INFORMAL PATIENTS DETAINED

DEAR SIR,

Dr Chiswick is correct in saying that data are not automatically sent to the Mental Welfare Commission on the use of consecutive Section 31 recommendations which do not lead to a Section 24 nor on the use of Section 31 recommendations for informally admitted residents (*Journal*, November 1979, **135**, 482–3).

Indeed there is no statutory provision at all for informing the Commission when Section 31 is used and, although many of our colleagues do so, this is entirely of their own volition and we appreciate it.

The Commission have no doubt but that such detention should carry with it a statutory obligation to notify them, and also that there should be a statutory limit on the number of occasions when the Section 31 procedure is consecutively used in respect of the same detention.

We have for long been concerned that a patient could be detained for an indefinite period by the use of consecutive Section 31 recommendations that this procedure does not have to be accounted for to anyone.

As Dr Chiswick says, there is a strong argument for its correction, and we have reason to believe that many of our senior colleagues in Scotland hold the same view.

A. N. M. BRITTAIN
J. M. LOUGHRAN

HM Medical Commissioners,
Mental Welfare Commission for Scotland,
22 Melville Street,
Edinburgh EH3 7NS

DEAR SIR,

Dr Derek Chiswick rightly points out (*Journal*, November 1979, **135**, 482–3) that we did not give the number of Section 31 reclassifications from informal status in our analysis of compulsory admissions (*Journal*, August 1979, **135**, 104–14). These data, *inter alia*, were lost during attempts to comply with editorial exhortations for brevity. In the decade 1963–72 there were 187 such reclassifications, representing 22 per cent of all Section 31s during that period; the annual mean in the first six years was 10.6 compared with 30.7 in the last four years. Dr Chiswick quotes 38 per cent for the Royal Edinburgh Hospital in his own recent study.

We agree with Dr Chiswick that the use of consecutive Section 31s is at variance with the intention of law makers although in many cases the time needed to contact the nearest relative and the family doctor before submitting the documents to the Sheriff may make a second seven days order essential. We would support any steps which might be taken in a review of the Scottish legislation to discourage such a practice and agree that the Mental Welfare Commission might be the appropriate body to monitor the use of Section 31 more strictly.

Our inability to find published evidence of dissatisfaction with the use of Section 31 was meant to be a factual statement and not a defence, spurious and ostrich-like or otherwise. Dr Chiswick's suggestion that patients subject to detention find difficulty in voicing their complaints may be true, but does not explain why there has been considerable public criticism and disquiet over the similar aspects of the Act in England and Wales.

The intention of our paper was to describe the operation of the Act as we found it but not to defend any particular practice. We welcome any comments and comparisons as part of the general debate in the period leading up to Review of the Scottish Act.

W. A. ELLIOTT
G. C. TIMBURY
M. WALKER

Area Alcoholism Unit,
Sunnyside Royal Hospital,
Montrose D D10 9JP

MICROCOMPUTERS IN PSYCHIATRY

DEAR SIR,

It is with deep regret that we learn of the death of Dr Christopher Evans, psychologist and computer scientist at the National Physics Laboratory. We feel it appropriate briefly to document the 'state of the art' in the applications of the microcomputer in psychiatry—applications that Dr Evans did much to foster and develop. From his recent television series—"The Mighty Micro"—and his book of the same name, it is evident that his death came just at the start of the decade that will realise many of his ideas.

The development of the microprocessor 'chip' in the early part of the 1970's has brought the cost of computer systems down to £5,000 or less, making them an economic proposition for clinical and research workers in the NHS.

Although there are ethical difficulties in the widespread use of computers, most of these do not apply to the small, self-contained microcomputers on which Dr Evans did most of his work. In his method, the patient is asked questions on a TV screen and answers directly on a keyboard—this technique where there is no intermediary between patient and machine being called 'interactive'. Dr Evans, in 1973, showed that patients were quite content to sit at a computer and answer questions about their symptoms. He later demonstrated (1977)

that with patients whose mother-tongue was not English, translated versions of standardized English questionnaires could be given by computer and remain accurate and valid.

