the domiciliary clinic was a failed patient contact when attending the home.

Of course, the elderly and general adult populations are not necessarily comparable. One of us (DL) subsequently piloted a similar domiciliary clinic for the 16–64 years age group specifically because the non-attendance rate for new referrals to the hospital clinic over the previous six months was 53%. For the following six months, new out-patient referrals who would have been seen in the hospital clinic were visited at home. The non-attendance rate fell to 15%.

It appears that visiting patients at home is another effective method of reducing non-attendance and has the advantage that the psychiatrist can directly observe the patient's home circumstances. From an efficiency point of view the limiting factor is time spent travelling to patients' homes and efficiency savings may not be realised where distances are large. The services described are inner city and adjacent districts of Liverpool that may be similar to the Sheffield service described by Rusius, who notes that the average distance between patients' home and hospital was only 3.7 miles. The average distance travelled in the elderly domiciliary clinic was 12.6 miles per clinic seeing an average 2.7 patients per clinic.

Experience indicates that patients like the domiciliary arrangements. Jones *et al* (1987) found that 72% of new general adult psychiatric referrals stated a preference for home visiting and only 12% for out-patients or general practice clinic. Eighty per cent felt assessors had gained a better idea of their difficulties because they were seen at home.

JONES, S. J., TURNER, R. J. & GRANT J. E. (1987) Assessing patients in their own homes. *Psychiatric Bulletin*, **11**, 117–119.

DAVID N. ANDERSON and DAVID LI
EMI Directorate, Sir Douglas Crawford Unit, Mossley Hill Hospital, Park Avenue, Liverpool L18 8BU

Progress in defeating depression

Sir: I note that one of the tasks of the Defeat Depression campaign as described by Priest *et al* (*Psychiatric Bulletin*, August 1995, **19**, 491–495) is public education, and that 90% of their sample "thought that depressed patients should be offered counselling." It is not clear from the discussion that follows whether they regard this as evidence of ignorance or as a valid request for services for depressed people.

SEBASTIAN KRAEMER
Child and Family Psychiatric Service, The Whittington Hospital, F Block, Highgate Hill, London N19 5NF

Sir: The answer to Dr Kraemer's question is found in the consensus statement on which the Campaign is based (Paykel & Priest, 1992). Psychological (non-drug) treatments have an important place in the armamentarium of treatments that we propose for depression. Cognitive therapy in particular deserves attention.

We did not regard the attitude revealed in this answer as worrying. What did concern us, however, was that the majority of respondents regarded antidepressants as addicting. I am pleased to say that there has been a significant improvement in this answer in a more recent survey. Nevertheless, it is probably still the case that, where the patient and the doctor agree that a course of antidepressants is called for, the doctor should make it very clear to the patient that addiction is not a problem with antidepressants. Non-compliance is a serious hazard when medication is prescribed for depression, and many patients probably give up their antidepressant prematurely because they are afraid of becoming dependent on it.

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

R. G. PRIEST
Chairman, Defeat Depression Campaign

Sexism or pragmatism?

Sir: We read with interest the article by Hall and Deahl on the inadequacies of history taking by trainee psychiatrists in casualty (*Psychiatric Bulletin*, September 1995, **19**, 538–540). While we agree that efforts are merited to increase alcohol and substance abuse histories in all groups, we disagree that this discrepancy is likely to represent ageist or sexist attitudes. The OPCS survey (Goddard, 1991) of drinking habits in the late 1980s (quoted in part in Hall & Deahl's article), found that 23% of men and 8% of women exceeded sensible drinking levels (21 units for men and 14 units for women). Excess drinking showed a decline with increasing age in both sexes. Based on these figures, if a full alcohol history had been taken in all cases at least a further 5.3% of men and 3.4% of women would have been identified as exceeding sensible drinking levels. The recording of disorders more likely

https://doi.org/10.1192/pb.20.4.248-b Published online by Cambridge University Press

to occur in a sub-population has a long history in medicine and we do not feel it should necessarily be dismissed as ageist or sexist.

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

MICHAEL VANSTRAELEN
Prudhoe Hospital, Prudhoe

RICHARD DUFFETT
Unit of Human Psychopharmacology, The Royal London Hospital (St Clements), London

Sir: We agree with Vanstraelen and Duffett that substance use occurs at different levels in different population subgroups. We also agree that it is clinically important to recognise such differences. However, in emergency clinic psychiatry we think that to let information about populations lead us into assumptions about individuals is clinically dangerous. One cannot exclude a diagnosis just because it is unlikely.

IAN HALL
St. George's Hospital Medical School, Division of Psychiatry of Disability, Jenner Wing, Cranmer Terrace, London SW17 0RE

"Peering into review"

Sir: Peer reviewed publication is the *sine qua non* of academe. Those of us wearied by incessant demands to justify our existence to funding quangos should welcome Dr Persaud's (*Psychiatric Bulletin*, September 1995, **19**, 529–531) informative article on the pitfalls of peer review and its adverse consequences. Having been at the receiving end of reviews which could be described euphemistically as impolite, I blame reviewer anonymity. Rejected authors play 'spot the reviewer': first, round up the usual suspects. Friends may have spied the paper on the suspect's desk; intimate knowledge of suspect's word processors is also useful, as is approaching them at meetings and observing their behaviour. Scrape at any 'tippex' on the report, sometimes they forget to leave their name off.

Either we should know who they are, or they should not know who we are. Open reviews may be less inclined to insults and destructiveness. If both sides were anonymous it could discourage bias on the grounds of who the author is, or who they are not.

Dr Persaud suggests the review should be an encouraging tutorial despite poor quality material. The focus of my comments as a reviewer is what is needed for publication (most researchers send their efforts to colleagues for informal advice prior to submission). It is infuriating to perform a significant re-write only to have the Editor reject the paper a second, final time: such practices cause interminable delay. I suggest that the convention of submitting to one journal at a time be abandoned. This would dispense with most of the waiting, generate a large variety of peer comments and even give the author a choice of journal.

Finally, I propose a radical solution to the peer review problem. Why not dispense with it and publish on the Internet? My husband, a network specialist, remarks that the current Internet "is the biggest waste of time ever invented by man". However, worldwide web pages and usenet groups have vast capacity. Research, reviews and teaching material could be accessed much more easily than hard copy. The Internet costs less than subscribing to journals, purchasers could invest in it alongside ordinary library facilities.

The funding quangos would have to assess academics more imaginatively: peer reviewed papers are a tiny part of what I, and I suspect many other academics, are here for. Best of all, there is no censorship on the Internet, which is what suppression of material by a disapproving handful of peers amounts to. We deserve to be allowed to make up our own minds on the merits of new research.

ANN MORTIMER
Charing Cross and Westminster Medical School

https://doi.org/10.1192/pb.20.4.248-b Published online by Cambridge University Press