Moscow (2.6-3.8), and Chandigarh (1.9-5.6 in different areas of India; no prevalence study had been carried out in the Chandigarh region). Honolulu was utilised as the American centre despite the fact that it is very atypical demographically and that previous first admission rates for schizophrenia show Hawaii to rank comparatively low among the states; by contrast New Haven, Baltimore, and St Louis were recently reported to have high prevalence rates of schizophrenia (Myers *et al*, 1984).

Aarhus was used as the Scandinavian centre; previous prevalence studies (2.7 per 1000) (Nielson, 1976) and incidence studies (Munk-Jorgensen, 1986) have shown rates for schizophrenia in Denmark to be comparatively low. By contrast, most studies in Norway, Sweden, and Finland have reported high rates, up to 17.0 per 1000 in the Book *et al* (1978) study of northern Sweden. The final centre used in the WHO study was the St Loman's case register in Dublin. In 1982 schizophrenia prevalence figures from this case register were only 1.7 per 1000 (Walsh, personal communication), less than one-third the 5.9 per 1000 rate for the County Roscommon case register in western Ireland and less than one-seventh the rate of 12.6 per 1000 reported by Torrey *et al* (1984) for a suspected high prevalence pocket in western Ireland.

In summary, the WHO incidence study of schizophrenia studied seven centres for which previous prevalence studies would lead one to expect no more than a two-to-three-fold difference in incidence. That is precisely what was found. Until a multi-centre incidence study is done utilising centres from suspected high incidence (e.g. northern Scandinavia, western Ireland) and low incidence (e.g. some tropical areas) countries it would seem unwise to regard the WHO incidence study as a reflection of worldwide incidence rates.

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Psychiatrists' views on Treatment of Depression

SIR: I note Armstrong & Andrew's paper on the treatment of depression by Australian psychiatrists (*Journal*, December 1986, **149**, 742–750). This is one of many papers supported by the Royal Australian & New Zealand College of Psychiatrists under a so-called Quality Assurance Project.

The implications of this work are actually quite astounding. The modal length of treatment for each of the case vignettes is over fifteen hours per patient. Simple arithmetic would suggest that every consultant psychiatrist would have reached total saturation point with the referral of one hundred patients per annum. Quality treatment for these one hundred fortunate people would totally absorb the Quality Assured Practitioner to the exclusion of all other professional activities. This work obviously has more to do with maximising psychiatrists' incomes than with making psychiatry more available to the masses.

In Australia, I would add, this Quality Assurance Project is being held up as a model of excellence to which the College hope all psychiatrists will ultimately aspire, or should I say, conform.

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'Afternoon Radiator-Sitting Syndrome': Hypothermia and Early Diagnosis of Self-Induced Water Intoxication

SIR: We report on a patient with schizophrenia and acute self-induced water intoxication (SIWI) who presented with symptoms of hypothermia. Further investigations revealed a clinical sign which may be useful in the early diagnosis of SIWI.

Case report: A 37-year-old man, who had been an in-patient for 17 years, presented at 1600 hours with complaints of feeling unwell accompanied by uncontrollable shivering, shaking, and chills. Oral temperature was 35.8°C. Over