Correspondence

Rebound psychosis following withdrawal of clozapine

Latif *et al*[1] address the crucial issue of blood dyscrasia associated with clozapine. Although they quite rightly mention that this is one aspect of a range of adverse effects (including seizures and cardiovascular complications), we would like to draw the readers' attention to a less well-emphasised, but nevertheless important, issue variously termed clozapine withdrawal, discontinuation or rebound psychosis.
This phenomenon may perhaps be neglected because, paradoxically, it may emerge after patients have suddenly stopped taking clozapine, and therefore it does not comfortably fit into the category of 'adverse effects'. Indeed, terms such as withdrawal and discontinuation have also led this phenomenon to be addressed within the addictions literature.

Emergence of a rapid 'supersensitivity psychosis' following sudden withdrawal of clozapine has been well documented;[2] various studies have attributed rapid relapse following clozapine withdrawal to clozapine-induced supersensitivity for dopamine, acetylcholine or serotonin receptors.[3] Seppala *et al*[4] found a rapid deterioration in mental state following withdrawal in almost half the patients of a group who had been on long-term clozapine treatment, whereas Seeman & Tallerico[3] discovered that the rate of psychotic relapse in patients withdrawn from clozapine is five times higher than that for a traditional antipsychotic such as haloperidol or flupenthixol. Clozapine withdrawal psychosis has also been observed to be severe in symptomatology and is in some cases associated with delirium.[5]

It is certainly not uncommon for clinicians to see patients with a severe rebound psychosis as a result of sudden clozapine withdrawal. Emphasis has rightly been placed on preventing a sudden discontinuation of other psychiatric medications with the potential of precipitating a rebound illness (e.g. lithium) by educating patients. Unfortunately, in our experience this does not necessarily extend to clozapine.

Patients should be made aware of the risks of sudden discontinuation of clozapine treatment, including the possibility of severe symptomatology, as early as treatment planning stage with a clear care plan to manage a rebound illness in the event of a sudden discontinuation. From a medico-legal perspective, given that rebound psychosis cannot be considered rare, a clear explanation of the phenomenon during the consent-to-treatment interview should form a crucial part of obtaining informed consent before prescribing clozapine.

1 Latif Z, Jabbar F, Kelly BD. Clozapine and blood dyscrasia. *Psychiatrist* 2011; **35**: 27–9.

2 Ekblom B, Eriksson K, Lindström LH. Supersensitivity psychosis in schizophrenic patients after sudden clozapine withdrawal. *Psychopharmacology* 1984; **83**: 293–4.

3 Seeman P, Tallerico T. Rapid release of antipsychotic drugs from dopamine D2 receptors: an explanation for low receptor occupancy and early clinical relapse upon withdrawal of clozapine or quetiapine. *Am J Psychiatry* 1999; **156**: 876–84.

4 Seppala N, Kovio C, Leinonen E. Effect of anticholinergics in preventing acute deterioration in patients undergoing abrupt clozapine withdrawal. *CNS Drugs* 2005; **19**: 1049–55.

5 Stanilla JK, De Leon J, Simpson GM. Clozapine withdrawal resulting in delirium with psychosis: a report of three cases. *J Clin Psychiatry* 1997; **58**: 252–5.

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Home treatment and an increase in detentions

Forbes *et al*[1] reported that the number of detained individuals increased following the setting up of an intensive home treatment team in Midlothian, with no reduction in admissions overall. In their discussion they identified a number of potential reasons for this rather disappointing result. However, they did not look at the relevance of staffing, nor the degree of adherence to the high-fidelity model of home treatment.

Middleton *et al*[2] looked at gatekeeping and concluded that admissions were more likely to be reduced if the team had a dedicated consultant psychiatrist and worked on a 24-hour basis. It was also noted that teams which were more 'mature' were more effective gatekeepers. In Midlothian the medical input is from a part-time staff grade doctor, the team operates from 8 am to 12 pm and in the period reported the team was only in its first year. We have little doubt that if Dr Forbes can persuade the commissioners to invest further in the service, bed reductions will be made.

Our home treatment team in Belfast was set up in April 2007 and covers a population of 350 000. It has 1.5 whole time equivalent dedicated consultants and operates 24 hours a day. We took on the role of gatekeeping all admissions in April 2009, and over the next 12 months the admissions dropped by 27%.

Forbes and colleagues propose that their team may have had a low threshold for accepting risk, in the context of the introduction of formal risk assessment procedures for all patients seen. They argue further that thresholds for risk are falling with an increasing use of community detention powers and longer-term hospital detentions.

This reflects concerns raised by the Care Quality Commission,[3] who noted that while the number of hospital detentions had not reduced, the number of community treatment orders (CTO) had 'greatly exceeded the number anticipated at the time the new legislation was introduced'. The premise on which CTOs were predicated was that they were a less restrictive alternative to hospital admission. In truth the evidence is that they are becoming an additional way of managing perceived 'risk', which has now regrettably become a key driver in psychiatric practice.

There is a grave danger that the natural instincts of the large majority of psychiatrists to move away from a paternalistic and risk-averse model of care are being compromised by paying too much heed to the often confused