Correspondence

Polypharmacy: saint or sinner?

Lepping & Harborne\(^1\) query the notion that polypharmacy rates are increasing. The general consensus, however, is that polypharmacy rates are indeed rising and previous studies clearly report this trend.\(^2\)\(^3\) It is also not certain that the study by Tungaraza et al\(^4\) is the first community study of polypharmacy in the UK, as our study\(^5\) probably predates it.

The findings from our study were strikingly similar to those of Tungaraza et al in showing almost identical out-patient polypharmacy rates of 17.4\% and 17.5\% respectively, and a prevalence of high-dose prescribing and sedative use in association with polypharmacy. These results were obtained despite the fact that our study population would not be considered severely ill. Both studies showed a tendency for atypical antipsychotics to be commonly involved in combination or high-dose prescribing – perhaps asking, as do Lepping & Harborne, about the efficacy of atypicals in the real-life clinical situation.

That polypharmacy continues despite repeated guidance against it may indicate that this is perhaps one area in which clinical practice and observation is ahead of research evidence, which is yet to catch up. Lepping & Harborne make the point that in the case of polypharmacy the evidence provides no support one way or the other. There appears now, however, to be a shift away from a blanket condemnation of antipsychotic polypharmacy to a search for evidence-based recommendations, which would support a role for polypharmacy in everyday clinical practice. Langan & Shajahan\(^6\) provide a number of excellent recommendations based on a thorough review of the existing literature. Not all of these recommendations may, however, be applicable in everyday clinical practice.

Several studies, including ours,\(^5\) have shown poor adherence to standards requiring documentation of clinical practice, or the recording of investigation reports such as electrocardiograms. Recent audits have advocated review by pharmacists, which may be feasible for in-patients but less so in out-patient populations. It is similarly problematic to conceive of a mechanism to ensure that cross-tapering of medication is completed and not abandoned half-way through. The idea of switching back from polypharmacy to mono-therapy in identified cases sounds attractive and has been shown successful in a proportion of patients,\(^6\) but clinicians may still remain wary of the problem of inducing psychotic relapses in otherwise stable patients, with all the associated consequences, including a fatal outcome.

What is clear perhaps is that the antipsychotic polypharmacy issue is unlikely to go away. The current attempts to ‘manage’ polypharmacy through audit, guidelines and recommendations have not led to change, and polypharmacy remains in many ways ‘treatment resistant’. It may be time to be open-minded about psychiatry’s ‘dirty little secret’ and allow the ‘co-prescribing’ of new measures focused on achieving a better understanding of the polypharmacy phenomenon.

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The jury is still out!

Lepping & Harborne\(^1\) highlight the unfortunate conflation of ‘psychotropically polypharmacy’ and ‘antipsychotic polypharmacy’, which is seen in the study by Tungaraza et al\(^4\) and which may confuse the reader. Their response falls foul of this issue when they refer to the statement that ‘only a third of [patients] were on one psychotropic medication’, and draw an implication of a shortfall in compliance with the National Institute for Health and Clinical Excellence schizophrenia guideline.\(^3\) The guideline advocates sequential use of antipsychotic monotherapy, but does not discuss polypharmacy involving other psychotropic medication. Lepping & Harborne rightly point out that both Taylor\(^5\) and Tungaraza et al have made assessments about the temporal change of incidence of antipsychotic polypharmacy without references, but later they mention studies of clozapine–amisulpride and clozapine–quetiapine combinations which are unreferenced.

An internal in-patient survey of antipsychotic polypharmacy in our own trust demonstrated an incidence broadly similar to that found in the literature at the time, but that antipsychotic polypharmacy regimes were not centred around attempts to optimise clozapine treatment. Rather, a variety of regimes involving diverse antipsychotics was seen. It is perhaps speculative to presume that in the Wrexham cohort\(^7\) most people on two or more antipsychotics were taking clozapine. In the forensic setting, complexity and diagnostic plurality is the norm, so antipsychotic polypharmacy is perhaps unavoidable at times. It is our concern that procedural aspects, such as preconditions for assured concordance before transfer to step-down services, may sometimes colour the prescribing decisions and drive the co-administration of depot antipsychotics with oral atypicals. We could not find reference to non-medical prescribers in Taylor’s article. Indeed, we feel that Tungaraza et al suggest that the emergence of new groups of prescribers points out the urgency of resolving issues around antipsychotic
polypharmacy, broadly anticipating the concerns of Lepping & Harborne. Finally, we respectfully suggest that the word polypharmacy be reconsidered, since pharmacy is seldom the originator of the plan!


