handout by mail and those who attended group meetings, nor was there any difference specifically in the last two questions about obtaining information about ADHD and the clinic. These two questions from patients who had been to the group sessions compared with those who received a handout by post were compared by *t*-tests.

Despite several limitations to this survey, which include 40% not returning their questionnaires, it is noteworthy that those who did return the questionnaires were equally satisfied whether they had attended the group sessions or received the handout by post. If this study is replicated by others it has an implication that could save clinics money and time – that written material mailed out is as effective as having clinic personnel present this information.

ATTKISSON, C. C. & GREENFIELD, T. K. (1994) Client satisfaction Questionnaire-8 and Service Satisfaction Scale-30. In *The Use of Psychological Testing for Treatment Planning and Outcome Assessment* (ed. M. Marvish), pp. 402–420. Hillsdale, NJ: Lawrence Erlbaum Associates.

STUART FINE, *Professor, Department of Psychiatry, University of British Columbia and Director of ADHD Assessment Clinic;* LORELEI FAULKNER, *Nurse Clinician and* PAULINE MULLANEY, *Social Worker, ADHD Assessment Clinic, British Columbia's Children's Hospital, Vancouver, British Columbia V6H 3V4*

Lithium monitoring

Sir: Kotak *et al* (*Psychiatric Bulletin*, February 1999, **23**, 83–86) surveyed lithium monitoring by general practitioners, noted the variability in their knowledge and concluded that monitoring based in their surgeries is potentially hazardous. Similar conclusions were reached by Ryman (1997) and by King & Birch (1998).

The authors suggest that the situation might be remedied by psychiatrists providing greater support and advice to general practitioners, for example, by sending postal reminders of when the next test is due. The problem with shared care arrangements, however, is that errors of communication arise and there can be confusion of responsibility over who does what (King & Birch, 1998).

The new NHS, we are constantly reminded, will be primary care led. Nevertheless I believe there are still areas which are safer when psychiatrists are in charge rather than being relegated to advisers and lithium therapy is one of them. Few arrangements can rival the specialist lithium clinic (or affective disorder clinic) where patients can be given expert advice at first hand and be advised on their results directly.

KING, J. R. & BIRCH, N. J. (1998) Delayed response to abnormal lithium results is no longer necessary. *Psychiatric Bulletin*, **22**, 471–473.

RYMAN, A. (1997) Lithium monitoring in hospital and general practice. *Psychiatric Bulletin*, **21**, 570–572.

J. R. KING, *Consultant Psychiatrist, Mental Health Directorate, Hill Crest, Quinneys Lane, Redditch B98 7WG*

Does a stitch in time no longer save nine?

Sir: The College is running an admirable campaign against the stigma of mental disorder but surely it is essential for the information it gives to the public to be accurate? The College's (1998) document *Mental Disorders: Challenging Prejudice*, says that psychiatrists are licensed to recommend compulsory detention ('sectioning') in a mental health unit when someone is judged a serious danger to themselves or others. How serious is serious? The Act just says the safety of the patient or the protection of other persons. However, even more important is the omission of any mention of admission for the health of the patient, a point that was literally underlined by Virginia Bottomley and John Redwood in their introduction to the 1993 edition of the *Code of Practice*. What has happened? Has the College been careless? Surely it cannot be ignorant of these matters? Or is the College trying to soften the image of psychiatry by denying it has this important responsibility? Deterioration in insightless individuals with psychosis is a tragedy and its prevention by early treatment must surely remain one of our most important duties. It is also one that rational and informed members of the public expect us to fulfil.

Could the College do something to retrieve the situation?

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Mental Disorders: Challenging Prejudice*. London: Royal College of Psychiatrists.

DAVID TIDMARSH, *Formerly Consultant Psychiatrist, Broadmoor Hospital, Crowthorne, Berkshire RG11 7EG*

Mental disorders: challenging prejudice

Sir: Overall, the Management Committee is delighted with the favourable reception to its Campaign booklets. They are not perfect; neither are they cast in tablets of stone. In our efforts to startle and thereby command attention we have, in particular, invoked the concern of some carers and professionals by our phraseology relating to the above matter. It may be a semantic point, as

to whether refusal of treatment does or does not comprise a danger to the self but, clearly, we are not seen adequately to be emphasising the essence of the 1983 Mental Health Act. Therein it is clear that compulsory detention and appropriate treatment in hospital of someone resisting such medical advice relating to their condition is only taken in the interests of their health or safety or for the protection of others. We are examining ways of printing an appropriate correction to the present text and will correspondingly change the text itself in the first reprint. In the meantime, we are making this latter change now to the text which shortly will be published on the College's website.

