Correspondence

Polypharmacy: saint or sinner?

Lepping & Harbone[1] query the notion that polypharmacy rates are increasing. The general consensus, however, is that polypharmacy rates are indeed rising and previous studies clearly report this trend.[2,3] It is also not certain that the study by Tungaraza *et al*[4] is the first community study of polypharmacy in the UK, as our study[5] probably predates it.

The findings from our study were strikingly similar to those of Tungaraza *et al* in showing almost identical out-patient polypharmacy rates of 17.4% and 17.5% respectively, and a prevalence of high-dose prescribing and sedative use in association with polypharmacy. These results were obtained despite the fact that our study population would not be considered severely ill. Both studies showed a tendency for atypical antipsychotics to be commonly involved in combination or high-dose prescribing – perhaps asking, as do Lepping & Harbone, about the efficacy of atypicals in the real-life clinical situation.

That polypharmacy continues despite repeated guidance against it may indicate that this is perhaps one area in which clinical practice and observation is ahead of research evidence, which is yet to catch up. Lepping & Harbone make the point that in the case of polypharmacy the evidence provides no support one way or the other. There appears now, however, to be a shift away from a blanket condemnation of antipsychotic polypharmacy to a search for evidence-based recommendations, which would support a role for polypharmacy in everyday clinical practice. Langan & Shajahan[6] provide a number of excellent recommendations based on a thorough review of the existing literature. Not all of these recommendations may, however, be applicable in everyday clinical practice.

Several studies, including ours,[5] have shown poor adherence to standards requiring documentation of clinical practice, or the recording of investigation reports such as electrocardiograms. Recent audits have advocated review by pharmacists, which may be feasible for in-patients but less so in out-patient populations. It is similarly problematic to conceive of a mechanism to ensure that cross-tapering of medication is completed and not abandoned half-way through. The idea of switching back from polypharmacy to monotherapy in identified cases sounds attractive and has been shown successful in a proportion of patients,[6] but clinicians may still remain wary of the problem of inducing psychotic relapses in otherwise stable patients, with all the associated consequences, including a fatal outcome.

What is clear perhaps is that the antipsychotic polypharmacy issue is unlikely to go away. The current attempts to 'manage' polypharmacy through audit, guidelines and recommendations have not led to change, and polypharmacy remains in many ways 'treatment resistant'. It may be time to be open-minded about psychiatry's 'dirty little secret' and allow the 'co-prescribing' of new measures focused on achieving a better understanding of the polypharmacy phenomenon.

1 Lepping P, Harborne GC. Polypharmacy: how bad are we really? *Psychiatrist* 2010; **34**: 208–9.

2 Centorrino F, Eakin M, Bahk WM, Kelleher JP, Goren J, Salvatore P, et al. In-patient antipsychotic drug use in 1998, 1993 and 1989. *Am J Psychiatry* 2002; **159**: 1932–5.

3 Gilmer TP, Dolder CR, Folsom DP, Mastin W, Jeste DV. Antipsychotic polypharmacy trends among medical beneficiaries with schizophrenia in San Diego County, 1999–2004. *Psychiatr Serv* 2007; **58**: 1007–10.

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 Ranceva N, Ashraf W, Odelola D. Antipsychotic polypharmacy in outpatients at Birch Hill Hospital: incidence and adherence to guidelines. *J Clin Pharmacol* 2010; **50**: 699–704.

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

Deji Odelola, Consultant Psychiatrist, Birch Hill Hospital, Rochdale, email: deji.odelola@nhs.net, **Nadezda Ranceva**, Academic Clinical Fellow in Psychiatry (CT1), Meadowbrook Hospital, Greater Manchester West Foundation Trust, Salford.

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The jury is still out!

Lepping & Harborne[1] highlight the unfortunate conflation of 'psychotropic polypharmacy' and 'antipsychotic polypharmacy', which is seen in the study by Tungaraza *et al*[2] and which may confuse the reader. Their response falls foul of this issue when they refer to the statement that 'only a third of [patients] were on one psychotropic medication', and draw an implication of a shortfall in compliance with the National Institute for Health and Clinical Excellence schizophrenia guideline.[3] The guideline advocates sequential use of antipsychotic monotherapy, but does not discuss polypharmacy involving other psychotropic medication. Lepping & Harborne rightly point out that both Taylor[4] and Tungaraza *et al* have made assessments about the temporal change of incidence of antipsychotic polypharmacy without references, but later they mention studies of clozapine–amisulpride and clozapine–quetiapine combinations which are unreferenced.

An internal in-patient survey of antipsychotic polypharmacy in our own trust demonstrated an incidence broadly similar to that found in the literature at the time, but that antipsychotic polypharmacy regimes were not centred around attempts to optimise clozapine treatment. Rather, a variety of regimes involving diverse antipsychotics was seen. It is perhaps speculative to presume that in the Wrexham cohort[2] most people on two or more antipsychotics were taking clozapine. In the forensic setting, complexity and diagnostic plurality is the norm, so antipsychotic polypharmacy is perhaps unavoidable at times. It is our concern that procedural aspects, such as preconditions for assured concordance before transfer to step-down services, may sometimes colour the prescribing decisions and drive the co-administration of depot antipsychotics with oral atypicals. We could not find reference to non-medical prescribers in Taylor's article. Indeed, we feel that Tungaraza *et al* suggest that the emergence of new groups of prescribers points out the urgency of resolving issues around antipsychotic

polypharmacy, broadly anticipating the concerns of Lepping & Harborne. Finally, we respectfully suggest that the word polypharmacy be reconsidered, since pharmacy is seldom the originator of the plan!

