way that would be impossible in any alternative that is entirely trust organised. Our scheme should also help psychiatrists to retain an overall identity by reminding us that we all share certain basic clinical skills, whatever our speciality within it. It should also help us to retain a say in what we do and what we stand for at a time when others may be only too willing to make these decisions for us.

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Are inappropriate admissions a problem?

Sir: Elwood's (*Psychiatric Bulletin*, January 1999, **23**, 37–40) study of inappropriate admissions suggests junior doctors can recognise when acute in-patient care is not the most appropriate treatment. Despite this, 24% of all admissions were deemed inappropriate, with the 'ideal' alternative ranging from social service referral to in-patient rehabilitation.

Occupancy rates are often much higher in England and Wales (Ford *et al*, 1998) than the recommended 85% (Royal College of Psychiatrists, 1988), making it desirable for patients who do not require acute in-patient care to be diverted to an appropriate alternative or to be discharged from hospital rapidly. As inappropriate admissions occupied only 3% of all acute in-patient beds in Elwood's study, diversion to more appropriate care, even if it were possible, might have only modest effects on occupancy rates. A much larger problem contributing to high occupancy rates are patients who, while admitted appropriately, have recovered sufficiently to be discharged. In a recent cross-sectional audit of 89 acute in-patients in Tower Hamlets, 23% were considered by their keyworker as no longer requiring treatment on an acute ward, and of these 25% were still in-patients three months later.

Focusing on all patients who do not require in-patient care, rather than only those for whom admission may not have been the ideal intervention is probably a better use of audit resources. In practice, however, inappropriate admissions may contribute to high occupancy levels both by occupying beds and diverting staff time from the review of settled patients who no longer require admission.

FORD, R., DURCAN, G., WARNER, L., *et al* (1998) One-day survey by the Mental Health Act Commission of acute adult in-patient wards in England and Wales. *British Medical Journal*, **317**, 1279–1283.

ROYAL COLLEGE OF PSYCHIATRISTS (1988) *Psychiatric Beds and Resources: Factors Influencing Bed Use and Service Planning*. Report of a Working Party of the Section for Social and Community Psychiatry of the Royal College of Psychiatrists. London: Gaskell.

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Anticholinergic treatment

Sir: We would like to compliment the excellent report on anticholinergic treatment by Williams (*Psychiatric Bulletin*, January 1999, **23**, 22–24). We would like to add a few points about the use of these medications.

Anticholinergic drugs are often considered as 'side-effect medication' by many patients as well as some clinicians. Hence, they are often prescribed inappropriately, unaware of the fact that they can worsen anticholinergic side-effects including dry mouth, dry eyes, dry flushed skin, dilated pupils and blurring of vision. Anticholinergic drugs help relieve tremor and rigidity, but bradykinesia is less likely to be helped. Extrapyramidal side-effects are not manifested during sleep. Hence, a bedtime dose is unnecessary. Moreover, its stimulant effect can impair sleep. Anticholinergic drugs are ineffective in the prevention and treatment of akathisia and neuroleptic malignant syndrome. Anticholinergic drugs not only increase the risk of developing tardive dyskinesia, but also worsen existing tardive dyskinesia.

Anticholinergic drugs can cause psychological dependence. The street value of procyclidine is about £1. This may partly explain why some patients feign extrapyramidal symptoms to get a continued and/or increased prescription of these drugs.

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Recent audit of people taking lithium

Sir: We were interested to read Anderson & Sowerbutt's paper (*Psychiatric Bulletin*, December 1998, **22**, 740–743). We recently carried out an audit of people on lithium (n=27, age range 66–98 years, mean 79.8) under the care of one old age psychiatrist. Fifty-five per cent had unipolar/psychotic depression, 30% had a bipolar affective disorder and 15% had a schizoaffective illness. Eleven had lithium for more than five years. Each person (or carer if the carer was

responsible for the medication) was interviewed using a semi-structured questionnaire based on the Central Manchester Healthcare Trust Directorate of Psychiatry Drug Advisory guidelines for the administration of lithium. Fifty-six per cent of people understood why they were taking lithium and 18% had partial understanding. Seventy per cent said they had received no written advice regarding lithium treatment and a further 22% could not remember whether they had received written advice. Only 33% could remember receiving verbal advice. Thirty-seven per cent were aware of the possibility of drug interactions. Only 22% knew the symptoms of toxicity. Seventy-eight per cent would contact their doctor or nurse if they thought something was amiss and another 7% would stop taking the drug and then contact a doctor/nurse.

Anderson & Sowerbutts concluded that lithium education in more than one form affected patients' level of knowledge. We concluded from our audit that practice should change. Currently people started on lithium are given written and verbal information at initiation of treatment. We suggest that this should be supplemented by repeat information annually.

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Unlawful discrimination

Sir: I enjoyed Glozier's article (*Psychiatric Bulletin*, January 1999, **23**, 3–6), concerning the Disability Discrimination Act 1995 and mental illness. There is however an omission, as he states that at present the cases of mental illness that have come to tribunal so far have not helped.

I quote the case of Paul Sheen *v.* The Writers' Guild of Great Britain (1998; further details available from the author upon request). Where the applicant was judged to have been unlawfully discriminated against by virtue of the refusal of the Writers' Guild of Great Britain to grant him membership.

This was a case where a playwright was denied membership of the above organisation, which is essentially a trades union for playwrights, on the grounds of a brief schizophrenic illness. He was granted quite substantial damages and this resulted in quite a shake up in the hierarchy of the Guild.

It may well be that these cases do not have a profound effect on stigma, however, the above case is now well established in case law and is available for other victims of discrimination to use along with their legal representatives.

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What will become of 'community care'

Sir: Now that the government has officially declared that community care has failed, I wonder what will happen to the term community psychiatry. If trusts continue to advertise using the term, the profession may start to look out of touch with contemporary trends. In an age where presentation and sound bites carry more weight in many quarters from substance and logical arguments, the value of much good work that is done in community psychiatry could be lost.

I suggest a solution is to return to the old term 'social psychiatry'. This carries the authority and weight of a profoundly significant and reforming post-war movement, and it is in keeping with the resurgence of interest in therapeutic communities, the questioning of pharmaceutical dominance, the development of new rigour in qualitative research methodology and the relevance of narrative based medicine. More widely, it would also reflect a widespread disenchantment with individualism, and a need to recognise social networks of responsibility.

If consultant posts were advertised in social psychiatry, the profession could grasp this opportunity and coordinate the development of what could become a new movement. It could represent the best practice of recent community psychiatry, with the philosophy and humanistic values of post-war social psychiatry.

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Enduring love

Sir: As McIvor has indicated in his excellent review of Ian McEwan's novel *Enduring Love* (*Psychiatric Bulletin*, January 1999, **23**, 61) this book is of great interest to psychiatrists. There is, however, a danger that the novel – and particularly its Appendix 1 (a case report on which the book is clearly based) – will unreasonably become an accepted part of the psychiatric literature on de Clérambault's syndrome.

Appendix 1 purports to be a reprint of a case report originally published in the *British Review*