Chandan Sehgal. Staff Grade Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust, email: chandan.sehgal@swyt.nhs.uk,

Paul A. Hardy. Pharmacy Services Manager, Fieldhead Hospital, Wakefield.
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Wide of the mark

It would seem that the basis for Christopher Cook’s objection to our paper is our perspective on Charles Taylor’s theory of the rise of secularity in the modern world.1 In doing so, he provides a skewed analysis of what we were actually saying. Taylor’s work was helpful to us in considering psychiatry’s attitude to religion. However, our main aim was to suggest that despite our deeply materialist age a sense of transcendent meaning was of great value to human beings and had never been lost. In this at least Cook seems to agree with us.

We were invited by the Editor to write a response to Harold Koenig’s interesting suggestion that psychiatrists might pray with their patients.2 In doing so, we took the stance that a focus on the practice of praying with patients was distracting attention from the far greater issue of spirituality and meaning in people’s lives. Cook appears to think we are against a thoughtful consideration of religion in psychiatry when that was never the case. He has missed our irony completely. One particular peer reviewer of our article had strikingly similar attitudes and forced our commentary through three revisions before they could accept it. The whole unhappy experience has made us worried about the increasing defensiveness of some religious psychiatrists in the College who appear to want to control discourse about psychiatry and religion. This should concern us all.


Michael King. Professor of Psychiatry, University College London, email: m.king@medsch.ucl.ac.uk, Gerard Leavey, Professor in Mental Health and Wellbeing, Northern Ireland Association for Mental Health, and University of Ulster, Belfast.
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Debating common ground and recognising differences

It is good to discover that Michael King, Gerard Leavey and I share more common ground than I had at first perceived based on my reading of their article.1 Perhaps a part of the problem was that I only saw the abstract after publication and that what I had interpreted as ambivalence towards spirituality in the main body of the article is now set in the context of the clear and positive statement regarding spirituality that the abstract provides.

However, it seems that we do have a different reading of Charles Taylor’s A Secular Age,2 and also probably hold different views of exactly what spirituality is. To explore these differences in academic debate seems to me to be a healthy thing, and this is why I was pleased to accept an invitation from the Editor to write a commentary on King & Leavey’s article. I would never wish to ‘control discourse about psychiatry and religion’ but I am glad to participate in a lively and critical debate about a subject that psychiatry has too long ignored and at times even denied.


Christopher C. H. Cook. Professionall Research Fellow, Durham University, email: c.c.h.cook@durham.ac.uk
doi: 10.1192/pb.34.8.355a

Spirituality, secularism and religion

The controversial claim of French philosopher André Comte-Sponville that spirituality is quite compatible with atheism could provide vital insights to continued discussion on the relevance of religion to psychiatry which began in The Psychiatrist with the article by Dein et al.2 Handling debates about the existence or otherwise of God can be difficult, unless one is a trained philosopher. Comte-Sponville summarises it best when he tells us that at the age of 18 he wrote: ‘If God exists then nothing follows; if God does not exist then nothing follows.’ However, a few years later he wrote: ‘If God exists everything follows; if God does not exist then everything follows.’

Religious systems depending on God as their pivotal point are in essence only relying on what human beings regard as the relevance of the Divine in human life. Those who have abandoned a belief in God also create what they think are the principles of life without God. They are all human creations.

Today we are surrounded by a variety of religions and ideologies and each of us as individuals makes our own evaluation of life and develops the values by which we live.

Many seem unwilling to take a serious part in any further discussion on the subject and seek only to abide by the law, live on good terms with others and follow the mores of the workplace. Many, like me, see the world as best understood in humanist terms. This means that we start and finish with ourselves. However, this does not prevent us from reaching out to others and beyond to the principles on which life is built.

There was an older humanism that seemed determined to negate all religion and to attempt to rebuild the world on a new atheistic agenda, but there can also be a humanism that seeks to understand the beliefs that are part of human evolution, both individually and collectively, and to reapply them to current needs.

