
columns

Draft Mental Health Bill in England

Dr Maden's commentary on . . . 'The Draft Mental Health Bill in England: without principles' (*Psychiatric Bulletin*, July 2005, **29**, 250–251) is dismissive of 'liberal hysteria' and suggests that therapeutic intent is a peripheral issue to use of mental health law. The perspective of someone viewing the issues from a tertiary service probably explains the failure to understand the ramifications that the proposed Bill will have on the population as a whole. The ability of general adult services to select in-patients on the basis of need or evidence of effectiveness would be paralysed. General psychiatric hospitals will return to the dark days of having a primary social control function. Apart from the ethical considerations of using a hospital as a prison, does anyone really believe this legislation will lead to better protection of the public? We are looking in the wrong legislative direction for solutions to this.

Dr Maden's commentary concludes by suggesting that our current mental health legislation is among the best and most liberal in the world in the way in which it deals with offenders with mental illness. Why on earth, then, are we proposing to change it?

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Electronic care record

Dr Holloway describes the moves to introduce an electronic care record (ECR) (*Psychiatric Bulletin*, July 2005, **29**, 241–243). He raises concerns that 'important qualitative aspects' may be lost in the transition from existing medical records.

There is no reason to suppose that this should be the case. There is nothing contained in traditional records that cannot be easily translated to electronic form. The 'qualitative aspects' may be contained in free text notes or diagrams, and technology to include these is readily available. In addition, the fact that the record will be permanently accessible nationwide (and clearly legible) may encourage fuller and more informative recording than at present.

Clearly, the mechanism of entry will change from pen and paper to keyboard and mouse. This will pose no problem to the many increasingly IT-literate trainees, and for some will make data entry faster and more accurate. For everyone else, emergent technologies such as voice recognition may be appropriate or the secretarial role could be expanded to include typing of entries. Many documents (out-patient letters, minutes of meetings, etc) are already typed and held on computer, so including these in the ECR should be straightforward. There are clearly resource implications, but there will also be savings, as many labour-intensive aspects of paper notes (fetching and carrying, filing, locating records, etc) will no longer be needed.

Many trusts have already introduced some form of electronic patient record with success. None of the problems posed is insuperable, and with appropriate planning the ECR should surpass traditional medical records in every aspect.

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Do we need a wider survey of physical healthcare provision for psychiatric patients?

Very few of us, I suspect, will have been surprised to read that there is inadequate recording of physical health parameters in psychiatric notes, but we should still be disappointed to learn of Dr Greening's findings (*Psychiatric Bulletin*, June 2005, **29**, 210–212). However, in failing to reflect upon the contribution of other professionals I am concerned that this study invites a distorted view of physical healthcare provision as a whole, which surely should be the main issue for our patients.

All psychiatric patients should be encouraged to register for and utilise primary care services, and this is especially so for rehabilitation for patients for who it is part of returning to a 'normal' way of life. When working in rehabilitation psychiatry, the prevailing attitude was that it is appropriate and non-discriminatory for our patients to take some of their physical complaints to general practitioners who see these presentations regularly. Sometimes (probably not often enough) we would be informed of these consultations by letter, but even then I doubt whether very many of us would copy this information into the hand-written notes. I am concerned that by only looking at secondary care case notes this survey would not have adequately detected input from primary care.

Auditing against pronouncements from the National Institute for Clinical Excellence has a certain kind of validity, but perhaps the salient question here is 'how is the physical health of our patients recorded in its entirety?' The new general medical services contract explicitly states that primary care is responsible for providing physical healthcare to people with serious mental illness (Lester, 2005). I am worried that in omitting mention of primary care's contribution in any part of the discussion this paper invites us to conclude that these findings represent the full extent to which the physical health of psychiatric patients is recorded by those who are responsible for doing so. I feel this is potentially misleading.

LESTER, H. (2005) Shared care for people with mental illness: a GP's perspective. *Advances in Psychiatric Treatment*, **11**, 133–139.

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Cranial computed tomography in old age psychiatry

I read with interest Dr Fielding's paper on the value of cranial computed tomography in old age psychiatry (*Psychiatric Bulletin*, January 2005, **29**, 21–23). In a similar audit in the old age psychiatry service in south-east Hertfordshire, exploring the role of neuroimaging in the investigation of dementia, of 88 patients, who had undergone computed tomography or magnetic resonance imaging of brain, two were reported to have potentially reversible causes of dementia. One showed a meningioma that was considered to be an incidental finding and not causally related to dementia. The other had disproportionately dilated ventricles, suggestive of normal pressure hydrocephalus. However, this diagnosis was not confirmed on subsequent review. There were 17 patients with other focal abnormalities: 14 showed old infarcts, not suspected from the clinical history in four; two patients had focal frontal atrophy, which was unsuspected in one prior to the scan; one patient had cavum septum pellucidum and basal ganglia calcification. Although the scans led to a revision of the aetiology of dementia in some cases, the impact on subsequent management was not significant. Although this audit was conducted in a smaller sample, its findings are largely in agreement with the results of Dr Fielding.

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Modernising psychiatric education

The article by Dr Brown *et al* (*Psychiatric Bulletin* June 2005, **29**, 228–230) on modernising psychiatric education summarised very well the current position and thinking with regards to the overhaul of medical education and psychiatric education in particular. I doubt though that enough emphasis has been