Polypharmacy Guidance: appropriate prescribing, making medicines safe, effective and sustainable 2025 – 2028

VOX Scotland's response to the Scottish Government consultation

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Introduction

Voices of Experience (VOX) Scotland is Scotland's national collective advocacy organisation for mental health. We are a membership organisation run for and by our members, all of whom have living or lived experience of mental ill health. We represent our members' views to Scotland's politicians, health professionals and other bodies, making sure that our laws and services reflect their needs and interests.

The issue of polypharmacy matters a great deal to VOX Scotland members. We are eager to respond to the Scottish Government's consultation on 'Polypharmacy Guidance: appropriate prescribing, making medicines safe, effective and sustainable 2025 – 2028'. We created a short questionnaire based on the parts most relevant to our members. We then shared this with our members to inform our response. We also provided the opportunity for members to share feedback in an online session. 25 members responded through these methods within a two-week period. 24 members had direct personal experience of polypharmacy and one had experience through caring for a relative.

We have structured this report to match the relevant questions in the consultation. As a result, it focuses on section 1, 'Delivery of comprehensive 7-Steps Medication reviews' and section 8, 'Mental health drugs: Antidepressants, Benzodiazepines, Antipsychotics'. We will then share further comments from our members.

We are grateful for the opportunity to respond to the consultation and we hope you find our members' views illuminating.

1A. Do you agree or disagree with the recommendations for those with polypharmacy and/or high-risk medicines?

There was broad support for the recommendations with 19 of the 25 members reporting that they agreed. Three were not sure, two neither agreed nor disagreed, and one member disagreed.

Our members felt that in practice, medication reviews are not being conducted regularly. 12 out of 25 members reported that they had *never* had a medication review, and a further five had had reviews less than once per year. Only eight received reviews annually or more frequently.

'I've never seen or heard of these. I think they are the least health services should be doing.'

'I've been on my meds for about 15 years. In all that time... I have never had a review.'

This theme also emerged in VOX Scotland's December 2024 report, 'Your Views: Psychiatrists in Scotland.' Respondents to that report called for more frequent and more comprehensive medication reviews, feeling that reviews are too rare in practice.

Some members suggested that a failure to review can itself cause problematic polypharmacy. One noted that practitioners are unlikely to prescribe multiple medications at once; instead, polypharmacy "creeps in" over time through repeat prescriptions that continue unnecessarily. This is particularly problematic when there are multiple prescribers, such as a GP and a psychiatrist. Our research provides some evidence for this: only six of the 25 had ever been deprescribed medication.

Members also suggested that pharmacists are unlikely to review or suggest deprescribing a medication that was initially prescribed by a consultant or other specialist, allowing the prescription to repeat without an end date. To make pharmacist reviews viable there would need to be clear authority, guidance, training and support given to pharmacists to enable them to

question prescriptions and a clear and efficient route for them to raise questions directly with consultants should they want further clarification around a particular medication or to request a review by the consultant. There is a concern that at present, pharmacists lack capacity in terms of their workload to have the main responsibility for arranging and conducting medication reviews. There is also some concern over clarity in the guidance over whether pharmacists or GPs should be responsible for reviews.

'There does need to be some mention of the workload element of all of this. I could imagine GPs and pharmacists will agree to do additional reviews but how will this be managed and coped with? And how can we make these multi-disciplinary so there is time and space and coordination for professionals to talk to one another?'

Members also noted that failing to provide regular reviews can lead to wasteful spending, echoing the guidance's aim to reduce costs and environmental damage.

'Wonder how much money is wasted every year… keeping patients on drugs which are not helping for longer periods of time than is necessary.'

'Regular reviews could reduce medication use - many people are prescribed short term drugs and take them for years because no one reviews. This is bad for the patient and costly for the NHS.'

1B. Do you agree or disagree with the recommendations on who should be targeted for a polypharmacy review?

Most members who responded (18 out of 25) agreed with the recommendations, though they raised concerns which are noted below. Two disagreed, four neither agreed nor disagreed, and one was not sure.

A common concern centred on the threshold of ten medications in the first point of the revised case finding criteria. Several members suggested lowering the threshold to five, six or eight medications. They felt that the threshold of ten medications will mean people experiencing inappropriate

polypharmacy are missed. The risk here is particularly acute for those who are vulnerable and less likely to request a review.

'I wonder about 10 being the threshold – it seems very high to me. Maybe there's a different way of doing it where people on 10 or more review every year and those on 5-9 have review every two years, for example.'

'Ten seems too high. Even two meds can interact badly.'

Some members also suggested that vulnerable adults and people living with mental ill health (especially severe and enduring mental illness) should be prioritised for review in addition to the groups listed.

'Reviews should be for all on psychiatric medication. These have long term side effects this alongside other medications could shorten life expectancy. People using medication like this need reassurance. They should be monitored regularly. And not be seen as nuisances.'

