Psychotropic prescribing. What am I doing?

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SUMMARY. A descriptive survey of five weeks' psychotropic prescribing by one general practitioner is presented. Out of 1,543 total contacts, 330 had, by defined criteria, a significant psychological problem. A total of 25 different psychotropic drugs were given to 231 different patients. A number of recommendations for change are suggested to provide a more rational pattern of prescribing.

Introduction

MANY articles have been published over the last few years extolling the virtues of medical audit. By early 1980 I had decided that, as a postgraduate training organizer, it was time I set an example by conducting an audit of my own prescribing of psychotropic drugs rather than just talking to others about it.

Aims

My aims were to describe my current pattern of psychotropic prescribing, to make suggestions for changing my prescribing and to establish the need for further study of the outcome of psychotropic prescribing.

Method

For a five-week period beginning 1 February 1980, I kept a record of all those patients consulting me personally in my surgery, their homes or on the telephone. Those asking for a repeat prescription without direct contact with me were also noted.

I selected for study those patients whom I thought to have a significant psychological problem. I considered a patient to have a significant psychological problem when the main reason for the consultation related to one or more of the following: sleep disturbance, loss of libido, tearfulness, tiredness, tension, anger or guilt, experienced to such an extent that the regular pattern of their life was altered. I abstracted the following particulars from the records: age, sex, type of consultation (excluding patients with epilepsy or enuresis), whether psychotropic drugs were prescribed or withheld and in the case of the former, the number of prescriptions and the preparations given.

By week five of the survey I found that my prescribing habits had already begun to change (mainly in the type of drugs used and the number of tablets given) and so I discontinued recording.

Results

During the five-week period, the total number of patient contacts, both direct and indirect, amounted to 1,543. Three hundred and thirty (21.4 per cent) of them had, by my criteria, a significant psychological problem. The types of consultation are given in Table 1 and the manner of treatment in Table 2. Of the total patient contacts in the five weeks, 7.8 per cent were given a tranquillizer, 5.7 per cent a hypnotic and 4.4 per cent an antidepressant. (Of the 277 patients who received a prescription for a psychotherapeutic drug, 59 were receiving more than one preparation.)

Of those newly diagnosed as having a psychological condition, there was no significant difference in age between those given a prescription (32.5 years) and those from whom psychotropic therapy was withheld (36.3 years). In the latter group, however, there were more men (32 per cent as opposed to 18 per cent). While the age variation in those having repeat prescriptions was wide (17 to 94), they tended to be older (average age 50.7 years for those not seen and 44.5 years for those seen). Those not seen had been on medication longer (4.3 years compared with 2.7 years) and were more likely to have been under the care of a psychiatrist in the preceding two years (43 per cent compared with 25 per cent). The types of drugs prescribed and the differences between new and repeat consultations are shown in Table 3. It will be seen that 25 different preparations were used and that only one third of these were by their generic names. However, due to their greater frequency of prescription, generic drugs were stipulated in four out of five of the 277 prescriptions.

Discussion

Although all general practitioners would agree that psychotropic disorders play a large part in the morbidity of general practice, there is, as Winter and Whitfield (1980) discovered in their Bristol survey, a wide variation in the apparent incidence of the problem. It is not surprising, therefore, that Harris (1980) wrote, "We use the words anxious and depressed so loosely that they have lost their meaning." Shepherd and colleagues (1966) were rather more cutting (or accurate?) when they said that differences in assessment are due to the vagaries of the doctor rather than changes in the patient. Marks and colleagues (1979) reported that there was a poor correlation between patients assessed by questionnaire, general practitioner and psychiatrist. My figure of 21.4 per cent of total contacts is consistent with the range found in the Bristol survey (Winter and Whitfield, 1980), thus my criteria for diagnosing a significant psychological problem are likely to be similar. In the absence of simple definitions for psychological problems, a wide variety of clinical judgements is likely to remain, and it seems more important to consider what the clinician does after making the diagnosis.

The number of patients taking psychotropic medication was higher than that found by Dunnell and Cartwright (1972) but contained much the same proportion of tranquillizers and antidepressants as found by Dennis (1979).

The results demonstrated a difference between the age groups of those newly diagnosed (whether treated or not) and those on continuing medication (whether seen or not). What they do not satisfactorily explain is the criteria used in deciding to give 3.4 per cent of those

Table 1. Type of consultation.

Surgery consultation	*67%*
Home visit	*14%*
Repeat prescription without being seen	*13%*
Telephone contact	*6%*

Table 2. Patients with psychological problems as a percentage of total contacts.

	Number	Percentage
Seen but given no prescription	99	*6.4*
Seen and given a repeat prescription of psychotropic drugs	105	*6.8*
Not seen by me but given a repeat prescription for psychotropic drugs	64	*4.2*
Newly diagnosed as suffering from a psychological disorder and given psychotropic medication	53	*3.4*
Taken off psychotropic drugs	9	*0.6*
Total	330	*21.4*

Table 3. Type of drugs used and a comparison of repeat and new prescriptions.

