ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Council Report CR26: Consensus Statement on the Use of High Dose Antipsychotic Medication*. London: Royal College of Psychiatrists.

PAUL BOSTON, *Department of Psychiatry, Faculty of Medicine, University of Leicester LE2 7LX*

Sir: We welcome the recent Consensus Statement on the Use of High Dose Antipsychotic Medication (Thompson, 1994) but would welcome further guidance on the use of high dosages, particularly when polypharmacy is involved.

The consensus statement provides clear guidance for the use of single medications at dosages exceeding the advisory limit for general use and in its *Guidelines and Suggestions* indicates that a combined dosage of more than one antipsychotic should not exceed the recommended upper limit. However no guidance is given as to how to calculate the maximum daily dosage when using two or more drugs. The difficulties in estimation of maximum dosages when using polypharmacy are exacerbated by the lack of a single scheme of "chlorpromazine equivalents". There is also a lack of consensus amongst the values given by the manufacturers and in the literature (Foster, 1989).

Relatively modest dosages of two antipsychotics may lead to dosage levels which if expressed in chlorpromazine equivalents far exceed the recommended daily dosage for one medication. However the simultaneous prescription of more than one antipsychotic occurs regularly in routine clinical practice without the rigorous safeguards and precautions laid out in the consensus statement.

It is unlikely that the pharmaceutical industry would wish to take the lead in the production of guidelines for use when polypharmacy is indicated. We would thus urge the College to encourage and facilitate further work in this important area.

FOSTER, P. (1989) Neuroleptic equivalence. *The Pharmaceutical Journal*, **243**, 431–432

THOMPSON, C. (1994) The use of high-dose antipsychotic medication. *British Journal of Psychiatry*, **164**, 448–458

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Registrar's note

The letters from Dr P. Boston and Dr A. Valmana & Dr M. Potter indicate that there is still much detailed work to be done following the well accepted but broadly defined consensus statement on high dose antipsychotic medication. These and other letters have been referred to the psychopharmacology group of the College for consideration.

The detail of four hourly or six hourly starting doses of antipsychotics either intramuscular or oral were not considered by the group. They are only relevant to the consensus statement when the total daily dose exceeds the daily BNF limit in which circumstances the group considered that it would be necessary for the dosing schedule to be seen and approved by a more senior psychiatrist, i.e. a psychiatrist with Membership of the Royal College of Psychiatrists. It is nevertheless an important point that dangers can arise in acute dosing schedules without the BNF dose being exceeded, and regardless of the general safety of neuroleptic agents, psychiatrists of all grades need to be constantly vigilant to motor and autonomic side effects.

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

The College's ethnic monitoring exercise

Sir: A circular from the Registrar states that our College is trying to eliminate discrimination on ethnic grounds in psychiatric practice and in the College's own activities. Having stated that a record of the ethnic origin of its members would help the College in this endeavour, he asks for information about country of birth and racial designation.

Only a person who has never experienced the disbelief, anger and distress inseparable from racial discrimination will fail to see how ill-advised, even dangerous, this undoubtedly well-intentioned exercise actually is. First, it calls upon members to think of themselves in racial terms which is counter to the effort to promote non-racial thinking. Those who are able to think non-racially will find the requirement disconcerting. Second, it calls upon non-white members whose 'British' or 'European'-type names have so far enabled them to slip past the short-listing obstacle to identify themselves by race, and perhaps alert people of ill-will on short-listing panels and Advisory Appointments Committees of their racial origins. Third, how would a record of ethnic origins help in eliminating discrimination in psychiatric practice? If the College is not contemplating assigning patients to therapists by race, where lies the logic in this? Finally, since discrimination enjoys the statutory support of such instruments as *Achieving A Balance*, how does our College propose to get past State-sponsored racial discrimination?

If we wish to make a beginning in reducing discrimination in College activities, all that is required is for the College to insist on merit as the only criterion for access to training and employment opportunities.

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