BNF recommended dosage

DEAR SIRS

We read with interest the report of Stanley & Doyle (*Psychiatric Bulletin*, May 1993, **17**, 299–300) about prescribing levels in the West Midlands regional secure unit. Both this experience and that of Fraser & Heppel (1992) represent special cases. Despite this Stanely & Doyle happily report few patients being prescribed doses above the British National Formulary (BNF) ranges.

We would like to report a similar exercise undertaken in an acute adult psychiatric unit based in a district general hospital serving a mixed urban and rural population. The drug charts for the in-patients of four consultants (excluding the drug and alcohol service) were reviewed on two occasions a month apart. The regular medication dosage for the last 24 hours was recorded and the PRN medication recorded as the single dose prescribed, the total dose given in the last 24 hours and whether any dose had been given. These observations were made (with the consent of the consultants) by CJB who was blind to the patients' diagnosis and without recourse to the medical notes.

The charts of 83 patients were reviewed. There were 129 regular prescriptions and 104 PRN prescriptions, a mean of 1.55 and 1.25 respectively per patient. Only two patients had no regular medication and only one virgin chart. Twenty regular (15.5%) prescriptions were for antidepressants, only one being a selective serotonin reuptake inhibitor. Sixty-two (48%) regular prescriptions were for neuroleptics including 14 depots (10.9% of regular prescriptions) and two (1.6%) for clozapine. Of the 104 PRN prescriptions, only 12 dosages (11.5%) had been given in the previous 24 hours. Procyclidine was the most commonly prescribed PRN medication (31 scripts, 29.8%) with temazepam close behind (27 scripts, 26%). Only one patient received regular medication in a dose above that recommended by the BNF, Modecate 200 mg two weekly (BNF maximum dose 100 mg two weekly).

The results suggest that the limits suggested by the BNF serve adequately for the majority of patients in an acute adult setting. Only the exceptional patient requires higher doses and this can be seen in the two studies cited above. There is little value in using very high doses of psychotropic drugs and there may be a worsening of outcome (e.g. Baldessarini *et al*, 1985). There is a need to ensure that clear indications are given for the use of medication above these guidelines and appropriate use of the Mental Health Act (1983) where informed consent cannot be obtained.

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See also page 557.

Burnout

DEAR SIRS

In relation to Dr Watson's conference briefing on 'Burnout', (*Psychiatric Bulletin*, April 1993, **17**, 235) I would like to report the findings of a survey of psychiatric trainees I carried out in 1987.

The General Health Questionnaire (GHQ-30) and another questionnaire were sent to a 10% sample of trainees (180) in England and Wales. The survey was anonymous and the return rate 50%. Thirty-five respondents (39%) scored 5 or more on the GHQ-30, 17 suspected they had had a past psychiatric illness and, of these, 14 scored high on the GHQ-30, even though no longer apparently suffering from psychiatric illness. Distress sufficient to interfere with home life and work was reported by 37 (42%) and 33 trainees respectively and 24 (27%) had considered giving up psychiatry. Half reporting such distress said it lasted for weeks or months.

Reported as stressful were listening to others' problems/distress 28 (32%), dealing with violent/potentially violent patients 21, realising the limitations of treatment 20, staff relationships 13, on-call duties 11, over-work 9, suicidal/potentially suicidal patients 8.

These results indicate a significant level of chronic distress during psychiatric training. Non-responders appear to be more distressed than responders (Vernon *et al*, 1984; Firth Cozens, 1987) and, even if the 50% who did not respond are in full health, there is sufficient distress to warrant further attention.

In terms of the causes of "burnout', trainees' reports of stressful aspects of training fall mainly into the "problematic relationships" category, whether doctor-patient or staff. These issues need more attention and should be addressed during training as the relationship aspects of psychiatry, whether it be to staff or patients, remain crucial throughout the psychiatrist's working career.

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