WHAT DETERMINES THE LENGTH OF PSYCHIATRIC INPATIENT TREATMENT?

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A descriptive analysis of data for 1914 psychiatric inpatients is offered. As part of a major study, the present report focuses on the duration of inpatient treatment and its association with diagnosis and soziodemographic variables. The patients were consecutive admissions at the Psychiatric department of Tübingen University 7/92–2/94. Stays of < 3 days were characteristic for substance abuse (40%) and adjustment disorders (11%). Stays of medium duration (30–120 days) were typical for schizophrenia (33%) and depression (18%), also for neurotic disorders (12%). Patients with very long stays (> 120 days) were most likely schizophrenic (53%), depressed (20%) or neurotic (10%). Mean duration of treatment was 41 days (all diagnoses). The patients with stays over 120 days duration were most frequently women, unmarried, living alone and German. Men and foreigners were prominent in the group treated < 3 days. Patients who had been hospitalized for a long time were more likely to be readmitted. 30% of the long stay patients were not discharged home, rather to another hospital or to aftercare units (!). Treatment duration thus seems only partly determined by diagnosis, rather, gender and soziodemographic traits exert considerable influence. Taking into account the enormous expenses caused by long term treatment, it seems mandatory to discern and reevaluate the reasons for ongoing inpatient treatment. More frequent use of soziotherapeutic or alternative treatment services is recommended.

REPRESENTATIVE SAMPLING IN A UK RANDOMISED CONTROLLED TRIAL

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The increasing use of randomised controlled trials in the evaluation of mental health services requires the "representativeness" of a sample to be addressed as a key methodological issue.

Method: In a UK trial evaluating intensive case management for the severely mentally ill one step taken to ensure "representativeness" was to use a criteria based sampling frame. All subjects identified as meeting the following criteria were approached for interview: aged 18–65, a diagnosis of psychosis, at least two psychiatric admissions one of which was within the last two years.

Basic demographic information and data regarding psychiatric history was collected for all subjects identified and the "representativeness" of the subjects who entered the study was analysed.

Results: 309 subjects were identified and of those 196 entered the study. Preliminary findings suggest that there were no significant differences between the subjects who entered the study and the identified population.

Conclusions: While this approach enabled the "representativeness" of the study population to be assessed it was achieved at the cost of targeting the clinically most relevant group who would be identified by asking "which of your patients is most difficult to maintain outside hospital?"

A STUDY OF COMBINED THERAPY WITH MOCLOBEMIDE AND SSRIS IN 50 PATIENTS: FINAL REPORT

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Non response to treatment in Major Depression is a sizable problem. This study was designed to obtain data on the safety of therapy with an SSRI/RIMA combination, and to gather open data on efficacy which might suggest that a placebo controlled study would be justified. A previous preliminary report in 19 patients had suggested that although there are possible interactions, combined treatment of this sort is adequately tolerated by the majority of patients.

Patients with Major Depression who had attained at least level 4 resistance were treated in a non blind protocol for six weeks. Moclobemide was added incrementally, target dose 600 mg/day, to stabilised therapy with paroxetine (20 mg) or fluoxetine (20 mg). Assessment of adverse events was made weekly using the ECDUE model. Symptoms were measured weekly with the MADRS, CGI(i), CGI(s) and pGI.

There were 188 adverse events in 50 evaluable patients. The severity of these events was; mild-67, moderate-79, severe-37, serious-5. The most common events were; insomnia (32), nausea or vomiting (20), headache (17), dizziness (11), dry mouth (9), myoclonic jerks (7) and cardiovascular symptoms (6). Insomnia and nausea were the events most consistently considered to be probably or definitely related to treatment. Serious events were ataxia, prostration, central chest pain, paracetamol overdose and visual hallucination. The central chest pain, paracetamol overdose and visual hallucinations were considered unrelated to the treatment. Mean MADRS fell from 29 points (week 0) to 22 points (week 6) (paired t-test $p < 0.01$). 11 patients achieved full remission (MADRS $\leq$ 11). The Global scales paralleled the changes seen in MADRS. Although total mean MADRS reduced serially at each week, scores on item 4 (reduced sleep) increased between week 0 and week 3, suggesting that the combination therapy was associated with an increase in sleep disturbance.

These findings, although open and uncontrolled, cause us to challenge previous reports of a low potential for interaction between RIMAs and SSRIs. The combination appears possibly effective, but potentially toxic. We recommend the use of this combination therapy only where close monitoring procedures can be assured.

A REVIEW OF THE PSYCHOMOTOR EFFECTS OF PAROXETINE

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All placebo controlled studies of the psychomotor effects of paroxetine are reviewed. The total number of subjects is 195. The majority of studies show little or no effect of paroxetine on psychomotor function.

In four single dose studies paroxetine did not differ significantly from placebo on any objective measure of psychomotor function whereas control drugs, such as amitriptyline and haloperidol, produced conspicuous impairments. In five of six repeat dose studies paroxetine did not differ from placebo in terms of adverse effects on psychomotor function. In the sixth study paroxetine 40 mg. produced abnormalities on 3 tests (critical tracking, divided attention task and choice reaction time) but paroxetine 20 mg. produced no such effects. The psychomotor effects of the 40 mg. dose of paroxetine