



the columns

correspondence

Urinary detection of olanzapine

Sir: Coates (*Psychiatric Bulletin*, August 2000, **24**, 316) recently reported the value of urine testing to provide objective evidence of non-adherence with olanzapine by a patient appearing before a mental health review tribunal. While this test has its value in the entirely non-adherent patient, the method may have its limitations with the more canny patient wishing to mislead the tribunal. The half-life of olanzapine is 32.4 hours (Coates, 1999), which results in olanzapine being detectable in urine for about 6 days after ingestion. In the absence of quantitative testing patients can take olanzapine on an infrequent basis and still appear adherent. A serious concern is that patients might choose to mislead tribunals about their adherence by providing the evidence of positive tests for the presence of olanzapine in their urine by taking olanzapine on an infrequent non-therapeutic basis, in order to help effect their discharge.

COATES, J.W. (1999) Urinary detection of olanzapine – an aid to compliance. *British Journal of Psychiatry*, **175**, 591–592.

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Concordance or collusion

Sir: The quality agenda laid out in the NHS plan is embodied by the National Service Framework and evidence-based treatment protocols. However attractive these approaches seem they fail to acknowledge the complex transactional nature of clinician–patient interactions. Inappropriate treatment can occur knowingly, and for many reasons.

For 1 month clinicians from an inner-London community mental health team (CMHT), which uses prescribing guidelines, identified medication they prescribed or dispensed although they believed it was not medically indicated.

Twenty-nine prescriptions for 28 patients were identified. White male patients were over represented. All major diagnostic categories were included and six patients had a drug induced psychosis.

The commonest reported reason for non-indicated prescribing was patient unwillingness to discontinue treatment. The medications prescribed were not trivial and included benzodiazepines, lithium and antipsychotics. In four cases prescribing was thought to facilitate engagement with the CMHT. Two patients received, as required, a supply of antipsychotics to reduce out of hours presentations. Failure to discontinue street drug use was sited in four cases.

Knowing deviation from good practice was readily identified, although uncommon, and made clinicians appropriately uncomfortable. Explanations are complex and include consumer demand, relief of anxiety, attempts to contain workload and lack of skills. We believe this highlights the importance of regular peer review to identify idiosyncratic practice and to consider the reasons why it occurs. We need to guard against our desire for concordance leading us into collusion.

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Lottery compulsive disorder – a new household syndrome

Sir: Lottery sales to date exceed £30 billion. Thirty million Britons play regularly and the game has nationwide status. For most the game is harmless fun. Despite one million winners each week, statistics do not tally those with psychosocial problems.

Pathological gambling is described as “frequent repeated episodes of gambling that dominate . . . life to the detriment of social, occupational, material and family values and commitments” (World Health Organization, 1992). Studies suggest that 5% of Lottery players are pathological

gamblers and 80% of Britons consider the game to be ‘addictive’.

Recently, a small player group randomly selected from replies to a newspaper advertisement described a symptom cluster similar to obsessive–compulsive disorder, anecdotally named lottery-compulsive disorder (LCD). LCD involves repetitive obsessions or compulsions to play the Lottery, which are irresistible owing to fears of the players’ ‘numbers coming up’. Despite acknowledging these impulses to be irrational, they are unable to resist. The gaming process may develop to interfere with social functioning, whether by ensuring the ticket purchase has priority over other activities, wasting time or financial implications. LCD may involve ritualistic behaviour, for example in the way the player chooses numbers, buys tickets or repeatedly checks numbers.

Psychiatric implications of lotteries are widely accounted in the USA, where a proactive stance is adopted towards problem players. Most states spend at least \$1 million per year on funding gambling helplines, education, publicity, gambling treatment programmes and promoting the ‘play responsibly’ campaign. By comparison, the UK is lamentable in its efforts, and research, treatment and public education is notable by its paucity. The Lottery Commission promises £250 000 over 5 years towards a study on problem gambling. Although this may console some critics, it seems a mediocre pledge, representing less than one-thousandth of profits. With the Lottery already funding counselling for winners and a daily retailer hotline, it seems reasonable in terms of costs and practicalities to afford similar services to Lottery losers under the criteria of the ‘good causes’. Only then can we regard the National Lottery as an innocuous family game and avert mental health disorders such as LCD.

WORLD HEALTH ORGANIZATION (1992) *The ICD–10 Classification of Mental and Behavioural Disorders*. Geneva: World Health Organization.

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