should reject the language of ICD–10 and DSM–IV when the topic under discussion is mental retardation?

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Discharge communication

Sir: The audit described by Shah and Pullen (*Psychiatric Bulletin*, September 1995, **19**, 544–547) was of particular interest to me, as I am carrying out an audit of discharge communication with primary care in our own service. We have not as yet addressed the issue of patient access to discharge summaries; the authors point out the importance of this, and I hope to incorporate relevant standards into our own project. However, I was concerned to find the avoidance of jargon as a standard by which our letters might be judged.

The examples quoted were non-standard versions of recognisable diagnoses and examination findings, but is this all that is meant by 'terms which are not intelligible without explanation' (*Access to Health Records Act*, 1990)? Surely terms such as 'borderline personality disorder' or 'passivity phenomena' are no less jargonistic by this definition? Specific terms exist for a reason, namely the succinct communication of assessment, treatment and prognosis to other professionals who understand them. It would seem onerous to suffix each term with bracketed explanations of the context in plain English. The alternative of providing large amounts of information to patients on receipt of their records with which to interpret these terms would be helpful to some, but confusing for others, and is no more sensible as a policy.

I would be interested to hear from Shah and Pullen as to how they dealt with this issue in their own audit. Certainly, letters should be written in plain error-free English, using standard psychiatric terms only. Easy access should be provided to the responsible consultant or an independent doctor if patients wish further explanation or clarification. Perhaps the real problem lies in the rarity with which we give personal written accounts to patients of our explanations, a measure which might aid understanding and insight, as well as promoting a more collaborative approach.

Access to Health Records Act 1990. London: HMSO.

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The misuse of alcohol in elderly psychiatric patients

Sir: We would like to present our findings from a survey on the use of alcohol in elderly psychiatric in-patients.

For a three month period, we identified all patients over 65 years of age, consecutively admitted to an acute psychiatric hospital. After obtaining patients' consent, we took a detailed alcohol history, particularly focusing on the alcohol consumption in the month prior to admission. In addition, we also administered the CAGE and the Short Michigan Alcohol Screening Test (SMAST; Selzer *et al*, 1975) questionnaires, and obtained a corroborative informant history when this was available. Of 89 consecutive admissions, 64 consented to the study (72%). All non-consenting patients had significant cognitive impairment, and were unable to consent as a result.

We found that 42% of the consenting population had used alcohol in the month prior to admission and 12.5% of patients had been exceeding the Royal College of Psychiatrists' recommended safe limits of alcohol consumption (i.e. more than 14 units per week for women and 21 units for men). A further 3% of patients were identified by the screening instruments used as having had previous problems with alcohol though not having exceeded the recommended safe limit in the month before admission. Alcohol misuse was significantly more common in male patients. Case notes failed to identify approximately one-third of patients who had misused alcohol.

These findings are broadly in line with those of Mears & Spice (1993), who identified 19% of psychiatric in-patients as being 'problem drinkers'. They also help to highlight two important and related issues: first it is certainly possible that the consumption of alcohol may contribute to the physical health problems, social difficulties, psychopathology and consequent need for admission, in a sizeable proportion of elderly patients with psychiatric problems. Furthermore, there is a continued need within the profession to raise the awareness of the possibility of alcohol misuse within this vulnerable population group.

MEARS, H. J. & SPICE, C. (1993) Screening for problem drinking in the elderly: a study in the elderly mentally ill. *International Journal of Geriatric Psychiatry*, **8**, 319–326.
SELZER, M. L., WINOKUR, A. & VAN ROOIJEN, L. (1975) A self administered Short Michigan Alcohol Screening Test. *Journal of Studies on Alcohol*, **36**, 117–126.

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