The new great interest in the spirituality of patients is to be welcomed but there is a risk that it will become just another part of service provision without fully regarding its complexity.
Nevertheless, to see conviction — and it does not necessarily need to be religious conviction — as part and parcel of someone’s life is important. It can form a crucial part of how they evaluate themselves and their world and it is hard to see how one can support them without taking it into account.

Thus a person’s personal conviction system is part of their personal history and identity. When George Kelly3 developed the personal construct theory he demonstrated that everyone has a personal template by which they evaluate life. If we seek to understand and respect this, we discover that we will need also to look at our own understanding because we in turn evaluate others on the basis of our own templates.

Historically, people seem to have regarded psychological processes as coming from the world outside themselves. Mental illness could be ‘the work of devils’ and even sexual feelings were sometimes perceived as some form of karma that entered people. Today, we have reached the opposite extreme and see that ethics, politics, law and finally religion were not delivered to us by some external agency but were created by ourselves.

With this in mind we can explore the spiritual pilgrimage of our patients with them without imposing on them preconceptions of our own. It is an interesting journey because everyone’s pilgrimage is different, and without knowing their story you will not understand where they are in the present, nor what will be the next step in their future.

Those who study religious and ideological traditions will find nuggets of great wisdom in all of them and this understanding is enhanced the more one knows the cultural and historical background in which they originated. We are all on a learning curve but I hope that it will not be long before there are consultants who have a vivid knowledge of religion and ideology from a psychological perspective and who will enhance our ability to understand the individual patients in our care more completely.

The more one tries to understand the depths of other people, the more one deepens one’s own understanding and this may help alleviate that hidden isolation, loneliness and even despair that comes from never being properly listened to, or at any rate to find someone who at least tries to understand.


John Edmondson. Consultant in Child and Adolescent Psychiatry, Lincolnshire, email: john.edmondson5@btopenworld.com
doi: 10.1192/pb.34.8.355b

When to use DoLS? A further complication

Shah & Heginbotham1 describe a number of issues relating to the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act. A recent court case2 appears to complicate matters further. The defendant was a 55-year-old lady with ‘a significant impairment in intellectual functioning as a consequence of a learning disability’ who developed an endometrial adenocarcinoma. She required major surgery if her life was to be saved. It was agreed that she lacked the capacity to make decisions about her healthcare and treatment.

She also suffered from hospital and needle phobias. Attempts to explain the need for surgery to her had failed and on occasions she refused to attend hospital for treatment (even when she had initially agreed).

The judge agreed the defendant could be sedated to ensure that she attended hospital for the operation and did not ‘leave it prematurely after the operation had taken place’. She would be ‘given analgesic medication which would have a sedative effect on her, thereby rendering it unlikely that she would be able to abscond. However, it might be necessary to use force as a last resort to ensure that she returned to her hospital bed’.

The judge then said ‘in my judgment . . . it will be necessary to detain [the defendant] in hospital during the period of post-operative recovery. After mature consideration, the Official Solicitor, on [the defendant’s] behalf, came to the view that it was not necessary to invoke the Deprivation of Liberty Provisions under Schedule 1 of the Act. I agree with that analysis. If it is in [the defendant’s] interests (as it plainly is) to have the operation, it is plainly in her interests to recover appropriately from it’.

Given that it was planned, if necessary, to use sedation and/or force to prevent this patient leaving hospital, she was clearly to be deprived of her liberty. The court determined that because the patient lacked capacity and it was in her best interest (two necessary criteria for the use of DoLS), the DoLS were unnecessary.

Other articles in The Psychiatrist1,2,4 discuss the problems surrounding the definition of deprivation of liberty and the interface between the DoLS provisions of the Mental Capacity Act and the Mental Health Act. It now seems there is a further difficulty in determining whether the DoLS provisions are needed even if there is clear deprivation of liberty.

