

Correspondence

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Success of community care?

There is debate regarding the success or otherwise of community care. The evidence deriving from the closure of Friern Hospital on which the Team for the Assessment of Psychiatric Services project is based, discussed by Leff (2001), cannot be generalised because, in contrast to typical hospital closures, in the region of £100 million was allocated to ensure the 'success' of the project. Despite this expenditure, the following points should be considered.

At the time of the closure of Friern Hospital an internal audit found that only 14 long-stay patients were there by compulsion and 11 of those were under court orders (Weller, 1989).

After closure, high wire netting was erected and 24-hour guard-dog patrols were instituted because of attempted returns by patients to the hospital.

Many of the patients offered 'a home for life' were subsequently moved.

Many have become 'revolving-door' patients.

The hospital building, of listed architectural merit (but which drew inexplicable opprobrium at the time), and spacious grounds are now luxury flats, and a £400 million deal has been struck for many more on other hospital sites (*The Times*, 12 September 2002: p. 3).

Twenty patients committed suicide in the first year after closure (further details available from the author upon request). This figure stands in contrast to the findings of Powell *et al* (2000), who showed that even within the high-risk group of in-patients, 100 patients would need to be detained unnecessarily in order to prevent one suicide.

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Declaration of interest

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Telephone support and suicide prevention

We read with interest the paper by De Leo *et al* (2002), which implied that needs assessment telephone calls and 24-hour emergency services had proved effective for elderly females, with a reported significant reduction in suicide rate.

In our study of 216 elderly suicides in Cheshire and Birmingham over a 5-year period (1994–1998; Salib *et al*, 2001), 30% of suicide victims were not known to psychiatric services. Surprisingly, 38% of the men and 16% of the women among those elderly suicide victims unknown to services were found to have had some defined, albeit untreated, psychiatric morbidity.

Evidence of psychiatric morbidity was extracted from coroner's records of statements provided by families and friends of the deceased. Men were less likely to be known to local services but more likely to be living alone and to harbour undetected psychiatric morbidity, hence the high risk of succeeding in their first suicide attempt.

Elderly male suicide victims do not tend to ask for help, whether face to face or over the telephone, so we must find a way to take the help to them, particularly at their moment of despair.

The findings of De Leo *et al* are hardly surprising. However, there is an obvious risk that we may evaluate our services

based on 'total' decline in numbers of suicides, in which women may be over-represented, thus giving a false impression of the actual reduction in suicide rate.

De Leo, D., Buono, M. D. & Dwyer, J. (2002) Suicide among the elderly: the long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry*, **181**, 226–229.

Salib, E., Tadros, G. & Cawley, S. (2001) Elderly suicide and attempted suicide: one syndrome. *Medicine Science and the Law*, **41**, 250–255.

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Qigong and suicide prevention

De Leo *et al*'s study (2002) confirmed that a TeleHelp–TeleCheck service reduced suicides among elderly service users in northern Italy. The authors comment that the highest suicide rates in almost every country (including Hong Kong and China) are among those aged more than 75 years. The literature suggests that considerable numbers of suicides among the elderly are due to depression. Conwell (1996) reported that 60–75% of those who committed suicide had a diagnosis of depression among patients aged ≥ 75 years. This is particularly relevant in elderly people with chronic physical conditions such as stroke and Parkinson's disease. My colleagues and I (Tsang *et al*, 2002) recently hypothesised, after a comprehensive literature review, that depression in elderly people with chronic physical illnesses results from disability and a reduction in psychosocial resources. If depression is left untreated, suicide may be a consequence.

In view of the high prevalence rates and seriousness of the consequences of the co-occurrence of depression and physical illnesses in later life, various approaches have been developed to counteract the effect of depressed mood. De Leo *et al*'s study reports one such approach, using a telephone helpline and emergency response service. We (Tsang *et al*, 2002) proposed *qigong* as a psychosocial intervention to help elderly people with depression and chronic physical illnesses. *Qigong* has a long history with diverse schools in China. It can be seen as a method to regulate the body, breathing and mind. In China, health and longevity are believed to be determined by strength, balance and cultivation of the three treasures: *jing* (essence),

qi (energy) and *shen* (spirit). *Qigong* focuses on these three treasures to represent a holistic view of the human being. 'Eight-section brocades' is one of the many forms of health-promoting Chinese *qigong*.

