case notes, were recorded as formal performance indicators.

Hospital In-patient Episode (HIPE) computerised data for the preceding eight months had shown that 52 patients had been admitted for detoxification from alcohol: we hoped to study a similar number. But daily contact with the admission wards yielded only 25 patients during the study period, one of whom refused to participate. Fourteen (57%) were on the waiting list for between two days and six months (median two weeks); the other ten were admitted on the day of referral. Ten were referred by general practitioners, nine by the district out-patient clinic for alcohol misusers, three by general psychiatrists, one by Alcoholics Anonymous and one by employment health services.

In common with users of specialist alcohol treatment units (Hore & Smith, 1981), the patients we studied were mostly middle-aged men with stable employment records and unstable personal relationships. Eighteen (75%) were men, mean age 38.2 years (range 26–58), and six were women, mean age 33.7 (range 21–50). Fourteen (61%) were employed, seven (43%) had suffered marital breakdown, and twenty (87%) had had previous treatment for alcohol problems. Fourteen patients (60%) had a family history of alcohol misuse. There were 21 regular drinkers who consumed a mean of 26 units of alcohol a day (range 10–75 units), and three binge drinkers. Seven patients were concurrently misusing illicit drugs, four others were admitted and discharged taking prescribed benzodiazepines. All patients were withdrawing from alcohol on admission. Two had had delirium tremens in the past but none experienced this syndrome or withdrawal fits during the study. Treatment regimens of chlormethiazole or chlordiazepoxide were used for detoxification, with chloral hydrate or temazepam for insomnia. Vitamin supplements were also given. Detoxification was not combined with any other specific treatments such as structured activity programmes or counselling sessions, but some patients attended local meetings of Alcoholics Anonymous.

Patients were discharged after a mean of seven days (range 2–14), 20 (87%) of them without experiencing any drug-free days. Six said that they had not been offered any follow-up. Eighteen thought that specific follow-up had been arranged but the discharge letters of only 12 mentioned any, and only seven patients (34% of the total sample) actually attended their appointments. This discrepancy between patients' expectations of follow-up and plans described in discharge letters may reflect misinterpretation of advice, poor communication between staff and patients or between ward doctors and GPs, or general ignorance about the functioning and range of community alcohol services. It would be interesting to know why some patients were not offered follow-up and why others did not comply with it. Other data obtained on discharge were too varied to show any trends.

A retrospective review of HIPE data at the end of the study showed 39 patients as suffering from "alcohol withdrawal syndrome", of whom we had studied 20. Of the 19 patients not studied, we had excluded nine because they had other primary problems (four were suicidal, three were clinically depressed, and two had serious physical complications of alcohol misuse). One who would have been eligible according to his casenotes discharged himself before we could interview him. We missed nine of these patients, but included five others who were not mentioned at all in the HIPE data, and overall saw 73% of eligible patients. Our reliance on these records to choose a reasonable period of study was misguided because some admissions were not recorded on the hospital computer and some were misclassified.

We were disappointed that the number of patients precluded statistical analysis, but even a small study such as this can show where improvements are needed. We hope that we may have stimulated more detailed assessment of detoxification services in this district, which may, in turn lead to change. The real value of audit lies in "closing the loop" – identifying deficiencies, making changes, and then showing that those changes make the service more effective.

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Code of Practice: Section 118 of the Mental Health Act 1983

DEAR SIRS

The Draft Code of Practice laid before Parliament on 5 December 1989 is a very welcome document, clarifying many issues and providing useful guidance. However, I consider that there are a number of deficiencies, particularly in relation to the use of the Mental Health Act in the General Hospital setting.

In Chapter 8, Doctors Holding Power (Section 5(2)), paragraph 8.4 states, "an informal in-patient, for the purpose of this section, is one who has understood and accepted the offer of a bed, who has freely

appeared on the ward and who has co-operated in the admission procedure. The section, for example, cannot be used for an out-patient attending a hospital's Accident and Emergency Department". This would also include patients admitted in an unconscious state following an over-dose and those attending out-patient clinics. However, the code provides no guidance to the management of patients considered to have a serious mental illness and adjudged to be at risk to themselves or others in such circumstances. I consider it would be beneficial to provide appropriate guidance in the use of common law, Section 136 and further procedures for professionals involved in such situations.

With regard to Nominated Deputies, Section 5(3), paragraph 8.14,C states, "Only Registered Medical Practitioners who are Consultant Psychiatrists should nominate deputies". This appears to preclude the use of Section 5(2) in the general hospital setting if the responsible medical officer is not immediately available and begs the question of how a patient admitted for physical illness, who has, for example, an acute psychotic episode and wishes to leave hospital is to be managed.

Many general hospitals do not have a psychiatric unit on site. By and large our colleagues there are unfamiliar with the workings of the Mental Health Act and how it relates to them. Although some are resistant, most wish to understand its principles and practice and use it appropriately. It is thus unfortunate that this Code of Practice contains many omissions and ambiguities and appears to neglect the issues which arise in this setting where it should be offering clear guidance. These need to be urgently addressed.

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Position Statement on Confidentiality

DEAR SIRS

It has been reported that "the majority of people in Britain support the introduction of a legal right to prevent their medical records being disclosed to others" (Mathews, 1990). If this is true the College Statement (*Psychiatric Bulletin*, February 1990, **14**, 97–109) will not be of comfort to this majority.

This Statement includes the recommendation that "patients should be made aware that appropriate sharing of information with other professionals is necessary in order to provide the best possible care, support and treatment". While it may be true that some sharing of information is desirable (*necessary* is surely too strong a term for much of adult general psychiatric practice) in certain circumstances, surely it is a separate and unacceptable further step to actively disseminate information or passively allow it to be taken without the patient's permission, except where there is a clear risk to safety or health. Perhaps the patient would opt for slightly less than the *best possible care* from a multidisciplinary team but with added confidentiality.

As the past secretary of the British Medical Association, Dr Havard, noted in a Green College Lecture (1989), "It would be difficult to name a democracy in the Western World that pays less respect to confidential medical information than the United Kingdom". The College's Statement while appearing to recognise the special nature of psychiatric notes (they are likely to contain more information and more sensitive information than general medical notes) does not follow with the then more obvious proposal that the notes should be treated in a more sensitive (confidential?) way, but rather the opposite as exemplified by the recommendation on shared information.

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Self-referrals to a psychiatric clinic

DEAR SIRS

We would like to clarify a number of points made in the letter by Grant *et al* (*Psychiatric Bulletin*, February 1990, **14**, 91–92) reporting on referrals to Ashmore House and commenting on our paper concerning the Mental Health Advice Centre (MHAC) in London (Boardman & Bouras, 1989).

First, there appears to be a misunderstanding concerning the sex ratio of GP and self-referrals. In the Lewisham data there was an excess of females in both GP and self-referrals. However, in comparison to the GP referrals there was a significant and *relative* excess of males in the self-referrals (43% v. 33.5%). This relative excess is also seen in Grant *et al's* data shown in their Table (39.2% v. 30.5%). Contrary to what Grant *et al* report in their letter, this difference is significant ($\chi^2 = 7.7559$, $P < 0.01$). Hutton (1985) reporting on the lower centre noted an *absolute* excess of males.

Second, Grant *et al* state that we suggested an excess of males in social classes I and II in our self-referral group. We did not. There was a significant excess of classes I/II in the self-referral group compared to the GP referral group, but this applied to

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