

## Correspondence

### Rebound psychosis following withdrawal of clozapine

Latif *et al*<sup>1</sup> address the crucial issue of blood dyscrasia associated with clozapine. Although they quite rightly mention that this is one aspect of a range of adverse effects (including seizures and cardiovascular complications), we would like to draw the readers' attention to a less well-emphasised, but nevertheless important, issue variously termed clozapine withdrawal, discontinuation or rebound psychosis. This phenomenon may perhaps be neglected because, paradoxically, it may emerge after patients have suddenly stopped taking clozapine, and therefore it does not comfortably fit into the category of 'adverse effects'. Indeed, terms such as withdrawal and discontinuation have also led this phenomenon to be addressed within the addictions literature.

Emergence of a rapid 'supersensitivity psychosis' following sudden withdrawal of clozapine has been well documented;<sup>2</sup> various studies have attributed rapid relapse following clozapine withdrawal to clozapine-induced supersensitivity for dopamine, acetylcholine or serotonin receptors.<sup>3</sup> Seppala *et al*<sup>4</sup> found a rapid deterioration in mental state following withdrawal in almost half the patients of a group who had been on long-term clozapine treatment, whereas Seeman & Tallerico<sup>3</sup> discovered that the rate of psychotic relapse in patients withdrawn from clozapine is five times higher than that for a traditional antipsychotic such as haloperidol or flupenthixol. Clozapine withdrawal psychosis has also been observed to be severe in symptomatology and is in some cases associated with delirium.<sup>5</sup>

It is certainly not uncommon for clinicians to see patients with a severe rebound psychosis as a result of sudden clozapine withdrawal. Emphasis has rightly been placed on preventing a sudden discontinuation of other psychiatric medications with the potential of precipitating a rebound illness (e.g. lithium) by educating patients. Unfortunately, in our experience this does not necessarily extend to clozapine.

Patients should be made aware of the risks of sudden discontinuation of clozapine treatment, including the possibility of severe symptomatology, as early as treatment planning stage with a clear care plan to manage a rebound illness in the event of a sudden discontinuation. From a medico-legal perspective, given that rebound psychosis cannot be considered rare, a clear explanation of the phenomenon during the consent-to-treatment interview should form a crucial part of obtaining informed consent before prescribing clozapine.

- 1 Latif Z, Jabbar F, Kelly BD. Clozapine and blood dyscrasia. *Psychiatrist* 2011; **35**: 27–9.
- 2 Ekblom B, Eriksson K, Lindström LH. Supersensitivity psychosis in schizophrenic patients after sudden clozapine withdrawal. *Psychopharmacology* 1984; **83**: 293–4.
- 3 Seeman P, Tallerico T. Rapid release of antipsychotic drugs from dopamine D2 receptors: an explanation for low receptor occupancy and early clinical relapse upon withdrawal of clozapine or quetiapine. *Am J Psychiatry* 1999; **156**: 876–84.

- 4 Seppala N, Kovio C, Leinonen E. Effect of anticholinergics in preventing acute deterioration in patients undergoing abrupt clozapine withdrawal. *CNS Drugs* 2005; **19**: 1049–55.
- 5 Stanilla JK, De Leon J, Simpson GM. Clozapine withdrawal resulting in delirium with psychosis: a report of three cases. *J Clin Psychiatry* 1997; **58**: 252–5.

**Dumindu Witharana**, honorary specialist registrar in forensic psychiatry, Broadmoor Hospital, Crowthorne, Berkshire, UK, email: duminduwitharana@nhs.net; **Amlan Basu**, consultant forensic psychiatrist, Broadmoor Hospital, Crowthorne, Berkshire, UK.

doi: 10.1192/pb.35.4.155

### Home treatment and an increase in detentions

Forbes *et al*<sup>1</sup> reported that the number of detained individuals increased following the setting up of an intensive home treatment team in Midlothian, with no reduction in admissions overall. In their discussion they identified a number of potential reasons for this rather disappointing result. However, they did not look at the relevance of staffing, nor the degree of adherence to the high-fidelity model of home treatment.

Middleton *et al*<sup>2</sup> looked at gatekeeping and concluded that admissions were more likely to be reduced if the team had a dedicated consultant psychiatrist and worked on a 24-hour basis. It was also noted that teams which were more 'mature' were more effective gatekeepers. In Midlothian the medical input is from a part-time staff grade doctor, the team operates from 8 am to 12 pm and in the period reported the team was only in its first year. We have little doubt that if Dr Forbes can persuade the commissioners to invest further in the service, bed reductions will be made.

Our home treatment team in Belfast was set up in April 2007 and covers a population of 350 000. It has 1.5 whole time equivalent dedicated consultants and operates 24 hours a day. We took on the role of gatekeeping all admissions in April 2009, and over the next 12 months the admissions dropped by 27%.

Forbes and colleagues propose that their team may have had a low threshold for accepting risk, in the context of the introduction of formal risk assessment procedures for all patients seen. They argue further that thresholds for risk are falling with an increasing use of community detention powers and longer-term hospital detentions.

This reflects concerns raised by the Care Quality Commission,<sup>3</sup> who noted that while the number of hospital detentions had not reduced, the number of community treatment orders (CTO) had 'greatly exceeded the number anticipated at the time the new legislation was introduced'. The premise on which CTOs were predicated was that they were a less restrictive alternative to hospital admission. In truth the evidence is that they are becoming an additional way of managing perceived 'risk', which has now regrettably become a key driver in psychiatric practice.

