The prescription of psychotropic medication in general practice — a descriptive study

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Summary

The prescriptions of all patients who attended an urban general practice from September 1987 to December 1987 were studied. Of the 111 patients (60 females and 51 males) who received a psychotropic prescription the commonest presenting complaint was insomnia (56 patients or 50.5%). This was followed by tension, headache and unexplained aches and pains (19 patients or 17.1%), and anxiety (nine patients or 8.1%). Consistent with these presentations a vast majority (92.8%) received a benzodiazepine. The commonest drugs prescribed were Lorazepam and Bromazepam whereas the longer acting benzodiazepines were rarely used. Polypharmacy was rare.

Key words: Psychotropics, general practice, benzodiazepines.

Introduction

It is by now widely recognised that there is much psychiatric morbidity in primary care medicine. As much as one-quarter to one-third of all general practice patients in some studies suffer from a mental disorder.[1] Furthermore up to a fifth of all persons in a community may be suffering from some psychiatric illness.[2] Only a small proportion of these present to the psychiatrist. The rest, mainly those with milder illnesses, either remain untreated or receive some form of treatment in the various primary care and general medical care settings. Various reasons have been given for this – the illness may be unrecognised, the stigma attached to a visit to the psychiatrist, or the forbidding distance to the psychiatric clinics. Alternatively cultural explanations for the illness may prevent the patients from seeking western medical treatment.

The general practitioner in this country has a number of options in the management of a patient with a psychiatric disorder – either with drugs, supportive psychotherapy or by referral to a psychiatrist. Drugs have become the mainstay of treatment in many psychiatric illnesses and warnings have been raised of the dangers of overprescribing.[3]

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The aim of this study was to look at the pattern of psychotropic drug prescription in a local general practice, examining the types and dosages of drugs and the persons for which they were used. The term "psychotropic" means all those drugs which are used primarily for an effect on mental functioning. Vitamins were excluded from this study.

Materials and Methods

The prescriptions of all patients who attended an urban general practice during the period of September to December 1987 were examined. The general practice was situated in the central financial district of Kuala Lumpur and catered largely to office workers – mainly executives, secretarial staff and other lower categories of office workers in the banking and business sectors and their dependants. Every prescription record was examined by either one of the authors. Case notes of all those receiving the psychotropic drugs were examined for details of diagnosis, type of drug, dosage etc. The case notes of patients who received psychotropic drugs were re-examined for the entire duration of their attendance at this clinic, i.e. before September 1987 and after December 1987, to see if these prescriptions were being repeated. This duration ranged from four months to eight years.

Results

There were a total of 5996 prescriptions written out in the four months under study. Only 2.5% of the prescriptions were for psychotropics – received by 111 patients whose characteristics are shown in Table 1. There were 60 females and 51 males and this broadly reflects the sex ratio of patients attending this clinic.

Table 1
Characteristics of Patients Receiving Psychotropic Drugs

	Malay	Chinese	Others	Total
Male	24	22	5	51
Female	19	34	7	60
Total No.	43 (38.7)	56 (50.5)	12 (10.8)	111 (100)

( ) = percentage

Reasons for prescription: Diagnoses were incompletely recorded. The commonest reason for prescribing a psychotropic drug was insomnia (50%) followed by tension headaches and other unexplained aches and pains (17%), and anxiety (8%). Only five cases were diagnosed as having a depressive illness. Another four had schizophrenia (Table 2).

Types of drugs: Anxiolytics and sedatives, were the most common drugs used, received by 103 (92.8%) patients. Of these, lorazepam (Ativan) was used in 68 (66%) of the 103 patients receiving this group of drugs, followed by bromazepam (Lexotan) in 20 patients (19.4%) with diazepam

Table 2
Reasons for Prescription of Psychotropic Drugs

Insomnia	56 (50%)
Tension Headaches & Unexplained Aches	19 (17%)
Anxiety	9 (8%)
Depressive Illness	5 (4%)
Schizophrenia	4 (4%)
Mixed Anxiety/Depression	3 (3%)
Premenstrual Symptoms	1 (1%)
Unknown	14 (13%)
Total	111 (100%)

(Valium) being a distant third (seven patients). Other less commonly used drugs were temazepam (Normison), midazolam (Dormicum) and clobazam (Frisium). These are shown in Table 3.

Antipsychotics and antidepressants were too infrequently used to yield much information. Dothiepin (Prothiaden) was used in four of the five depressed patients whereas the phenothiazines were the only group of antipsychotics used for schizophrenic patients with two of them receiving a depot preparation of fluphenazine (Modecate). This is shown in Table 4.

Dosage: In general low doses of anxiolytic/sedative drugs were prescribed. The mean daily dose of lorazepam was 0.8 milligrams (mg) and that of diazepam was 8.5 mg (Table 3). Among the antidepressants the mean dose of dothiepin was 80 mg.

