

## Correspondence

EDITED BY TOM FAHY

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### Psychiatrists' dress and address

**Sir:** With reference to Gledhill *et al*'s (1997) recent article on forms of dress and address, I am writing to report some interesting differences between their findings and our own. We used questionnaires to examine the attitudes of psychiatric in-patients in three hospitals in east London to forms of address (Ford & Pfeffer, 1997) and staff dress (Tham & Ford, 1995). The dress code study also investigated the views of nursing and medical staff.

In our study, only 56 out of 97 patients wanted to be called by their first names, even when they had become familiar with staff, although there was a non-significant trend towards greater informality with nursing staff compared with medical staff. Less than a quarter wanted to call staff by their first names. Titles were seen as polite (75%) and offering respect (71%), whereas first names were perceived to be friendly (79%). Age, gender or number of admissions did not affect attitudes.

Although our study produced a similar proportion of doctors who felt that they should be dressed smartly to that reported by Gledhill *et al*, patients and nursing staff were divided between formal and casual dress for medical staff, and over 70% felt that nursing staff should be dressed casually, as opposed to in uniform or formally. Thirty-six per cent felt that formal dress made staff less approachable.

To summarise, compared with Gledhill *et al* (1997), our sample, from an extremely deprived area, was less concerned with smart attire, but more formal with regard to keeping of titles. These differences may relate to subtle cultural differences between the two populations from socio-economically distinct areas of London. The preference for greater informality with nurses as opposed to doctors found in both our studies, and echoed by Gledhill and colleagues, is interesting in terms of differing roles within the multi-disciplinary team.

**Ford, T. J. & Pfeffer, J. (1997)** What's in a name? *Journal of Mental Health*, **6**, 169-172.

**Gledhill, J. A., Warner, J. P. & King, M. (1997)** Psychiatrists and their patients: views on forms of dress and address. *British Journal of Psychiatry*, **171**, 228-232.

**Tham, S. & Ford, T. (1995)** Staff dress on acute psychiatric wards. *Journal of Mental Health*, **4**, 297-300.

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**Sir:** Gledhill *et al* (1997) do not refer to the *Patients' Charter* (Department of Health, 1991), which states "You can expect all the staff you meet face to face to wear name badges". The figure for psychiatrists wearing name badges, in their study, was only 19%.

We have carried out an audit of psychiatrists' use of name badges and identity cards, and compared it with the rates of badge-wearing by ward nursing staff in a mental health services trust. Our local acute services trust had a policy that all staff should wear an identity badge, and disciplinary action could follow non-compliance.

Our audit involved surveying all the psychiatrists working for the mental health trust and a sample of ward psychiatric nursing staff. The staff were approached during a working day and while they were on the hospital site. They were asked to produce their identity badges. If the badge was visible or capable of being produced within one minute, we counted this as 'Yes'. As we audited each staff member, we explained the purpose of the audit and the standard expressed in the *Patients' Charter*. We then completed the audit cycle after one month, checking only the psychiatrists.

We found that while 24 (96%) of 25 nursing staff wore badges, only 12 (48%) of 25 psychiatrists did so. After one month the latter figure had risen to 18 (72%). Although there was a trend toward increased badge-wearing among doctors on

the second survey, the results of our small survey did not reach statistical significance. There was no difference in rates of badge-holding between junior doctors and consultants. We did not insist on the badges being on display for our study, as many of the psychiatrists spent time in the community and it may not have been appropriate to keep a badge on display. We decided that one minute was a reasonable time limit to allow people to search for their badge. This difference may explain the higher levels of badge-carrying that we found among doctors than in the Gledhill *et al* study.

It is important that psychiatrists carry some form of identification, particularly as our work is increasingly based in the community. The *Patients' Charter* indicates that wearing an identity badge is essential for National Health Service staff, and police advise that people should ask to see proof of identity before allowing entry to strangers. The study by Gledhill *et al* indicates that psychiatrists should consider wearing badges to help patients identify them in hospital, but our data suggest that the attitude change needs to start at a more basic level, with psychiatrists accepting the need to carry identification.

**Gledhill, J. A., Warner, J. P. & King, M. (1997)** Psychiatrists and their patients: views on forms of dress and address. *British Journal of Psychiatry*, **171**, 228-232.

**Department of Health (1991)** *Patients' Charter: Raising the Standard*. London: Department of Health.

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### Ethnicity and dissatisfaction with mental health services

**Sir:** The findings of Bindman *et al* (1997) lend support to the need for greater communication between general practitioners (GPs) and psychiatric services in the provision of a more effective service for their patients with mental illness. This is particularly pertinent to Black patients who, while reporting general satisfaction with the care they receive from GPs (Bindman *et al*, 1997), continue as in-patients to be reported as less likely to be registered with GPs and more likely to be in locked wards and under Section 2 or 3 of the

Mental Health Act (Koffmann *et al*, 1997). Non-registration with a GP has been shown to be predictive of compulsory admission (Cole *et al*, 1995) and this is likely to be the greatest mediator of dissatisfaction with psychiatric services in which Black patients are over-represented, particularly those born in the UK (Parkman *et al*, 1997). It may therefore be necessary to distinguish between the experience and perception of services in patients at different stages of their illness course, as this might indicate at which point difficulties arise in terms of their interaction with health services. It is also necessary to examine intra-ethnic differences in perception of the services, as it appears that rejection of the services is greater among second-generation Black people.

