# LETTERS

**Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than five references and should be submitted in duplicate in a double-spaced format. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, APA, 1400 K Street, N.W., Washington, D.C. 20005. Letters can also be sent via electronic mail to psjournal@psych.org.**

## Neuroleptic Dosages

***To the Editor:*** In the May 1996 issue, Dr. Lin and colleagues (1) reported on factors influencing neuroleptic dosing among psychiatric outpatients at three public clinics. In this era of managed care in which consumers can choose from a number of prepaid plans, providers would be well advised to collect data about the factors influencing medication dosing in their own programs.

At our prepaid mental health plan, we undertook a review similar to Lin's as an outcome of our cultural awareness activities. We limited our study to clinically stable outpatients under the age of 65 years who were on neuroleptics alone and had a *DSM-IV* diagnosis of schizophrenia. We identified 186 such patients, on whom we collected information about variables such as medication dose, body weight, race, and gender. The daily neuroleptic dose was converted to chlorpromazine equivalents for analysis.

The sample group consisted of 99 females and 87 males; 106 were African American, and 80 were white. On average, they received a daily neuroleptic dose of 800 mg chlorpromazine equivalents with a relatively moderate dosing range (200 to 2000 mg chlorpromazine equivalents). Calculated in dose per unit of body weight, the average daily neuroleptic dose was 9.81 mg chlorpromazine equivalents per kilogram (kg) of body weight, with a range of 1 mg per kg to 20 mg.

White patients received an average daily dose of 750 mg chlorpromazine equivalents (with a range of 200 to 2000 mg), which translated to 9.76 mg of chlorpromazine equivalents per kg of body weight. African-American patients received an average daily dose of 800 mg chlorpromazine equivalents, which amounted to 9.85 mg per kg of body weight.

Differences between the two racial groups became clearer when gender was taken into account. Compared with white males, African-American males received a higher daily dose as well as a higher dose per unit of body weight (900 mg per day, or 10.92 mg per kg body weight). The average daily dose for white males was 700 mg, or 8.53 mg per kg body weight. White females received a higher daily dose (800 mg, or 10.68 mg per kg of body weight) than did African-American females (700 mg, or 8.78 mg per kg body weight).

The fact that African-American males and white females received similar doses per unit of body weight (10.92 mg versus 10.68 mg) seems to indicate that dosing choices were not made along gender or racial lines. The relatively higher daily doses received by African-American males and the low doses received by African-American females add to the confusion about pharmacokinetics in African Americans that is currently reflected in studies with contradictory results (2,3).

Our review confirms the need for further studies to review pharmacokinetics in African Americans. Dosing patterns among outpatients of different ethnic groups may depend on associated factors such as use of mood-altering drugs or a history of violence. Studies to elucidate what factors go into neuroleptic dosing are warranted. Meanwhile, our study has increased awareness among our medical staff of the need to pay attention to dosing issues.

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### *References*

1. Lin K-M, Matsuda A, Nuccio I: Neuroleptic dosage in psychiatric outpatients (ltr). Psychiatric Services 47:536, 1996
2. Lin K-M, Poland RE, Nakasaki G (eds): Psychopharmacology and Psychobiology of Ethnicity. Washington, DC, American Psychiatric Press, 1993
3. Midha KK, Hawes EM, Hubbard JW, et al: Variation in the single dose pharmacokinetics of fluphenazine in psychiatric patients. Psychopharmacology 96:206–211, 1988

## Clinical Rating Scales for Substance Abuse

***To the Editor:*** In their paper on the concurrent validity of physicians' ratings of substance abuse in the August 1996 issue, Carey and associates (1) conclude that clinical rating scales may be used to reliably identify substance abuse among psychiatric outpatients. This conclusion is based on their finding of significant correlation between clinicians' ratings of alcohol and drug use and information obtained in more detailed interviews conducted by a research assistant.

The authors are not alone in using concurrent validity between sets of rating scales as a measure of these instruments' usefulness in the diagnosis of substance abuse (2). However, it may well be incorrect to assume that if a patient gives approximately the same history on more than one occasion, then the information must be accurate.

Studies using urine drug screening as an objective measure to validate patient histories of substance abuse have demonstrated that patients frequently do not give reliable histories. There is often considerable discrepancy between patients' self-reports of recent drug intake and the results of urine drug screens (3,4). Failure to disclose a history of substance abuse may be due to a number of factors, including the illegal nature of the drug use, denial of the extent of substance