psychiatrist than Professor Anthony Clare who has agreed to take on the job of Public Education Director following this year's annual general meeting. Let us hope that this public identification with the College will do something to mitigate the stigma of being a psychiatrist which Dr McKenzie and I both deplore.

BRICE PITT, *Chairman, Public Education Committee, Royal College of Psychiatrists*

Patients not clients – a community survey among elderly patients

Sir: May I congratulate Drs Upton, Boer and Neale on their survey on how psychiatric inpatients wished to be called (*Psychiatric Bulletin*, March 1994, **18**, 142–143).

A complementary enquiry among elderly patients (over the age of 65) and their carers in the community shows a similar trend. Out of 16 patients attending the day hospital one wanted to be called a client, one wished to be addressed by her surname, and the rest wished to be called patients. Among 20 patients visited at home by community psychiatric nurses, 18 wished to be called patients, one saw himself as a service user and one as a client. When carers attending the Alzheimer's Disease support group were approached, they wished their ill relative to be called a patient in 15 cases out of 18 and 3 out of 18 saw the sufferer as a person with a problem. None of the questioned patients or carers chose the term customer or consumer.

Clearly the commercial jargon in the NHS has not received much support among patients in the community.

EVA CYBULSKA, *Stone House Hospital, Thameslink NHS Trust, Cotton Lane, Dartford, Kent DA2 6AU*

Delegation of section 5(2) Mental Health Act 1983

Sir: Crichton & Townsend (*Psychiatric Bulletin*, March 1994, **18**, 176) draw attention to an important source of uncertainty for junior doctors, the delegation of powers under section 5(2) of the Mental Health Act 1983. As the authors point out, the Code of Practice (HMSO, 1993) suggests that only consultant psychiatrists should nominate deputies. In practice confusion arises when an inexperienced junior doctor in a non-psychiatric specialty is requested to act as deputy.

An additional source of uncertainty is the issue of who is the responsible consultant for the purpose of section 5(2) when a patient on a non-psychiatric ward is referred to and seen by the junior duty psychiatrist. Paragraph 8.6 of the Code of Practice seems to indicate that in such a situation, for the purposes of the Mental Health Act, the individual is a 'psychiatric patient' and the (duty) consultant psychiatrist is the responsible doctor.

HMSO (1993) *Code of Practice, Mental Health Act 1983*. London: HMSO.

RICHARD PRETTYMAN, *Queen's Medical Centre, Nottingham NG7 2UH*

Home Office Index of Addicts and Regional Databases

Sir: I read with interest the article by Ghodse, Jones & Thorley (*Psychiatric Bulletin*, March 1994, **18**, 169–170) on the value of the database which holds information on drug abusers (and which may become linked to European database). They did not mention its original, still appropriate, function, which was to identify addicts getting supplies from more than one legal source. Unfortunately ever since the Home Office Drugs Branch has kept the data on a computer, the computer has kept going down and when it recovers its health it has residual amnesia. Even when it is functioning at its best it often does not recognise patients whom I know to have a long drug history.

Another fault is that from the start there has been a reliance on the date of birth to spot double scripters – which is naïve and of course known by addicts. Right at the beginning, about 1966, I suggested that recording a simple cheese-bite would be useful. I am sure our dentist colleagues would be able to suggest a way of coding it.

DALE BECKETT, *18 Ockendon Road, Islington, London N1 3NP*

Sir: I acknowledge Dr Beckett's point about the function of the Home Office Index, and would like to emphasise that the Regional Substance Misuse Databases have a completely different role. Because they collect information on a voluntary basis from a wide range of agencies, both statutory and non-statutory, about any type of current drug problem, they are able to monitor trends in substance misuse much more comprehensively than the Index (which only deals with dependence on notifiable drugs) and can, therefore, make a valuable contribution to service planning.

The other important difference is the total anonymity of patient records on the Regional Substance Misuse Database. However, to prevent duplication of effort when one individual has to be 'notified' to both systems, the database managers have incorporated the necessary procedures into a single process, so that both