



thioridazine has been restricted to second-line use in psychosis (Breckenridge, 2000) and the manufacturers, because of these dangers, have withdrawn droperidol.

In May 2000 we carried out a survey of prescribing among psychiatrists in Newcastle. A questionnaire with a typical presentation of an acutely agitated young male was circulated to all psychiatrists. Respondents were asked for preferred first- and second-line management regimes. The response rate was 48%. Seventy-eight per cent of respondents indicated that droperidol plus lorazepam would be their first choice, followed by zuclopenthixol acetate (9%) and others (15%). The second-line choices were zuclopenthixol acetate (28%), droperidol (28%), lorazepam (28%) and others (16%).

If these results represent common practice in adult psychiatry, there is cause for concern. Withdrawal of droperidol therefore requires urgent revision of guidelines regarding acute agitation and consideration of alternatives. These could include olanzapine in intramuscular form (currently being used experimentally) and the more widespread use of intravenous sedation protocols. However, using the above would have considerable implications for already hard-pressed drug budgets and the level and skill of nursing observation available.

BRECKENRIDGE, A. (2000) Thioridazine: restricted indications and new warnings on cardiotoxicity. Committee on Safety of Medicines. <http://www.open.gov.uk/mca/ourwork/monitorsafeequalmed/safetymessages/thiolet>.

REILLY, J. G., AVIS, S. A., FERRIER, N., et al (2000) QTc-interval abnormalities and psychotropic drug therapy in psychiatric patients. *Lancet*, **355**, 1048–1052.

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Hyoscine patches in clozapine-induced hypersalivation

Sir: Hypersalivation associated with clozapine can be a distressing and difficult to manage side-effect (Cree et al, *Psychiatric Bulletin*, 2001, **25**, 114–116). In recent months we have used hyoscine hydrobromide patches in a group of patients with disabling hypersalivation. We had used the patches to treat severe hypersalivation in a patient on depot medication on the advice of a colleague working in ear, nose and throat medicine. This patient had gained some relief from atropine drops but could not tolerate the bitter taste. He had not been helped by oral anticholinergic medication and it was to our surprise that he responded dramatically to the use of the patches.

We have since used the patches on four patients with severe disabling, clozapine-induced hypersalivation (dosage 500–800 mg/day). These patients had obvious drooling that often required a change of clothing with marked soaking of their pillows each morning. A dramatic improvement has been noted in each case.

The patches are well tolerated. They are sited on bare skin behind the ear and release 1 mg of hyoscine over a 72-hour period. They have brought about a sustained improvement in our patients' quality of life. This small sample suggests that hyoscine patches are effective especially in those patients suffering severe hypersalivation. It is interesting to note that the patches proved effective in patients who had not responded to oral treatments, including oral hyoscine.

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Patient or client?

Sir: The article by Ritchie et al (*Psychiatric Bulletin*, December 2000, **24**, 447–450) provides an 'evidence base' for a debate that has been going on for some time now. It confirms the beliefs of many clinicians, that patients prefer to be called patients. We have so far refrained from using the words 'client' or 'service user' without any problems.

The origins of the word patient go back to the 14th century and are derived from old french, from the latin word 'patiens' – meaning one who is suffering. *Webster's Dictionary* defines patient as an "individual awaiting, or under medical treatment". Client is defined as a "customer or patron, or one who depends on the protection of another". By these definitions, it is the word patient that best suits the people under our care.

As far as we are aware, it is only patients under psychiatric care who face these dilemmas in nomenclature. People receiving general medical care are still called patients. By calling patients under psychiatric care anything different and by denying that they too suffer from a medical illness, we only minimise their suffering and stigmatise them further.

Let us not deny that they are going through pain and suffering. There is enough stigma attached to suffering from a mental illness. Let us not segregate them further. Our patients have expressed what they wish to be called. For once, let us listen to them.

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Sir: We read with interest the article by Ritchie et al (*Psychiatric Bulletin*, December 2000, **24**, 447–450) describing the preferences for the terms patient and client with respect to people attending a psychiatric clinic. Our prior study (Sharma et al, 2000), which involved a survey of 550 service providers and 427 service recipients at four sites in Canada – two provincial psychiatric hospitals, a private mental health centre and a psychiatric unit of a general hospital – showed similar results. The term patient was favoured by both service providers (68.4%) and service recipients (54.8%). The logistic regression results for service recipients' preference for the term patient showed that the variables of site, diagnosis and employment status contributed the most to prediction. More specifically, service recipients from the rural provincial psychiatric hospital had lower odds of preferring the term patient than did service recipients from the urban provincial psychiatric hospital. Service recipients with the diagnosis of mood disorders had higher odds of preferring the term patient than those with substance misuse disorders. Retired service recipients were more likely to prefer the term patient than those who were employed (Sharma et al, 2000).

The consensus among providers and recipients in current publications favours the use of the word patient. In our view the word patient carries a broader and perhaps deeper fiduciary commitment than does client.

SHARMA, V., WHITNEY, D., KAZARIAN, S., et al (2000) Preferred terms for users of mental health services among service providers and recipients. *Psychiatric Services*, **51**, 203–209.

