Correspondence

Polypharmacy: how bad are we really?

The February edition of *The Psychiatrist* features a number of articles about psychotropic polypharmacy. Taylor concludes that 'rates of antipsychotic polypharmacy seem not to have changed'[1] while Langan & Shajahan conclude that 'polypharmacy is an increasingly encountered clinical scenario'[2] without providing any evidence for this. Both authors assert that polypharmacy is by and large very undesirable with little evidence backing its use, with the possible exception of using aripiprazole as co-therapy with clozapine in order to reduce patients' weight.[3] We work in the Trust (now Health Board) in which Tungaraza *et al* did their research into polypharmacy and concluded that 'only a third of individuals were on one psychotropic medication'.[4] This implies poor adherence with National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia which suggest that polypharmacy is best avoided unless there are exceptional circumstances and clozapine has been offered. We would like to explore the results of this last study as well as its underlying presumptions.

First, is it the patients? It is surprising that this is the first community study looking at polypharmacy and we obviously applaud Tungaraza *et al* for having conducted it. We also agree with the general sentiment that polypharmacy is by and large undesirable. However, the patient group they investigated is on the whole quite an ill cohort. The Schizophrenia Service in the old North East Wales Trust where Tungaraza *et al* conducted the study is moderately recovery focused. The standard of primary care is high and many people with good outcome and responsive schizophrenic illnesses are looked after in primary care, mostly on antipsychotic monotherapy. The patients in secondary care often include people who used to live in hospital settings, and have complex illnesses and problems that are often treatment resistant. They would all fall into the remit of having a severe and enduring mental illness as prescribed by the National Service Framework for Wales. In other words, these are patients with complex problems and significant comorbidity. Achim *et al* put the combined comorbidity of anxiety-type disorders at a staggering 50.1%.[5] Dernovsek & Sprah remind us that 40% of people with chronic psychotic disorders have clinical levels of depression and 60% have anxiety symptoms.[6] In a sample we examined, the rate of active symptoms of an anxiety disorder was 10%.[7] These patients need treatment for their depressive and anxiety disorders as well as for their schizophrenia, which almost always requires additional medication on top of the anti-psychotic. In summary, the patients that are seen in community care today are a cohort of patients with complex and often treatment-resistant problems and with high levels of comorbidity.

Second, is it the guidelines? Guidance is only guidance, so there is an expectation that exceptions may occur. The main problem with guidance, however, is that it is only as good as the evidence that it is based on. Lack of evidence for efficacy is not the same as evidence for lack of efficacy. Because something has a poor research base does not automatically make it unreasonable or ineffective. We agree that there have not been many large-scale studies looking at polypharmacy, but there have been some studies that suggest that polypharmacy might be useful in limited situations and circumstances. Mortimer reaffirms that 'amisulpride has the best evidence as an affective adjunct to clozapine treatment'.[8] The other problem with evidence-based research that primarily considers randomised controlled trials is that it always looks at an average. This does not take into account the fact that although some patients will have a good effect from an intervention, others will have no effect from a particular intervention even if the overall effect size might be average. This means that to get an average effect size we need some people who had particularly good effects and others who had no effect. Although we admit that we often do not know who is going to respond particularly well, it is clearly necessary to find inventive solutions for people whose illness will otherwise remain treatment resistant. Additionally, the recent update of the NICE guidelines for schizophrenia take into account the increasing amount of evidence that suggests that second-generation antipsychotics are not a homogeneous group and some of them are clearly more effective than others.[9] This evidence is emerging and has been changing the way in which psychiatrists practice all around the world.

Third, is it the drugs? Karunakaran *et al*[10] have shown that clozapine/aripiprazole combinations can be a useful regime to allow people on clozapine to reduce their clozapine dose without a loss of efficacy. Similar studies have shown such effects for amisulpride and quetiapine. The service that Tungaraza *et al* researched in North Wales has a specialist clozapine clinic and a high number of patients on clozapine (143 in February 2010). Many of them are enabled to reduce their clozapine dose and thus their clozapine-related side-effects by introducing a second antipsychotic. We question whether this should be seen as good practice rather than condemned as polypharmacy.

