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EDITORIAL

Rational prescribing of psychotropic medicines

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The progressive development of effective psychotropic medicines over the past 50 years has undoubtedly revolutionised the care of people with a mental illness, so that they now have a very important role in modern health care. Increasingly, however, concern is being expressed in a number of countries about the excessive use of these medications (International Narcotics Control Board, 2001, 2004).

It is perhaps worthwhile to analyse why the increasing use of psychoactive drugs arouses so much concern among the public when the increased prescription of non-psychoactive drugs rarely provokes such strong reactions. The difference in response arises predominantly because the symptoms for which psychoactive drugs are prescribed – such as insomnia, depression, anxiety and inability to cope – often result from underlying personal or social problems rather than from a recognised medical condition (Fombonne *et al*, 1989). Thus, medical professionals, and particularly psychiatrists, find themselves providing a pharmacological response to non-medical problems. This situation has profound implications for society as a whole, and leads to a deep unease, which is exacerbated by the knowledge that these drugs are associated with a number of ill effects, some long term.

The validity of such concern is highlighted by the different treatment practices in different countries. For example, the consumption of central nervous stimulants is on average ten times higher in the USA than in European countries, whereas the consumption of benzodiazepine-type sedative hypnotics and anxiolytics in Europe is three times higher than that in the USA. Even within the European Union, despite efforts to harmonise prescribing policies, the consumption of benzodiazepines in France was for many years more than twice that in Germany or Norway (Ghodse, 2003).

Such large discrepancies in use in different countries can hardly be explained away by different prevalence rates of mental illness, and other reasons must therefore be sought. These include the economic and social conditions in a country, together with the importance accorded to health care, the availability of medicines in general and the effective functioning of regulatory control. Most low- and middle-income countries, for example, lack the resources and expertise required to determine medical needs and to adjust drug supply accordingly. At the same time, newly gained wealth in countries experiencing rapid economic growth is often associated with rapidly increasing drug consumption. Thus, the 'pill-popping' culture of many countries in the developed world is spreading fast to developing countries (International Narcotics Control Board, 2001).

Excessive reliance on pharmacotherapy is often associated with polypharmacy, that is, the use of multiple drugs, often in irrational combinations, at inadequate dosages and for excessively long periods. This is contrary to the principles of rational, evidence-based therapy and cannot be cost-effective. The medical profession (particularly psychiatry) bears an important responsibility to prescribe appropriately; in this light, national medical associations and other professional bodies have, in the past, undertaken useful initiatives to promote good practice.

The pharmaceutical industry is equally important in curbing excessive drug consumption and most manufacturers exhibit responsible and ethical behaviour in the promotion of all medicinal products. None the less, certain psychotropic medicines continue to be promoted even when better treatment options are available. In addition, direct financial support is provided to associations and other advocacy groups by drug manufacturers, which also disseminate promotional material for certain psychotropic drugs. Furthermore, contrary to the provisions of the 1971 United Nations Convention on Psychotropic Substances, some of these drugs are directly advertised to the consumer.

Despite all this, the role of the individual prescribing clinician is of paramount importance. A well-founded therapeutic decision is based on a good clinician–patient relationship, accurate assessment and diagnosis by the clinician, and careful consideration of the available

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therapeutic options, including the expected benefits and risks. The clinician–patient interaction involves responsibilities on the part of both, the extent of which is influenced by the culture of the country in question. In an age of wider access to health-related information, of 'concordance' and of joint decision making, the patient is seen as an increasingly important contributor to the entire therapeutic process and it is hoped that this 'therapeutic alliance' will improve compliance with treatment (Ghodse & Khan, 1988; International Narcotics Control Board, 2001).

In the midst of concern about the excessive use of psychotropic drugs, it is easy to ignore or forget the important facts about their therapeutic usefulness. However, the scientific evaluation of a drug should not be influenced by attitudes and value judgements, and psychotropic drugs should be assessed using the same tests and standards that are applied to non-psychotropic drugs. Within this context it is important to remember that a lack of appropriate drugs deprives patients of their fundamental right of relief from suffering. At the same time, excessive use and over-medication leads to suffering of a different kind. The problem is that there is no universal consumption standard for psychotropic medication and no country or even region can be held up as an example of best practice.

The prescription of psychotropic medicines may be inappropriate if it is: uninformed; inconsistent or lax; knowingly done for misuse of the drug by the patient; for self-administration. The underlying causes of such behaviour appear to be: inadequate training; shortage of information; lenient or lax attitudes; lack of sense of professional responsibility; unethical behaviour; personal drug addiction; criminality or corruption (Ghodse & Khan, 1988).

Psychiatrists can and should play an important role in educating doctors and other health care professionals as well as the public at large to achieve a culture of rational prescribing of psychotropic medicines. However, there is a wide range of policy makers, including government, health authorities, universities, postgraduate colleges, medical professional organisations and the pharmaceutical industry, all of which have an important influence on the education of health care professionals and so must also acknowledge and implement their collective responsibilities in this area.

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THEMATIC PAPERS – INTRODUCTION

Patient satisfaction with psychiatric care

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We are enjoined nowadays to be ever more cognisant of the views of patients about the care they receive, in all forms of health service. From the point of view of psychiatry, there is a small but growing literature on this subject and we have three opinions from around the world in this issue. First, Australian colleagues from psychiatric nursing (Brenda Happell and Monica Summers) surveyed patients with mental health problems who attended an accident and emergency department. One important issue, which is reflected in many such departments around the world, is the length of time spent waiting for an assessment. Despite the fact that a triage process was available, which presumably did increase efficiency, the wait was too long for many clients, who left before being seen. (Most had attended after self-harming behaviour.)

A second article, from the United States, also from colleagues in psychiatric nursing (Patricia Howard *et al*) considers patient satisfaction with the quality of service received, and with treatment outcomes, in public sector psychiatric hospitals. Increasingly, the quality of care provided is being measured, in part, by how satisfied patients are with it. We anticipate these considerations will soon motivate care widely in the developed world. Noting that the majority of patients in this survey had been involuntarily confined, it is fascinating to learn what they felt had been the greatest sources of satisfaction during their confinement (mainly the opportunities to talk to other patients and to staff). The sources of dissatisfaction appear to be related to a failure of staff to listen sufficiently carefully to the needs of the patients.

Finally, we have a survey from the Swedish health care system. Håkan Johansson points out that there is a structural problem with the very idea of measuring satisfaction. Outcome measures vary from survey to survey, and there is no clear relationship between satisfaction with care and treatment outcomes. The style of this survey was quite different to that of the previous two, for

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