Table 3
Types, Frequency and Doses of Drugs
(Anxiolytics/Hypnotics)

	Frequency	Mean Daily Dose (mg)
Lorazepam (Activan)	68	0.80 mg
Bromazepam (Lexotan)	20	3.25 mg
Diazepam (Valium)	7	8.50 mg
Temazepam (Normison)	4	10.00 mg
Midazolam (Dormicum)	3	15.00 mg
Clobazam (Frisium)	1	10.00 mg
Total	103	

Table 4
Types, Frequency and Dosage of Drugs
(Antipsychotics & Antidepressants)

Antipsychotics (n=4)	Frequency	Mean Daily Dose (mg)
Thioridazine (Melleril)	1	100
Chlorpromazine (Largactil)	1	75
Fluphenazine-depot (Modecate)	2	25 monthly
Antidepressants (n=5)		
Dothiepin (Prothiaden)	4	80
Mianserin (Bolvidon)	1	60

Repeat prescriptions: Most patients (65 or 63% of those on a minor tranquiliser) received them only once or twice, and then subsequently the prescriptions were terminated.

Drug combinations: Drug combinations were hardly ever used. Only one depressed patient received an antidepressant and an anxiolytic at the same time.

Discussion

Salient features documented in this study are the low rate of prescription of psychotropic medications in general, short duration of medication, highly popular use of the short-acting benzodiazepines, sparse use of antidepressants and reasons for the use of such medications. Given that there is a significant psychiatric morbidity in general practice[1] it is interesting that only 2.5% of prescriptions in this study were for psychotropic drugs. This is much less than in most studies.[3] An obvious reason is non-detection of psychiatric disorder. This has been recognised elsewhere even when the general practitioner (GP) is a trained psychiatrist as Goldberg and Blackwell have shown.[4] The busy GP is often unable to spend the extra minutes required to obtain a psychosocial history when the patient presents with a somatic complaint. However other reasons are possibly at work. A large number of patients received vitamins, tonics and other substances believed to improve general health. In the authors' experience it was highly likely that these were being used in place of psychotropic drugs in some cases.

Another interesting finding was that one of the GPs in this practice who had a greater interest in psychiatric aspects prescribed psychotropic drugs twice as often as each of the other three GPs. Thus exposure to and interest in the psychosocial aspects of illness may alter prescribing practice. The implication for continuing education of the GP in psychiatric problems in general practice is obvious.

The extremely popular use of the shorter acting benzodiazepines is understandable. Most of these patients had milder illnesses and continued to work while on medication. Many needed help mainly with sleep related problems. Hence longer acting drugs with hangover effects were avoided. But the side-effect profile was only one of the reasons for the choice of drugs. The influence of the drug industry's promotional efforts is not to be discounted besides the cost of the drugs themselves.

The sparse use of antidepressants deserves comment. Many depressed patients have mixed depression and anxiety and experience some relief when a benzodiazepine is prescribed. In the experience of the second author (TSG) many of these patients present with insomnia, and they tolerate the traditional tricyclic antidepressants poorly. It is therefore understandable that only four patients received antidepressants, a drug which in all cases has less anticholinergic side-effects. However it still remains likely that depressive illness is under-diagnosed. The first author's survey of the patients in this clinic using a psychiatric screening instrument showed that a third of the patients were likely to be psychiatrically ill with anxiety and/or depression predominating (study in preparation).

It appears that GPs tend to respond to presenting complaints rather than underlying psychopathology. However this is not to detract from the fact that time is spent in counselling and providing other general supportive measures.

Only 41% of patients in this study received a psychotropic prescription more than twice, even including the time period before and after the study, a period that ranged from four months to eight years. This is perhaps an indication of the short-lived nature of psychiatric illness in general practice. Studies elsewhere[4] showed that two-thirds of general practice patients with psychiatric morbidity were functioning well at six months follow up.

Another feature of prescribing practice seen here is that relatively few types of benzodiazepines are used, considering that about a dozen of them are on the market. Just two drugs accounted for 85% of all benzodiazepine prescriptions. Combination drug therapy was found in only one patient. Psychotropic polypharmacy was thus practically non-existent in this practice.

It has been said, more in jest, that in the early part of this century pharmacology was so primitive that the general practitioner could do little more than sit by bedsides, feel pulses and look grave and wise. Since the introduction of firstly the phenothiazines, and later the antidepressants and benzodiazepines, the psychopharmacological armamentarium of the general practitioner has increased so greatly that, as Cooperstock has noted, there is little need to look grave, though it is still helpful to look wise.[5] This study underscores the need to know a few drugs well. The current teaching of psychiatry in many medical schools should perhaps give greater emphasis on the use of the benzodiazepines and their abuse potential.

The need for training in interviewing, counselling and listening skills cannot be overemphasised. There is also a great need for systematic in-depth studies of the range of psychiatric disorders in primary care medicine in the local setting so that the training of future primary medical care doctors may be evaluated accordingly. In a previous study in this practice[6] it was found that about 20% of all patients presented with vague somatic symptoms for which no specific cause could be found. These are patients who are likely to have a minor psychiatric disorder, in keeping with studies elsewhere,[7] where it is a common observation that a majority of GP patients have depression with or without anxiety and present themselves to the GP with somatic complaints.

In the light of these circumstances, the diagnostic skills of the practitioner take on added importance. The training of medical students in psychiatry at many medical schools is heavily weighted towards experience with severely ill, inpatient populations suffering from such illnesses as schizophrenia and affective psychoses. There is not enough exposure to psychiatry in a primary care setting or even in a general medical setting, considering that it is these last two settings which will be for most students their eventual areas of practice.

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