Europe, held in Stockholm early in 1985, where the Italian legislation was acknowledged as a pilot scheme worth following. Moreover, the Italian reform is closely modelled on the concepts officially expressed by the World Health Organization (1978) with regard to psychiatric services and their organisation, the rights of patients, etc. When the Italian law was passed, a number of cities (Trieste, Perugia, Arezzo, Reggio Emilia, Portogruaro, etc.) had already been working for some years with a profoundly changed approach and new patterns of psychiatric help, with results that were proving rewarding (Perris & Kemali, 1985; Tranchina & Serra, 1983). Thus the law actually proved too backward for advanced centres (like those mentioned), yet too advanced for backward centres such as those in the South of Italy. The Italian experience "In general terms can be viewed as an ambulatory form of psychiatric care, but where the mental hospital no longer has any functional role to play" (Vanistendael, 1985). And the validity of this approach is confirmed by numerous studies demonstrating the effectiveness of alternative treatment replacing traditional psychiatric hospitalisation, as well as the difficulties standing in the way of extending the new kinds of treatment (Mosher, 1983). Such difficulties explain the disappointment attendant on the legislative illusion nursed by many in Italy: the hope, namely, that once the new law was approved, everything would change automatically and painlessly. Instead, it has been seen that the realisation of a reform is above all determined by subsequent action. The problems facing Italian psychiatry now are still those indicated accurately by Mosher (1982), in one of the first reports on the new law to appear abroad:

1) Non-compliance with the new legislation by many local authorities.

2) The training or retraining and numerical increase of staff, who should provide the essential "instrument" for creating a new style of work and new patterns of psychiatric care.

3) Development of community-based services, indispensable for meeting the various different needs of the population, previously dealt with artificially, either by constraint (i.e. committal to a psychiatric hospital) or else by neglect.

And these are problems that need to be dealt with urgently: the risk, otherwise, is that we may lag behind after being one of the first in getting started!

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DEAR SIR,

Since their two-week tour of Italy in April 1984, Professor Kathleen Jones and Alison Poletti have been zealous to protect us from Italian contamination. Their paper in the *Journal* (April 1985) only repeats the message they have already published in *New Society* (4th October 1984)—namely, we can learn nothing whatever from the Italian reforms except to be careful about closing mental hospitals. Can that really be true? Given their strong regional differences and their many and various efforts to produce new patterns of psychiatric practice, can the Italians have *absolutely nothing* to teach us? Should we sit back and just let them envy and copy us! Maybe Professor Jones and Alison Poletti, who write from York, could read the simultaneous but very different paper by Dr. Johl (*Bulletin*, April 1985) about the exposition on Italian Psychiatry held nearby in Sheffield last year. I wonder if Professor Jones attended?

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Race, Culture and Mental Disorder

DEAR SIR,

We are amazed that Philip Rack's book should have received such a contemptuous review (*Journal*, February 1985, **146**, 219) and we are grateful for space to correct that dismissive statement. The book has grown from the clinical and educational

experience of the Transcultural Psychiatric Unit which Dr. Rack first established more than a decade ago in the City of Bradford. This Yorkshire city has one of the highest proportions of immigrant peoples, of all ethnic backgrounds, of any area in Britain. In order to put the book in perspective we would first describe this unique service which has now achieved international recognition.

When he was appointed to a post of consultant psychiatrist in Bradford, Dr. Rack immediately set himself the task of understanding the background, traditions and experience of ethnic miniority groups and providing for them an improved psychiatric service based upon good education of all professional people who were to be concerned in their welfare. The essential first step was, and remains, clear communication and this involved the recruitment of interpreters who have personal knowledge of the culture of the patients whose distress they interpret. After some years the work was further strengthened when Dr. John Bavington returned from Pakistan where he had established a psychiatric community service in a region where no such service had existed. His lifelong familiarity with Pakistani people and his fluency in Urdu and Pushtu further strengthened the work of the Unit.

The Transcultural Unit recognises that the presentation and symptomatology of mental illness and other expressions of stress are bound up with the culture of the patient and cannot be understood or correctly treated without knowledge of this. The Unit also teaches that the treatment of mental distress is not a matter for the narrow expertise of psychiatrists alone, and an important function is the continuing educational activity for all who are concerned with the welfare of ethnic minority peoples, and the understanding which precedes treatment of those who become ill.

This then is the backdrop to the book which is not a textbook of psychiatry; nor is it a political statement about the relationship of immigrants to the host community or to the National Health Service. It is in fact a splendid account of all that Dr. Rack and his colleagues have learned and, from this experience, now have to offer to others. The book may be read with advantage by people, from whatever professional background, who wish to increase their understanding, and Dr. Rack has provided excellent references for further reading. The pages of learning are enlightened with brilliant insights into the experiences of people in minority groups. Later chapters deal with the broad issues of working across cultures and consider the complexity of offering a service, and especially a psychiatric service, to people whose health beliefs are not those of the host community.

In the light of our knowledge of all that the Transcultural Psychiatric Unit has achieved and Philip Rack's unflagging effort in this achievement, it comes as a shock and a grave injustice to read that the book and the efforts and ideas which inspired it are an example of "inverse racism". Let those who have themselves made such efforts to improve understanding, welfare and health among ethnic minority groups be the ones entitled to cast such stones. In a foreword, Professor Morris Carstairs points out that the book can be read by all who wish to be constructively engaged in the promotion of good community relationships. We support this view and would add that the book is essential reading for all who are to be educated in the field of psychiatric work in multicultural Britain.

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Dexamethasone Suppression Test Normalisation and Treatment Outcome in Elderly Depressives

DEAR SIR,

The Dexamethasone Suppression Test (DST), although not necessarily diagnostically specific for depression (Coppen *et al*, 1983), may have clinical utility as a measure of treatment outcome. Reports of DST normalisation on clinical recovery from depression have been consistently reported (Carroll, 1982; Greden, *et al*, 1980). However, the populations studied in this respect have tended not to include enough elderly patients to make generalisations of their findings applicable to the geriatric age group.

We report here a significant finding of DST normalisation in recovered elderly depressives:

Nineteen elderly drug-free patients all meeting DSM III criteria for depression and scoring greater than 20 on the 17 item Hamilton Depression Rating Scale (HDRS) were medically assessed to ensure none had features previously reported to affect DST results. A 1 mg. dexamethasone suppression test with a single blood sample drawn for cortisol evaluation at 1600 hours the next day, following the method of Carroll *et al* (1981), was administered one week after initial hospitalisation and before treatment was begun. Following four weeks of desi-