determined by several interacting variables. If the MORI poll is to be repeated on the same population (to test the efficacy of the campaign), it would become evident that such 'impressions' are far from robust. We assume the campaign would then conclude that any shift in 'impression' was due to its health education programme.

Our intention was not pejorative as Priest suggests: the campaign *is* glossy, linking antidepressants with happiness, gala dances, and 'fun' runs, video packs, leaflets and press releases, not to mention the unfortunate similarity between its logo and that of a currently marketed antidepressant.

Professor Priest decries our critiques as 'syllogisms'. We are unable to detect any such Aristotelianism in our letter, but one could rephrase his response as:

(a) the campaign is based on a dubious experimental method
(b) the campaign is justified on other grounds.

Therefore: criticisms of the method are irrelevant.

ROLAND LITTLEWOOD and SUSHRUT JADHAV, *University College London Medical School, Riding House Street, London W1N 8AA*

Sir: I am sorry that Littlewood & Jadhav cannot see the wood for the trees. I am very pleased to say that their negative view is not shared by many others.

The scientific basis of the Defeat Depression Campaign was published in the *British Medical Journal* (Paykel & Priest, *British Medical Journal*, 1992, **305**, 1198–1202). Littlewood & Jadhav were confused about the need for our campaign. To most doctors the *fact* that people affected by depression suffer in silence without going to their GPs, that GPs fail to recognise a substantial proportion when they do attend, and that depressed patients do not get the best treatment when they are recognised is motivation enough.

The campaign is going well. The initiative to improve the recognition and treatment of depression in primary care is now at full steam. Over the last 12 months we have started our project to get the public more prepared to seek treatment for depression (whether by psychological or pharmacological means) and we have had a gratifying response from the media. The general reaction has been very sympathetic. Our educational materials have been funded from a variety of sources, including public donations, the results of appeals and grants from charities. A more detailed report will appear in the *Psychiatric Bulletin* within the next few months.

R. G. PRIEST, *Chairman, Defeat Depression Campaign Management Committee*

Psychiatry in Argentina

Sir: Professor McClelland's article 'A visit to Argentina' (*Psychiatric Bulletin*, 1994, **18**, 569–571) describes with accuracy many problems psychiatry faces in that country. Most of his description is focused on Buenos Aires. Other provinces do not necessarily share identical problems, such as Mendoza, the fourth largest city of Argentina, where I began my training. The scheme I joined had a strong influence from the department of psychiatry at the local university which had firm roots in existentialist philosophies and a discouraging attitude towards pyschoanalysis. The recommendations made in the article were to a great extent met in that scheme in Mendoza, but not necessarily so in other parts of the country, as Argentina is a Federal Republic.

As pointed out, many Argentinian psychiatrists, particularly those occupying posts of power such as hospital directors, overidentified with various political regimes. This overidentification stood firm even when the political regimes changed from totalitarian to more democratic ones; most of those people continued in charge of those same posts, greatly impeding change.

Those who voiced the needs of psychiatric patients and denounced corrupted practice were labelled subversive or reactionary, and the lesser punishment was loss of their jobs. This also happened in other areas of the medical profession. It is unfortunate that echoes of some of my experience in Argentina are happening in this country; the *Daily Telegraph* (September 1994) published an article referring to a consultant physician who was facing dismissal because he made unfavourable comments on the reforms about the NHS.

I left Argentina almost ten years ago; I still exchange correspondence with friends who trained with me. Regrettably, their recent comments reflect a similar picture to the one I remember.

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I sincerely hope that Professor McClelland's influential visit will mark the beginning of a better era in Argentinian psychiatry.

DAVID MARCHEVSKY, *St Bernard's Wing, Ealing Hospital, Southall UB1 3EU*

Rights of appeal

Sir: We wish to take issue with Dr Stern's response (*Psychiatric Bulletin*, 1994, **18**, 578) to Blumenthal & Wessely (*Psychiatric Bulletin*, 1994, **18**, 274–276). Appealing against section may be therapeutic or counter-therapeutic, but is not intended to be part of patient care.

Rights of appeal are properly seen in the context of a just society in which nobody, regardless of their state of health, can be arbitrarily detained. The administrative and judicial review of the grounds for detention is a small part of the cost of maintaining such a society.

The Law Centre (referred to by Dr Stern) does not ask detained patients whether they wish to appeal. The hospital is required by law to inform them of their rights to apply to the hospital managers and to Mental Health Review Tribunals. If a detained person approaches us we will assist in applying for discharge. The application is inevitably adversarial as the legal representative is there to press the applicant's case.

The days of blanket compulsory institutional treatment have passed, and to caricature psychiatrists as people who recklessly lock away the vulnerable is counterproductive. Responsible medical officers (RMOs) emphasise that they are now community based and are under pressure to discharge from in-patient care, against their clinical judgement, because of the reduced availability of beds. But after admission most patients are on a recovery curve.

There is a period when the criteria for compulsory admission are no longer satisfied, but the grounds for mandatory discharge are not yet satisfied. An application at this stage requires a difficult balance to be struck between the medical ethos of 'the right to treatment', and the libertarian ethos of 'the right to self determination'. It would be unfair to the patient, and to the RMO to leave the balancing to be done by the RMO alone.

Appeals at Springfield Hospital suggest that the review body considers the RMO strikes the correct balance in the majority of cases, but there is a significant minority (around 25% at Springfield Hospital) when the review body concludes that the balance favours discharge. This is a measure of how worthwhile they are.

ROBERT DENTON, STEPHEN ROBERTS, LORAINE GONZALES and CATHERINE CASSERLEY for *Springfield Advice and Law Centre, 61 Glenburnie Road, London SW17 7DJ*

Sir: Thank you for giving me the opportunity of replying to the letter by Robert Denton *et al.*, from the Springfield Advice and Law Centre. It should be remembered that my initial letter was a response to an article in the *Psychiatric Bulletin* pointing out the enormous cost of running the appeals. Of course I am aware that these appeals are not directly meant to be part of patient care but my point was that because they are so expensive, they detract monies which could be better spent in patient care.

I was not meaning in any way to demean the excellent work of the Law Centre at Springfield Hospital. In fact, I am very impressed by the way they often deal with obviously difficult and psychotic patients at the actual hearings. My point rather, was that there are too many of these hearings and they can be harmful to patient care. I have had to deal with many cases in which schizophrenic illnesses relapsed in my view, as a direct response to the stress of the appeal. In two cases recently when patients were discharged on appeal against my medical advice, fairly disastrous results followed. In one case, the patient had said he would continue his treatment to the tribunal but in fact as soon as he was discharged by the tribunal, left hospital, got on a railway train and went to another part of the country where he was involved in violence and had to be restrained by the police and brought back to us. In another case, a patient's carefully planned rehabilitation programme was interrupted when she was discharged by a Managers' Hearing. This resulted in a serious relapse of a very precarious patient. I would be very interested to hear from other psychiatrists who have had this experience of 'toxic tribunals' by which I mean, an appeal at a tribunal which has precipitated a relapse of a psychotic illness.

R. S. STERN, *Morden Community Mental Health Team, Springfield Hospital, 61 Glenburnie Road, London SW17 7DJ*

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