Version of the Glasgow coma scale on neurological observation charts in UK hospitals managing patients with traumatic brain injuries. Values are numbers (percentage)

Version of Glasgow coma scale (points)	Emergency departments (n=233)	Wards for observing patients with traumatic brain injuries (n=233)		Neurosurgical units (n=32)
		Emergency department observation wards (n=58)	Other* (n=175)	
15	178 (76.4)	41 (70.7)	90 (51.4)	18 (56.3)
14	55 (23.6)	17 (29.3)	81 (46.3)	13 (40.6)
Not used	0	0	4 (2.3)	1 (3.1)

*Only about a quarter of all emergency departments have their own observation ward. In most British hospitals, patients with traumatic brain injuries are admitted to general surgical or orthopaedic wards. More rarely, patients are observed on medical, otorhinolaryngological, or neurosurgical wards.

scale in 1976 was not accompanied by an explanation and did not result in a clarifying change of name.

No evidence has been published that the continued use of the 14 point scale may have caused harm to any patient. The practice does, however, lead to difficulties. Staff from one hospital told us about their recurrent problems communicating with the local neurosurgical unit because the two were using different scales. In another trust, the neurological observation charts were changed after a recent coroner's inquest: relatives of a patient who had died of severe traumatic brain injury had raised questions about the logic of two different versions of the Glasgow coma scale being used within the same trust.

Users of the Glasgow coma scale need training to ensure consistency and reliability of scoring.[5] The continued employment of two different scales can only add to the confusion. Although the 15 point Glasgow coma scale is not perfect, it should be used by everybody who manages patients with traumatic brain injuries until even better measures of consciousness are devised.

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Substance misuse in psychiatric inpatients: comparison of a screening questionnaire survey with case notes

Ben Barnaby, Colin Drummond, Annie McCloud, Tom Burns, Nicola Omu

Doctors are poor at taking alcohol histories in many clinical settings.[1 2] Given the increasing prevalence of drug misuse in the general population and in psychiatric patients, the extent of detection of drug misuse is also important. For patients with comorbid substance misuse and psychiatric problems, the UK Department of Health states, "Individuals with dual problems deserve high quality, patient focused, and integrated care. This should be delivered within mental health services."[3] If substance misuse is not detected, however, such care is unlikely to be delivered. We examined data to investigate the prevalence of alcohol and drug misuse in inpatients admitted to psychiatric wards and the extent and accuracy of detection by the psychiatrists doing assessments on admission.

Participants, methods, and results

We aimed to approach all new admissions to six acute psychiatric wards in two London hospitals over three months. Patients who consented completed the alcohol use disorders identification test (AUDIT) and a short version of the substance abuse assessment questionnaire.[4] An AUDIT score ≥ 8 indicates hazardous alcohol use and ≥ 15 indicates alcohol dependence. We excluded patients who did not speak English, who were admitted to the psychiatric intensive care unit, or who were younger than 18 or older than 75. We also excluded patients admitted to specialist wards for addiction or eating disorders and those admitted to forensic wards.

We studied case notes to determine whether a history of substance misuse had been recorded on current admission, its comprehensiveness, whether relevant investigations had been performed, and whether any screening tools had been completed. We considered alcohol and illicit drugs separately. A full history was one including the age of first misuse of each substance, and questions about problems related to using substances and symptoms of dependence, periods of abstinence, and use of specialist services. A partial history contained any one or more of these but less than a full history.

Of a total of 364 new admissions, 326 (89%) were eligible; we approached 263 patients, and 200 (76% of those eligible) gave consent. Not seeing patients was usually because they were admitted and discharged over a weekend or because they absconded.

Of the 200 patients who took part, 106 (53%) were men and 94 (47%) were women. Mean age was 41 years;

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Substance misuse and related history in the case notes of 200 patients admitted to psychiatric wards in London*

Measure	No (%)
Results of screening questionnaire	
AUDIT score ≥8 (hazardous alcohol use)	97 (49)
AUDIT score ≥15 (alcohol dependence)	44 (22)
Lifetime illicit drug misuse†:	
Any	110 (58)
Cannabis	104 (52)
Cocaine or crack	56 (28)
Stimulants	52 (26)
Hallucinogens	52 (26)
Inhalants	38 (19)
Opiates	36 (18)
Illicit drug misuse in previous 30 days†:	
Any	52 (27)
Cannabis	36 (18)
Cocaine or crack	22 (11)
Stimulants	6 (3)
Hallucinogens	2 (1)
Inhalants	1 (0.5)
Opiates	20 (10)
Review of case notes	
Full alcohol history	1 (0.5)
Partial alcohol history	54 (27)
Liver function test	30 (15)
Assessment tool‡	1 (0.5)
Referral to specialist alcohol service	7/44 (16)§
No record of alcohol use	146 (73)
Full drug history	3 (1.5)
Partial drug history	49 (25)
Urine toxicology	36 (18)
No record of drug misuse	148 (74)

*Values for misuse of individual drugs do not sum to value for misuse of any drug because some patients misuse more than one.
†Substance abuse assessment questionnaire.
‡Severity of alcohol dependence questionnaire.
§Seven patients with AUDIT scores ≥15.

158 (79%) were white and 22 (11%) were black. A total of 97 (49%) scored ≥8 on AUDIT, indicating hazardous alcohol use—53% of men and 44% of women. Forty four (22%) scored ≥15 or above on AUDIT, indicating alcohol dependence. More than half of the patients (110; 58%) reported lifetime substance misuse, and 52 (27%) reported taking illicit drugs in the 30 days before admission. One patient had had a full alcohol history taken; 54 (27%) had partial alcohol histories in their notes. Three quarters of patients (146; 73%) had no record of using alcohol in their notes. Most patients (148; 74%) had no record of drug misuse in their notes. The ratio of women to men who use alcohol hazardously (1:1.2) was considerably higher than in the general population (1:2.5).[5]

Comment

Substance misuse is common in psychiatric inpatients, but most patients have not been asked about these disorders by admitting psychiatrists. The high prevalence of substance misuse and low screening rates could have an important impact on the quality of the treatment provided, including missed opportunities for substance misuse intervention.

Staff in mainstream mental health services, particularly admitting psychiatrists, urgently need training in detecting and managing comorbid substance misuse. "To overlook or neglect substance misuse in the course of mental health treatment will result in poor treatment outcome."[3]

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