In conclusion, rather than lamenting that only a third of patients studied in North East Wales were on monotherapy, we think it would be more appropriate to applaud the fact that no patient was on more than two antipsychotics. Most of the patients on two antipsychotics would have been on clozapine and either aripiprazole or amisulpride, which is used in order to reduce side-effects caused by clozapine. Additional psychotropic medication would primarily include antidepressants used to treat depression and anxiety disorders in our patients with schizophrenia or mood stabilisers in bipolar affective disorder, both following current NICE guidelines. This means that we have followed NICE guidelines even if it means using polypharmacy. We therefore feel that in many of the cases that sound like undesirable polypharmacy there may actually be very good reasons in accordance with guidance why two or three psychotropic drugs are being used. This is in order to benefit patients whose side-effect profile can be improved and their debilitating anxiety or depressive disorders treated on top of the treatment for their schizophrenic illness. We would therefore like to see a more balanced view with regard to

https://doi.org/10.1192/pb.34.5.208 Published online by Cambridge University Press

polypharmacy in a patient group that is often non-responsive to medication and usually has complex comorbidities.

Furthermore, we would dispute the notion that Taylor[1] suggested: that non-medical prescribers may improve the situation. We have concerns which are rather in contrast to this. Non-medical prescribers are more likely to follow guidance but if guidance changes or is flawed, as we have seen with the NICE guidelines for schizophrenia, non-medical prescribers are more likely to lack the flexibility to respond adequately to these challenges and may therefore contribute to suboptimal treatment rather than improve it. Lastly, we wholeheartedly embrace the recommendations that Langen & Shajahan put forward,[2] which ask for the regular review of all instances of polypharmacy including clear documentation as to why polypharmacy is continuously used.

1 Taylor D. Antipsychotic polypharmacy – confusion reigns. *Psychiatrist* 2010; **34**: 41–3.

2 Langan J, Shajahan P. Antipsychotic polypharmacy: review of mechanisms, mortality and management. *Psychiatrist* 2010; **34**: 58–62.

3 Fleischhacker WW, Heikkinen T, Olie JP, Landsberg W, Dewaele P, McQuade RD, et al. Weight change on aripiprazole-clozapine combination in schizophrenic patients with weight gain and suboptimal response on clozapine: 16 week double-blind study. *Eur Psychiatry* 2008; **2**: s114–5.

4 Tungaraza TE, Gupta S, Jones J, Poole R, Slegg G. Polypharmacy and high-dose antipsychotic regimes in the community. *Psychiatrist* 2010; **34**: 44–6.

5 Achim AM, Maziade M, Raymond E, Olivier D, Mérette C, Roy MA. How prevalent are anxiety disorders in schizophrenia? A meta-analysis and critical review on a significant association. *Schizophr Bull* 2009 Dec 3 [epub ahead of print], doi: 10.1093/schbul/sbp148

6 Dernovsek MZ, Sprah L. Comorbid anxiety in patients with psychosis. *Psychiatr Danub* 2009; **21** (suppl 1): 43–50.

7 Sharma VK, Lepping P, Cummins AG, Copeland JR, Parhee R, Mottram P. The Global Mental Health Assessment Tool – Primary Care Version (GMHAT/PC). Development, reliability and validity. *World Psychiatry* 2004; **3**: 115–9.

8 Mortimer AM. Update on the management of symptoms in schizophrenia: focus on amisulpride. *Neuropsychiatr Dis Treat* 2009; **5**: 267–77.

9 Leucht S, Corves C, Arbter D, Engel RR, Li C, Davis JM. Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis. *Lancet* 2009; **373**: 31–41.

