MEDICAL PRACTICE

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General Practice Observed

Monitoring of psychotropic drug prescribing in general practice

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Summary and conclusions

Over 1000 repeat prescriptions of psychotropic drugs, which were given without the doctor seeing the patient, were analysed from a population of over 100 000 patients during a two-week period. The analysis showed that the longer repeat prescribing had taken place the older the patient was likely to be and the less closely were they monitored by their general practitioner.

Introduction

All psychotropic drugs are prescribed by doctors, 61% of them having been first prescribed by general practitioners.[1] The medical profession can therefore control and monitor their use.

A two-week survey carried out in 1972 by Dunnell and Cartwright showed that of all adults and children who were taking tablets, 10% were taking sedatives, hypnotics, or tranquillisers and 1% antidepressants. The rate of prescribing psychotropic and hypnotic drugs is also increasing faster than for any other drug group.[2]

Reliance on self-referral by elderly patients is unsafe.[3] At the same time repeat prescribing without consultation is increasing in general practice. More than three-quarters of all regularly taken prescribed medicines are obtained by repeat prescription. Repeat prescriptions of longer duration than six months are usually for drugs acting on the central nervous system.[2]

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The case for the appropriate use of psychotropic drugs in general practice is overwhelming, but treatment with psychotropic drugs should always be scientific, specific, and limited, and demands constant surveillance by the general practitioner.[4]

This audit was carried out on those patients requesting repeat prescriptions for psychotropic and hypnotic drugs without requesting a consultation with a doctor.

Method

Trainee general practitioners in 13 practices in Bath, Cirencester, and Swindon were asked to gather information with their trainer's consent. All repeat prescriptions of psychotropic drugs without doctor consultation were recorded for a two-week period from 5 to 19 February 1979. The information recorded was the patient's age, sex, duration of time the patient had been prescribed the treatment as a repeat prescription, when the patient was last seen for any reason by a doctor, and whether there was a predetermined time interval in the patient's notes after which the patient could not obtain a further repeat prescription without seeing a doctor.

The information was collected anonymously, so that there was no practice-to-practice comparison, although a practice could compare its own results with those of the group.

Results

Thirteen practices covering mixed urban and rural populations took part in the audit. Practice list size varied from 2500 to 18 000, and the practices covered a total population of 106 350. The total number of repeat prescriptions of psychotropic drugs for the two-week period was 1031. The ages of the patients ranged from 2 to 98 years (mean 58); the average age of those patients who had been receiving repeat prescriptions for more than 10 years was 65.

The female:male ratio for the total number of patients receiving repeat prescriptions was 2·4:1, which after 10 years rose to 3:1.

A doctor had seen 60% of patients for some reason within three

months of the prescription. A small percentage, however, had not been seen for many years, some not for over ten. Those practices with a predetermined time interval after which the patient had to be seen by a doctor to obtain their drugs varied this interval from one week to two years. The average time lapse from when a patient was last seen in these practices was 19 weeks. In those practices without a "routine consultation interval" it was 24 weeks. In the former group all patients had been seen in the last two years.

One-tenth of the patients who had been receiving repeat prescriptions for their psychotropic drugs had been doing so for more than 10 years (table I). The longer the patient had been taking a drug the longer it was since they had been seen by a doctor (table II).

TABLE I—*Number of patients receiving continuous treatment for varying lengths of time*

Duration of treatment (yr)	1	2	3	4	5	6	7	8	9	10	>10
No of patients	200	130	140	100	79	80	50	50	60	50	100

TABLE II—*Average time since patient was last seen by doctor in relation to duration of treatment*

Duration of treatment (yr)	1	2	3	4	5	6	7	8	9	10	>10
Last consultation in weeks (average)	10	17	21	18	28	25	23	38	43	33	40

Table III shows the drugs prescribed; their distribution is much as one would expect. The fact that diphenhydramine/methaqualone (Mandrax) and amphetamines represent such a small percentage (about 1%) is encouraging, although one may wonder why they are still prescribed at all.

The category of drugs altered with the length of time the patient had been taking them (table IV). The most striking feature is that one-quarter of patients on psychotropic drugs for more than 10 years take barbiturates. Of the "others" category, diphenhydramine/methaqualone played a prominent part more than 10 years ago, antihistamines in the five- to six-year group, and now they are represented by the several different drug categories of recent introduction.

Discussion

The distribution of type of psychotropic drug prescribed in relation to the duration of treatment is in keeping with the appearance of the various drugs on the market. The longer a patient had been prescribed a drug, however, the more likely it was that that patient was an elderly woman taking barbiturates and also the less likely she was to have been seen frequently by her doctor.

That some patients have been taking tricyclic antidepressants for more than 10 years is disturbing, and whether this reflects poor monitoring or unenlightenment on the part of the doctor is impossible to say from this study. Patients taking tricyclic antidepressants for more than one year should be reassessed. Conversely, many patients, particularly the elderly, taking long-term hypnotics and anxiolytics may benefit from antidepressants, as depression may be their real problem and their present medication only compounding it.

The sex ratio confirms that more women than men are prescribed psychotropic drugs. Some reasons put forward for this are: problems associated with childbirth and the rearing of young families, obesity, menstrual and menopausal problems, widowhood, and musculoskeletal disorders in old age.[5]

Interestingly, most of the longer-term prescriptions were for hypnotics. One-quarter of patients on psychotropic drugs for more than 10 years are taking barbiturates and, despite patients' reluctance to change, the situation continues only because the medical profession continues to prescribe them. Perhaps fewer hypnotics would be prescribed to the older age group if their sleep patterns and requirements were better understood by doctor and patient alike. Complaints about sleep become commoner with advancing age, especially among women and among the nervous and introverted.[2,6-9] Education of the patient to regard any hypnotic drug as a temporary expedient will diminish the long-term use that is so common.[10]

Many doctors do not agree with a repeat-prescribing system, whereas others find the time saved necessary to deal with their increasing work commitments or desirable to allow more time in consultation, and also acceptable to the patient by reducing time spent in the waiting room. General practitioners tend to underestimate the frequency of repeat prescriptions in their consultations. In 1970 Balint *et al* showed that one-quarter of patients who saw a doctor in his surgery reported that they received no more than a repeat prescription.[11] It is postulated that long-term repeat prescribing represents a failure in doctor-patient communication. If repeat prescribing is carried out in a practice then a facility for reassessment of treatment should be incorporated. One method of achieving this is that the patient has a repeat prescribing card, which is duplicated in his notes. Each request for a repeat prescription is noted by the date on each card. After a predetermined time of repeat prescriptions the patient can no longer obtain the drugs without consulting a doctor, thereby affording an opportunity to reassess the patient's needs of and conformity to that treatment.

TABLE III—*Frequency of drugs as a percentage in relation to duration of prescription over a 10-year period*

Drug	6/12–1 yr	5–6 yr	>10 yr
Benzodiazepines	71%	68%	56%
Barbiturates	0%	7%	25%
Tricyclics	21%	21%	7%
Others	8%	4%	12%

TABLE IV—*Frequency with which certain psychotropic drugs were prescribed and their respective percentages*

Drug	No of scripts	% total
Benzodiazepines	684	66
Tricyclics	178	17
Barbiturates	66	6
Antihistamines	23	2
Monoamine oxidase inhibitors	11	1
Diphenhydramine/methaqualone (Mandrax)	6	0·5
Amphetamines	4	0·5
Others	59	6

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