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!'

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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.

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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.

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Transfers from special hospitals: trial leave

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

https://doi.org/10.1192/pb.18.12.774 Published online by Cambridge University Press