One member questioned the use of the phrase 'hoarding medications' in the second recommendation. They felt that this language is problematic as it 'implies that people who are housebound should be blamed for being prescribed medication they no longer use.' People who do have unused medications at home may be in this situation through no fault of their own, but rather because they need their pharmacist or GP to arrange and conduct a medication review.

8A. Do you agree or disagree with the recommendations for antidepressants?

22 of the 25 members had been prescribed antidepressants, making this the most common type of medication used by VOX Scotland members. 16 of the 25 agreed with the recommendations while three neither agreed nor disagreed, three were not sure and one disagreed.

8B. Please provide any further comments about our recommendations.

Many members echoed the need for psychological therapy as an alternative or supplement to medication. Their comments on the need for psychological therapy reflect their agreement with the recommendations for antidepressants.

'Psychological therapy referrals should be part of the prescription process for antidepressants.'

'Immediate access to talking therapy and low level supports in the third sector is required and will cut the medicines bill.'

However, several members expressed concern about whether non-pharmacological psychological therapies are, in practice, available. This is related to a perception that GPs often prescribe antidepressants because they lack other options, particularly in the context of long waiting lists for talking therapies.

'The recommendations are good in theory, but rely on the availability of non-pharmaceutical interventions such as therapy which can be difficult for patients to access in reality. This makes the recommendations difficult to follow in practice as pharmaceutical interventions are the most easily and quickly available to reduce patient distress and improve functioning.'

'Often because waits for psychological therapies are so long, GPs go to medications first in the meantime to give patients some help.'

Members also raised concerns about antidepressants' side effects and the effects of discontinuing their use. In a related point, several members called for discontinuation to be planned from the beginning of treatment:

'The route off the drug must be clear before the drug is prescribed in all cases.'

'If a doctor or practice nurse prescribes medication it should be mandatory for a route off the drug to be established.'

8C. Do you agree or disagree with the recommendations for benzodiazepines?

Fewer members had experience of benzodiazepines and z-drugs, with four of the 25 members having been prescribed them. 12 members agreed with the recommendations while three disagreed. A further three neither agreed nor disagreed and five were not sure. Of those who had been prescribed benzodiazepines and z-drugs, two agreed with the recommendations and two were not sure.

8D. Please provide any further comments about our recommendations.

In their comments, several members emphasised the risks associated with benzodiazepines and z-drugs and expressed wariness about their use.

'Should explore every other option before prescribing these.'

'These really need managed by psychiatrists not GPs.'

'I would ask not to be prescribed either.'

'I was hospitalised when I had to come off benzodiazepines. No one told me of the withdrawal consequences and experiences I might have to cope with.'

Two members asked for the guidance to be made clearer and more specific around the duration of treatment and the timing of reviews:

'Unclear if it is recommending long-term use the way the first section is worded - my understanding is that they should be for short term use only.'

'The reason I disagree is we need to be more specific around periodicity. "Regularly" means different things to different people. "After four weeks", "at least annually", "every 6 months" are better.'

Another member felt that the guidance should make explicit reference to the management of benzodiazepines and z-drugs for patients leaving hospital (which links to the third recommendation for the delivery of comprehensive 7-Steps reviews).

'Immediately withdrawing these medications upon discharge (as has been my experience after multiple hospitalisations) is not only risky in terms of any withdrawal symptoms but also adds to patient anxiety.'

8E. Do you agree or disagree with the recommendations for antipsychotics?

15 of the 25 members had been prescribed antipsychotics. 14 of the 25 agreed with the recommendations while three disagreed, four were not sure and one neither agreed nor disagreed.

8F. Please provide any further comments about our recommendations.

Common themes included concerns regarding duration, the lack of regular review and consideration of side effects.

'I agree with these recommendations but definitely do not believe they are followed in practice. I have been prescribed multiple antipsychotics (never concurrently) by both General Practitioners and psychiatrists, which have never been reviewed or prescribed for a set duration.'

'More consideration of the side effects of antipsychotics should be given - for example the intense fatigue and drowsiness, weighing this up against results.'

Where members disagreed with the recommendations they gave a variety of reasons. One member said psychosis should be considered not as an illness, but as a trauma response. Another suggested that the guidance should refer to bipolar disorder specifically as it is 'also severe and enduring'. This member also referred to the need for balance when prescribing antipsychotics.

'The trauma experienced by requiring multi-month hospitalisations through premature withdrawal of antipsychotics has to be balanced with any potential harms of long-term antipsychotic use.'

14. Please provide any further comments on our polypharmacy guidance.

We asked members to share their experiences of taking medications to treat physical health and mental health conditions concurrently. From members' previous inputs, we were aware that this is often the case and we were keen to explore the ways in which polypharmacy might affect our members in this specific circumstance. In their responses, members described a lack of integration and communication between clinicians.

'There is a disconnect between the Advanced Nurse Practitioners at the GP surgery assisting me to manage my physical conditions. They appear to have little understanding of the medication I am prescribed for mental health.'

