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Correspondence

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Time to change – let's end mental health discrimination: the challenges ahead

October 2007 marked the launch of another programme in England to tackle stigma and discrimination. 'Time to Change' models national initiatives from New Zealand and Scotland drawing on an expanding stigma evidence base[1] as well as lessons from past projects, including the Royal College of Psychiatrists' 'Defeat Depression' and 'Changing Minds' campaigns.

How might this programme succeed where others have stalled? The programme is resource rich with £18 million from the Big Lottery Fund and Comic Relief to channel into 35 linked programmes. It has 4 years to prove change among targeted audiences within a 30 million adult reach. It is a four-party coalition with a desire to learn from organisations across health and disability fields. It is adopting an evidence-based approach[2] – national social marketing, service user leadership and engagement, local direct action, multiple targets using 'stick and carrot' approaches – but this does not guarantee success.

Key challenges are identifiable. Preparatory consultation during February 2008 using a pragmatic, non-systematic survey method through the membership networks of 18 organisations generated responses from 3038 service users and 661 family or friend carers.

This consultation emphasised first, that stigma and discrimination are widespread and their impact far-reaching.

(a) Seventy-one per cent reported to have stopped doing things – accessing employment, making friends, joining groups, engaging with health professionals.

(b) Seventy-three per cent reported anticipated discrimination including one in two who fear disclosing their health problems because of the negative reactions they might receive.

(c) Carers reported fewer personal effects but 85% felt that the person they supported was affected.

(d) Time to Change will need to target its efforts to have a meaningful impact in any one area.

Second, that combating stigma and discrimination is not straightforward. Service users and carers warned that the entangled nature of mental illness and their own and other people's reactions make generic solutions difficult to find. Pinpointing exact goals for the 35 Time to Change programmes in terms of what needs to change will be central to proving any success.

Third, that Time to Change must set realistic goals. Variation in experiences particularly relating to physical health disabilities, sexuality, severe mental illness diagnosis and ethnicity of carers were found. Stakeholders will not equally benefit from Time to Change and the programme must be open and honest about its limitations from the outset. There is a danger that if it 'fails' to have an impact on lived experience of stigma and discrimination, people will give up hope that any change is possible.

Health professionals have a key role to play. General practitioners and psychiatrists were listed as stigma-generating agents, while National Health Service mental health trusts were prioritised by one in ten as the key target location for the social marketing campaign. However, the role goes far beyond being a target for interventions. Alongside Time to Change, momentum behind recovery-driven services is gathering pace.[3] Joining initiatives across psychiatry that have an impact on stigma and discrimination will assist this programme. For more information, please visit www.time-to-change.org.uk.

Declaration of interest

V.P. is employed by Rethink, one of the Time to Change partners.

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2 Thornicroft G. *Shunned: Discrimination against People with Mental Illness*. Oxford University Press, 2007.

3 Sheppard G, Boardman J, Slade M. *Making Recovery a Reality*. Sainsbury Centre for Mental Health, 2008.

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Neuropsychiatric systemic lupus erythematosus associated with neuroleptic malignant syndrome

Neuropsychiatric manifestations such as anxiety, mood disorders, and psychosis are frequent features of systemic lupus erythematosus. A psychosis prevalence of 5% has been reported.[1,2] Neuroleptic malignant syndrome is a life-threatening complication of treatment with antipsychotics.[2] High-potency antipsychotics increase the risk.

We report the clinical case of a 23-year-old woman presenting early-onset neuropsychiatric systemic lupus erythematosus with interstitial pneumopathy, glomerulonephritis and malar rash. When she was 20 years old, she had been hospitalised for her first episode with acute psychotic symptoms (mystic delusions) and agitation. The introduction of droperidol led to a neuroleptic malignant syndrome with high creatinine phosphokinase levels, muscular rigidity, hyperthermia and blood pressure dysregulation. The droperidol was stopped and benzodiazepines were used.

The patient was rehospitalised when she was 23 years old in a similar state because she had not observed the immunosuppressant treatment. No new gliotic cerebral lesions appeared on cerebral magnetic resonance imaging. The psychiatrist decided to introduce valproic acid and benzodiazepines in order to avoid antipsychotics. However, the mental state of the patient quickly led to delirium with repetitive, delusional and incoherent speech and behaviour. Despite the risk of neuroleptic malignant syndrome, a one-shot intramuscular injection of clotiapine was administered. Once again, we observed muscular rigidity, dehydration (148 mEq/l natrium) and systolic hypertension. Her

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clinical state became serious with lethargy, aspontaneity, disinhibition and executive dysfunction.

Biological features were abnormal with elevated creatinine phosphokinase (3415 UI/l), increased C-reactive protein (3.7 mg/dl) and hepatic cytolysis. Her treatment consisted of cyclophosphamide and methylprednisolone, and the introduction of a titrating-dose (up to 600 mg) of quetiapine for the psychiatric symptoms was decided upon. Her creatinine phosphokinase levels returned progressively to normal, and no signs of neuroleptic malignant syndrome were observed. Six weeks after continuing this treatment, biological and clinical features were normalised.