1 Lepping P, Harbone GC. Polypharmacy: how bad are we really? *Psychiatrist* 2010; **34**: 208–9.

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

3 National Institute for Health and Clinical Excellence. *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (Update) (CG82).* NICE, 2009.

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

Chandan Sehgal, Staff Grade Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust, email: chandan.sehgal@swyt.nhs.uk, **Paul A. Hardy**, Pharmacy Services Manager, Fieldhead Hospital, Wakefield.

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Wide of the mark

It would seem that the basis for Christopher Cook's objection to our paper is our perspective on Charles Taylor's theory of the rise of secularity in the modern world.[1] In doing so, he provides a skewed analysis of what we were actually saying. Taylor's work was helpful to us in considering psychiatry's attitude to religion. However, our main aim was to suggest that despite our deeply materialist age a sense of transcendent meaning was of great value to human beings and had never been lost. In this at least Cook seems to agree with us.

We were invited by the Editor to write a response to Harold Koenig's interesting suggestion that psychiatrists might pray with their patients.[2] In doing so, we took the stance that a focus on the practice of praying with patients was distracting attention from the far greater issue of spirituality and meaning in people's lives. Cook appears to think we are against a thoughtful consideration of religion in psychiatry when that was never the case. He has missed our irony completely. One particular peer reviewer of our article had strikingly similar attitudes and forced our commentary through three revisions before they could accept it. The whole unhappy experience has made us worried about the increasing defensiveness of some religious psychiatrists in the College who appear to want to control discourse about psychiatry and religion. This should concern us all.

1 Cook CCH. Spirituality, secularity and religion in psychiatric practice. Commentary on . . . Spirituality and religion in psychiatric practice. *Psychiatrist* 2010; **34**: 193–5.

2 Koenig HG. Religion and mental health: what should psychiatrists do? *Psychiatr Bull* 2008; **32**: 201–3.

Michael King, Professor of Psychiatry, University College London, email: m.king@medsch.ucl.ac.uk, **Gerard Leavey**, Professor in Mental Health and Wellbeing, Northern Ireland Association for Mental Health, and University of Ulster, Belfast.

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Debating common ground and recognising differences

It is good to discover that Michael King, Gerard Leavey and I share more common ground than I had at first perceived based on my reading of their article.[1] Perhaps a part of the problem was that I only saw the abstract after publication and that what I had interpreted as ambivalence towards spirituality in the main body of the article is now set in the context of the clear and positive statement regarding spirituality that the abstract provides.

However, it seems that we do have a different reading of Charles Taylor's *A Secular Age*,[2] and also probably hold different views of exactly what spirituality is. To explore these differences in academic debate seems to me to be a healthy thing, and this is why I was pleased to accept an invitation from the Editor to write a commentary on King & Leavey's article. I would never wish to 'control discourse about psychiatry and religion' but I am glad to participate in a lively and critical debate about a subject that psychiatry has too long ignored and at times even denied.

1 King M, Leavey G. Spirituality and religion in psychiatric practice: why all the fuss? *Psychiatrist* 2010; **34**: 190–3.

2 Taylor C. *A Secular Age*. Harvard University Press (Belknap), 2007.

Christopher C. H. Cook, Professorial Research Fellow, Durham University, email: c.c.h.cook@durham.ac.uk

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Spirituality, secularism and religion

The controversial claim of French philosopher André Comte-Sponville that spirituality is quite compatible with atheism could provide vital insights to continued discussion on the relevance of religion to psychiatry which began in *The Psychiatrist* with the article by Dein *et al*.[1,2]

Handling debates about the existence or otherwise of God can be difficult, unless one is a trained philosopher. Comte-Sponville summarises it best when he tells us that at the age of 18 he wrote: 'If God exists then nothing follows; if God does not exist then nothing follows.' However, a few years later he wrote: 'If God exists everything follows; if God does not exist then everything follows.'

Religious systems depending on God as their pivotal point are in essence only relying on what human beings regard as the relevance of the Divine in human life. Those who have abandoned a belief in God also create what they think are the principles of life without God. They are all human creations.

Today we are surrounded by a variety of religions and ideologies and each of us as individuals makes our own evaluation of life and develops the values by which we live.

Many seem unwilling to take a serious part in any further discussion on the subject and seek only to abide by the law, live on good terms with others and follow the mores of the workplace. Many, like me, see the world as best understood in humanist terms. This means that we start and finish with ourselves. However, this does not prevent us from reaching out to others and beyond to the principles on which life is built.

There was an older humanism that seemed determined to negate all religion and to attempt to rebuild the world on a new atheistic agenda, but there can also be a humanism that seeks to understand the beliefs that are part of human evolution, both individually and collectively, and to reapply them to current needs.

The new great interest in the spirituality of patients is to be welcomed but there is a risk that it will become just another part of service provision without fully regarding its complexity.