Correspondence

Information requirements of people with dementia

Sir: We were interested to read the article by Clafferty on the arguments for and against telling patients with Alzheimer's disease information about their diagnosis (*Psychiatric Bulletin*, July 1999, **23**, 394–395). We recently carried out a preliminary study to ascertain the views of patients on this topic. Thirty patients, with a variety of clinical forms of dementia from mild to moderately severe degrees of impairment, consented to be interviewed. They were asked what they would like to know about their illness. Nine patients (30%) clearly indicated they had no wish to receive any information about their illness. Of the 21 patients (70%) who wanted to know more information, the most common requests were for diagnosis and cause of the condition (11 patients), the possibility of improvement (five patients) and an explanation of specific symptoms (three patients). Other questions included 'How long will I suffer?' and 'Why me?' Four patients were not able to explain what information they would have liked. When asked from whom they would expect to receive this information, 60% expected it to come from a doctor, 20% from another member of the clinical team and 20% would expect to be told this type of information by a family member.

We suggest that diagnostic information is not forced onto reluctant patients. Considerable care is needed in what information is imparted and how it is delivered. Patients with dementia expect us to discuss more than just their diagnosis with them.

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Atypical neuroleptics and elderly patients with dementia

Sir: Drs Wismayer & Sipos have demonstrated hopeful findings of what can be achieved in monitoring the prescription of neuroleptics to patients with dementia (*Psychiatric Bulletin*, July 1999, **23**, 409–412).

However, they misquote me (Thacker & Jones, 1997) as the percentages they quote refer to the proportion of patients with dementia receiving greater than 50 mg chlorpromazine equivalent of standard neuroleptics (32% in nursing/residential care and 23% living in their own homes).

The clinical standards on neuroleptic prescribing in dementia described by Wismayer & Sipos make no mention of appropriate neuroleptic dosages. It would be interesting to know whether closer follow-up of prescribing led to dose reductions in the 1996 survey compared with that of 1995.

I note the increasing use of sulpiride at Bristol. Many old age psychiatrists now favour atypical antipsychotic drugs for their elderly patients. Prescribing patterns are, therefore, in a state of flux over time and wide geographical variation due to both different consultant opinions and the geographical lottery involved in the funding of atypical neuroleptics.

However, there is emerging evidence of a more beneficial profile of both short- and long-term side-effects with atypical drugs compared with low doses of standard neuroleptics in older patients (Jeste *et al*, 1999). On the basis of first doing no harm, the availability of atypical neuroleptics to patients with dementia is probably a more important issue than that of anticholinesterase inhibitors.

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Mental Health Act and adult attention–deficit disorder

Sir: Recently a patient under my care was discharged from a Section 3 by a mental health review tribunal on the grounds that his diagnosis did not constitute evidence for a mental illness under Section 1 of the Mental Health Act 1983.

For some years previously, the patient had been managed as a case of atypical bipolar affective disorder, but another consultant in my trust bravely had put forward the hypothesis

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