There is a grave danger that the natural instincts of the large majority of psychiatrists to move away from a paternalistic and risk-averse model of care are being compromised by paying too much heed to the often confused

and fear-based concerns of policy makers and the media who want us to 'move into the community', while simultaneously guaranteeing that adverse outcomes will not occur.

- 1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.
- 2 Middleton H, Glover G, Onyett S, Linde K. Crisis resolution/home treatment teams, gate-keeping and the role of the consultant psychiatrist. *Psychiatr Bull* 2008; **32**: 378–9.
- 3 Care Quality Commission. *Monitoring the Use of the Mental Health Act in 2009–10*. Care Quality Commission, 2010.

**Philip McGarry** and **Ashling O'Hare** are consultant psychiatrists in home treatment and **Ciaran McNally** is specialty trainee (ST6), Belfast Health and Social Care Trust, Belfast, UK, email: McGarry.philipj@belfasttrust.hscni.net

doi: 10.1192/pb.35.4.155a

The increase in compulsory treatment following introduction of a crisis resolution service as observed by Forbes *et al*<sup>1</sup> was to be entirely expected as other studies have mentioned this association before.<sup>2,3</sup> However, I am a bit puzzled about the explanation the authors provided regarding this finding – the team probably having a low threshold for accepting risk and being more likely to consider the use of the Mental Health Act. I certainly do not believe this to be an explanation that would ring true with other crisis teams, for I am under the impression that the staff in most crisis teams have a very high threshold for admitting someone; this is, I think, to do with their role of gatekeeping admissions (and controlling the beds).

The other important aspect that needs to be considered here relates to the fact that the team in the study do not have control over admissions under the Mental Health Act outside working hours, which are between 8 am and 12 pm. It would be useful to see the numbers of people admitted under the Act out of hours, who were being assessed by other professionals undertaking their own risk assessments. It should also be remembered that many patients assessed and admitted under the Mental Health Act during working hours are not always assessed by the crisis team; community mental health teams undertake their own Mental Health Act assessments.

Finally, let us consider the staffing levels within the crisis team: one part-time staff grade psychiatrist but no dedicated consultant. This in itself may explain the fact that the team has to rely heavily upon others to undertake assessments. Once professionals outside the crisis team make a decision to detain someone there is nothing that the crisis team can do about it; they simply have to find a bed for the detained person.

- 1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.
- 2 Keown P, Tacchi MJ, Niemiec S, Hughes J. Changes to mental healthcare for working age adults: impact of a crisis team and an assertive outreach team. *Psychiatr Bull* 2007; **31**: 288–92.
- 3 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

**Mohinder Kapoor** is specialty registrar (ST5) in old age psychiatry, South West Yorkshire Partnership NHS Foundation Trust, Becks Court, 286 Bradford Road, Batley WF17 5PW, UK, email: moe.kapoor@nhs.net

doi: 10.1192/pb.35.4.156

## Age discrimination across the lifespan

Many of Anderson's observations<sup>1</sup> on unjustified age discrimination at the later stages of the lifespan apply also to children and adolescents with mental health problems. They receive a disproportionately low level of funding, are excluded from much research, are subject to often inappropriate extrapolation of treatment guidelines for adults, and until recently have been excluded from formal mental health strategic thinking (both the *National Service Framework*<sup>2</sup> and *New Horizons*<sup>3</sup> specifically excluded child and adolescent mental health services (CAMHS) from their remits).

Anderson states that the Royal College of Psychiatrists' position statement on age discrimination in mental health<sup>4</sup> incorporated contributions from all of its constituent faculties and sections. It is unclear to me where the contribution from the Child and Adolescent Psychiatry Faculty is to be found. In this regard, the government's new mental health strategy<sup>5</sup> is to be welcomed as it adopts an all-age approach to mental health by explicitly including CAMHS within it. Strategies aimed at addressing age discrimination need to consider the whole of the lifespan if they are not unwittingly to recreate it.

- 1 Anderson D. Age discrimination in mental health services needs to be understood. *Psychiatrist* 2011; **35**: 1–4.
- 2 Department of Health. *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, 1999.
- 3 Department of Health. *New Horizons: A Shared Vision for Mental Health*. Department of Health, 2009.
- 4 Royal College of Psychiatrists. *Age Discrimination in Mental Health Services: Making Equality a Reality (Position Statement PS2/2009)*. Royal College of Psychiatrists, 2009.
- 5 Department of Health. *No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health, 2011.

**Andrew F. Clark**, consultant in adolescent psychiatry, Greater Manchester West Mental Health NHS Foundation Trust, Manchester, UK, email: andrew.clark@gmw.nhs.uk

doi: 10.1192/pb.35.4.156a

## No physical health, only mental health

In the canteen of our psychiatric hospital I found myself standing behind an in-patient who had been escorted by a nurse from the ward. I was rather concerned to witness the patient request, and be sold, three hot dinners, three sandwiches, four packets of crisps and four bottles of an energy drink. The nurse escorting the patient confirmed that all the food was indeed for the patient himself and that he did this every day, which was also confirmed by the patient's obesity. I expressed my concern that the patient was putting his health at risk by being allowed to buy and eat so much food in the hospital. The reply given by the nurse was that the treatment team were all aware of the situation but were of the opinion that 'Well, what can we do, the patient has rights to eat what he wants, who are we to stop him?' Those responsible for the care and treatment of the patient (detained under the Mental Health Act) were aware of his extreme overeating but they were merely observing such behaviour, believing themselves to be attending to his mental health needs in isolation, even to the extent of escorting the patient on his bingeing trips.