The second group of doctors referred to by Dr Jarrett includes many of those unable to obtain senior registrar posts in the past. Indications are that the number of applicants for higher training posts are falling and many of these doctors could now be successful in obtaining specialist registrar posts. JCHPT would no doubt advise whether in these cases a shorter period of higher training could lead to the award of the Certificate of Completion of Higher Specialist Training and so allow them to apply for consultant posts. College regional advisers and others are already able to offer career advice to such colleagues.

The College will be energetically using the new workforce planning procedures to ensure an adequate number of both full-time and part-time training posts are available to ensure a supply of well-trained applicants for consultant posts.

DAVID STORER, *Chairman, College Manpower Committee, Royal College of Psychiatrists*

Sir: Dr Jarrett, in common with many other people, is concerned about the inability to recruit fully trained consultant psychiatrists in many parts of the country. This is clearly related to the inadequate senior registrar numbers. Dr Jarrett's second paragraph would, I believe, not be acceptable to government since they have firmly set their face against the idea that doctors qualified outside the European community can enter and have permanent careers in medicine in this country. Doctors from the European Union are of course eligible to enter the country for training or permanent posts.

Dr Jarrett's second suggestion of a 'rehabilitation' course for locum doctors has been considered by the College. I think it is fair to say that there is a good deal of sympathy for doctors in this position who wish to enter substantive consultant posts but at the present time, with queues of qualified registrars waiting to join higher psychiatric training, it would require a separate 'stream' of higher psychiatric training so that such doctors did not have to compete with others straight off MRCPsych training schemes. The Department of Health appear to see this as a way of circumventing manpower planning. However, even they are now beginning to see the extreme damage which is being caused to the service by their previously inadequate vision of the needs for consultant manpower. Perhaps they could be persuaded that Dr Jarrett's arguments have validity. We can but try.

C. THOMPSON, *Registrar, Royal College of Psychiatrists*

Clash of the Titans

Sir: At last, in your May 1995 issue, the clash of Titans, Azuonye and Culliford! (Azuonye, 1995; Culliford, 1995).

I must confess that I have sometimes had difficulty in following Dr Culliford's reasoning and have even wondered whether the title 'Wisdom' was, perhaps, a trifle pretentious. But then it occurred to me that were a piece of great pottery to be included in an MRCPsych examination paper, it would probably be described by the candidates as showing classical schizophrenic thought disorder, and I realised that my difficulty in understanding him merely reflected my own lack of imagination. I certainly do not object to your continuing to publish Dr Culliford's pieces, provided that it is made clear that they are not College policy statements.

I have never experienced the same difficulty in understanding Dr Azuonye's numerous letters in your columns. However, I would like to point out that a few years ago Dr Azuonye wrote a book (Azuonye, 1992) in which he suggested, *inter alia*, that the United States, Mexico and Canada should unite to form the United States of North America, that there should be no further immigration into that country and that its borders should be partially sealed with close monitoring of all air- and seagoing traffic, that the punishment for causing death by dangerous driving should be at least 40 years in jail, that a deadline should be set for the abolition of the internal combustion engine and that research should be concentrated on the use of the "natural energies contained within the electro-magnetic spectrum, including our planet's force fields as sources of energy . . .". It was also proposed that all political parties should be abolished, that all borrowing of money, both governmental and individual, be forbidden, and that professional sport be terminated.

I therefore conclude that when Dr Azuonye accuses Dr Culliford of offering a superficial and simplistic picture of the nature of things,

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.

I. G. BRONKS, *27 Friar Gate, Derby DE1 1BY*

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 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.

SIMON THACKER, *Department of Health Care of the Elderly, Medical School, University Hospital, Nottingham NG7 2UH*

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