Work currently being done by my colleagues and I at the Maudsley Hospital examining perceptions of racism in Black patients found that 55% of Black patients reported perceptions of racial bias and discrimination within the health care service. The same study found that second-generation Black patients are more likely than any other group questioned to express a preference for case managers of the same race. It is therefore relevant to assess the demographics of the service providers, particularly with regard to age, cultural allegiance and ethnicity, as this may identify some of the problems that result in dissatisfaction with services among Black patients at both primary and secondary levels. The perception of GPs of feeling less involved in the care of their Black patients also deserves investigation as it may provide further insight into the reluctance of Black patients to become registered with them from the outset.

**Bindman, J., Johnson, S., Wright, S., et al (1997)** Integration between primary and secondary services in the care of the severely mentally ill: patients' and general practitioners' views. *British Journal of Psychiatry*, **171**, 169–174.

**Cole, E., Leavey, G., King, M., et al (1995)** Pathways to care for patients with a first episode of psychosis. A comparison of ethnic groups. *British Journal of Psychiatry*, **167**, 770–776.

**Koffman, J., Fulop, N. J., Pashley, D. et al (1997)** Ethnicity and use of acute psychiatric beds: one-day survey in North and South Thames regions. *British Journal of Psychiatry*, **171**, 238–241.

**Parkman, S., Davies, S., Leese, M., et al (1997)** Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: PRISM Study 4. *British Journal of Psychiatry*, **171**, 260–264.

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## Subjective memory complaints, depression and dementia

**Sir:** The report by Schmand *et al* (1997) confirms our own findings on a community sample of elderly subjects with subjective memory complaint (SMC) (Tobiansky *et al*, 1995).

Using the short-CARE nine-item screening instrument (Gurland *et al*, 1984), 87% of all elderly residents in one inner-London electoral ward were screened for the presence of objective memory disorder, depression and SMC in 1988, and again in 1990. In this way, we studied the value of SMC as a predictor of future depression or dementia in elderly residents. SMC was common, occurring in 25% of all subjects. Forty-seven per cent of subjects who fulfilled criteria for dementia and a similar percentage of those with depression had SMC.

When followed-up over two years, a sample of subjects with SMC who were neither demented nor depressed when first seen, were at a five-fold greater risk of developing future dementia and a 2.5-fold greater risk of developing depression compared with those without the complaint. The presence of SMC cannot be regarded as an entirely benign symptom.

In our study, uni- and multivariate comparisons indicated that certain SMC items ("Forgets what he/she had read or heard", "Forgets where he/she has placed things" and "Says impaired memory is a problem for him/her") were more likely to predict the onset of future dementia, while the item "Is embarrassed by memory problem" was more likely to predict depression.

A number of instruments have been developed for the purposes of quantifying self-ratings of memory failure (Dawe *et al*, 1992). Comparison of the short-CARE SMC scale with other SMC instruments would be of interest.

**Dawe, B., Procter, A. & Philpot, M. (1992)** Concepts of mild memory impairment in the elderly and their relationship to dementia: a review. *International Journal of Geriatric Psychiatry*, **7**, 473–479.

**Gurland, B. J., Golden, R. R., Teresi, J. A., et al (1984)** The short-CARE: an efficient instrument for the assessment of depression, dementia and disability. *Journal of Gerontology*, **39**, 166–169.

**Schmand, B., Jonker, C., Geerlings, M. I., et al (1997)** Subjective memory complaints in the elderly: depressive symptoms and future dementia. *British Journal of Psychiatry*, **171**, 373–376.

**Tobiansky, R., Bilzard, R., Livingston, G., et al (1995)** The Gospel Oak Study stage IV: the clinical relevance

of subjective memory impairment in older people. *Psychological Medicine*, **25**, 779–786.

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## Lithium withdrawal mania supports lithium's antimanic action and suggests an animal model involving serotonin

**Sir:** In his cogent response to Moncrieff's (1997) dismissal of lithium's therapeutic properties, Cookson (1997) points out that the well-documented occurrence of lithium withdrawal mania provides indirect evidence for the antimanic properties of lithium on which Moncrieff casts doubt.

Animal studies have also demonstrated behavioural changes associated with lithium withdrawal after long-term treatment, in which rats show increased attention and attraction to stimulus change without significant alterations in overall levels of motor activity (Harrison-Read, 1988). Similar behaviour occurs briefly during the initiation of lithium treatment, and may provide the basis for an animal model of the cognitive and emotional features of hypomania and mania.

During the course of long-term (three weeks or more) treatment with lithium in doses giving typical average plasma concentrations of 0.6 mmol/l, rats develop behaviour (e.g. fore-paw treading) typical of a mild 'serotonin syndrome'. This abnormal behaviour can be attenuated by acute treatment with (–)-propranolol, possibly by blocking 5-HT<sub>1</sub> receptors within the brain. At the same time, propranolol unmasks the novelty-seeking behaviour characteristic of lithium withdrawal, even though lithium administration continues. Lithium-dependent novelty-seeking behaviour can, in turn, be selectively attenuated by drugs with 5-HT<sub>2</sub> receptor blocking properties, such as cyproheptadine.

In rats, at least, lithium initially appears to enhance cognitive and motivational processes by increasing neurotransmission at 5-HT<sub>2</sub> receptors, which somewhat paradoxically may mimic the situation in untreated patients with mania. These effects are later opposed and balanced by an increase in neurotransmission at 5-HT<sub>1A</sub> receptors within the brain, possibly accounting for some of the antimanic and