

this is an example (I hope that I will not be accused of being racist) of the pot calling the kettle black.

AZUONYE, I. O. (1992) *America the Beautiful in Our Lifetime. A Step by Step Program for the Radical Transformation of America*. New York: Vantage Press.

— (1995) Is this an article too far? *Psychiatric Bulletin*, **19**, 328–329 (letter).

CULLIFORD, L. (1995) Response to Azuonye. *Psychiatric Bulletin*, **19**, 329.

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patients. The few doses above the guidelines are confined mainly to younger, elderly patients with early-onset psychosis, while doses below the ranges given by Taylor & Duncan are commonly used in older, elderly patients with late-onset psychosis, suggesting that in psychogeriatric practice clinicians prescribing 'depots' do not pay too much heed to minimum dose recommendations.

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### Use of depot neuroleptics in elderly patients

Sir: By collating prescribing information on depot antipsychotics, Taylor & Duncan (*Psychiatric Bulletin*, June 1995, **19**, 357) provide valuable guidance for doctors interested in auditing their use of these agents. I have used their table to re-analyse data collected in a survey I conducted in June 1994 of the use of depot neuroleptics in elderly patients (aged 65 and over) receiving care from Nottingham psychiatric services.

Nurses from psychogeriatric, rehabilitation and general psychiatric teams identified 97 elderly patients receiving regular depot antipsychotics. Formulations used were flupenthixol decanoate, fluphenazine decanoate, zuclopenthixol decanoate and haloperidol decanoate. Only eight patients (age range 65–78, median 68) were on doses of 'depot' greater than those suggested in Taylor & Duncan's article (based on reducing the figures given for younger adults by half). Six of these patients had schizophrenia with onset before the age of 55. Two received a dose greater than the maximum suggested for younger adults. By contrast, 27 patients (age range 65–87, median 75) were on weekly 'depot' doses below half the minimum suggested for younger adults: only one was on additional oral antipsychotics and 17 (63%) had a diagnosis of paraphrenia (onset defined as occurring beyond the age of 55). Fourteen patients (age range 68–87, median 77), all under the care of psychogeriatricians, were on doses below one-quarter of the minimum for younger adults. Ten (71%) of these patients had a diagnosis of paraphrenia.

These data indicate that Nottingham psychiatrists are generally prescribing conservative doses of 'depot' to their elderly

### Neuroleptic prescribing practice

Sir: We were interested to read about the change in antipsychotic prescribing brought about by Warner, Slade & Barnes' audit at Horton Hospital (*Psychiatric Bulletin*, May 1995, **19**, 237–239). We too were inspired by the Concensus Statement from the Royal College of Psychiatrists (*British Journal of Psychiatry*, 1994, **164**, 448–458) to survey the antipsychotic prescribing within our two hospital sites of 199 acute adult, forensic, rehabilitation and long-stay psychiatric in-patients.

We would like to make three points. Firstly, due to the wide case-mix of patients within the Horton study from several sub-specialties, it would be interesting to general psychiatrists to express separately the proportion of acute general psychiatric in-patients receiving treatment above *British National Formulary* (BNF) limits since it is our experience that this is far higher than the 1% quoted in a recent study by Torkington *et al* (*Psychiatric Bulletin*, 1994, **18**, 375–376).

Secondly, we would like to highlight the hidden potential of 'as required' or PRN antipsychotics in potentially increasing the proportion of patients above BNF limits. Although previous studies have suggested few patients are at risk of this, our survey found that the risk of being prescribed above BNF limits (i.e. above 100mg chlorpromazine equivalents) increased from 23.4% to 42.5% of our total sample if all PRN medication had been dispensed in addition to regular treatment.

Thirdly, despite chlorpromazine equivalents being a recognised 'currency' for antipsychotic dose conversion there are still wide variations in published tables. We explored alternative