A. H. CRISP, *Changing Minds Campaign Management Committee and Professor of Psychiatry, Psychiatric Research Unit, Atkinson Morlay's Hospital, 31 Copse Hill, Wimbledon, London SW20 0NT*

Use of placebo

Sir: "There are only a few articles published on the use of placebo, either for diagnostic or treatment purposes; one notable and helpful example being Miller (1988)" (Cooney, *Psychiatric Bulletin*, January 1999, **22**, 53–54). Your correspondent must be referring only to diagnosis, for even if reports on placebo-controlled clinical trials are ignored, a search of Medline or the Cochrane Collaboration Library would list many publications on placebo therapy.

False modesty prevents direct reference to my own publications, but there have been several later articles on aspects of placebo treatment in the *Lancet* in 1994 (further details available from the author upon request), for example; and Shepherd & Sartorius (1989) have edited a comprehensive volume on *Non-Specific Aspects of Treatment* that deals in even more general terms with the topic. Attention may also be directed to the proceedings of a recent symposium (Schmidt, 1998).

SCHMIDT, J. G. (1998) Placebo – valuable if it helps the patient? *Research in Complementary Medicine*, **5** (suppl. 1), 102–111.

SHEPHERD, M. & SARTORIUS, N. (eds) (1989) *Non-Specific Aspects of Treatment*. Toronto: Huber and Geneva: WHO.

C. R. B. JOYCE, *Department of Psychology, Royal College of Surgeons in Ireland, Mercer St Lower, Dublin 2, Ireland*

Women in Psychiatry Special Interest Group

Sir: I was interested to read the survey by Blower (*Psychiatric Bulletin*, January 1999, **23**, 24–29) concerning staff grade psychiatrists, of whom the majority would appear to be female. The Women in Psychiatry Special Interest Group would like to encourage any staff grade psychiatrists who are Members, Affiliates or Inceptors of the College to join this group, which can be done in the usual way by contacting the College. The aims of the Group are to support and promote the careers of women psychiatrists and the health needs of female patients with mental illness.

ANNE CREMONA, *Chairman, Women in Psychiatry Special Interest Group, 2 Maids of Honour Row, Richmond-upon-Thames, Surrey TW9 1NY*

Inappropriate antidiuretic hormone secretion associated with zopiclone

Sir: The syndrome of inappropriate antidiuretic hormone (SIADH) is a well recognised complication of many psychotropic drugs (Thomas & Verbalis, 1995). Reports of an association with benzodiazepines are uncommon (Engel & Grau, 1988). To our knowledge this is the first report of SIADH associated with zopiclone, a cyclopyrrolone hypnotic which acts at benzodiazepine receptors.

A patient was treated by a general practitioner with zopiclone 7.5 mg nightly for a two-week history of insomnia. Over the next nine days the patient became confused, lethargic and depressed, culminating in an overdose of six zopiclone tablets. The previous medical history included hypertension controlled by felodipine 5 mg daily for the past two years. The patient had suffered two previous episodes of diuretic-induced SIADH which were confirmed by measurements of serum and urine osmolality.

On admission serum sodium was 129 mmol/L, falling to 113 mmol/L four days later. Serum osmolality was low at 240 mmol/kg and urine sodium was 20 mmol/L suggesting a further episode of SIADH. All other investigations were normal. Psychiatric assessment revealed mild cognitive impairment and depressive features which resolved spontaneously as the serum sodium returned to normal, 12 days after discontinuation of zopiclone.

The rapid resolution of symptoms and correction of hyponatraemia after discontinuation are consistent with this being related to prescription of zopiclone. Furthermore investigations excluded other causes of SIADH. 'Rechallenge to confirm' was considered

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