that they use it as an escape from boredom and as a stimulant.

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Recording of information in case notes

SIR: The medical defence societies regularly draw the attention of consultants to the proper recording of information in case notes, as it can have both clinical and medico-legal consequences. The fact that inadequacies continue, even in this increasingly litigious age, is regularly brought home to one of us (DD), in the capacity of second opinion appointed doctor and Mental Health Commissioner.

An audit of the use of lithium carbonate was conducted (by PLC) in a small district general hospital psychiatric unit. Of 73 patients on lithium treatment the case notes of 25 were randomly selected and studied in detail to investigate the adequacy of record-keeping and monitoring of treatment. In only two case notes was there any mention of information given about lithium treatment before it was started, and in no case notes was there any mention that the patient had been informed of the adverse and toxic effects, the need for monitoring, the need to maintain adequate fluid intake and so on.

It seems likely that if a similar survey was performed in most hospitals in this country, the same results would be obtained. Lithium is known to be a toxic drug, and patients are almost certainly counselled about its use, but there should be some mention of this in the case notes. If we fail to make notes in the case of such potentially dangerous drugs, we are much less likely to do so when the drug profile causes us less anxiety. If this was a routine practice some colleagues would have been able to avoid the heartache caused by the impending litigation over benzodiazepine dependence, where one of the most frequent allegations being made is that inadequate information was given about dependence and the need for gradual withdrawal.

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Motor disorders of the mentally handicapped

SIR: We agree with Rogers *et al* (*Journal*, January 1991, **158**, 97–102) that a crucial point in the motor disorders of the mentally handicapped population is to resolve the question of whether neuroleptic medication may contribute to motor disorders. We also agree that future studies on motor disorders of the mentally handicapped population should have a control group of similar population who have never been treated with neuroleptics.

Our pilot results from the dyskinesia screening project at the Cell Barnes Hospital (Kohen & Mathew, *Journal*, 1990, **157**, 621) show that 85.5% ($n=53$) of the 62 randomly selected residents rate positively by a score of two in at least one area of the body as defined by DISCUS (Sprague *et al*, 1989). Of the 37 subjects who are on neuroleptic medication, 86.5% ($n=32$) and of the 25 subjects who have never been on neuroleptics, 84% ($n=21$) have a motor disorder in at least one area of the body.

The neuroleptic medication is clearly not a necessary or sufficient cause for the motor disorder in this complex and varied institutionalised population. The next step will be to delineate the anatomical distribution of the motor disorders in a significantly large population and to attempt to subtype the different subsyndromes according to the usage of neuroleptics, overlay of psychiatric illness, chronicity of the illness, length of stay in hospital and other demographic characteristics.

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Reference

SPRAGUE, R. L., KALACHNIK, J. E. & SHAW, K. H. (1989) Psychometric properties of the Dyskinesia Identification System; Condensed User Scale (DISCUS). *Mental Retardation*, **27**, 141–148.

Engagement of relatives in intervention programmes

SIR: McCreadie *et al* (*Journal*, January 1991, **158**, 110–113) report on their attempts to engage the relatives of schizophrenic patients in an intervention programme. They found a disappointingly high level of refusal by relatives – just over half of those approached. In our experience, the timing of offers of help is crucial; we approach relatives while the