Prescribing restrictions for expensive psychiatric drugs

Sir: Drug expenditure has, historically, accounted for only a small percentage of the total cost of caring for patients with schizophrenia. One suggested figure is 3% (Davis & Drummond, 1990). This differs markedly with the relative costs in other therapeutic areas where the drugs budget accounts for approximately 10% of the total cost of patient care. Clozapine is a prime example of a relatively new drug for the treatment of schizophrenia which may alter the disproportionately low prescribing costs for this condition. Its use, therefore, has high cost implications for the field of psychiatry. Pharmacoeconomic studies have suggested that, although the acquisition cost of clozapine is high in comparison with other neuroleptics, the clinical benefits of the drug may confer medium to long-term economic benefits in patients with treatment resistant schizophrenia (Fitton & Benfield, 1993). However, in the current economic climate, concerns have been expressed regarding the prescribing of expensive drugs and whether the use of these drugs is being restricted for purely economic reasons.

In response to these concerns a telephone survey of 20 hospitals in the United Kingdom was performed in May 1994. The hospitals were randomly selected. Using an open semi-structured questionnaire the hospitals' use of clozapine and any restrictions placed on its use were determined from pharmacists working closely with the mental health unit.

The number of patients prescribed clozapine at each hospital ranged from one to approximately 100 (median 15–20 patients). It was found that at 11 hospitals the use of clozapine was reported to be on consultant request as per data sheet requirements. Six hospitals had written guidelines for the use of clozapine in operation with a further three units in the process of developing guidelines. An assessment of the patient's resistance to standard neuroleptics was a prime requirement of the guidelines. This was achieved by a medication history prepared by either the medical team or pharmacist. A second opinion of the patient's diagnosis was a requirement at one hospital. Predictors of response to clozapine were included in the guidelines. Therapeutic trials of varying lengths (18 weeks to one year) were recommended, after which an assessment of the benefits gained from the drug was to be performed using a variety of rating scales. Prescribing of clozapine on discharge of the patient into the community remained under the care of the consultant at all of the hospitals contacted. Four of the pharmacists contacted were aware that extra funding had been obtained for the use of clozapine at their hospital. Interestingly, a number of pharmacists thought that the increased drug expenditure through the use of clozapine had been contained by the recent appreciable decrease in bed numbers at their hospital.

In conclusion, guidelines for the use of clozapine were found to be in operation at a number of units. However, these did not appear to be for purely economic reasons but with the aim of targeting the use of clozapine to those patients who would most benefit from its use. Limiting the use of clozapine on the grounds of cost alone would appear, from this survey, to be unusual. It is appreciated that only a random sample of hospitals were included in this survey; however, no economic limitations on the use of clozapine were found.

If your prescribing of clozapine is being limited for purely economic reasons – is this ethical?

DAVIES, L. M. & DRUMMOND, M. F. (1990) The economic burden of schizophrenia. *Psychiatric Bulletin*, **14**, 522–525.

FITTON, A. & BENFIELD P. (1993) Clozapine: an appraisal of it's pharmacoeconomic benefits in the treatment of schizophrenia. *Pharmacoeconomics*, **4**, 131–156.

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ECT machines: identical, but different

Sir: As an extension of our audit of ECT in three Liverpool hospitals we evaluated patient case-note data from one of the hospitals over 12 months, July to December 1992 (period 1), and January to July 1993 (period 2) when the ECT clinic inherited an Ectron Duopulse Series (E2) machine from the local district general hospital. For reasons unknown the inherited machine was used in preference to the existing clinic machine, an apparently identical E2.

Fit length was not recorded in 42% of first stimulations in period 1 (n=87) and 28% in

period 2 (n=113) so we calculated three inadequate seizure ratings (expressed as a percentage of the total number of first stimulations) for each series: 'minimum' (all incompletely documented seizures assumed to be adequate); 'known' (only completely documented seizures rated) and 'maximum' (all incompletely documented seizures assumed to be inadequate).

There were no significant differences between period 1 and period 2 patients for age (means 74.3 and 85.9), sex, concurrent treatment with medication with anti-convulsant properties, mean number of treatments (7.2 and 8 respectively), incidence of missed seizures (4 and 3% of first stimulations) and global clinical outcome. There were, however, significant differences (P<0.05, 2 tailed t-test) in the minimum, known and maximum inadequate seizure ratings for period 1 and period 2 (means 30, 47, 66% and 14, 14, 44% respectively), failed treatment session ratings (27% and 17%) and incidence of partial seizures (19% and 3%).

Our findings suggested that two apparently identical E2 machines were not equally effective in inducing adequate seizures. We were aware that there are two possible versions of the E2 (Pippard, 1992) – the unmodified version (E2), which would have a power output at the standard setting used ('ECT 1' × 4 seconds of 106 mQ), and the modified version (E2+), with an output of 149 mQ at the same setting (both output figures are quoted in units of charge, milliCoulombs, and assume a 200 ohm impedance load). The manufacturers confirmed that the inherited machine had been returned for modification in the mid-1980s.

Our audit findings were comparable with Pippard's findings in his audit of ECT in two health regions where an estimated 22% of applications were considered therapeutically ineffective (Pippard, 1992). Two interrelated factors contribute to the problem: underpowered ECT machines and ignorance on the part of the operator which amplify the problem.

PIPPARD J. (1992) Audit of electro-convulsive treatment in two National Health Service regions. *British Journal of Psychiatry*, **160**, 621–637.

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Mental Health Review Tribunals and the Home Office

Sir: We much appreciate the comments by Agarwal & Kumar (*Psychiatric Bulletin*, 1994, **18**, 649–650) about our letter on Mental Health Review Tribunals (*Psychiatric Bulletin*, 1994, **18**, 374).

We do agree with Agarwal & Kumar that the Home Office passes the buck. Perhaps it does so deliberately.

In considering whether civil servants "hundreds of miles away at the Home Office should ever make decisions about complicated and dangerous patients", Agarwal & Kumar open up the whole question of whether the system of Home Office control of patients detained under section 41 orders is the best one.

We are aware that these civil servants do not wish to have a psychiatrist among them, preferring to judge questions of parole, transfer and discharge from hospital of restricted patients from the points of view of intelligent and informed lay people. In the current climate of concerned public response to tragedies associated with psychiatric patients in the community, the civil servants are all the more likely to delegate decisions about restricted patients to Mental Health Review Tribunals.

We know too that in Scotland the Mental Welfare Commissioner, who is a psychiatrist, keeps in close contact with the medical officer responsible for restricted patients by visiting him and discussing the relevant issues; in Canada patients detained indefinitely as 'Not Criminally Responsible' are under the jurisdiction of a Provincial Review Board comprising a Judicial Chairman and psychiatric and lay members; and countries in Europe and states in the USA have their own different provisions for governmental control of dangerous mentally abnormal offenders.

Has anybody done worldwide research on procedures in other countries for mentally abnormal patients requiring restrictions?

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Delegation of section 5(2) Mental Health Act 1983 II

Sir: The issue of who acts as the consultant's nominated deputy continues to crop up. It is a