make plans for her future and a hostel placement was being considered with the patient and her parents.

An appeal held by the managers' lay representatives was held after she had been in hospital for approximately two months. She presented herself well to the panel. Although written and oral evidence of the patient's mental state and progress was provided by six different members of the multidisciplinary team, the panel did not enquire whether she still believed her father had her face (she did). The panel failed to make a decision at their first meeting but, one week later, we were informed indirectly that the patient had been discharged home. I received a brief written statement to this effect one week later.

I was also told, again indirectly, that the panel had obtained an assurance from the patient that she would see her social worker weekly, take medication and attend the Day Hospital. On the basis of her agreement to these conditions they terminated her Section and she returned home. Her parents had not received any information from the review panel regarding her discharge and were naturally very concerned. On leaving the in-patient unit she refused depots and was soon reducing her oral medication. Her attendance at the Day Hospital had been unplanned as full consultation with the staff had not been possible before she started, and she soon sought to reduce the number of days she should attend.

The Code of Practice is vague about the managers' role in reviewing sections. The MHO Commissioners consider that the managers' responsibility should be to ensure that the legal documentation and procedures have been correct and that consideration of the patient's discharge should remain with the full Mental Health Review Tribunal which includes expert clinical opinion.

In this case the clinical team and the patient's family were given very little information about the patient's early discharge from Section. Not only was communication poor, which interferes with the long-term management of a severely mentally ill young woman, but the lay panel also took upon itself matters regarding the clinical management of the patient. This is a serious infringement into areas where they do not have expertise to the detriment of patient care. As well as the right to be freed from Section, consideration must also be taken of the rights of severely ill, insightless individuals to assured and optimal treatment. Only a property constituted Mental Health Review Tribunal has the expertise to evaluate such matters.

This case is illustrative for two reasons: first, this is yet another example of the increasing intrusion of NHS managers into areas of clinical responsibility. Second, the case highlights the deficiencies of the MHA Code of Practice failing to clarify managers' role with regard to reviewing Sections. It is our view that these matters should be debated further within our profession.

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Hidden differences between psychiatric treatment in the USA with respect to UK

DEAR SIRS

The major differences in treatment strategies between the United States and the United Kingdom are a direct function of rising health care costs, increasing demands by persons requesting care and the changes in attitude by insurance companies which finance the treatment offered.

Health care costs in the USA have risen at a rate greater than inflation and consequently have forced the delivery of psychiatric care to be governed more by cost containing strategies than clinical judgement. National health expenditure rose from 7.4% to 11.1% GNP between the years 1970 and 1987. Taking into account the size of the US GNP, this is a vast amount of money.

These trends have led to a shift from a separate public and private system of hospital care to a quasi joint public-private system which relies mainly on the financial support of the insured or private patient for its funding. The chronically ill (who are costly to treat) and the un-insured (who have no means of paying) are unwanted or unwelcome in this system.

The level of privatisation within the health system is significantly greater than in the UK, with more than 50% of hospital beds owned by investor operated systems which are, or strive to be, profit-making. The proportion of diagnostic categories treated depends on, or is determined by, ease and speed of treatment with a view to rapid reimbursement. Hence there is a tendency to treat fewer schizophrenic and more depressive patients than would be the case in the public system.

Within the US system the trend is towards treatment of patients in scatter beds throughout a general hospital. This has been found to be 3–20 times less expensive than treatment in an organised psychiatric unit but the benefit of the ward milieu is sadly lost.

Managed care (quality care at low cost) and utilisation review (whereby reimbursement may be denied for services deemed unnecessary) regulate the behaviour of doctors and other health care providers resulting in little initiative in treatment procedures and a lack of enthusiasm for experimenting with new but unproven methods of care.

There is a high mobility rate in the US population; between 1987–1988 over 17% of the population moved house and more than 6% moved to a different state. Taking into account that they do not have the equivalent of a general practitioner as found in the UK, follow-up of patients becomes very difficult. This results in duplication of work, delays in treatment while trying to collect relevant data, and difficulties monitoring type and extent of care offered to all patients.

Self referral is the norm in the USA, allowing patients much more input into what type of specialist they see, how long they attend and when they decide to re-refer themselves to someone else. Obviously difficulties in transference may not be addressed but avoided, and may hinder treatment regimes. The decision to attend two therapists of diametrically opposing views, either in succession or concurrently, may lead to obvious difficulties in treatment, for patient and therapists.

Patient autonomy is also more in evidence in the US setting. Anorexic patients, for example, may not consent to bed rest or increasing calorie consumption and so treatment plans will have to accommodate this. Insurance companies also influence the hospital treatment a professional may wish to prescribe by determining length of stay and types of treatment which will be reimbursed.

This covert but powerful influence accounts for many of the differences in attitudes to medical care that exist between the US and UK systems. In the final analysis, cost containment must be balanced with ultimate care to all patients to ensure adequacy of service provided.

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References are available on request to Dr McNicholas.

Smoking among psychiatric in-patients

DEAR SIRS

I read with interest the article 'Smoking Among Psychiatric In-patients' by Claudia Corby and Jennifer Barraclough (*Psychiatric Bulletin*, June 1992, **16,** 235–236). They did not report the frequency of smoking among those patients detained under a section of the Mental Health Act 1983. As hospitals move towards non-smoking or restricted smoking policies the rights of this particularly vulnerable group of psychiatric patients should be considered. No-one has suggested that non-psychiatric patients should compulsorily be made to give up smoking (Lavin, 1990) and the same should be true for psychiatric patients. In contrast with physical illnesses, the restriction of smoking is not likely to facilitate recovery, indeed for heavy smokers it might even constitute an additional emotional stress.

When non-smoking policies are drawn up for psychiatric hospitals, it should be taken into account that detained patients cannot exercise their right to leave the premises. For example, in one hospital at which I worked, the sale of cigarettes in the hospital shop was stopped but arrangements were made for staff to purchase cigarettes for those patients detained under the Mental Health Act who requested them.

There is no doubt that smoking is injurious to health. Where patients express a wish to reduce their smoking they should be encouraged and supported. Non-smoking areas on wards certainly should be made as attractive as possible. It should not be forgotten that detained patients are the illest group and that their needs should be given special consideration.

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Reference

LAVIN, M. (1990) Let the patients smoke: a defence of a patient privilege. *Journal of Medical Ethics,* **16,** 136–140.

Patients too intoxicated for assessment

DEAR SIRS

We read with concern a letter from Huw Thomas (*Psychiatric Bulletin*, June 1992, **16,** 368) regarding patients who are too intoxicated for assessment and his extraordinary proposed solution to breathalyse patients on arrival, presumably to exclude them from being assessed. We believe that even the drinkers have the right of assessment and that psychiatrists have the duty to do so. Many of these patients have other psychiatric and medical problems unrelated to drinking.

A probable reason for the low rate of subsequent uptake in some areas may be the hostile approach of those who assess intoxicated patients. An empathetic approach which respects the dignity of the patient is the obligation of medical practitioners and may lead to a better outcome. Dr Thomas is asking for long-term solutions for this problem. If the treatment approach is community based, with involvement and support of families and availability of home detoxification, more problem drinkers could be helped and, if part of community domiciliary orientated intervention, may lead to reduction of numbers of people coming to the wards for help while intoxicated.

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