Correspondence

Defeating the Defeat Depression Campaign

Sir: The recent Defeat Depression Campaign is an excellent example of preventive medicine at its best, for which the Royal College of Psychiatrists and the Royal College of General Practitioners should take full credit. Why then is the Department of Health seeking to undermine this campaign, for this is surely what it will achieve with its recent guidelines to NHS occupational physicians advising on the suitability for employment of someone with a past history of depression. These guidelines have arisen out of the Beverly Allitt affair.

Recently I learnt that a woman applied to work as a Macmillan nurse assistant at a nearby hospital. She has a past history of post natal depression, treated successfully as an outpatient and she made a full and normal recovery. She is not on any current medication. She was successful at interview, and her appointment was confirmed subject to a medical examination. At this she was told that it was Department of Health policy that people with a significant past psychiatric history cannot be employed in direct patient contact in the NHS. She was offered the alternative of applying for a different type of post.

There is clearly something seriously wrong here. Nor is this the first instance that I have come across whereby people with a psychiatric history have been penalized for it. The recent Department of Health initiative on supervision registers smacks of 'big brother' and social control. The point is that these policies will directly add to the stigma of mental illness and serve only to drive it further underground. Patients will be even less keen to admit to their suffering, and most of the good work achieved by the Defeat Depression Campaign will be lost. It is worth remembering that the NHS is the single biggest employer in the country. It is not going to help those with a history of depression to find themselves excluded automatically from working in the organisation. Moreover, other employers may follow the NHS' example, compounding matters.

It is time that the Department of Health showed an example, and acted to reduce the stigma of depression, not increase it. Our college should insist that it does so.

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High dose antipsychotic medication

Sir: There has been much recent interest in the dosage limits given in the British National Formulary (BNF, 1994) for high dose antipsychotic medication and the Consensus Statement of the Royal College of Psychiatrists (1993) has recently been published. One of its recommendations is that trainee psychiatrists should not take the decision to exceed BNF limits.

The Consensus Statement focuses mainly on maximum daily dosage during regular administration. However, the BNF recommendations for acute dosing may contain surprises for many clinicians. For example, the starting dose for chlorpromazine, even in acute psychoses, of 25 mg tds appears extremely low compared with that generally used. Few very disturbed patients are likely to respond to only 50 mg chlorpromazine intramuscularly, repeated at a maximum interval of six hours. Dollery (1991) suggested up to 100 mg intramuscularly every four hours in acute schizophrenia.

The BNF gives dose equivalents for a number of drugs, although since these drugs act on a wide range of receptors, equivalence for dopamine blockade may not be equivalence for sedation or tranquillisation. In terms of dose equivalents, much greater antipsychotic potency within BNF limits is possible by using drugs other than chlorpromazine. From the dosage viewpoint, in the acute situation, haloperidol would appear the drug of choice, since it has the greatest flexibility of dosage both orally and intramuscularly. For oral use, thioridazine can be given in much larger equivalent dosage (300 mg bd) than chlorpromazine. However, there is no good evidence that thioridazine and haloperidol are safer to use than chlorpromazine.

I would like to suggest that the BNF limits for initiating therapy with antipsychotics appear inconsistent and it is not clear that there limits have any pharmacological or toxicological basis. However, these limits have considerable medico-legal significance since they are generally based on the terms of the manufacturer's product licence. There is clearly an urgent need for reappraisal of appropriate dosage regimes to be used for initiation of acute therapy with antipsychotic drugs in clinical practice.

BNF (1994) *British National Formulary, Number 27*. London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

DOLLERY, C. (1991) In *Therapeutic Drugs*. London: Churchill Livingstone.