

the clinician's time and of the medication prescription charts, and also could remove flexibility.

'As required' prescribing was a significant contributor to polypharmacy, although this was reduced significantly on re-audit. The use of two drugs may be deceptive when considering the risks of high dose, and using different p.r.n. drugs could lead to overprescribing, at least in terms of chlorpromazine equivalence, although it is not clear how dangerous this is (Hillam & Evans, 1996).

It is interesting that some changes were achieved but not others. The standards that changed more readily, such as oral/intramuscular prescriptions, may be those that are more readily acceptable to the clinical team, easy to remember and change and appear most important and relevant.

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Antipsychotic drugs for non-psychotic patients

Results of a questionnaire survey of prescribing practices among Wessex psychiatrists

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Aims and method The aim of this study was to examine the pattern and basis of use of psychotropic drug prescriptions by psychiatrists to relieve anxiety symptoms arising from non-psychotic disorders. A questionnaire survey was conducted among senior psychiatrists in the Wessex region.

Results The response rate was 74%. A range of psychotropic drugs was used to treat non-psychotic anxiety symptoms, most commonly selective serotonin re-uptake inhibitors, tricyclic antidepressants and antipsychotic drugs. Antipsychotic drugs are reserved for second- and third-line treatments, mainly in low

doses but sometimes in high doses and for long periods. The use of antipsychotic drugs as anxiolytics was seen by the majority of responders as reasonable practice, and they are considered suitable alternatives to benzodiazepines. This practice was based mainly on personal experience.

Clinical implications Anxiety symptoms arising from non-psychotic disorders are common in the out-patient population. Although antipsychotics are used by psychiatrists to relieve these symptoms, the 'evidence base' for such practice is flimsy and mainly based on clinical experience. The benefit/risk ratio should be

considered carefully before prescribing antipsychotics for non-psychotic anxiety. Further research is needed in this area, contributing towards general guidelines.

Antipsychotic drugs are not used solely for the purpose of reducing or relieving psychotic phenomena. The consensus statement of The Royal College of Psychiatrists notes that antipsychotic drugs have two main actions: first and foremost they eliminate or reduce the intensity of psychotic experiences (i.e. delusions, hallucinations, thought disorder, experiences of passivity, thought alienation and inappropriate or incongruous mood); second, they have a calming effect (Thompson, 1994). Over time, antipsychotic drugs have come to be used outside the original indication, namely the relief of psychosis, being employed to reduce anxiety symptoms arising from non-psychotic mental disorders, in particular various states of anxiety and depression. The recent World Health Organization study of psychological disorders in primary care settings (Ustun & Sartorius, 1995) found that antipsychotic drugs were used varyingly for the treatment of generalised anxiety disorder and panic disorder: in 5.5% of patients in Manchester, 6.8% of patients in Mainz, Germany, and 14.3% of patients in Seattle, USA. The frequency of use of antipsychotic drugs in patients suffering from non-psychotic mental disorders attending secondary care mental health services is not known.

Although several papers have recommended the use of antipsychotic drugs in the treatment of patients with anxiety disorders, the 'evidence base' for this practice is limited. Most studies that examined the use of antipsychotics in non-psychotic disorders have considerable methodological flaws, and none have considered the risk/benefit ratio carefully (El-Khayat & Baldwin, 1998). Because of an impression that antipsychotic drugs were being used by psychiatrists to treat patients with anxiety symptoms arising from non-psychotic disorders, and being aware of the limited evidence to support this clinical practice, we decided to enquire into the pattern of use of antipsychotics by senior psychiatrists in the Wessex region.

The study

Following a pilot study of the acceptability of a preliminary version of our questionnaire, involving colleagues within the Southampton University Department of Psychiatry, we sent an amended questionnaire with a covering letter to all senior or specialist registrars and all consultants in general and old age psychiatry working in Wessex. The letter explained that we were interested in obtaining information about the use

of antipsychotic drugs in patients with non-psychotic mental disorders: the questionnaire was two pages long, the pilot study showing that it could be completed within five minutes. If a questionnaire was not returned within eight weeks, a reminder letter and a second questionnaire were sent to the psychiatrist.

Findings

Completed questionnaires were returned by 94 doctors, that is, 74% of the total sample ($n=127$). Specialist registrars were more likely to return the forms than consultants (91% and 70%, respectively). Two-thirds of respondents stated that 40–80% of their patients are troubled by anxiety symptoms; in around half of this group of patients, the anxiety symptoms arise from non-psychotic mental disorders. These symptoms are being treated by a range of psychotropic drugs (see Table 1).

Tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors (SSRIs) and antipsychotic drugs are all used frequently to relieve non-psychotic anxiety symptoms; benzodiazepines and beta-blockers are used less often. Monoamine oxidase inhibitors and buspirone were used most infrequently.

SSRIs were used as a 'first-line' treatment by 52% of respondents, and TCAs by 25% (see Table 2). Antipsychotic drugs tended to be reserved for second-line or third-line treatment. Seventy-three per cent of respondents agreed or strongly agreed that it is reasonable clinical practice to use antipsychotic drugs as anxiolytics in patients with non-psychotic mental disorders, 65% regarding antipsychotics as suitable alternatives to benzodiazepines.

The majority (78%) of respondents who used antipsychotic drugs prescribed them at 'low' doses (i.e. no more than 75 mg/day of thioridazine, or equivalent), although a significant minority (20%) sometimes used them in higher doses. When antipsychotics are prescribed,

Table 1. Stated frequency of prescription of psychotropic drugs

	'Never' (%)	'Rarely' (%)	'Sometimes' (%)	'Usually' (%)
Benzodiazepines	11	49	37	2
Tricyclic antidepressants	4	18	62	15
SSRIs	4	15	44	36
MAOIs	33	51	14	2
Antipsychotics	4	21	62	13
Buspirone	59	24	15	2
Beta-blockers	27	44	25	3

SSRIs, selective serotonin re-uptake inhibitors; MAOIs, monoamine oxidase inhibitors.

Table 2. Pharmacological management strategies

	Benzodiazepines (%)	TCAs (%)	SSRIs (%)	Antipsychotics (%)
First-line	7	25	52	17
Second-line	9	36	16	25
Third-line	26	10	7	30

TCAs, tricyclic antidepressants; SSRIs, selective serotonin re-uptake inhibitors.

treatment courses of between one and four weeks were common (85%); however, the duration of treatment varied, 64% of courses lasting between one and three months, and 44% more than three months. The vast majority of respondents (90%) used regular dosing strategies, although 'as required' approaches were also common, being 'sometimes' or 'usually' employed by 69% of respondents.

The practice of using antipsychotic drugs to relieve anxiety symptoms usually stemmed from personal clinical experience (89%), only 22% stating that their practice was based on recommendations in textbooks (including 4.3% on advice within the *British National Formulary*) or articles in journals. Twelve per cent described their practice as being learnt from their colleagues. When asked to compare their current practice to that five years ago, 42% of respondents said that they were using antipsychotic drugs less frequently than before, 41% of respondents stated that their frequency of use was unchanged and 13% reported that they were using antipsychotic drugs more frequently for this indication.

Comment

The results of this questionnaire survey indicate that a range of psychotropic drugs is used to treat the anxiety symptoms arising from non-psychotic mental disorders. The response rate in this survey (74%) was good, but clearly the results of an investigation of prescribing habits among senior psychiatrists in Wessex do not necessarily reflect clinical practice in other areas.

The most striking observation is that benzodiazepines are used relatively infrequently to relieve anxiety symptoms, compared with TCAs, SSRIs and antipsychotic drugs. The widespread use of SSRIs is indicative of the penetration of these drugs into the treatment of mental disorders other than depression. Antipsychotic drugs tended to be reserved for patients with chronic symptoms or complex clinical presentations who had not responded to one or two previous pharmacological treatments. Although

this may appear to be rational pharmacotherapy, the 'evidence base' for the use of antipsychotic drugs in this indication is flimsy, and the majority of responders based their practice on personal clinical experience. Some psychiatrists (less than 5%) based their practice on *British National Formulary* recommendations, where antipsychotic drugs can be used as an adjunctive treatment for severe anxiety. It may be that the responding psychiatrists, by using antipsychotic drugs, are reflecting previous fears about the risks of tolerance, dependence and withdrawal with benzodiazepines. In this sample, the general view was that antipsychotics are satisfactory alternatives to benzodiazepines and it is reasonable practice to use them to treat non-psychotic anxiety symptoms. It would be interesting to see whether clinical practice changes following the new College statement, which suggests that benzodiazepines may perhaps have been rather overlooked in recent years (Royal College of Psychiatrists, 1997). Alternatively, it is possible that antipsychotic drugs do, in fact, have real value in managing anxiety symptoms arising from non-psychotic mental disorders. If so, further research is required to support or refute this possible example of 'medicine-based evidence' (Knottnerus & Dinant, 1997).

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