particular relating to 'Alcohol Misuse/Abuse' and 'Alcohol Dependency'.

Edwards *et al* (1973) found a prevalence of 3% for 'problem drinking'; while Mayou & Hawton (1986) found about 20% of general hospital in-patients to have 'alcohol problems'. More recently, Goddard (1991) has shown that 23% of men and 8% of women drink more than the recommended 'sensible' limits of 21/14 units per week respectively. Bearing these indications of a high prevalence in mind, it is interesting to consider the DVLA guideline concerning the definition of 'alcohol misuse/abuse':

> "a state which because of consumption of alcohol, causes disturbance of behaviour, related disease of other consequences, *likely* to cause the patient, his family or society harm now or *in the future* and which may or may not be associated with dependency. In addition assessment of the alcohol consumption with respect to current national advised guidelines is necessary" (emphasis added).

Thus, a male drinking more than 21 units or a female drinking more than 14 units in a week showing a "disturbance of behaviour" (such as intoxication?) which may cause "harm . . . in the future" is in the firing line. The subjective assessment of 'likelihood' determines whether the doctor should advise the patient to inform the DVLA that he or she has an alcohol problem, which will entail revocation or refusal of a licence for "at least one year".

'Alcohol misuse' is effectively defined by the DVLA as 'excessive use'. This guideline is too debatable. It might be fatal if, as a consequence, it were ignored.

DRIVER & VEHICLE LICENSING AGENCY (1993) *At a Glance Guide to the Current Medical Standards of Fitness to Drive*. Swansea: DVLA.

EDWARDS, G., HAWKER, A., HENSMAN, C., *et al* (1973) Alcoholics known or unknown to agencies: epidemiological studies in a London suburb. *British Journal of Psychiatry*, **123**, 169–183.

GODDARD, E. (1991) *Drinking in England and Wales in the Late 1980s*. London: HMSO.

MAYOU, R. & HAWTON, K. (1986) Psychiatric disorder in the general hospital. *British Journal of Psychiatry*, **149**, 172–190.

J.C. HUGHES and C.C.H. COOK, *Alcohol Treatment Unit, Princess Alexander's Hospital, RAF Wroughton, Swindon, Wiltshire SN4 0QJ*

Sir: I read with interest the article on mental disorder and driving, (Laurie & Milne, *Psychiatric Bulletin*, April 1994, **18**, 214–216). It addressed the important issue of medical standards of fitness to drive with regard to the Driver and Vehicle Licensing Centre. In my experience, patients have been less concerned about this particular area than the potential effect on their insurance cover if they were to have an accident and it was discovered that they were using psychotropic medication.

I am unaware of any test cases but would be interested to hear from colleagues on their views and also their experiences with insurance companies and patients on medication.

CHRISTINE M. TYRIE, *Garlands Hospital, Carlisle, Cumbria CA1 3SX*

Refusal of visas

Sir: It was interesting to read the article 'Do patients who have been on "sections" get refused visas', by Allen & Allen (*Psychiatric Bulletin*, April 1994, **18**, 216–217).

I worked as a psychiatric registrar in the West Indies and there was a firm belief that the US Embassy tends to refuse visas to patients who have had formal admissions to psychiatric hospitals. It would be interesting to go through the visa application forms completed by these individuals and compare the data with the outcome of how many of them succeed in getting a visa. There may be ethical or policy objections to this kind of survey.

Many countries say that they would not refuse a visa unless there is a written policy stating otherwise, such as Nepal. But even if the real reason to refuse a visa is formal admission to a psychiatric hospital, it may not be officially given as the reason.

CHANDRUDU DUGGIRALA, *Leicester Frith Hospital, Groby Road, Leicester LE3 9QF*

Improving psychiatry's image

Sir: Although the Public Education Committee has been toiling away for the past several years to improve the image of psychiatry by producing the Help is at Hand leaflets, mounting frequent media briefings, producing the careers pack, training members of the College in media activity, promoting the Morris Markowe prize and the Boots prize for the best video on a career in psychiatry, organising a network of regional and public education offices and fielding hundreds of questions every year from the media, with the help of our teams of experts, to say nothing of launching the Defeat Depression Campaign, we are well aware that the image of the psychiatrist is sometimes tarnished, or blurred; it is therefore enormously helpful to have Dr Kwame McKenzie's suggestion that we need an image consultant (*Psychiatric Bulletin*, April 1994, **18**, 231–232). Gosh, if only we had though of that before.

However, there may be light at the end of the tunnel. Nobody presents a better image of the

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

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