psychiatrists in the Soviet Union who submitted to political pressure against the ethical standards of their profession. Now, colleagues throughout this country seem prepared to acquiesce in a similar way with the unchallenged requirements of government. Now is the time for a censure motion to be brought against British psychiatrists, as it was against those of the Soviet Union a decade ago, or at least there should be a cry of 'Shame!'

DAVID GILL, *Mapperly Hospital, Nottingham, NH3 6AA*

Support registers instead of supervision registers

Sir: I am writing to express concern about the use of the title supervision register and sociolinguistic aspects of informing a recently traumatised person recovering from his illness that his name is going to be placed on a supervision register.

The implications of the word 'supervision' may seem condescending and patronising to some patients with psychiatric disorders, especially when they are going to be on an official register and a computerised databank for that purpose. The idea of 'being on a computer' and 'being supervised' may lead to provision of new material for delusional elaborations in some psychiatric patients. The latter will hardly be likely to come forward and confide their homicidal thoughts and place their trust in their doctor or key worker (Adams, 1994). This also may further reduce the acceptibility of psychiatric services to these patients (Caldicott, 1994).

I suggest that the title of supervision register be changed to support register as the use of the latter seems less likely to have an adverse effect on therapeutic relationships. Using the designation support register would also make easier the task of psychiatrists who must formally let their patients know about the decision of placing their names on such a list.

It is also true that the aims of the register are not to facilitate pure policing of psychiatric patients, but to promote such support as to make recurrence less likely, and to render regular monitoring by a key worker more acceptable to these patients. In this perspective, calling the lists support register would give a better message about the other side of the coin, i.e. what patients may perceive as true care.

ADAMS, R.D. (1994) The dangers of the supervision register *Psychiatric Bulletin*, **18**, 429.

CALDICOTT, F. (1994) Supervision registers: The College's response *Psychiatric Bulletin*, **18**, 385–388.

R. HAGHIGHAT, *University College and Middlesex Medical School, London W1N 8AA*

Towards three tiers?

Sir: A cornerstone of the NHS reforms is the establishment of GP fund-holding practices which are able to purchase services for their patients. However, concern exists about fund-holders' willingness to purchase services for the chronic mentally ill who require labour intensive and expensive interventions (Soni *et al*, 1993). Since more and more GPs will become fund-holding, either alone or in consortia, it is important to look at their involvement in acute psychiatric admissions. I have recently completed a study looking at this.

One hundred consecutive admissions to West London Healthcare Trust from 1 March 1994 of patients between 16 and 65 were considered prospectively. This trust serves the London Borough of Ealing and has 80 beds for acute adult care only. When the patient had a GP, the GP was contacted by letter. When GPs denied the patients were on their lists, or the patients were unsure of their GP, the patients' names were checked with the local health agency to determine if they were unregistered.

Of the 100 patients in the study, eight had no GP. Ninety-two patients had GPs who were sent the questionnaire, 69 (75%) of these replied. Of the 69 patients with a GP, 41 (59%) of the GPs knew the patient was unwell and were involved in his or her referral, 18 (26%) knew the patient was unwell, but were not involved in his or her referral and ten (14%) were not aware of the patient's current mental health problems.

That only 8% of admissions did not have a GP was surprisingly low. The majority of patients were referred by GPs; yet a substantial minority (41%) had been admitted through alternative routes – usually self-referral, referral from family, friends, or social services. With GP fund-holding one could assume that the former admissions would be secure, while the latter admissions, where sanctioning was not clearly from the GP, may not be secure. It is important that safeguards are available to patients without GPs, and those admitted to hospital without direct GP involvement, are not penalised under the health reforms.

SONI, S.D., MAHMOOD, R.F. & SHAH, A. (1993) The future of services for the chronically mentally ill: a priority case? *Psychiatric Bulletin*, **17**, 582–585.

ANDREW J. SMITH, *South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London SW10 9NG*

Transfers from special hospitals: trial leave

Sir: There appears to be discrimination in how restricted and non-restricted patients are treated

by the Special Hospitals' Services Authority in relation to trial leave to another hospital. It is usual practice that patients from special hospitals are sent to another hospital on six months trial leave prior to their formal transfer but when it comes to authorising a formal transfer different sets of rules seem to apply. Our observations are based on a number of patients transferred to a medium secure unit.

