

Taniguchi, T., Ishikawa, M., Iino, K., et al (1998) Jinko-Dotai-Tokei ni miru Jisatsu no Genjo (Suicide trend in demography). *Kosei no Shihyo*, **45**, 3–9.

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Assessment and discharge following deliberate self-harm

The paper by Hurry & Storey (2000) raises some important points pertaining to the psychosocial assessment of young people presenting with deliberate self-harm (DSH) to accident and emergency (A&E) departments. It is disconcerting that only 54% of children in the 12–15 age group received a specialist assessment prior to discharge from A&E. Department of Health and Social Security guidelines (1984) state that admission to hospital is desirable in most cases in this age group. It is interesting that the rate of specialist assessment was not dependent upon the existence of on-site psychiatric facilities, which in many cases will be based in the community child and adolescent mental health services (CAMHS). The finding that although senior clinicians believe that admission and subsequent specialist assessment is the rule, in practice nearly half the young people in the 12–15 age group are discharged, highlights the need for good liaison between CAMHS and A&E. As minors, most 12- to 15-year-olds will be accompanied by carers, and will be discharged to their care. It is difficult to envisage a situation where a casualty officer would consider discharging a minor following DSH without the involvement of a responsible carer. In the absence of on-site specialist assessment, and with a favourable short-term risk assessment, a casualty officer may be justified in discharging a young person if he or she can be confident that rapid specialist follow-up has been arranged, and that the carer has given an undertaking to ensure that the young person attends. It is, therefore, important that casualty officers receive training in the assessment of short-term risk following DSH, and in communicating with the families of young people.

Such training, regularly undertaken, is the responsibility of senior clinicians in A&E and their psychiatric colleagues. It should ensure awareness of DSH guidelines and the route to fail-safe follow-up, and

address the situation reported by Hurry & Storey (2000) of junior doctors who are believed to be “. . . ill-equipped to make such assessments adequately . . .”, owing to “. . . lack of experience or lack of concern with the psychological aspects of treatment”.

Department of Health and Social Security (1984) *The Management of Deliberate Self-Harm*. HN(84). London: DHSS.

Hurry, J. & Storey, P. (2000) Assessing young people who deliberately harm themselves. *British Journal of Psychiatry*, **176**, 126–131.

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Hurry & Storey (2000) highlight the relatively low rates of specialist assessment for patients who present at hospital following deliberate self-harm (DSH). One contributing factor not commented upon by the authors may be those patients who leave the accident and emergency (A&E) department prematurely.

We surveyed psychiatric presentations to an inner-London A&E department over a four-month period and found that premature discharge was taken by 32% of adult patients following an overdose and 7% of those following other forms of DSH. The majority left before assessment by a casualty officer. A survey of premature discharges from Glasgow Royal Infirmary raised a similar problem (Pennycook *et al*, 1992).

Identifying the reasons for premature discharge will form the basis of a future audit. Possible factors include ambivalence about seeking help, long waiting times and adverse interactions between staff and patients.

Premature discharge may have repercussions for patients, as well as medico-legal implications for A&E. Local guidelines for A&E staff are being drawn up, to minimise the rate of premature discharge by these patients. For those who do leave, there should be careful documentation of the attendance and an attempt to organise follow-up. This should at least include telephone contact with the general practitioner.

Hurry, J. & Storey, P. (2000) Assessing young people who deliberately harm themselves. *British Journal of Psychiatry*, **176**, 126–131.

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Ambient iodine and lithium-associated clinical hypothyroidism

Johnston & Eagles (1999) report a prevalence of hypothyroidism, in terms of the indication for thyroxine treatment, under long-term lithium therapy which by far exceeds the estimated prevalence of clinical hypothyroidism in the local population (Aberdeen area). Like Kirov (1998), who also retrospectively found a similar prevalence in a lithium-treated cohort from London, they compare their findings with results reported from North America and Sardinia. Whereas the Italian researchers (Bocchetta *et al*, 1996) did not find an excess of hypothyroidism under long-term lithium therapy, results of studies from the USA and, above all, from Canada are close to those from the UK, suggesting a considerable excess of clinical hypothyroidism under lithium treatment.

The well-known discrepancies in results among studies of lithium's anti-thyroid effects that have emerged frequently in different parts of the world over 30 years may not only be due to different study designs. In Canada, there is an overabundance of nutritional iodine (Dussault, 1993); Italy is an iodine-deficient country. As in the general population (Laurberg *et al*, 1998), in patients treated with lithium, ambient iodine seems to play a major role in the manifestation of thyroid failure. Conversely, iodine deficiency may act as a protective factor under lithium therapy. In iodine-deficient Germany, Italy and Spain, an excess of clinical hypothyroidism in patients taking lithium has never been reported, whereas in Canada, six papers from different clinics consistently reporting high prevalence of hypothyroidism under lithium therapy have been published (Leutgeb, 1999). Sorting the studies published on this topic geographically provides a confirmation of the early (case-report-based) assumption by Shopsin *et al* (1973) of a synergism between iodine and lithium in the manifestation of thyroid failure.

Consequently, in those countries where the World Health Organization's iodisation programme is gaining ground (Dunn,