		Repeat prescription		New prescription	
	Generic name used	Patient seen	Patient not seen	Number	Average duration of prescription in days
1. Chlordiazepoxide	No	8	10	1	14
2. Diazepam	Yes	26	17	12	10
3. Lorazepam	Yes	9	4		
4. Medazepam	No	4			
5. Oxazepam	No	2	1		
6. Doxepin	No	2			
7. Benzhexol	No	1	1		
8. Chlorpromazine	Yes	7	3	2	7
9. Promazine	No	2	3		
10. Fluphenazine	No	1			
11. Thioridazine	No	1			
12. Trifluoperazine	No	3			
13. Phenobarbitone	Yes			1	
14. Amylobarbitone sodium	No	1			
15. Dichloralphenazone	No	1			
16. Pimozide	No	1			
17. Nitrazepam	Yes	25	26	4	12
18. Flurazepam	Yes	14	16		
19. Imipramine	Yes	20	7	16	24
20. Clomipramine	No	4			
21. Amitriptyline	Yes		2	2	21
22. 'Slow release' amitriptyline	No	5	6		
23. Nortriptyline	No		1		
24. Nortriptyline and fluphenazine	No		3		
25. Mianserin	No	2			

patients who were seen a first prescription for a psychotropic drug, but denying such therapy to a much larger group (6.4 per cent). My impression is that an anxious or depressed young man is less likely to get a psychotropic drug when coming to see me than a woman of the same age.

What drugs are used?

There are 127 psychotropic preparations listed in the current edition of *MIMS*. I used 25 of these in the five-week period of the study. Several of those which I used only a few times were prescribed initially by a consultant, but I nevertheless feel that 25 is too many. It seems most unlikely that I know all I should about such a wide range of compounds.

The prescribing of barbiturates has been declining nationally over the last seven or eight years. *Health Trends* of February 1980 (Williams, 1980) showed that in 1975 14 per cent of psychiatric prescribing was for barbiturates, but Dennis and his colleagues in Bath found that this had fallen to six per cent by 1978. Wilks, in his two articles (1975; 1980), has shown that, while his barbiturate prescribing fell by over 80 per cent by 1976, he was still issuing prescriptions at a rate of 2,120 a year. In the light of this, my two prescriptions over a period of five weeks seems a more satisfactory result.

We are all being encouraged to prescribe generically. While only a third of my psychotropic drugs are written in this form, they make up 76.9 per cent of the total. Thus the benefits to be gained from converting fully to generic usage may be relatively small.

Repeat prescribing

The average length of time that patients have been on their psychotropic therapy (4.3 years for those not seen and 2.7 years for those seen) is no worse than those found in the Bath study, but, in the light of the guidelines published by the Committee on the Review of Medicines (1980), all general practitioners need to rethink the concept of long-term prescribing. At the moment it looks as if those of my patients attending a psychiatrist are likely to remain on their preparations indefinitely.

What changes do I need to make in my prescribing habits?

This is the central question of any audit or 'What am I doing?' exercise. Following a period of self-analysis and based on comments made by the trainees, the area pharmacists and from reading the relevant literature, I have made the following decisions for change. I will:

1. Reduce the variety of drugs I prescribe.
2. Always use generic names.
3. Plan to give benzodiazepines to new patients for less than one month, as recommended by the Committee on the Review of Medicines.
4. Use a short-acting benzodiazepine, temazepam 10mg, at night for no longer than two weeks where a hypnotic is needed (chlormethiazole for those elderly patients newly prescribed a hypnotic). This is consistent with the advice offered by Briggs and colleagues (1980).
5. Use as routine benzodiazepine therapy diazepam twice a day for a week and then half the dose for a further week at night (Straughan, 1979; *Drug and Therapeutics Bulletin,* 1978).
6. Use amitriptyline in a single dose at night when a sedative antidepressant is indicated. (There would appear to be no indications for the use of Lentizol, as all amitriptyline is long acting.) When a non-sedative antidepressant is indicated, I shall use imipramine in divided doses. The newer antidepressants (nomifensine and mianserin) do seem to have advantages in a reported reduction of minor side-effects. However, for the moment I intend to use them sparingly.
7. Plan slowly, carefully and rationally to wean patients off long-term usage, being aware of potential withdrawal symptoms.

Conclusions

Having completed my first self-audit, I still prefer the phrase 'What am I doing?'. It turned out to be easier than I expected, less threatening than I had feared and more stimulating than I had realized. The point that remains in my mind is much the same as that discussed in this Journal (Ryan *et al.,* 1979), namely, that it is outcome of patient care that really matters. Although the evidence about the inappropriate use of psychotropic drugs in relation to their pharmacological half-lives is important, no-one yet knows whether it makes a practical difference to patients (do they feel better, go back to work sooner and score more highly on psychological testing if on the short-acting pharmacologically 'correct' medication?). Ryan and colleagues (1979) and Wilks (1980) have described the incidence of psychotropic prescribing. This study has taken their work a little further in proposing recommendations for change. The next stage will be to look later on in the year at the patients for whom I initially prescribed therapy during February 1980. This study has certainly produced a change in my knowledge of the pharmacology of psychotropic drugs, an increase in my skill in prescribing drugs and a development of my attitudes to both patients and prescribing. Next year I shall repeat the process in order to see whether the seven changes that I decided to make have been implemented.

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Attitudes of patients after 'genetic' termination of pregnancy

Twelve of 15 women who had had abnormal fetuses agreed to be interviewed after termination of the pregnancy. The survey showed that persistent adverse psychological and social reactions may be much commoner in patients undergoing termination of pregnancy for genetic rather than 'social' indications. Adequate information and counselling before, and support after termination of an abnormal pregnancy are essential if these women are to cope with the experience.

Source: Donnal, P., Charles, N. & Harris, R. (1980). *British Medical Journal,* **282**, 621-622.

Tuberculosis in children

A five-year-old girl in Salford was seen by her general practitioner because of erythema nodosum; she was sent into hospital, and was found to have primary TB. The child was in the same class as another whose mother had advanced pulmonary TB. The two specialists in community medicine who report this case tell us that, of 750 children in the school, eight were found to have TB and 723 were Heaf test negative; 90 per cent were given BCG.

Source: PHLS Communicable Disease Surveillance Centre, CDR 80/50 (unpublished).