

that they use it as an escape from boredom and as a stimulant.

JEAN CLAUDE MONFORT
ANDRÉ MANUS

*Service de Psychiatrie
Hôpital Albert Chenevier
40 Rue de Mesly
94010 Creteil
France*

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Recording of information in case notes

SIR: The medical defence societies regularly draw the attention of consultants to the proper recording of information in case notes, as it can have both clinical and medico-legal consequences. The fact that inadequacies continue, even in this increasingly litigious age, is regularly brought home to one of us (DD), in the capacity of second opinion appointed doctor and Mental Health Commissioner.

An audit of the use of lithium carbonate was conducted (by PLC) in a small district general hospital psychiatric unit. Of 73 patients on lithium treatment the case notes of 25 were randomly selected and studied in detail to investigate the adequacy of record-keeping and monitoring of treatment. In only two case notes was there any mention of information given about lithium treatment before it was started, and in no case notes was there any mention that the patient had been informed of the adverse and toxic effects, the need for monitoring, the need to maintain adequate fluid intake and so on.

It seems likely that if a similar survey was performed in most hospitals in this country, the same results would be obtained. Lithium is known to be a toxic drug, and patients are almost certainly counselled about its use, but there should be some mention of this in the case notes. If we fail to make notes in the case of such potentially dangerous drugs, we are much less likely to do so when the drug profile causes us less anxiety. If this was a routine practice some colleagues would have been able to avoid the heartache caused by the impending litigation over benzodiazepine dependence, where one of the most frequent allegations being made is that inadequate information was given about dependence and the need for gradual withdrawal.

D. L. F. DUNLEAVY
P. L. CORNWALL

*Division of Psychiatry
The Royal Victoria Infirmary
Newcastle upon Tyne NE1 4LP*

Motor disorders of the mentally handicapped

SIR: We agree with Rogers *et al* (*Journal*, January 1991, **158**, 97–102) that a crucial point in the motor disorders of the mentally handicapped population is to resolve the question of whether neuroleptic medication may contribute to motor disorders. We also agree that future studies on motor disorders of the mentally handicapped population should have a control group of similar population who have never been treated with neuroleptics.

Our pilot results from the dyskinesia screening project at the Cell Barnes Hospital (Kohen & Mathew, *Journal*, 1990, **157**, 621) show that 85.5% ($n=53$) of the 62 randomly selected residents rate positively by a score of two in at least one area of the body as defined by DISCUS (Sprague *et al*, 1989). Of the 37 subjects who are on neuroleptic medication, 86.5% ($n=32$) and of the 25 subjects who have never been on neuroleptics, 84% ($n=21$) have a motor disorder in at least one area of the body.

The neuroleptic medication is clearly not a necessary or sufficient cause for the motor disorder in this complex and varied institutionalised population. The next step will be to delineate the anatomical distribution of the motor disorders in a significantly large population and to attempt to subtype the different subsyndromes according to the usage of neuroleptics, overlay of psychiatric illness, chronicity of the illness, length of stay in hospital and other demographic characteristics.

D. KOHEN

*Charing Cross/Westminster Medical School
Unit of Mental Handicap
Fulham Palace Road
London W6 8RF*

G. MATHEW

*Cell Barnes Hospital
St Albans
Hertfordshire*

Reference

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Engagement of relatives in intervention programmes

SIR: McCreadie *et al* (*Journal*, January 1991, **158**, 110–113) report on their attempts to engage the relatives of schizophrenic patients in an intervention programme. They found a disappointingly high level of refusal by relatives – just over half of those approached. In our experience, the timing of offers of help is crucial; we approach relatives while the

patient is still in hospital with an episode of schizophrenia. At a time of crisis, which this represents, relatives are often desperate for help and welcome the offer of information about the illness. The process of engagement is greatly facilitated by the therapists' willingness to see relatives at home, and by a clear statement at the outset that the relatives are not viewed either as the cause of the illness or in need of psychological treatment themselves. The explanation we give for our intervention is "to help you to help the patient". This gets round the objection made by six of McCreadie's refusers that "it's the patient who needs help, not me".

Once the acute episode is over and the patient back home, the family rapidly returns to its routine and becomes relatively impervious to offers of help, as McCreadie and his colleagues discovered.

The authors acknowledge that their intervention was "an approximation of what was achieved in other studies", but it is impossible to tell how close or distant the approximation was since insufficient detail is given in their Brief Report. We are conscious that we have not produced a manual for our intervention, which would lay the groundwork for others to apply it clinically. However, we have run one pilot training course for ten psychiatric nurses of one and a half hours per week over nine months which has helped us towards creating a manual. It has also reassured us that the techniques can be acquired by clinical staff. Therefore, we do not share the pessimism of McCreadie and his group that professionals "in hard-pressed NHS psychiatric facilities" will not be seconded for this type of training.

JULIAN LEFF
LIZ KUIPERS
DOMINIC LAM

*Institute of Psychiatry
De Crespigny Park
London SE5 8AF*

Patient data in child psychiatry

SIR: The contribution of Treffers *et al* (*Journal*, November 1990, 157, 744–747) to the debate about the development of computerised databases in child psychiatry was welcome but in some respects misleading. The utility of such a system is determined largely by the extent to which it fulfils the clinical, administrative and research needs of a particular centre. The requirements of a teaching hospital department with extensive research interests will, of necessity, be different from those of the large number of clinical departments to which most patients relate. In the design of information systems, account must

be taken of the need for flexibility to suit local needs (Sein, 1990). The demands of medical audit and management processes will call more for a common data-set between clinics which will facilitate cross-district and regional comparisons.

It is perhaps misleading to entitle a paper "Collecting patient data . . ." when, despite some well made general points about the issues, more than half the text is devoted to an exposition of an unvalidated and complex system of classifying family types. Useful though such an endeavour could be, it is exceedingly unlikely that such detailed demographic data collection would be economically viable as a routine feature of a clinical information system for child psychiatry in the National Health Service (NHS). In their introduction, the authors note that the development of information systems for child psychiatry has been slow. This is unsurprising since the impetus in the past has been predominantly research-based, necessitating such complex and detailed data collection as is described in this paper.

In the UK now a new impetus has been provided by the emphasis in the NHS reorganisation on systems for medical audit and monitoring of clinical activity. Small specialities such as child psychiatry may find it difficult to generate the resources to develop information systems which will 'travel' to other centres, although some pioneering systems have been installed in more than one centre (Berger, 1989; Byrne, 1989).

In order to meet these wider demands, databases need to be economical, efficient and relatively simple to use. If the authors' data-set is to achieve greater utility than that of a tool for epidemiological research then I suggest it will need piloting in several centres with careful evaluation, both of the scale of resources needed to support it, and of its usefulness within a scheme for medical audit.

PATRICK J. BYRNE

*Croydon Child Guidance Clinic
Victoria House
Southbridge Place, Croydon CR0 5HA*

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