sharing certain white middle-class professional values, have a tendency to perceive black patients as 'more psychotic' than analogous white patients, and hence are more likely to diagnose them as schizophrenic. We shall find it difficult to examine this in any sort of simple 'double-blind' study, for an extended video film of doctor–patient encounters cannot keep ethnicity as the single dependent variable.

If there is no ideal approach, we can nevertheless look at certain aspects. Do psychiatrists, for instance, carry around with them some sort of schema in which certain behaviours and experiences in one ethnic group are accorded a greater or lesser 'pathological weighting' than in another? To start examining this, admittedly restricted, hypothesis, I wrote a brief clinical vignette prepared in two versions, identical in all respects except that Afro-Caribbean origin was specified in one version but not in the other. The vignette was piloted and modified to offer a picture of what appeared to a group of colleagues could equally well be rated as one of six diagnoses (manic depressive psychosis, major depressive disorder, neurotic/stress reaction, paranoid psychosis, personality disorder, schizophrenia). One or other version of the vignette was randomly given to 338 health professionals: 103 doctors (61 of them psychiatrists), 32 social workers and psychologists, 39 nurses, 48 medical students before they had studied any psychiatry, and 116 medical students after their psychiatry teaching. They were invited to select one diagnosis alone as the most likely. There were three refusals/spoiled returns. The results suggested at this level no trends or significant effects of race on diagnosis, either taken as the separate categories or when collapsed into broader groups such as 'psychosis' or 'depression'. Neither training nor profession affected selection of diagnosis except that the 'medics' (doctors and medical students) were more likely to diagnose schizophrenia in both ethnic groups (taken together, $P < 0.025$).

We cannot, however, now claim that there is no pre-existing mental set whereby qualified psychiatrists or others preferentially associate one or other pattern of psychopathology with a particular ethnic group. While a different vignette may have demonstrated an association, there are more serious problems. The 'neutral' components of a case history may already have an ethnic bias. My own example included repeated unemployment: as this is a more common experience for the black community in general, it will have a greater diagnostic salience for the whites where psychopathology may be presumed to have a greater effect on determining unemployment. Similar objections can be raised in relation to family constellation and so on. In other words, significant distress may be rated as 'normal' in black patients.

While I am thus not claiming any unique advantage for simulated clinical situations, it does seem important to attempt to use vignettes, both written and video, to examine the perception of patients by psychiatrists in more detail. Certainly the perception of 'dangerousness' is amenable to a similar study, inelegant and partial as it may be. The wider issues of the role of psychiatry as one among a number of social control procedures are not so amenable to such an experimental design and could more usefully be examined through an 'interpretative' approach.

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SIR: We are able to support some of the conclusions made by Lloyd & Moodley (*Journal*, June 1990, **156**, 907). We have also examined differences in neuroleptic dosage given to white patients of Caribbean origin and patients of Asian origin (Milner & Hayes, 1990). Data concerning 210 consecutive admissions to the All Saints Hospital in inner-city Birmingham were recorded. The sample comprised 138 (60%) British, 30 (14%) Asian, 34 (16%) Afro-Caribbean and 8 (4%) other subjects.

Of those admitted under section were 14% (19) of the British group, 33% (10) of the Asian group, and 41% (14) of the Afro-Caribbean group. It was found that 85% (32) of the Afro-Caribbean group, 57% (17) of the Asian group and 33% (60) of the British group were diagnosed as suffering from a psychosis (mainly schizophrenia). When each group was matched for diagnosis, there was no difference in mean oral chlorpromazine equivalents given in the first three days (all neuroleptic medication was included in the calculation). Each patient was rated on the Krawiecka scale (Krawiecka *et al*, 1977) in order to obtain a 'psychotic' rating. Those who were diagnosed as suffering from schizophrenia (and other psychoses) received a higher rating irrespective of ethnic group.

This confirms the suggestion made that black inpatients are more likely to receive antipsychotics

because they are more likely to be diagnosed as suffering from a psychotic illness, particularly schizophrenia. The higher rate of sectioned admissions may reflect differential access to services among black groups or presumptions about willingness of black patients to receive treatment.

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Unmet needs for medical care

SIR: We are pleased that Daly (*Journal*, June 1990, **156**, 909) finds our procedure for measuring unmet need potentially useful. We agree that it would be sensible, following our initial study (*Journal*, December 1989, **155**, 777–781), to apply the procedure cautiously to other populations. As we have pointed out in other papers on the same project, we can draw no conclusions beyond those based on our sample (Brewin *et al*, 1987, 1988; Brugha *et al*, 1988; MacCarthy *et al*, 1989). Thus, for example, the particular value of thyroid and liver-function tests in our study cannot be taken yet as a specific recommendation for their general use in this kind of population. It is difficult to see why Dr Daly disagrees with this position.

The surprising conclusion that unmet need was as high in the social services day centres as in the day hospitals was based on findings set out at the end of the fourth paragraph of the results, a point that Dr Daly appears to have overlooked. So far as physical examination is concerned, we did look for the side-effects of medication, including tongue tremor, and thus were able to comment on the patient's need for dental care.

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Compliance with antidepressant medication

SIR: Depressed patients may comply poorly with drug treatment; non-compliance may range from 15–44% (Myers & Calvert, 1984; Willcox *et al*, 1965). Compliance with newer antidepressants such as mianserin and lofepramine has been little studied in an everyday National Health Service setting. We therefore examined drug compliance in all patients prescribed tricyclics or mianserin and over a three-month period under the care of one consultant psychiatrist (n = 29: 16 out-patients, four day-patients, nine in-patients). Eight patients each received amitriptyline, imipramine and mianserin, and five received lofepramine. The dose of tricyclic varied from 25 mg to 210 mg daily and of mianserin from 30 mg to 90 mg daily. A blood sample was taken 8–12 hours after the previous dose, and the plasma antidepressant level measured by high-pressure liquid chromatography techniques. The plasma level was categorised as absent, low, therapeutic or high (Montgomery *et al*, 1977; Orsulak & Schildkraut, 1979). Depression and anxiety were assessed at the time of sampling by the Krawiecka scale for chronic psychotic patients, and a note made of current side-effects (e.g. dry mouth, blurring of vision, weight gain).

No antidepressant was detected in the serum of only one patient, a day-patient prescribed imipramine. Thus only 3% of the population were clearly non-compliant with their drug therapy. A further seven patients, all receiving tricyclics, had 'low' plasma levels. Non-compliance may be suspected in these patients but pharmacokinetic factors must also be considered. Inspection of the data did not suggest these eight patients differed from the others with regard to sex, hospital status, dose of antidepressant, duration of treatment, current anxiety or depression, and prescriber.

A previous study which also used the 'no antidepressant detected' category assessed non-compliance