Reynolds, 1979). I would suggest that macrocytosis and cognitive decline in Down's syndrome is likely to be related to undetected folate vitamin deficiency consequent on institutional nutrition, complicated by the gastrointestinal malabsorbtion that some Down's syndrome patients have.

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Dependence on Pseudoephedrine

SIR: Sympathomimetic amines are a major ingredient in proprietary medications for the treatment of upper respiratory tract infections. We describe a patient dependent on pseudoephedrine.

Case report: The patient first presented at the age of 21, with symptoms of depression. This responded poorly to treatment, and continued for 12 years. In the eleventh year she was convicted of the theft of a medical prescription pad and for making a prescription for herself for Actifed. She subsequently admitted taking between 50 and 300 ml/day of this preparation — the recommended dosage is 30 ml/day. She said that she took it because it "gave her a lift". A year later she began to describe psychotic symptoms, which have lasted for four years. She had auditory and visual hallucinations and passivity feelings. These symptoms fluctuated and were variable in content; she showed none of the negative symptoms of schizophrenia. Although it was not possible to make a diagnosis of schizophrenia, she clearly suffered from depression, had an unstable personality, and had abused Actifed. Treatment included both oral and depot phenothiazines in addition to supportive psychotherapy, but her compliance was poor.

The present report is important because it shows that dependence and possibly psychosis can occur with over-the-counter preparations. Each 5 ml of Actifed contains 30 mg of pseudoephedrine hydrochloride and 1.25 mg of triprolidine hydrochloride. Dependence on amphetamines and other sympathomimetic drugs is well known. There is, however, only one report of dependence on pseudoephedrine (Diaz *et al*, 1979). Visual hallucinations on attempted withdrawal are described in that report. Paranoid psychosis after abuse of Actifed has also been described (Leighton, 1982). The patient's fluctuating psychosis is thus in accordance with previous findings.

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LEIGHTON, K. M. (1982) Paranoid psychosis after abuse of Actifed. *British Medical Journal*, **284**, 789–790.

Admission Rates and Lithium Therapy

SIR: Dickson & Kendell (1986) recorded admissions for mania and psychotic depression in Edinburgh over the years 1970–1981 and found a rise which they could not explain. They had expected a fall, because the use of long-term lithium therapy had increased ten-fold during the same period, and they felt that their findings cast doubt on the efficacy of lithium prophylaxis in ordinary clinical practice. Such a conclusion might have far-reaching consequences for patients with recurrent manic-depressive illness, and Dickson & Kendell's analyses merit close scrutiny.

It seems a dubious procedure to draw conclusions about the efficacy of a treatment given to a limited number of patients from admission rates for a much larger number. Not all manic-depressive patients receive prophylactic lithium treatment: it is given only to those with frequent recurrences and is started only after the patients have had several episodes. So even if lithium treatment were 100% effective, it could be expected to prevent only a fraction of the admissions for mania and depression.

Even so, a fall in the admission rate, albeit a small one, would be expected if lithium treatment was the only factor influencing admissions. It obviously was not; powerful forces with an opposite effect must have been at work. Dickson & Kendell examined some factors, such as change in diagnostic fashions or admission thresholds, but were unable to account for the rise. One could think of several others.

Be that as it may, the fact remains that the admission rate for mania and depression showed a pronounced rise, and the rise must have been caused by something. The moderate effect of lithium may

easily have been overshadowed by the marked effect of the unknown factor or factors, and Dickson & Kendell's inference about the poor effect of lithium therapy under ordinary clinical conditions is not vindicated by their data. Examination of rates of readmission for manic-depressive patients actually in long-term lithium treatment might have provided information more suited to assess the efficacy of lithium prophylaxis.

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DICKSON, W. E. & KENDELL, R. E. (1966) Does maintenance lithium therapy prevent recurrences of mania under ordinary clinical conditions? *Psychological Medicine*, **16**, 521–530.

Community Care of the Acutely Mentally Ill

SIR: Whether Hoult's study (*Journal*, August 1986, **149**, 137–144) shows that "it is feasible to treat most psychiatric patients in the community as an alternative to mental hospital care" is open to doubt.

For example, 40% of his experimental group required hospital admission at some time. Certainly this was much less, in terms of numbers and duration, than the control sample, but the latter's rates for hospital admission seem inordinately high. It appears that admission was almost automatic for any control group patient turning up at the hospital. Furthermore, there is for some reason a significant increase in neurotic syndrome scores for this control group, and over one fifth are lost to follow up, despite being local residents. It is also worrying that the most difficult cases in psychiatric practice (those over 65, mentally retarded, brain-damaged and drug/alcohol dependent) are excluded. It is certainly reasonable to have a refined sample for research into aetiology, but assessment of care must surely include all the complicated problems that so often provide the greatest management difficulties. Finally, I am uncertain as to the basis of his costing of the alternative care systems. Does he include the on-call availability of psychiatrists "covering the rest of the catchment area service", and the fixed costs of running a hospital anyway — (regardless of patient usage) — since his patients certainly had to use this resource?

It seems that the problem in this work is the "degree of artificiality" created by a research project. The "assertiveness", 24 hour availability, enthusiasm and job satisfaction of the staff involved are crucial factors, and a false dichotomy between hospital and community care is set up. Yet it is not the "where" that matters, it is the "what" and "who" that are essential. Hoult and his workers have clearly shown that the quality of care, at the personal level, is central to a good outcome in psychiatric illness. They have fallen into the non-scientific trap of obtaining findings that "confirmed our aims" — (where is the null hypothesis in this?) — and have not pursued the obvious control situation, namely putting their motivated research team, and its methods, into the hospital. While it is gratifying to see their success — and the value of having a psychiatrist on-call continually — it may be more realistic to see the hospital as a community resource and not to create either/or contrasts.

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A HUNDRED YEARS AGO

Asylum Reports

YORK. DR. HITCHCOCK REPORTS: "During the winter months I have been giving a course of lectures on elementary anatomy, physiology, and the immediate treatment of injuries and accidents, etc to the nurses and attendants of the asylum. I was much gratified by their regular attendance and the interest manifested in the subject; the more so that several, not specially engaged in attendance on the patients, were amongst my class; even some of the patients asked if they could attend, but I drew the line there. I shall not mind if the knowledge they gained is not tested by practice; but at all events the subject was right and necessary for them to be instructed in, and if all's well I shall give a similar course next year."

Reference

Journal of Mental Science (April, 1886) **32**, 146.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey.