Correspondence

Another greetings survey?

Vinjamuri *et al*[1] point out that there has been little research into patients' preferences about how they are greeted by their psychiatrist. I have discovered that there is virtually nothing published on how we should greet those with whom we work, and the issues are similar.

It is quite common for paramedical staff to be addressed by their first names by doctors, especially consultants, who seem to expect to be called by their title in return. As a trainee, I have been struck by how often, without asking, I am greeted by my first name by seniors in rank, but often not in age, who expect me to use their title when speaking to them. It is hardly surprising then that this sort of power imbalance is perpetuated in our dealings with patients.

It is worth noting that the 1982 edition of the classic book on polite behaviour, *Debrett's Etiquette and Modern Manners*,[2] is quite clear on forms of address in business: 'The use of Christian names should work both ways except where there is a substantial age gap. It is arrogant of a superior to choose to be addressed formally, yet to call subordinates by their first names (or by last names only).' We would do well to remember this and extend this to all with whom we come into contact.

1 Vinjamuri IS, Nehal MAM, Latt MM. Greetings survey (letter). *Psychiatr Bull* 2009; **33**: 313.

2 Burch DE. *Debrett's Etiquette and Modern Manners*: 254. Pan Books, 1982.

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Crisis team fidelity in Wessex

We conducted a small-scale survey to investigate the management and operational procedures of local crisis teams within the Wessex Deanery in a similar vein to the 2006 national survey.[1] These findings were compared with the Department of Health's *Guidance Statement*.[2]

A senior practitioner or team manager from local crisis teams completed a form on their respective case-load, staffing, available resources and the service they provide. We were particularly interested to see whether the teams had day-hospital facilities and whether they provided services outside the 16–65 year age group as outlined by the Department of Health.[3] We compared the results with the national survey data.

Six out of the nine teams responded. All provided a 24-hour service and gate-keep in-patient beds, significantly more than what the national survey showed (72% of teams gate-keep in-patient beds and 53% provided a 24-hour service).

Only 33% (two teams) provided a service for 16- to 65-year-olds, with the rest covering 18- to 65-year-olds. Outside this scope, half (three teams) provide services for individuals with intellectual disability and only 17% (one team) for older persons. Only one team had a day hospital.

There was a wide range of team staffing levels, including part-time staff, from 11.7 to 37.5, with patient episodes varying from 284 to 900. Given the government guidelines on staffing (15 per 150 000 population with 300 patient episodes), only half of teams had sufficient staffing (88% in the national survey).

There was a similar input from nurses in Wessex and nationally (100% *v.* 98%), higher input from support workers (100% *v.* 70%), approved mental health professionals (83% *v.* 49%), occupational therapists (50% *v.* 30%) and psychologists (50% *v.* 8%).

All teams had medical staff input. The proportion composition found was 8.6%, higher than the 5.2% reported by Middleton *et al*.[4] All teams had consultants and 83% (five teams) had dedicated consultants with other medical staff and half (three teams) had dedicated non-consultant staff.

To ensure crisis resolution and home treatment teams are successful as alternatives to hospital admission, it is vital to have sufficient staff and resources. Teams in Wessex had higher multidisciplinary team staff diversity than the national average,[1] but only half of them had adequate staffing according to the Department of Health guidance.

1 Onyett S, Linde K, Glover G, Floyd S, Bradley S, Middleton H. Implementation of crisis resolution/home treatment teams in England: national survey 2005–2006. *Psychiatr Bull* 2008; **32**: 374–7.

2 Department of Health. *Guidance Statement on Fidelity and Best Practice for Crisis Services*. Department of Health, 2007.

3 Department of Health. *Mental Health Policy Implementation Guide*. Department of Health, 2001.

4 Middleton H, Glover G, Onyett S, Linde K. Crisis resolution/home treatment teams, gate-keeping and the role of the consultant psychiatrist. *Psychiatr Bull* 2008; **32**: 378–9.

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Ethnic distribution of personality disorder

The prevalence of personality disorder in the UK is between 4% and 33% and ranges from 13% of general practitioner patients to 40–50% of psychiatric in-patients. There are no figures relating to ethnicity. Ethnic minorities are over-represented in psychiatric services and especially in compulsory psychiatric care. Black clients are less likely than White clients to be diagnosed with personality disorder and more likely to be diagnosed with schizophrenia. Ethnic minorities are underrepresented in specialist psychotherapy services and are less likely than White clients to be offered counselling or psychological therapy.[1]

In a cross-sectional survey of in-patient data collected over 2 years (2007–2009), we examined the prevalence of personality disorder with regard to ethnic distribution among 6531 psychiatric in-patients. The survey was conducted in Mersey Care National Health Service Trust, a mental healthcare provider in the north-west of England. Ethnicity was divided into two broad categories: White British, and Black and minority ethnic.