edged that our sample did not include intensive care units (PICU) or rehabilitation wards (although, one hospital did not have a PICU). There may also be subtle methodological differences between the studies, for example, in calculating as-required doses.[8]

A more significant factor may be the introduction of various national guidelines, most notably by NICE. One aim of NICE is to reduce inappropriate prescribing variation[9] and ensure an evidence-based approach to disease management. Our survey was completed three years after the NICE guidance on the use of newer antipsychotic drugs for the treatment of schizophrenia,[2] which effectively recommends atypicals for schizophrenia as do the British Association of Psychopharmacology (BAP) guidelines for bipolar disorder.[10] Only two hospitals approach compliance with these guidelines in the use of atypicals. There is obvious variation in as-required prescribing that could be reviewed by analysing policies and the ward environment.

While co-prescription of antipsychotics still remains common it does not always result in supra-BNF doses. In the majority of cases, this prescribing combines an atypical with a typical agent. In the two hospitals with the lowest atypical prescribing rates, typical/typical combinations were common. Dual prescription is often seen as poor prescribing although there is some evidence that outcomes may not be as compromised,[11,12] as has been suggested.[13]

Formularies were in operation at all hospitals except hospital two, which, paradoxically, appears to have the narrowest range of prescribing. The formularies at the other hospitals were broad and should not have impeded the prescribing of atypical antipsychotics. The range of drugs prescribed has economic implications as there are likely to be wastage and storage problems if drugs are intermittently prescribed.

A limitation of this prescribing survey is that while we have identified significant variation in prescribing practice, we do not have data that may further facilitate its interpretation. We cannot ascertain if patients suffer more adverse incidents when receiving polypharmacy or whether polypharmacy reflects significant variation in patient complexity that is not evident on comparison of basic demography. Ito *et al.*[14] noted that basic demographic features, use of physical restraint, legal status, and admission and Global Assessment of Function (GAF) score did not appear to influence prescribing. However, at discharge, poor functioning (GAF score) and severity of illness did. In our study we do not know if 'better prescribing' (defined as following NICE or BAP) results in shorter admissions, increased patient satisfaction and better clinical outcomes. However, later local audits have suggested a positive association.[15]

There are other potential reasons for variations in prescribing practice. We did not collect data on the prescriber. Variables such as age, experience and qualifications might reasonably be expected to influence prescribing decisions although Ito *et al.*[14] reported that this was not the case. However, they did note that a clinician's view of algorithms was a significant predictor of prescribing behaviour; with high-dose prescribing being associated with unwillingness to accept the validity of algorithms. Also, hospi-