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Leisure activities of people with schizophrenia: listening to music and playing the National Lottery

Sir: Although much has been written about the behavioural aspects of people with schizophrenia living in the community (Leff & Trieman, 2000), little is known about their leisure activities. We recently asked patients and normal subjects in Nithsdale, South West Scotland, about their access to music ($n=136$ patients and 114 controls) and the National Lottery ($n=62$ patients and 57 controls).

More controls owned a cassette (96% v. 73%), record (60% v. 40%) or CD (85% v. 52%) player; patients owned fewer cassettes, records or CDs. More patients



(16% v. 3%) never or very rarely listened to music and fewer listened to music every day (40% v. 55%). The range of music listened to by patients was narrower. Abba and Elvis were most often mentioned by the patients as their favourite group or artist, Daniel O'Donnell and Abba by the control subjects.

Seventy per cent of patients had played the National Lottery at some time compared with 87% of controls. Normal subjects had played more recently (70% v. 42%; in the past week); and patients played less often (52% v. 30% once a month or less) and spent less money on tickets (£1.50 v. £2.30 on average).

It is probably a matter of regret that our patients, with lots of leisure time, listen to less music, which can be both relaxing and stimulating. That they play the National Lottery less often is probably to be welcomed because the lottery is likely to make poor people in Britain even poorer (McKee, 1995).

LEFF, J. & TRIEMAN, N. (2000) Long-stay patients discharged from psychiatric hospitals. Social and clinical outcomes after five years in the community. The TAPS project 46. *British Journal of Psychiatry*, **176**, 217–223.

McKEE, M. (1995) Gambling with the nation's health? *British Medical Journal*, **311**, 521–522.

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How should a mental health liaison team communicate with general practitioners?

The Islington Mental Health Liaison Team provides an acute psychiatric assessment service for patients attending the Whittington Hospital, North London. Many patients are discharged back to their general practitioner (GP), however there have been no studies investigating the communication from liaison psychiatric teams to GPs. Therefore, the liaison team conducted a survey to discover how Islington GPs would like information relayed to them. Currently, we send letters that are 2–3-sides long via the hospital postal system.

One hundred and fourteen Islington GPs were sent a dated letter, a one-sided questionnaire and copies of four different types of assessment letter. Of the 59 (52%, which is comparable with other postal surveys) GPs who responded, 95% requested same-day feedback of the assessment and 85%

thought that a faxed one-page structured form most suitable for this; 92% indicated that they would prefer a full letter at a later date; and 83% indicated that they would prefer the mental health liaison team to prescribe initially if a change of psychotropic medication was indicated.

It was clear from these results that we were not matching GPs' expectations because 50% of our letters took more than 3 days to arrive. The findings were consistent with similar surveys about GP communication (Essex, 1991; Smith & Trotter, 1992; Walker *et al*, 1998). As a consequence the liaison team are now faxing one-page structured forms on the same day as the assessment and providing fuller letters if requested, or felt appropriate by senior staff.

ESSEX, B. (1991) The psychiatric discharge summary: a tool for management and audit. *British Journal of General Practice*, **41**, 332–334.

SMITH, S. & TROTTER, C. (1992) A new discharge summary. *Psychiatric Bulletin*, **16**, 607–608.

WALKER, S. A., BOENLHOFF, G. A. & EAGLES, J. M. (1998) Early discharge summaries. *Psychiatric Bulletin*, **22**, 148–149.

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Perinatal Maternal Mental Health Services. Recommendations for Provision of Services for Childbearing Women

Council Report CR88 £5.00. 32 pp.

Psychiatric disorder following childbirth is common, and much of it is serious. After childbirth, women are at increased risk of suffering from an affective illness, and those with pre-existing psychiatric disorders may face a relapse or recurrence of their condition. Psychiatric illness occurring at this time may have an adverse effect not only on the woman herself, but on her marriage, family and, in particular, on the future development of her infant.

Perinatal mental health problems should therefore be of concern not only to those involved in maternal and infant care, but also to psychiatric services because child-bearing women will form a significant minority of their patients.

This new Council Report updates and replaces CR28 (published by the College in 1992) and a report published in 1996 in conjunction with the Department of Health. The revision takes into account developments in national health policy – including new commissioning arrangements, service governance and the *National Service Framework for Mental Health* – as well as the findings of key reports, including the *Confidential Enquiry into Maternal Deaths (Why Mothers Die)* (1998) and *Fatal Child Abuse and Parental Psychiatric Disorder* (1996).

The report recommends that:

- Every health authority should have a perinatal mental health strategy that aims to provide the knowledge, skills and resources necessary for detection and prompt and effective treatment at all levels of health care provision.
- Every health authority should identify a consultant with a special interest in perinatal psychiatry. This consultant should take a lead role in promoting these aims and in establishing a specialist multi-disciplinary team.
- All women with a perinatal psychiatric disorder who require specialist psychiatric care should have access to a consultant and other mental health professionals with a special interest in their condition, irrespective of their place of residence.
- Mother and baby units should be established to serve the needs of a number of health authorities.