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.

DEREK F. O'SULLIVAN

Hollymoor Hospital
Northfield, Birmingham B31 5EX

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.

D. M. BOWKER

Birch Hill Hospital
Rochdale OL12 9QB

References

HAVARD, J. D. (1989) The responsibility of the doctor: Green College Lectures. *British Medical Journal*, **299**, 503–508.

MATHEWS, V. (1990) Backing for secrecy law on medical files. *Daily Telegraph*, 1 January.

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

males and females. The social class findings thus did not explain the sex differences.

It would thus appear that the experiences at Ashmore House and the MHAC are similar. This similarity is reinforced when the source of referrals are compared. In Lewisham, GPs refer the bulk of patients seen each year, with self-referrals forming the next largest group. In Lewisham the proportion of self-referrals rose over the past 2–3 years but has always formed 15–20% of all new referrals. In Ashmore the self-referrals began at a high level and have risen, being 20–26% of all referrals. The Ashmore self-referrals form a slightly high proportion but one of approximately the same order as that found in Lewisham.

It is gratifying to see that other Community Mental Health Centres are monitoring new services and that in Ashmore, at least, the experiences are similar. It is hoped that centres will report any monitoring findings especially in view of the potential dangers of repeating the USA experiences in the UK which has been indicated in a recent survey of new CMHCs in this country (Sayce, 1987).

JED BOARDMAN
NICK BOURAS

Medway Hospital
Gillingham ME7 5NY

References

BOARDMAN, A. P. & BOURAS, N. (1989) Self-referrals to a community psychiatric clinic. *Psychiatric Bulletin*, **13**, 490–492.

HUTTON, F. (1985) Self-referrals to a community mental health centre: a three year study. *British Journal of Psychiatry*, **147**, 540–544.

SAYCE, L. (1987) Revolution under review. *Health Service Journal*, **97**, 1378–1379.

Funding and planning of child psychiatric services in the NW Thames Region

DEAR SIRS

Questionnaires were circulated to all consultant child and adolescent psychiatrists in the North West Thames Region in mid-1988. So as to increase the response the same questionnaire was again circulated in early 1989. Out of 46, 29 responded.

The following questions were asked:

(1) *In what unit of management is the child psychiatric service?*

Since respondents might work in more than one district allowance was made for this.

The choices were: psychiatry; acute; community; other.

Virtually all our respondents were able to identify their unit(s) of management. Of the 29 who responded, all but two reported that they were managed in either a psychiatric, community or acute unit. Of the remaining 27, 24 worked in one district only, and three worked in two districts. None worked in more than two districts. Of the 27 who worked in the first district 20 were managed in one of the above units, while the remaining seven were in split units of various combinations. Of the three who worked in a second district, two were fully managed in a psychiatric unit, and one in a community unit.

Since these questionnaires were circulated, it is likely that some units of management will already have changed again.

(2) *In the district(s) in which you work is it possible to identify the percentage of the total health service budget, and/or the percentage of the psychiatric budget, spent on child psychiatry?*

Only eight felt able to say that they could identify any budgetary details. Six of the eight positive respondents gave further information. They reported the following percentages of the child psychiatric budget to the total psychiatric budget: 0.9%, 1.0%*, 1.5%, 2.7%, 7.0%, 7.7%, which are extremely low and indicate that child psychiatry as a specialty is seriously underfunded. It is surprising to find that although all the percentages of the total budget spent on child psychiatry were well below 10%, there was an eightfold difference between the highest and the lowest cases.

(3) *If not, have you attempted to achieve this? (i.e. budgetary figure)*

Of those who were unable to identify a budget answers were almost equally divided between 'yes' and 'no'.

Comments make it clear how difficult it is to get these figures. However, since this is a vital piece of information, it is in the interests of all child psychiatrists to make determined attempts to extract budgetary information from administrators.

Only three of our respondents were budget holders. Holding the budget gives some control over the service, and it is suggested that all child psychiatrists need to consider carefully and urgently whether they should not now be seeking to take responsibility for such control.

MICHAEL BLACK

3a Gayton Road
Hampstead, London NW3 1TX

*Partial costing only. Percentage figure includes contribution from psychiatric unit, but not that of community unit which was not available.

Services for pregnant drug users

DEAR SIRS

London *et al* (*Psychiatric Bulletin*, January 1990, **14**, 13–15) report results of urine drug tests on pregnant