'I take blood pressure medication and oral contraceptive, at mental health reviews these medications are not discussed (despite known interactions). Feels siloed between GP and psychiatrist.'

'No medical person reviews discusses or supports this combination of medication. You only hope and pray that there are no contraindications.'

'I find that psychiatrists and CPNs are unfamiliar with both my physical health conditions as well as the medications I take. Some of the medications I have been on for physical health are also prescribed in mental health settings, and staff have assumed that I was prescribed them for that reason and tried to take me off of them.'

Members also expressed concern about the impact managing polypharmacy can have on people living with mental ill health:

'I don't know who should be responsible for this, but someone should take responsibility for ensuring that the patient is taking the medicine correctly when the patient has multiple handicaps.'

'Patients with mental health issues need to be carefully supported with taking medication for physical issues. There is likely to be a higher risk of confusion or of anxiety.'

Our members described a need to request medication reviews rather than having them scheduled by pharmacists or other practitioners. In one notable example, a member's elderly father had his medications reduced from 16 to four but only after the member requested a review from a GP. Without our member's intervention, the review would not have taken place and their father would have continued to experience inappropriate polypharmacy. Other members also described a need to advocate for themselves or have family members advocate on their behalf.

'The only time I have been deprescribed one antipsychotic to change to another has been on my request... Despite having 3-monthly reviews with a psychiatrist from my Community Mental Health Team, my medication was never even brought up for over a year until my Mum attended an appointment with me and asked the doctor about it.'

'Some of the medications I have been on for physical health are also prescribed in mental health settings, and staff have assumed that I was prescribed them for that reason and tried to take me off of them. I've been able to explain why I take them and advocate for myself, but during times where I am more unwell, I don't know that I would have been.'

For those who are unable to advocate for themselves, or who do not have relatives who can advocate on their behalf, there is a greater risk of inappropriate polypharmacy if patients are expected to request their own medication reviews. This risk may be particularly acute for people living with mental ill health. As a result, we would urge consideration of how practitioners can be proactive in arranging reviews, moving the onus from patient to professional.

A related, concerning theme emerged around monitoring medications in the context of polypharmacy. Several of our members described instances in which they had to correct or remind prescribers about a potentially harmful interaction, side-effect or contraindication.

'I was prescribed co-cyprindiol for polycystic ovary syndrome alongside chlorpromazine for my mental health… I was then deprescribed the co-cyprindiol due to developing pulmonary emboli, and instead prescribed eflornithine cream for hirsutism, apixaban for the blood clots and codeine for the associated pain. Again, I was never told explicitly these medications were safe to take together, and upon reading the Patient Information Leaflet provided with my codeine, I realised it had a specific warning about taking it alongside chlorpromazine, which I was never warned about upon being prescribed it. Additionally, prescribing practice used in relation to my mental health medication has been ignored when prescribing medication for my physical health.'

'Often, I am responsible for researching potential medication interactions, e.g. a GP wanting to prescribe a medication that carried a risk of serotonin syndrome when taken with my SSRI. I have a background in healthcare, so I am aware of drug interactions and how to research this, but most people in my situation will not have this knowledge.'

The risk of harm here is clear. As the member quoted above noted, most patients cannot monitor their own medications in this way; none should be expected to do so. As a result, we urge consideration of a specific recommendation requiring prescribers to consider and monitor potential drug interactions.

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Summary

Polypharmacy is a significant issue for people with lived and living experience of mental ill health. Many of our members have long-term and complex conditions which have required them to take multiple medications concurrently. As a result, this consultation is very welcome.

Overall, VOX Scotland members are supportive of the Polypharmacy Guidance and its recommendations. Specific recommendations – such as consideration of non-pharmacological options for depression and anxiety – have been welcomed particularly strongly.

Our members also broadly supported the recommendations for the delivery of comprehensive 7-Steps Medication reviews, though it was striking to note how many reported that reviews are not currently being conducted regularly. The point that failure to review medication can lead to problematic polypharmacy is also worthy of emphasis, especially since deprescribing appears to be uncommon. The Polypharmacy Guidance is rightly very ambitious, but the Scottish Government and health boards must now ensure that the recommendations can be implemented.

Our findings also demonstrate that polypharmacy across mental and physical health treatment is not only common, but also fraught with difficulty. There is a pressing need for a system of medication review that considers interactions between drugs which have been prescribed by different clinicians (for example, a psychiatrist and a GP) for different purposes. At present, our members feel that physical and mental health clinicians operate in different 'silos' with potentially dangerous consequences, especially when patients themselves must be alert for harmful drug interactions and contraindications. The guidance on multidisciplinary reviews of medication is very welcome, but there is concern about how this will be coordinated and resourced. There is also concern that the thresholds for priority are too high, leading to cases of inappropriate polypharmacy being missed.

We are grateful for the opportunity to help shape this essential guidance. Please do not hesitate to contact VOX Scotland for further information.

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