10 Karunakaran K, Tungaraza TE, Harborne GC. Is clozapine-aripiprazole combination a useful regime in the management of treatment-resistant schizophrenia? *J Psychopharmacol* 2007; **21**: 453–6.

Peter Lepping Consultant Psychiatrist, Honorary Senior Lecturer and Associate Medical Director; **Giles C. Harborne** Consultant Psychiatrist and Chief of Staff Mental Health, Betsi Cadwaladr University Health Board, Wrexham, UK. Email: peter.lepping@wales.nhs.uk

doi: 10.1192/pb.34.5.208

Let's not throw the baby out with the bath water

Tyrer *et al*'s study on the effectiveness of crisis resolution and home treatment teams (CRHTs) is a good addition to the debate on the evidence base of these teams. The authors concluded that the introduction of CRHTs in Cardiff was associated with an increase in compulsory admission, a decrease in informal admission and bed days, and an increase in the number of suicides in the area covered by CRHTs. In as much as the authors can be commended in their fairly robust appraisal of the research methodology employed, nonetheless it is hard to overlook the major deficiencies in the study design. The findings, but for the increased rate of suicides, are not new, and need not reflect negatively on CRHTs. The authors highlighted that none of the victims of suicide were under the care of the CRHT at the time of their death.

The often-cited North Islington Study[2] also showed that compulsory admission was not significantly reduced; however, in recent years a number of possible explanations for this finding have emerged. It is highly likely that a sizeable proportion of the patients who were compulsorily admitted were not only severely ill, but lacking in insight or capacity to consent to a treatment plan. Gould *et al*'s[3] study on patients presenting with acute onset of first-episode psychosis concluded that in this group of patients, although living in an area in which alternatives to admission were well developed, compulsory admission was still high.

Crisis resolution and home treatment teams exist within complex local systems and politics and it is inevitable that other key services such as the traditional community mental health team, in-patient service, mental health liaison team, primary care gateway service, assertive outreach and early intervention team in psychosis will play key roles in its effectiveness. An interesting enquiry is whether such specialist teams working jointly with CRHTs will be able to prevent compulsory in-patient admissions for these severely ill patients more effectively than CRHT alone.

A Cochrane review[4] continues to gather increasing long-term evidence to support the implementation of the CRHT worldwide. The evidence for reducing informal admission, bed usage and patient satisfaction has been replicated in various studies. Crisis resolution and home treatment teams should not be seen as a government-enforced innovation, but rather a viable and acceptable approach to treating people with severe mental illness. Evidence suggests that improvements in outcome of CRHTs are most convincing where psychiatrists have embraced this development and use their informal power to support them.[5] Let's not throw the baby out with the bath water.

1 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

2 Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, et al. Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ* 2005; **331**: 599–602.

3 Gould M, Theodore K, Pilling S, Bebbington P, Hinton M, Johnson S. Initial treatment phase in early psychosis: can intensive home treatment prevent admission? *Psychiatr Bull* 2005; **30**: 243–6.

4 Irving CB, Adams CE, Rice K. Crisis intervention for people with severe mental illness. *Cochrane Database Syst Rev* 2006; **4**: CD001087.

5 Middleton H, Glover G, Onyett S, Linde K. Crisis resolution/home treatment teams, gate-keeping and the role of the consultant psychiatrist. *Psychiatr Bull* 2008; **32**: 378–9.

Stephen Ogunremi is Locum Consultant Psychiatrist, Portsmouth City Teaching Hospital, email: Stephen.Ogunremi@ports.nhs.uk; **Bilal Talat** is Locum Staff Grade Psychiatrist, Portsmouth City Teaching Hospital.

doi: 10.1192/pb.34.5.209

Confusing title and misleading assumptions

The title and the aim of the study by Tyrer *et al*[1] state that they had made a controlled comparison of two crisis resolution and home treatment teams (CRHTs). However, reading through the