The use of microcomputers is of special interest in psychiatry, as a large part of diagnosis depends on explicit answers to questions. There is a growing interest in structured interview techniques (for example, the Present State Examination of Wing *et al*). In the United States many workers have shown that even disturbed psychiatric patients are amenable to computer interview (for example, Williams, 1975).

At the present time, we are engaged in a number of studies looking at applications of the computer in different psychiatric populations:

The assessment and treatment of phobic disorders;
The assessment of severity of depression;
The assessment of suicidal ideation;
Designing a program for general history taking;
The assessment of elderly patients;
The assessment of the deaf psychiatric patient;
The assessment of intelligence.

We would be interested to hear from other workers engaged in similar work.

R. Ancill
A. Carr
A. Ghosh

Clinical Computer Room,
Institute of Psychiatry,
De Crespigny Park,
Denmark Hill,
London SE5 8AF

References

Evans, C. (1979) *The Mighty Micro*. London: Gollancz.

—— (1973) Computer interrogation of patients with respiratory complaints in a London hospital. *National Physics Laboratory Report*, COM 79.

—— (1977) Some experiments in interviewing immigrant patients in their own language using automated presentation of questionnaires. In *Proceedings of 2nd World Conference on Medical Informatics*. (Eds. D. Shires and H. Wolf). The Netherlands: Elsevier.

Wing, J. *et al* (1974) *Measurement and Classification of Psychiatric Symptoms*. Cambridge University Press.

Williams, T. *et al* (1975) Computer-assisted psychiatric assessment. *American Journal of Psychiatry*, **132**, 1074–6.

PSYCHIATRIC ILLNESS AND HYPERCALCAEMIA

Dear Sir,

Dr Weizman and his colleagues in their paper on Hypercalcaemia-Induced Psychopathology in Malignant Diseases (*Journal*, October 1979, **135**, 363–6) have missed what appears to me to be the most important conclusion from their data, namely, that the psychiatric disturbances in patients with hypercalcaemia are in most cases organic brain syndromes (confusional states).

In the first place I note that they describe Case 1 in their table as "anxiety, depression" but report that he had mild symptoms and that in the admission examination he showed memory disturbance. Although there sometimes may be an apparent disturbance of memory in *severe* affective disorders this is not the case here and the diagnosis is clearly an organic brain syndrome. Secondly, although it seems that the descriptions of Cases 2 and 3 may have been interchanged in the table in error, even so *each of* these patients had an organic brain syndrome, and the paranoid symptoms in Case 3 are to be regarded as part of this and of no diagnostic importance per se. Thus at least 5 of their patients with psychiatric disturbance suffered from organic brain syndromes. (Might one not, perhaps, be excused for suspecting that Cases 4 and 6 described in the table as "depression" and "severe depression" respectively might also have been suffering from organic syndromes?).

Finally I note that they state that "patient no. 1 was suspected to suffer from a psychogenic anxiety depressive syndrome reactive to malignancy until hypercalcaemia was found". The diagnosis of an anxiety state on the one hand or a confusional state on the other does not depend upon the level of calcium but upon a correct evaluation of the clinical features. I find it difficult to see how anyone could ascribe "cognitive dysfunction . . . to emotional reactions to the basic disease". From the information given it seems to me that if the clinical features had been correctly evaluated then "potentially harmful treatment with . . . drugs" could have been prevented long before the diagnosis of hypercalcaemia.

A sound clinical basis is essential for proper research in psychiatry.

Samuel I. Cohen

The London Hospital,
Whitechapel, E1 1BB

UP-TO-DATE RECORDS OF LONG-STAY PATIENTS

Dear Sir,

Assessment of long-stay psychiatric patients is often made difficult because the past records are inadequate. It may be impossible for staff having no previous knowledge of the patients to extract an adequate account of the clinical course and treatment from unorganized handwritten notes.

I would like to suggest a cumulative type of record making; in essence, a brief typewritten statement of