Of 91 patients, 66 (73%) sat opposite the psychiatrist and 25 (27%) to the side. There was no statistical difference between first and other attenders. Thus the majority of patients sat opposite the psychiatrist across a desk. Although the study measured seating behaviour rather than patient preference, individual patients later suggested they preferred to have a desk between them and the doctor as this made them feel more comfortable.

In view of these findings we question the "received wisdom" that patients should not be interviewed across a desk.

ALFRED C. WHITE
Queen Elizabeth Psychiatric Hospital
Birmingham B15 2QZ

MONICA DOSHI
Highcroft Hospital
Birmingham B23 6AX

R. N. CHITHIRAMOHAN
Hollymoor Hospital
Birmingham B31 5EX

JUDITH NICHOLLS
Hollymoor Hospital
Birmingham B31 5EX

References

MARTIN, P. *et al* (1985) *Towards Better Practice*. Churchill Livingstone. Pp 189–190.

MYERSCOUGH, P. R. (1989) *Talking with Patients. A Basic Clinical Skill*. Oxford University Press. Pp 14–15.

Advocacy services

DEAR SIRS

The introduction of an advocacy service in our local long-stay hospital is causing what can at best be described as teething problems. At worst it is taking psychiatric rehabilitation back half a century.

We had naively assumed that the advocacy service would confine themselves to representing the patients' views about alternative placements to hospital. However, it seems that advocates see their role as much wider. After meeting with the advocate our patients are refusing to cooperate with even the most basic of daily living activities. They now spend their days lying on their beds or sitting in easy chairs saying they do not have to do anything "because the advocacy person told them they didn't". We are having to stand by helpless while these patients lose their hard-won basic daily living skills and choose instead to pursue the non-deliberate self-harm which being in hospital is intended to prevent. Everything learnt from the decades of post-war research on institutionalisation seems wasted.

The greatest concern arises with the small minority of patients who are detained long-term under a renewed Section 3 of the Mental Health Act, 1983. As Responsible Medical Officer, I feel I have a burden of responsibility to ensure these patients receive the treatment necessary for their health. My treatment is vetted regularly by the Mental Health Act Commission and by Mental Health Review Tribunals. Yet a lay person with neither training nor vetting has equal and opposite power to sabotage my recommended treatment. Further, this person has no responsibility for the outcome.

I wonder if others are having similar experiences and whether they have any helpful suggestions?

ANTHONY WHITE
County Hospital
Durham DH1 4ST

Length of stay: a more meaningful approach?

DEAR SIRS

A problem of current bed usage statistics is that large psychiatric hospitals provide a number of distinct types of service: admission, respite, rehabilitation and long-stay. Each of these occupies beds for different lengths of time. Glover *et al* (1990) showed that analysis of percentiles of length of stay after admission can be used to separate out the acute component of care. However, the method remains retrospective. We report here the results obtained using a new method to analyse the in-patient population of a large psychiatric hospital. The method was developed to model the patient flow in the St George's Department of Geriatric Medicine in conjunction with academic mathematicians. It produces a mathematical model of the current in-patient population and hence provides up to the minute information which relates to the current bedstate and can be used to make predictions about the future.

The duration of stay since admission is analysed using the BOMPS (Bed Occupancy Management and Planning System) software package. The date of admission, date of birth and ward of residence of all in-patients is obtained from a midnight bed return provided in ASCII code by the Patient Administration Office. The software determines the best fit, demonstrates the relation between curve and data and calculates the overall length of stay and the two compartmental statistics. The results can then be produced graphically and numerically.

Analysis of the pattern of bed occupancy in one psychiatric hospital indicates that the method can be used to separate out distinct components of a hospital's work, i.e. to produce statistics relating to the average length of stay of two groups of patients, a short-stay and a long-stay group. Analysis of 469 in-patients in Goodmayes Hospital showed two groups of patients, one representing the adult unit, the other the elderly unit. The acute adult unit had 67

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.

PAUL W. MILLARD
The Royal London Hospital (St Clements)
2A Bow Road
London E3 4LL

PETER H. MILLARD
*Professor of Geriatric Medicine**
St Georges Hospital Medical School
Cranmer Terrace
London SW17

Reference

GLOVER, G., FARMER, R. & PRESTON, D. (1990) Indicators of mental hospital bed use. *Health Trends*, **22**, 111–115.

**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.

ROBERT M. COHEN
West London Healthcare NHS Trust
Ealing Hospital, Southall
Middlesex UB1 3EU

ATHANASIOS DOUZENIS
Gordon Hospital

PAUL H. ROBINSON
Gordon Hospital
London SW1V 2RH

Reference

ARONSON, J. K. & REYNOLDS, D. J. M. (1992) ABC of monitoring drug therapy: lithium *British Medical Journal*, **305**, 1273–1276.

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