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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