With regard to restricted patients, the Secretary of State does not appear satisfied with a good progress report over six months' duration and takes an overcautious view advising the Special Hospital Authority to extend the trial leave period, even when the consultants from the special hospital and the receiving hospital have agreed and supported the transfer of the patient. Such uncertainty over formal transfer and extension of trial leave can have detrimental effects on patients' progress.

Regarding trial leaves of unrestricted patients, the Special Hospitals' Services Authority refuses to grant an extension to trial leave, even when there are good grounds and both consultants support such an extension. Such a policy forces the receiving hospital to decide whether to accept a formal transfer after six months or to return the patient to the special hospital. Both of these options, if taken hastily, may not be in the best interest of the patient and can lead to inappropriate placements.

We were faced with a similar dilemma at the end of a trial leave period in respect of two patients transferred from a special hospital. Miss A, detained under section 37 and 41 of the Mental Health Act, behaved well and progressed satisfactorily and could not understand why she was not formally transferred while Mr B, detained under section 37, was transferred formally after six months despite displaying aggressive and violent behaviour.

We should be glad to hear the experiences of other psychiatrists and the views of colleagues in special hospitals and the Special Hospitals' Services Authority.

*ANIL KUMAR, *Medium Secure Unit, Calderstones NHS Trust, Whalley, Clitheroe BB7 9PE* and MEENA AGARWAL, *46 Larkhill Cottages, Old Langho, Blackburn, BB6 8AR*
*Correspondence

Conceptualisation of depression

Sir: Jadhav & Littlewood refer to the study by Weiss *et al*, (1992) as evidence that "inculcating professional medical models do not necessarily bring about reduced stigmatisation or improved compliance" (*Psychiatric Bulletin*, September 1994, **18**, 572–574). I beg to differ. Patients in that study showed an increased medication adherence rate (79% for study patients as opposed to 46% for non-study patients, $P<0.0001$, Fisher's exact test) after being given a 'medical model' of leprosy during the initial interview. That paper did not report any findings on stigma at follow-up.

However, Jadhav & Littlewood raise important questions which remain unanswered. Is a 'biomedical model' the only way to conceptualise depression? The Defeat Depression campaign, in title and content (Paykel & Priest, 1992), carries an implicit message that depression is a 'disease' one 'catches' and which can be 'understood' and 'treated' with no reference to the socio-cultural context. It emphasises the primacy of the biomedical model when there is no evidence that a belief in or practice of such a model is associated with better outcome or greater patient acceptance.

PAYKEL, E.S. & PRIEST, R.G. (1992) Recognition and management of depression in general practice: consensus statement. *British Medical Journal*, **305**, 1198–1202.

WEISS, M., DOONGAJI, D. *et al*, (1992) The explanatory model interview catalogue (EMIC): a contribution to cross-cultural research methods from a study of leprosy and mental health. *British Journal of Psychiatry*, **160**, 819–830.

SOUMITRA PATHARE, *Academic Unit of Psychiatry, St Thomas' Hospital, London SE1*

Sexist language

Sir: I agree with Dr Y. K. Mirza (*Psychiatric Bulletin*, September 1994, **18**, 584) that the use of the word "Sir" in the correspondence section may be construed as sexist. As Dr Mirza invites us to suggest a single non-sexist word, I would propose the word "Editor" be used instead.

TALAL AL RUBAIE, *Psychotherapist in private practice, 41 Denison Close, East Finchley, London N2 0JU*

Sir: Dr Mirza is rather lacking in imagination if he cannot think of an alternative to 'Sir' for prefacing a letter to the Editor of the *Bulletin*. (*Psychiatric Bulletin*, September 1994, **18**, 584). What about 'Dear Dr Kerr' as I have started this missive (if it appears in the pages of the *Bulletin* prefaced 'Sir', that is not how it left my desk) or Dear Editor, or even Dear Colleague? It is possible to start a letter with a salutation of more than one word.

I found the thinly veiled and unsympathetic sarcasm of both Dr Mirza's and Dr Steinberg's letters quite offensive. This kind of attitude to the issue of sexism is a much greater problem than the consecutive occurrence of the letters M.A.N. in a word.

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