This case illustrates the importance of differentiating delirium caused by a neuropsychiatric systemic lupus erythematosus, a steroid-induced delirium[1] (which was not the case here as the patient had not been receiving any steroids when she developed the second psychotic episode) and an alteration in the consciousness level due to neuroleptic malignant syndrome, which was the case here.

Although there are no guidelines for the treatment of the psychiatric manifestations of systemic lupus erythematosus, it usually includes immunosuppressants associated with second-generation antipsychotics.[3] The diagnosis of neuroleptic malignant syndrome is based on muscle rigidity, hyperthermia, delirium and autonomic disturbances.[4] The dopaminergic hypothesis of the syndrome is well documented.[5] Neuroleptic malignant syndrome is not an absolute contraindication for further antipsychotic treatment and some factors can reduce that risk: avoiding the long-term use of antipsychotics, using low-potency agents, adjunctive treatments and slow titration.[2]

In this case, we suggest that the introduction of quetiapine – a lower D_2-affinity antipsychotic – was an interesting alternative.

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2 Haddad PM, Dursun SM. Neurological complications of psychiatric drugs: clinical features and management. *Hum Psychopharmacol Clin Exp* 2008; **23**: 15–26.

3 Stojanovich L, Zandman-Goddard G, Pavlovich S, Sikanich N. Psychiatric manifestations in systemic lupus erythematosus. *Autoimmunity Rev* 2007; **6**: 421–6.

4 Ananth J, Parameswaran S, Gunatilake S, Burgoyne K, Sidhom T. Neuroleptic malignant ayndrome and atypical antipsychotic drugs. *J Clin Psychiatry* 2004; **65**: 464–70.

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Are antidepressants safe during pregnancy?

Ramos *et al*[1] report that the use of antidepressant medications by women during the first trimester of pregnancy is not associated with an increased risk for major congenital malformations in children. The authors have a good database to study this topic but have described and analysed it using a case–control framework. They assembled two cohorts, with and without exposure to antidepressants during pregnancy. They then observed the various outcomes in both groups. We calculated the relative risk (RR) for major congenital malformations following use of antidepressants during first trimester of pregnancy as 1.13 (95% CI 0.86–1.48) from their published data. Estimating such relative risk and population attributable risk (5.76%) would have bolstered their arguments, as a cohort design is superior to a case–control strategy.

However, we suggest caution in generalising these findings because of two important limitations that were not acknowledged in their paper. If antidepressants are associated with more spontaneous abortions and an increased number of minor congenital anomalies, their lack of association with major congenital anomalies will not imply safety. A previous meta-analysis of 3567 women established a significantly increased RR of 1.45 (95% CI 1.19–1.77) for spontaneous abortions following use of antidepressants during pregnancy.[2] Individual antidepressants such as selective serotonin reuptake inhibitors[3] and other newer antidepressants[4,5] have led to more miscarriages when compared with unexposed control groups. As Ramos *et al* have included exclusively women who had their pregnancies ending in delivery, they do not add any information regarding spontaneous abortions.

In another study of 482 pregnant women,[6] fluoxetine caused significantly more prematurity (RR=4.8, 95% CI 1.1–20.8), more admissions to special care nurseries (RR=2.6, 95% CI 1.1–6.9) and worse neonatal adaptation (RR=8.7, 95% CI 2.9–26.6) after adjusting for all potential confounders. A total of 15.5% of infants exposed to fluoxetine had three or more minor congenital anomalies compared with 6.5% of infants who were not exposed to fluoxetine (P=0.03).[6] However, Ramos *et al* excluded minor congenital anomalies during case ascertainment without any explicit justification. Absence of association between use of antidepressants and major congenital malformations will not make a clinician confident to continue antidepressants during the first trimester of pregnancy if there are concerns over spontaneous abortions, prematurity and minor congenital anomalies. Hence, we encourage cautious interpretation of these findings as well as judicious use of antidepressants for women of reproductive age.

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3 Pastuszak A, Schick-Boschetto B, Zuber C, Feldkamp M, Pinelli M, Sihn S, Donnenfeld A, McCormack M, Leen-Mitchell M, Woodland C. Pregnancy outcome following first-trimester exposure to fluoxetine (Prozac). *JAMA* 1993; **269**: 2246–8.

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Authors' reply: The nested case–control approach that we used is the most effective design to study rare outcomes such as major congenital malformations.[1,2] This is even truer since it was performed in a well-established cohort of women with pre-pregnancy diagnosed psychiatric disorders. We disagree with Rajkumar & Jacob that a cohort approach would have been better, based on the fact that it lacks power for research in perinatal pharmacoepidemiology. This was clearly apparent when several small human cohort studies published in the 1990s did not suggest