

# LETTERS

Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

## When Taking Medications Is a Sin

**To the Editor:** In Massachusetts the *Rogers* decision gave patients the right to refuse medications in non-emergency situations unless they are deemed incompetent (1). Once patients are found incompetent to make treatment-related decisions, a "*Rogers* petition" is filed, seeking the court's substituted judgment in authorizing use of antipsychotic medications (2). As part of this process, psychiatrists first evaluate patients' competence to make treatment-related decisions (3). They then determine, among other things, whether patients have any religious reasons for not taking medications (1). At our institution, we found that in making these determinations, psychiatrists were considering only the active ingredients of medications, not their inert components.

Most religions do not restrict the use of antipsychotic medications. However, several of these medications contain inert substances that may be considered objectionable in some religions. In many cases, the capsules or coatings of medications are made from gelatin. Gelatin is derived from collagen, a protein found in animal skin and bones. Collagen, which is usually derived from cows

and pigs, is extracted by pretreating the tissues with alkali or acid and then boiling them (4). Followers of three major religions—Hinduism, Judaism, and Islam—consider it a sin to consume products from one or both of these animals.

In a recent case, we were required to recommend an involuntary treatment plan for a patient whose religion prohibited consumption of pork products. To explore our options in this and similar cases, we sought the opinions of religious leaders of the three faiths. The leaders were unanimous in suggesting that available alternatives should be tried first. When alternative approaches fail or are not available, and if using the medications is the only way to preserve life or prevent further harm, then their use may be justified.

Psychiatrists have an obligation to respect their patients' religious preferences whenever they recommend any medications. Obtaining informed consent should include an acknowledgment that the recommended medications may contain offending animal products. If patients do not have the capacity to provide informed consent, psychiatrists should discuss this issue with a family member or guardian. Alternative approaches that are consistent with patients' religious wishes should be considered. If this is not possible, a risk-benefit analysis of the need for these medications should be made.

In many cases, the offending medications can safely be avoided. Several medications are available in liquid or elixir preparations that serve as viable alternatives to gelatin capsules. If capsules must be prescribed, the option of removing medications from the capsules should be explored. Sustained-release pills contain gelatin, and in some cases the non-sustained-release form of the medication can be substituted without causing significant harm. The gelatin composition of generic and brand-name medications may also differ.

Information on the gelatin content of medications can be obtained from reference texts and from pharmaceu-

tical manufacturers. Table 1 provides information from the *Physicians' Desk Reference* (5) on the gelatin content of commonly prescribed psychotropic medications.

If no alternatives are available, religious leaders of the patients' faith may be consulted. However, in sub-

**Table 1**

Gelatin content of commonly prescribed psychotropic medications

Medication	Gelatin present
Antipsychotics	
Clozaril	-
Haldol	-
Loxitane	+
Mellaril	+
Moban	-
Navane	+
Risperdal	-
Seroquel	-
Stellazine	+
Thorazine	+
Trilafon	+
Zyprexa	-
Mood stabilizers	
Depakote (tablet or capsule)	
Eskalith (capsule)	+
Eskalith CR	+
Eskalith (tablet)	-
Lamictal	-
Lithobid SR	-
Neurontin	+
Tegretol (tablet)	+
Topamax	+
Anticholinergic agents	
Benadryl	+
Cogentin	-
Antidepressants	
Celexa	-
Desyrel	-
Effexor	-
Effexor XR	+
Luvox	-
Paxil	-
Prozac	+
Remeron	-
Serzone	-
Wellbutrin	-
Wellbutrin SR	-
Zoloft	-
Anxiolytics	
Ativan	-
Klonopin	-
Librium	+
Restoril	-
Serax	-
Valium	-
Xanax	-

stituted-judgment cases, the decision to use these medications may rest ultimately with the court.

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2. Gutheil TG, Appelbaum PS: The substituted judgment approach: its difficulties and limitations in mental health settings. *Law, Medicine, and Health Care* 13:61-64, 1985
3. Rogers v Okin, 478 F Supplementary 1342. [Mass Supreme Judicial Court, 1981]
4. Britannica Encyclopedia CD-ROM, 1999
5. Physicians' Desk Reference. Montvale, NJ, Medical Economics Company, 2001

## Rational and Irrational Polypharmacy

**To the Editor:** I appreciated the thoughtful column "Rational and irrational polypharmacy" by Kingsbury and his colleagues in the August 2001 issue (1). However, for the benefit of individuals targeted by the conscientious malpractice attorneys who may have read the article, it should be said that there are factors that contribute to what might appear to be "irrational polypharmacy" other than those cited in the column, which include fear, laziness, sloppy diagnoses, botched cross-titrations, magical thinking, inadequate knowledge of receptor pharmacology, and blind adherence to recommendations listed in the *Physicians' Desk Reference*.

It is generally acknowledged that some patients have illnesses that are refractory to all known antipsychotic agents. In such circumstances, it is not unusual for psychiatrists to use more than one antipsychotic agent, although the authors cite the use of "several antipsychotics at the same time" as an example of irrational polypharmacy.

Psychopharmacology is not an exact science. Even drugs in the same pharmacological class do not have exactly the same receptor-blocking profiles. Psychiatrists and other physicians vote with their feet. They will walk toward whatever combination works. They will walk away from regimens that do not work. This has nothing to do with fear or laziness. It has to do with pragmatism.

For some patients, such apparently irrational treatment has worked better than any previously constructed approach based on rationality. Improvement can occur for unknown reasons, but when it does occur, the reasons underlying the effectiveness of an apparently irrational approach are generally worked out later, after the fact. Such fortuitous events are not unheard of in the process of treatment; indeed, serendipity has always had a prominent role in medicine.