A pilot study (Tsang *et al*, 2002) using a group of eight out-patients (two males and six females) suffering from chronic physical illnesses was conducted in Hong Kong. The mean age of the participants was 68 years (s.d.=10.7). Rating on the Geriatric Depression Scale showed that the participants had a certain degree of depressed mood, even though they did not carry a clinical diagnosis of depression. The participants received 1 h practice of *qigong*, twice a week, under the supervision of a qualified practitioner. As all participants had satisfactory standing balance, the standing-style eight-section brocades were used as the intervention protocol. The participants were asked to practise it daily (under the supervision of their relatives, who were also trained by the practitioner) for at least 30 min (in addition to the twice-weekly supervised practice in the hospital). The feedback from the participants showed that six of them (75%) felt better in terms of their psychosocial functioning after the 12-week programme. Before 6 weeks of practice, only three (37.5%), however, reported improvement. At an early stage, the feedback centred around physical function such as movement of the limbs and activities of daily living. At a later stage, the feedback then shifted more to psychological aspects. The improvement included feeling more relaxed, more comfortable, better sleep and being more optimistic. All of these reported improvements in psychosocial functioning are indicative of less depressed mood and improved quality of life. This preliminary report showed that *qigong* is promising as an alternative intervention for elderly people with depression and with chronic physical illness to improve their biopsychosocial health and possibly reduce their suicide rate. More systematic evaluation with larger samples and a longer period of intervention is now underway in Hong Kong.

Conwell, Y. (1996) Suicide in elderly patients. In *Diagnosis and Treatment of Depression in Late Life* (eds L. S. Schneider, C. F. Reynolds III, B. D. Lebowitz, *et al*). Washington, DC: American Psychiatric Press.

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Olanzapine toxicity in unconjugated hyperbilirubinaemia (Gilbert's syndrome)

We have recently observed symptoms of toxicity caused by olanzapine at therapeutic dosages. Olanzapine metabolism was hampered because the patient had idiopathic unconjugated hyperbilirubinaemia (Gilbert's syndrome). As this is a frequent disorder in the general population (occurring in 10% of the European population), we feel that it is important to consider the possibility of Gilbert's syndrome before prescribing olanzapine.

A 19-year-old male with paranoid features and schizophrenic symptoms was treated with 2.5 mg olanzapine for 2 days, which was increased to 5 mg on the third day. On the fourth day, because of a suicide attempt and extreme agitation, the patient was admitted to a psychiatric centre. He was given oral doses of 10 mg olanzapine and 5 mg lorazepam. The patient was conscious on the sixth day but did not respond to verbal stimuli and his symptoms of mutism persisted over the next few days. Communication was possible by monosyllables on day eight. On day ten he was bradypsychic, oriented and capable of articulating short sentences with great effort. Speech returned to normal on day twelve. The patient described his experience as a sensation of not being able to find the words in his head. He had not previously displayed speech alterations, nor did they appear later.

Gilbert's syndrome and Crigler–Najjar syndromes type I and II are familial unconjugated hyperbilirubinaemias caused by genetic lesions involving a single complex locus encoding bilirubin uridine diphosphate – (UDP)–glucuronosyltransferase, which is involved in the detoxification

of bilirubin by conjugation with glucuronic acid.

Over the past few years a number of different mutations affecting this gene have been characterised, in which a greater frequency of schizophrenia has been described (Miyaoka *et al*, 2000). Olanzapine is metabolised in the liver through direct glucuronidation reactions. Polymorphisms in glucuronosyltransferases, which often result in a decreased capacity for bilirubin glucuronidation, may have a significant impact on our capacity to detoxify and eliminate drugs and toxins (Mackenzie *et al*, 2000). Drug-mediated toxicity caused by genetic deficiency of UDP-glucuronosyltransferases is known (Burchell *et al*, 2000), as in the case of the administration of phenothiazine antipsychotics or tricyclic antidepressants. Mutism with olanzapine use has been reported in cases of overdose (Hanel *et al*, 1998; Cohen, 1999).

The use of therapeutic dosages of olanzapine can cause toxic symptoms if a lack of bilirubin UDP-glucuronosyltransferase is present. We should keep in mind idiopathic unconjugated hyperbilirubinaemia when prescribing olanzapine.

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