patients with an average stay of 91 days, eight patients staying 1061 days and 155 staying 9198 days (25.2 years). The elderly unit had 19 patients staying 78 days and 198 staying 983 days (2.7 years).

The benefits of this method of bed occupancy analysis are that it provides up to the minute information which is based on all the current in-patients, rather than the recently discharged. Given that the performance in a hospital can be represented mathematically, the model can be used to make predictions about changes in admission rates following alterations in the numbers and usage of beds thus avoiding wasteful and disruptive experimentation. Such information would be invaluable to purchasers and providers in planning and evaluating services.

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**For information on the availability of the BOMPS software package.*

A lithium clinic in the real world

DEAR SIRS

To improve monitoring of patients on lithium, a "lithium clinic" was instituted in 1991 for general adult psychiatric patients of one consultant (PHR) in which day hospital patients and out-patients treated with lithium, when identified in ward rounds or out-patient clinics, were referred for extra appointments with the senior registrar. No new resources were available for this extra clinical task.

To evaluate the efficacy of the clinic, an audit was performed at the end of the first year, comparing the technical and clinical aspects of monitoring for those 13 patients who had been taking lithium both during the year prior to the inception of the clinic (1991) and during its first year (1992). Demographic details showed seven men, six women; age range 26–63, mean 45; contact with psychiatric services 5–38 years, mean 16.5; diagnosis bipolar affective disorder in nine, schizoaffective disorder in four.

In 1992, patients received more lithium tests (6.08 tests/patient v. 4.85, NS), with time post dose recorded more often (52% v. 5%, $P<0.001$), more frequently within the 11–13 hour time span (30% v. 3%); more samples were tested for urea and electrolytes (61 v. 36, $P<0.01$) and thyroid function tests (46 v. 23, $P<0.001$). In 1992, fewer patients were admitted as in-patients (5 v. 6), less often (1.6 admissions/patient v. 2), less frequently under Section (38% v. 58%, NS) and for shorter periods (74 days/patient v. 89.5).

This small study suggests that devoting specific time to lithium patients improves technical aspects of lithium monitoring and psychiatric morbidity, and that monitoring should be regular and organised rather than *ad hoc*, as suggested by Aronson & Reynolds (1992). However, even after one year, only 52% of samples are being timed, nearly half outside 11–13 hours: initially an afternoon clinic could be changed to a morning slot only with difficulty, and even then specific time allotted to lithium monitoring could not always be protected against the demands of other out-patients.

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Audit of antipsychotic use in relation to BNF guidelines on dose, route and polypharmacy

DEAR SIRS

There has been concern recently about the use of antipsychotic drugs in doses above those recommended in the *British National Formulary*. At Broadmoor 38–60% (Fraser & Hepple, 1992) and at Reaside 6.5% (Stanley & Doyle, 1993) of in-patients were noted to exceed one gram of chlorpromazine equivalents daily. However, as well as a maximum dose, the BNF also recommends that only one drug of this class should be used, and by one route of administration.

I examined the use of antipsychotics at the Wallingford Clinic (the Interim Secure Unit of Oxford Region) in all 12 in-patients one day in 1992; one was receiving one drug in >BNF dose, and five others >BNF dose of more than one drug, by more than one route. I also examined the drugs of all 53 patients discharged since the unit's opening; 19 were

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on regimes meeting all three BNF advices but 15 were outside. Of this 15, eight were above BNF limits; two failed one indicator, six failed two, and seven failed three.

Thus, a careful reading of the BNF highlights more drug regimes of potential concern than just dosage. Sometimes, e.g. small doses of two drugs, the departure seemed technical, though not insignificant (n.b. compliance, interaction). In other cases, the departures seemed more substantial, perhaps especially from a potentially medico-legal point of view.

I wrote to the BNF about the exact legal status of its advice: the editor of the Joint Formulary Committee replied: "it is intended to provide general guidance ... if you and your colleagues wish to establish alternative protocols, you are, of course, free to do so ..." However, since the recent advice from the College's General Psychiatry Section Psychopharmacology Subcommittee that "very high doses ... should be the treatment of last resort", to exceed BNF dose without careful consideration and possibly a second opinion may leave oneself exposed.

It needs to be debated whether this also applies to BNF advice on route and polypharmacy.

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Registrar's note: Council has recently approved a statement on high dose antipsychotic medication (available as CR 26). This guidance has been adopted by the BNF for its forthcoming edition.

Personality disorder; a declining diagnosis?

DEAR SIRS

In the early hours one morning, I saw an angry, drunk patient in Casualty. Diagnosis was difficult but I was greatly helped by finding in his old notes, that following attendance once at a day hospital in 1978, he had been given the diagnosis of "personality disorder". Following a full assessment and with this additional information, I eventually felt confident about discharging him to out-patient follow-up, whereas otherwise I would have unnecessarily admitted him.

With the advent of the Data Protection Act, patients are now able to see their notes. On several occasions, I have observed multidisciplinary colleagues tending to leave out personality disorder as a diagnosis "in case he/she sees his/her notes".

One wonders also whether GPs may be tempted to omit this diagnosis from referral letters and psychiatrists to omit it from discharge summaries. This would lead to partial or incorrect diagnosis and skew audit or service planning.

Do other doctors have evidence that this is occurring?

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Self-treatment for early waking

DEAR SIRS

You are bound to think it somewhat impertinent for a layman to write to you in this vein, but I hope you will find it justified.

For several years I have suffered from depression, suicidal at times; now having stumbled across a very effective self-treatment, I feel I want to pass the idea on in some quarter where it may be used. On the other hand, I must recognise that the underlying principle of it may be "old hat" and already well exploited. I am 78.

Like most depressives, I always woke early in the morning, even if I was taking something to help sleep. It seems to me that it is during the wakefulness of the small hours that the little black dog comes along and starts bad thoughts which set the tone for the ensuing day.

My treatment has been to accept the early waking, sit up in bed (extra pillows) and have a hot drink from a thermos. The drink, I suppose, could be anything, but for me Ribena works best. This is the moment to wash down a partial dose of sleeping pill. In my case it's Lorazepam (Ativan) which, in spite of the things said on the media, I confirm to be a truly mild anxiolytic with no side effects. The tablets can be cut with scissors, and my 3 a.m. fragment gets less and less, say 1/3 mg, now mainly a placebo. A little biscuit may further help.

The resultant change in my mood was so prompt when I started this on New Year's Day that it could not be dismissed and the effect has now endured for seven months. I used to dread every night; now I look forward to it, feeling that I get two deep sleeps for the price of one. The interval after the snack can be spent reading, writing or just relaxing, until sleepiness returns.

One sees that all this could be disturbing to a spouse who did not sleep deeply. Depending on space, a good solution is beds apart with a screen between. Further than that, the drastic arrangement

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