2 DH NHS Foundation Trust v. PS (by her litigation friend the Official Solicitor) [2010] All ER (D) 275 (May).

Tony S. Zigmond. Psychiatrist, Royal College of Psychiatrists’ lead on mental health legislation, Leeds, email: azigmond@doctors.org.uk
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Doctors are not adhering to General Medical Council prescribing guidelines

In light of recent media coverage of the General Medical Council (GMC) suspension of Adam Osborne,1 we became interested in the issue of doctors prescribing to non-patients: friends, family and self. The GMC recommends that doctors do not self-prescribe or prescribe to family and friends, except in an emergency.2

We audited prescribing practices among doctors working in London to determine whether GMC guidelines are being followed. We composed a 13-question online questionnaire
about prescribing practices, and invited doctors, all above F1 training level, to complete this by email.

We emailed 120 doctors and received 72 completed questionnaires; 52.1% of the respondents were female, 53.4% had more than 6 years’ experience as a doctor and 66.0% had prescribed to non-patients. Of that last group, 93.3% did not inform the person’s regular general practitioner, with 95.0% feeling it was unnecessary to do so. The most commonly prescribed medications were antibiotics (77.3%), followed by analgesics (25.0%) and the oral contraceptive pill (18.2%). Of note, a number of respondents stated that they had prescribed sleeping pills (16.8%) and smoking cessation medications (8.5%).

Most doctors felt it appropriate to prescribe antibiotics, analgesics and inhalers, and some felt it was acceptable to prescribe the oral contraceptive pill and antipsychotic medication, to family and friends; 58.9% admitted to self-prescribing.

Although the majority of doctors had used private prescriptions, approximately a fifth had used National Health Service prescriptions (21%). Finally, 55.3% reported never reading the GMC guidelines on prescribing.

Our results show that a large proportion of doctors are not adhering to GMC guidelines on medication prescribing. In many cases this may be attributable to simply not reading the guidelines. We suggest that the GMC considers publicising its prescribing guidance more widely to ensure good medical practice and to avoid the consequences of escalating poor prescribing habits.


Lubna Karim, Psychiatric Trainee, The Royal Free Hospital, email: lubna.karim@doctors.org.uk, Golnar Aref-Adib, General Practice Vocational Training Scheme, Barnet Hospital, Apu Chakraborty, Consultant Psychiatrist, The Royal Free Hospital, London.

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Three consultants for one patient

Singhal et al concluded that communication between consultants is vital but is not necessarily the key to success in provision of service for patients. The model in their study quite rightly looked at the role of two key workers (consultants), but did not look at the provision of care for patients in the intervening period between discharge from hospital and follow-up appointments with the community mental health team (CMHT) consultant. The crisis resolution home treatment team (CRHTT) plays a vital role in this intervening period. In an evaluation of our services, we found 44% of patients are now discharged into the CRHTT. The teams are obliged to care for these patients until their mental state is sufficiently stable for safe and effective transfer to the CMHT, and this period of intervention varies from a few days to several weeks. In effect, with the New Ways of Working, over a third of patients with an in-patient stay would have received care from three different consultants. While the patient is under the care of the CRHTT there may be changes to the overall care plan including changes to psychotropic medication. For these patients it is then three consultants for one patient and maybe four consultants if they have comorbid drug and alcohol dependence as well. It is therefore not surprising that most patients are not aware of the demarcations between the services. Communication and sharing of information with service users and their carers is as important as it is between two or more consultants and their teams.

Of the 170 mental health professionals who participated in Singhal et al’s study, only two were from the liaison service. In our experience of working in a CRHTT, some patients were unaware of the role of the consultant despite being fully informed by the team. It is not unusual for patients to request to remain permanently under the care of the CRHTT. Singhal et al’s suggestion that there is a need for a larger nationwide study is necessary and most welcome. Although the jury is still out on the advantages and disadvantages of two consultants for one patient, the current process of service provision for a significant number of patients involves a third consultant in the CRHTT, and we recommend that further studies should seek the views of mental health professionals and service users who received care from a third consultant. Crisis resolution home treatment teams have to a large extent filled the gap created by New Ways of Working with regard to continuity of care and their role in provision of service should not be overlooked.


Kishen Neelam, ST6 in General Psychiatry, Greater Manchester West Mental Health NHS Foundation Trust, email: kishen.neelam@yahoo.co.uk, Fola Williams, Trust Consultant Psychiatrist, Crisis Resolution and Home Treatment Service, Salford.

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