

## Reference

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## Comparative Trial of a New Antidepressant

SIR: Few would argue with the point raised by Dunn (*Journal*, August 1987, **151**, 269) and Thompson (*Journal*, November 1987, **151**, 702–703) that a comparison of a new antidepressant with a placebo to establish that some efficacy exists is desirable. Clearly, ethical issues are a problem, and there is an extensive literature highlighting these (Klerman, 1986; Rickels, 1986). Practical issues are also a factor, and in a current clinical trial involving placebo control an eminent colleague withdrew his involvement because he felt that every patient should receive an active compound.

Studies previously carried out comparing fluoxetine, a tricyclic antidepressant, and a placebo (Stark & Hardison, 1985; Colin & Wilcox, 1985) confirmed that fluoxetine was more effective than placebo.

My study (Levine *et al*, *Journal*, May 1987, **150**, 653–655) was carried out to establish further evidence of efficacy and to compare the occurrence of side-effects with those of imipramine. The numbers involved allowed for any significant difference to be discriminated. A minimum score on the HRSD of 17 permitted less severe cases to be included. The suggestion by Thompson that 75 mg of a tricyclic antidepressant is “well accepted to be inadequate” is surely an idiosyncratic view, and is at variance with established practice over almost 30 years. Perhaps the as yet unpublished paper quoted in his letter will inform us otherwise.

The need for new antidepressants clearly exists when present compounds are only marginally more effective than placebo at any dose level, and future research will hopefully not be influenced by the “overcrowded market”.

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## Depressed Mood After Stroke

SIR: For Wade *et al* (*Journal*, August 1987, **151**, 200–205) to compare their finding that 20% of their stroke patients were definitely depressed and 10% probably depressed with Bergmann's (1982) reported rate of 4.4% for depressive illness and neurosis in 360 elderly women is of doubtful relevance. Reported rates of depression in community studies of the elderly vary enormously, and one could equally well argue on the basis of comparison with the work of Zung (1967) or Stenback (1979) that stroke protects against depression, as both these studies can be interpreted as demonstrating depression in well over 40% of elderly subjects. It is possible to quote studies which purport to show rates of depression in old age which vary from 48% right down to 1%. None of them help to interpret the findings of Wade *et al*, whose study is flawed by the lack of an age-matched control group, and the use of an instrument which was not developed in order to measure depression in stroke victims with a mean age of 70 but to measure the severity of the depressive syndrome in a group of patients already diagnosed as depressed whose mean age was in the mid-forties (Snaith *et al*, 1971).

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SIR: We thank Ames for stressing that the Wakefield Self-Assessment Depression Inventory was not developed for use with elderly people, and for pointing out that we did not have an age-matched control population. We discussed both points in the original paper, although we acknowledge that we did not refer to the population studies he mentioned.

The study was under several constraints. In particular, we were not aware of any simple measure of depression which could be used in a large number of elderly people. Indeed, we still do not know of any such index. There was not time within the constraints of this study to identify and assess a similar group of control patients. This study is purely descriptive, and generates many hypotheses needing further investigation. We sincerely hope that the two major weak links identified by Ames will be investigated in future.

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#### Long-Term Psychiatric Patients in the Community

**SIR:** The debate concerning the wisdom of continuing psychiatric hospital closures and the advantages of community care ultimately rests on the evidence, which at present is scanty. Bell *et al* (*Journal*, August 1987, 151, 275) have investigated this issue. The interpretation of their data is really a question of one's outlook, but whether one chooses to describe a cup as half empty or half full, it certainly will not be running over.

Out of 25 patients who had been selected for discharge over an 11-year period, and who had been in hospital for at least two years, we are advised that "half" had lost contact with psychiatric services, one was in prison and four were dead. It is true that the dead had all been "at an advanced age", but one might question the wisdom of relocation in these circumstances. Of the remainder, we are advised that five had been readmitted to hospital, one indefinitely, and that when interviewed, in a semi-structured way, "a roughly equal" proportion of the remaining population who were still in touch with psychiatric services were leading "somewhat discontented lives". The authors place a generally optimistic interpretation on this data.

We compared two well-supported out-patient groups with long-stay hospitalised patients and found that the in-patient groups had a better quality of life on a number of measures. This was despite the fact that in one of the hospitalised groups the patients were significantly older than the comparison out-patient group.

Two groups of in-patients, at St Mary's Hospital, Stanington, Northumberland ( $n=40$ ) and Friern Hospital, in North London ( $n=23$ ), were interviewed, together with out-patients from both hospitals ( $n=40$ , St Mary's;  $n=16$ , Friern). All the

out-patients were actively supported by community nurses. The interviews were conducted according to a prepared schedule that had been piloted, modified, and discussed with the nurses prior to use. The nurses, including community psychiatric nurses, held a variety of views on the intended transition to community care.

The Friern in-patients were significantly older than the out-patients ( $U=66.5$ ,  $P<0.001$ ) (in-patients, range=37–73 years, mean=56.5, s.d.=11.2; out-patients, range=20–64 years, mean=40.9, s.d.=13.77) but were carefully matched for age and sex in the St Mary's groups (in-patients, range=23–77 years, mean=51.3, s.d.=15.14; out-patients, range=24–73, mean=50.4, s.d.=13.86).

In all, we enquired into 20 indicators of quality of life. Hospitalised patients were significantly advantaged (Mann-Whitney, two-tailed probabilities) in terms of attending social gatherings ( $U=550$ , St Mary's;  $U=107.5$ , Friern;  $P<0.05$ , both groups), going to places of entertainment ( $U=242$ ,  $P<0.001$ , St Mary's), the number of meals per week ( $U=24$ ,  $P<0.001$ , Friern), the number of hot meals ( $U=154$ ,  $P<0.001$ , St Mary's;  $U=26.5$ ,  $P<0.001$ , Friern), and the number of baths per week ( $U=481.5$ ,  $P<0.005$ , St Mary's). As might be expected, the in-patients were also advantaged in the amount of time they spent in rehabilitation programmes ( $U=260$ ,  $P<0.001$ , St Mary's), and in passive amusements ( $U=585$ ,  $P<0.05$ , St Mary's;  $U=103$ ,  $P<0.05$ , Friern, watching TV;  $U=479$ ,  $P<0.005$ , listening to the radio at St Mary's). However, if contacts with nursing, medical, and paramedical staff are disregarded, the Friern in-patients enjoyed less company ( $U=275$ ,  $P<0.01$ ), which might reflect their advanced age, and they attentively listened less to the radio ( $U=287.5$ ,  $P<0.005$ ). In other respects the groups were comparable.

Our study, which we hope to report more fully, causes us to wonder whether the intended closure of the two hospitals will be entirely advantageous to all our patients. We are incompletely reassured by the findings of Bell *et al* in a selected population.

We thank the nursing staff at St Mary's and Friern Hospitals for their help in data collection.

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