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1. Kingsbury SJ, Yi D, Simpson GM: Rational and irrational polypharmacy. *Psychiatric Services* 52:1033-1034, 1036

**In Reply:** We thank Dr. Fleishman for his comments about our recent article on rational and irrational polypharmacy and appreciate the opportunity to further clarify points we attempted to address in that article. As Dr. Fleishman noted, many patients fail to show an adequate response to a single antipsychotic, even when they receive the optimal dosage, which can set the occasion for using two antipsychotics together. However, in our experience, many patients who are taking two antipsychotics have never been given a trial of clozapine, which appears to have superior efficacy to that of all other antipsychotics.

Further, there is no controlled research on such combinations, only case reports. Therefore, as we stated in our article, we view such combination trials as necessary but experimental. Objective criteria should be used to monitor whether the patient

improves, and one of the medications should be discontinued if the patient shows no improvement after an adequate trial—from six to eight weeks. We have also observed many patients on combinations of antipsychotic medications who showed no evidence of improvement according to the chart, the physician, the patient, or the family. We continue to regard this as irrational polypharmacy.

**Steven J. Kingsbury, M.D., Ph.D.**

**Donna Yi, M.D.**

**George M. Simpson, M.D.**

## Prescriptions of Medications to Youths

**To the Editor:** I read with great interest the article by Goodwin and colleagues in the August issue about the prescription of psychotropic medications to children and adolescents in office-based practice (1). The finding that clinicians were more likely to prescribe medications to Caucasian patients than to patients from other ethnic groups was of particular interest to me because of my involvement in another study that had somewhat different results (2). We found, as Goodwin and her colleagues did, that Caucasian children and adolescents received prescriptions for antidepressants more frequently than African-American youths. However, in contrast to their findings, we noted a trend toward higher rates of prescriptions for stimulants among African-American patients.

One possible explanation for the discrepancy between these findings may lie in the difficulty of assessing racial differences. Goodwin and colleagues divided participants into two categories—Caucasian and other—in their analyses of ethnicity. They may have adopted this classification system to enhance statistical power. However, the classification minimizes cultural factors, such as differences in symptom presentation, and it may obscure certain findings. For example, Hispanic patients may have been prescribed proportionally fewer stimulants than African Americans in the study by Goodwin and colleagues,

which may have affected the findings. Future studies that examine differences between ethnic groups will help determine the degree to which racial disparities in the prescription of certain medications exist.

A second point that deserves mention involves the tendency of researchers to classify participants into clear-cut racial and ethnic groups. Such classification often does not create homogeneous categories. For example, blacks from Africa have different characteristics from those from the Caribbean. On the other hand, ignoring racial classification is to falsely assume that findings from Caucasian samples are generalizable to other ethnic groups (3). The use of non-overlapping racial categories may erode the validity of this variable, and this potential problem should be acknowledged in discussions of results.

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3. Lawson WB: Clinical issues in the pharmacotherapy of African-Americans. *Psychopharmacology Bulletin* 32:275-281, 1996

## Dissemination of Skills Training

*To the Editor:* In the September issue, Schoenwald and Hoagwood (1) provided a thoughtful and well-organized overview of factors that influence the transportability of mental health innovations in effectiveness and dissemination studies. They quite rightly highlighted the importance of the intervention's complexity, organizational support, and a favorable therapeutic or ideological climate among clinicians who are asked to use the innovation. Our own work in the design

of modules for teaching social and independent living skills to persons with serious and persistent mental disorders has proceeded from validating these interventions in efficacy studies, demonstrating their effectiveness in field studies, and then disseminating them throughout the world.

The first generation of modules, which was developed in the crucible of an ordinary community mental health center, were shown to have efficacy and to be associated with consumer satisfaction (2). The next step was to select six modules that appeared to be most applicable to the full range of U.S. community mental health centers and to offer them to 40 such centers in 22 states. These centers were chosen on the basis of the enthusiasm expressed by staff and administrators from more than 100 centers that asked to participate in the dissemination program. After one year, we found significant improvements in their attitudes toward the modules and their familiarity with the principles on which the modules are based (3). In addition, in contrast to the 10 percent adoption rate reported in the Fairweather Lodge dissemination effort, our two-day training program followed by six peer-mediated in-service training sessions led to an adoption rate of 67 percent.

A second generation of modules, designed to be even more user-friendly, have been shown to be efficacious (4) and to be effective in field studies when used with fidelity (5). They have been disseminated to several hundred mental health facilities in the United States and elsewhere, with only minor language and cultural adaptations for use in 26 countries using 17 languages, including Japanese, Chinese, Arabic, Russian, French, Dutch, German, Spanish, and Swedish.

Key elements in the successful dissemination of the modules have included live demonstrations of the intervention at the site where the clinicians were considering adoption, identification of "internal champions" for the innovation at each site and on-

going consultation with them, mobilization of top and middle managers to visibly and tangibly support use of the modules, provision of feedback and support to clinicians through newsletters and meetings, and encouragement of clinicians to "reinvent" the modules to fit their own circumstances, needs, and constraints.

Schoenwald and Hoagwood carefully articulated these factors in their article (1). They also made sound recommendations to promote action research that builds collaborations between the researchers who design novel, evidence-based interventions and the managers and clinicians who are expected to adopt them. We intend to develop and maintain such collaborations in the next phase of our studies on dissemination of skills training programs for people with mental disabilities.

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