patients as well. All possible scenarios, based on empirical cost data from our study, underline that community-based mental health care is the more inexpensive option.

Salize, H. J. & Rössler, W. (1996) The cost of comprehensive care of people with schizophrenia living in the community. A cost evaluation from a German catchment area. *British Journal of Psychiatry*, **169**, 42-48

Stanley, A. K. & Macmillan, J. F. (1996) Costing community care (letter). *British Journal of Psychiatry*, **169**, 670.

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Impact on caregivers of the symptoms of dementia

Sir: Donaldson *et al* (1997) add welcome clarity to the difficult literature concerning the impact on caregivers of the symptoms of dementia. However, some additional points should be made.

First, despite reliance on the General Health Questionnaire in many studies of caregiver psychopathology, the validity of this instrument for assessing chronic morbidity is put in doubt by the inclusion of 'no more than usual' responses, which may indicate long-standing symptoms rather than their absence.

Second, the profound methodological difficulties involved in disentangling the relationship between patient behaviour and the caregiver's perception of it are inadequately addressed by even the most advanced instruments, which rely solely on reports by the caregiver and have not been validated against observational assessment using caregiver-blind video-recording.

Third, the authors fail to mention the importance of feelings of 'entrapment' in mediating between the symptoms of dementia and distress in caregivers. Impaired activities of daily living and the non-cognitive features of dementia generate a large caring commitment and consequently the feeling of being 'trapped', but when combined with lack of gratifying feedback from the patient (perhaps due to apathy or irritability, a poor pre-morbid relationship, lack of respite etc.), an accompanying desire to 'escape' is created. A thwarted wish or need to escape is highly depressogenic in animal models and is likely to be so for human carers (Gilbert, 1992).

Donaldson, C., Tarrier, N. & Burns, A. (1997) The impact of the symptoms of dementia on caregivers. *British Journal of Psychiatry*, **170**, 62-68

Gilbert, P. (1992) *Depression: The Evolution of Powerlessness*. Hove: Lawrence Erlbaum.

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Seasonal variation in bipolar disorder

Sir: Partonen & Lönnqvist (1996) report no seasonal variation in bipolar disorder, except for a small group of autumnal depressions. They also point to the significant peak for manic and depressive admissions during the week after the autumnal equinox, thus bringing up the importance of a more precise definition of seasons (normally considered as three calendar months).

Irrespective of precise beginning and end points, the season as conventionally defined may not be the most suitable unit for testing psychiatric hypotheses. As the photoperiod increases progressively during winter and spring, and decreases during summer and autumn, it would be more rational to consider semesters rather than seasons. Even better would be an approach that considers each period of three months around solstices

and equinoxes. In this way, we might test the influence of the increasing (February–April) or decreasing (August–October) photoperiod, and insufficient (November–January) or excessive (May–July) daylight.

Since Partonen & Lönnqvist do not report monthly frequencies, we cannot apply these criteria to the Finnish data. However, we have applied them to a Portuguese sample of 34 longitudinally followed bipolar patients (Pio-Abreu & Pires, 1985), and to 178 female admissions for mania and depression (Boto *et al*, 1991). Both studies revealed a peak of bipolar episodes during the equinoctial periods, where depressions predominate from February to April, and manias between August and October. In contrast, mixed and switching episodes, as well as some unipolar depressions, tended to occur around the solstices.

Although these results are consistent with an extensive review by Wehr & Rosenthal (1989), they may be idiosyncratic to Portugal. Since sunshine varies with latitude, more studies are needed worldwide in order to understand the problem better. However, it would be preferable if results were presented in terms of monthly frequencies, and not simply as the required figures for testing seasonality as conventionally defined.

Boto, I., Craveiro, A. & Pio-Abreu, J. L. (1991) Manias e depressões: distribuição sazonal e relação com factores climáticos. *Psiquiatria Clínica (Coimbra)*, **12**, 171–174.

Partonen, T. & Lönnqvist, J. (1996) Seasonal variation in bipolar disorder. *British Journal of Psychiatry*, **169**, 641–646.

Pio-Abreu, J. L. & Pires, I. C. (1985) Incidência sazonal das psicoses afectivas bipolares. *Psiquiatria Clínica (Coimbra)*, **6**, 181–188.

Wehr, T. A. & Rosenthal, N. E. (1989) Seasonality and affective illness. *American Journal of Psychiatry*, **146**, 829–839.

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Terminology of learning disability

Sir: Few would disagree with Reid (1997) that learning disability is not an ideal term. It may also be true that it was adopted by the Royal College of Psychiatrists simply for the sake of political correctness. This, however, even when coupled with the objection that the term contains no medical or psychiatric dimension, provides no adequate grounds for yet a further unwelcome change in terminology.

Mental handicap, the term generally discarded in the UK but nevertheless still favoured by Dr Reid and many others,

remains less appropriate than learning disability for two important reasons. The first is, as Reid himself points out, because of the objections of those suffering from the condition and able to express an opinion. The second is the difficulty experienced by the general public in distinguishing between mental handicap and mental illness, largely because of the use of the word 'mental'. Not surprisingly, this confusion led to the assumption that mental handicap was primarily a medical problem. If now, instead, it is thought that the term learning disability implies that the condition is essentially educational, rather than register dismay we should instead throw our hats in the air. This description does after all contain a greater element of truth.

The problems of people with learning disability can be met only by a multi-disciplinary approach. It is unlikely that the emphasis on the word 'learning' can diminish the contribution of medicine, particularly psychiatry, to the care of this group.

Reid, A. H. (1997) Mental handicap or learning disability. A critique of political correctness. *British Journal of Psychiatry*, **170**, 1.

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manipulation of mental images (i.e. non-verbal thinking), the invention of words or neologisms to express new ideas for which no words previously existed, the phenomenon of ambiguity in language, etc. (Pinker, 1995). Thus, if language is not thought, the notion that language predetermines how we think loses much of its plausibility. It is our thought which contaminates the euphemisms, not the euphemisms which disinfected our thought. For these reasons also Reid is right: in the case of mental handicap or learning disability it is our attitudes which must change, not our terminology.

Liddell, H. G., Scott, R. & Jones, H. S. (1961) *A Greek–English Lexicon*. Oxford: Clarendon Press.

Pinker, S. (1995) *The Language Instinct*. Harmondsworth: Penguin.

Reid, A. H. (1997) Mental handicap or learning disability. A critique of political correctness. *British Journal of Psychiatry*, **170**, 1.

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Valproate and neuroleptic medication

Sir: Barnes *et al* (1996) point out the paucity of data on adjunctive use of valproate in the treatment of psychotic disorders only partially responsive to neuroleptics.

We have conducted an open trial of 17 out-patients (six male; mean age 34; s.d. 10 years) to ascertain whether valproate can be used to 'spare' neuroleptics in patients with bipolar disorder with psychosis ($n=13$) and schizoaffective disorder ($n=5$). All patients had been stabilised on neuroleptics for at least six months. Mean pre-valproate neuroleptic dose was 260 mg chlorpromazine equivalents per day (s.d. 150 mg; range 25–500). In the six months post-valproate, only two patients required ongoing neuroleptics, with doses of 100 and 200 mg chlorpromazine equivalents daily (prior doses 200 and 500 mg, respectively).

This preliminary study, with the methodological limitations inherent in open, non-randomised, non-blind designs, nevertheless raises the possibility of wider use of valproate to spare neuroleptics in patients with bipolar and schizoaffective disorders, and potentially schizophrenia as well (three further treatment-resistant schizophrenia patients have been commenced on valproate