

to junior referral between psychiatric hospitals frequently means the consultant ultimately responsible for the patient's continuing care may remain ignorant about the admission and have little input into the initial assessment. Unfortunately treatment in the peripheral hospital may be limited to the goal of 'return to sender' or an entire episode of in-patient care may by-pass the patient's own psychiatric team.

The current "perpetual crisis" in bed occupancies requires clear guidelines from senior hospital medical staff on how local urgent admissions are dealt with and placed. Benefits would be twofold; reducing the stress and tension encountered by psychiatric trainees admitting urgent cases and preventing patients passing "out of sight and out of mind" during episodes of acute psychiatric illness.

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### General practitioners and lithium

Sir: Some fund-holding practices have wanted to take over the supervision of lithium prophylaxis once patients have been stabilised. I believe psychiatrists should strongly resist this.

It would be expecting a lot of GPs, each of whom has only one or two patients on lithium, to be up to date with the renal, cardiac, electrolytic, cyetic, and post-natal contraindications and to monitor partners and deputising doctors prescribing the 14 classes of drugs interacting with lithium. Under GP care in my psychiatric sector, three patients had no blood test for three to three and a half years, one had six blood tests in 22 years, two had lithium-induced delirium, one had a wrong diagnosis, none had regular annual thyroid or renal function tests, two had unnecessary diuretics, one becoming uraemic and the other suicidal as the lithium was stopped; NSAID prescriptions doubled a patient's serum lithium concentration and two became manic on stopping lithium unnecessarily when an antibiotic was prescribed.

In Edinburgh, general practitioners prescribed maintenance lithium, advised and reminded about blood tests by the hospital, yet the admission rate for mania increased three-fold, the drop-out rate being one per three to four patient-years (Dixon & Kendell, 1986;

Marker & Mander, 1989). By contrast, in my local lithium clinic, the admission rate of manic-depressives was reduced by 70%, or by 86% taking into account Angst's finding of a naturally increasing relapse rate (Angst *et al.*, 1969). The drop-out rate from all causes has been one per 35 patient-years.

Lithium alone is not enough for Coppen *et al.* (1971) found that 50% needed additional antidepressants or neuroleptics during two years' follow-up. My patients took neuroleptics or antidepressants for 40% of the time they were on lithium, 61.4% requiring no admissions during 350 patient-years audited. Support from the clinic reduced suffering, admissions, tribunals, loss of productivity, and social security costs. During 350 patient-years on lithium there were no suicides or renal failure, and just two patients required thyroxine for incipient hypothyroidism.

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MARKER, H. R. & MANDER, A. J. (1989) Efficacy of lithium prophylaxis in clinical practice. *British Journal of Psychiatry*, 155, 496-500.

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### Some unusual legal issues

Sir: We wish to bring readers' attention to some unusual legal issues.

Miss A, aged 28, was admitted to hospital informally with a two month history of increasingly severe psychotic depression with psychomotor retardation. Her psychiatric history included long-standing poly-drug and alcohol abuse, repeated self-laceration, and a suggestion of anorexia nervosa. Refusal to remain in hospital necessitated detention under the Mental Health Act 1983.

Ten days after admission she was due to get married. She had lived with her fiancé for 18 months. The team felt that she was too depressed to give valid consent. Her partner was unable to accept she was ill and demanded her discharge, and threatened to