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.

CLIFFORD HALEY and R. N. CHITTY, *West Cheshire NHS Trust, Liverpool Road, Chester CH2 1UL*

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, eletrolytic, cyetic, and post-natal contra-indications 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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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 phychiatric 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

remove her forcibly from the hospital. Fellow consultants, the Mental Health Act Commission, hospital managers and trust solicitors agreed that the patient's best interests were paramount, but were unable to give practical advice. We decided that she should not have leave at that time, and the wedding was postponed with her agreement.

Were we ethically and legally justified in preventing her marriage as her decision to marry (we assume) was made when she was well? Had she married, could her illness become the basis for later annulment?

Miss A's fiancé subsequently agreed for her to be detained under section 3 of MHA. She was treated with ECT, to which she responded, but remained a high suicide risk in the early stages of treatment. In spite of thoroughly and repeatedly explaining the severity of her illness to her fiancé, he was party to her repeated removal from hospital. Only the threat of legal action was sufficient to prevent this and to allow her to receive treatment. He was fully informed of his rights to apply for her discharge but did not pursue this. He appealed to hospital managers who upheld the section. She eventually recovered, was discharged and now attends the day hospital, where she is reported to be well.

To treat disturbed patients without the full co-operation of relatives is difficult, but to anticipate and manage surreptitious attempts to remove patients from hospital illegally poses special problems. What other steps might be taken to prevent the removal of the vulnerable from hospital? Have other readers found themselves in similar circumstances? We welcome comments on the legal issues raised and suggestions as to how best to resolve such problems.

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Supervision registers

Sir: I am writing this letter about this matter after a thought-provoking talk given at the College's recent East Anglian meeting.

It was made apparent that the Department of Health would not budge from their decision to implement these registers. In some areas there are over 200 patients on the register already.

The Department of Health has given its overall guidelines and criteria for placing patients on these registers. It may be a good idea for the College to develop its own operational criteria so there are no ambiguities in the minds of psychiatrists or vague interpretations in coroner's and courts of law when tragedies occur. In this way the College would determine good practice and there would be no other use of these registers except clinical and patient care. Similarly, there should be withdrawal operational criteria which would benefit patients and doctors alike.

To help in this, a brief depression and suicide risk questionnaire may help. Like all operational criteria these would not be perfect but one can review and audit them regularly.

M. A. MAKHDUM, *Turner Village Hospital, Colchester, Essex*

Communication between GPs and psychiatrists (or communication between psychiatrists and GPs!)

Sir: The article by Prakash Naik & Alan Lee (*Psychiatric Bulletin*, 1994, **18**, 480–482) highlights not only, as they mention, "problems in communication between hospitals and GPs" but also the difficulties experienced by those in secondary care trying to influence the behaviour of their colleagues in primary care. Such difficulties also apply to GPs trying to influence behaviour of hospital staff.

Closer understanding of GPs' working patterns, roles and responsibilities by secondary care staff is required if progress is to be made towards resolving such 'problems in communication'. One step forward would be an increase in the number of psychiatric trainees doing attachments in general practice (Burns *et al*, 1994). Likewise, GP insight into the working of the psychiatric team is vital.

GPs receive a large amount of mail daily (the 'thud factor'). It is impractical for them to absorb and then implement all requests received. Perhaps, as the authors themselves hypothesise, a telephone or personal contact would have had more impact of referrers' behaviour than a ten page guide or letter? Prospectively it would be interesting if the authors met at least some of the GPs