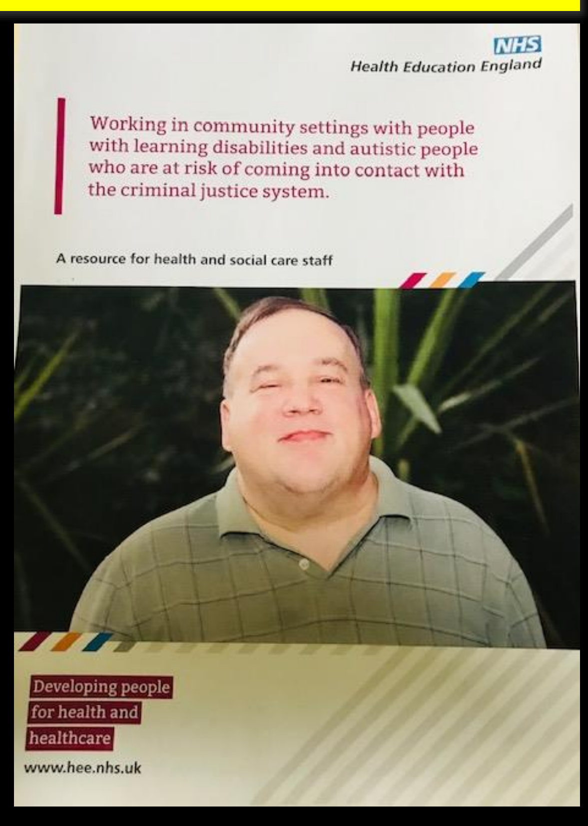
PSYCHOTROPIC MEDICATION FOR CHALLENGING BEHAVIOUR AND MENTAL HEALTH PROBLEMS



Regi Alexander
Consultant Psychiatrist, Hertfordshire Partnership NHS Foundation Trust
Visiting Professor, University of Hertfordshire & Convenor, RADiANT

Reena Tharian
Clinical Pharmacist, Norfolk & Suffolk Foundation NHS Trust

Document 1: Primary Care Prescribing
www.ihalorg.uk

- Nearly 1/3 of people with LD on antipsychotics or antidepressants.
- 58% of those on antipsychotics and 32% of those on antidepressants have no relevant diagnosis recorded.

"…..30-35000 adults with learning disability are on antipsychotics or antidepressants or both without appropriate indications (psychosis or affective disorder)".

Document 2: Pilot Improvement project
www.nhsiq.nhs.uk/winterbourne

- “Deep dive” at 6 sites
- Some examples of good practice, Evidence of benefits of MDT working, in particular deployment of clinical pharmacy expertise
- Patients and families did not know why medicines had been prescribed
- Inadequate communication

Document 3: SOAD reports from CQC

- 945 reports
- ½ not for "recognised indications"
- "In general, limited rationale offered for entirety of treatment plan, particularly for polypharmacy and high doses".
- SOADs changed 25% of plans

Document 4: Sheehan et al 2015
http://dx.doi.org/10.1136/bmj.h4326

- 33000 ID adults, 500+ GP practices
- Proportion of people with ID treated with psychotropics exceed the proportion with recorded mental illness.
- Antipsychotics are prescribed for people with no recorded severe mental illness, but with challenging behaviour

Document 4: Sheehan et al 2015

http://dx.doi.org/10.1136/bmj.h4326

- However, the assumption that if a person with LD is on antipsychotics and has no recorded psychosis, then the prescription must be for challenging behaviour may not be entirely accurate.

- **9135 pts on antipsychotics, 2362 (26%) had neither challenging behaviour or a mental illness recorded.**
- **71% of those with ID prescribed an antipsychotic did not have a severe mental illness. But in general population, 50% of those prescribed an antipsychotic also did not have a recorded severe mental illness.**
- **The issue of recording accurate mental health diagnosis in primary care ?**

Challenges in ID

- **Mental health co-morbidity: point prevalence 30%, diagnostic overshadowing and under- recognition**
- **Vulnerability to psychosocial disadvantage and physical health co-morbidity**

Challenges with challenging behaviour

- A descriptive term, a social construct, but used as if it is a diagnosis
- Covers a very wide and disparate range of behaviors
- Implications of this on the relationship between challenging behaviour and psychiatric diagnosis

Approaches to prescribing

- Challenging Behaviour NOT associated with any mental illness or disorder
- Challenging Behaviour associated with a mental illness or disorder
- Challenging Behaviour associated with some psychiatric symptoms; but they do not quite fulfil the full criteria for a mental illness or disorder

The importance of a full diagnostic assessment/ formulation before prescribing

- Degree of ID
- Cause of ID
- Other developmental disorders
- Mental illnesses
- Personality disorders
- Disorders related to substance misuse
- Physical disorders
- Psychosocial stressors
- <u>Types of behaviours that challenge</u>

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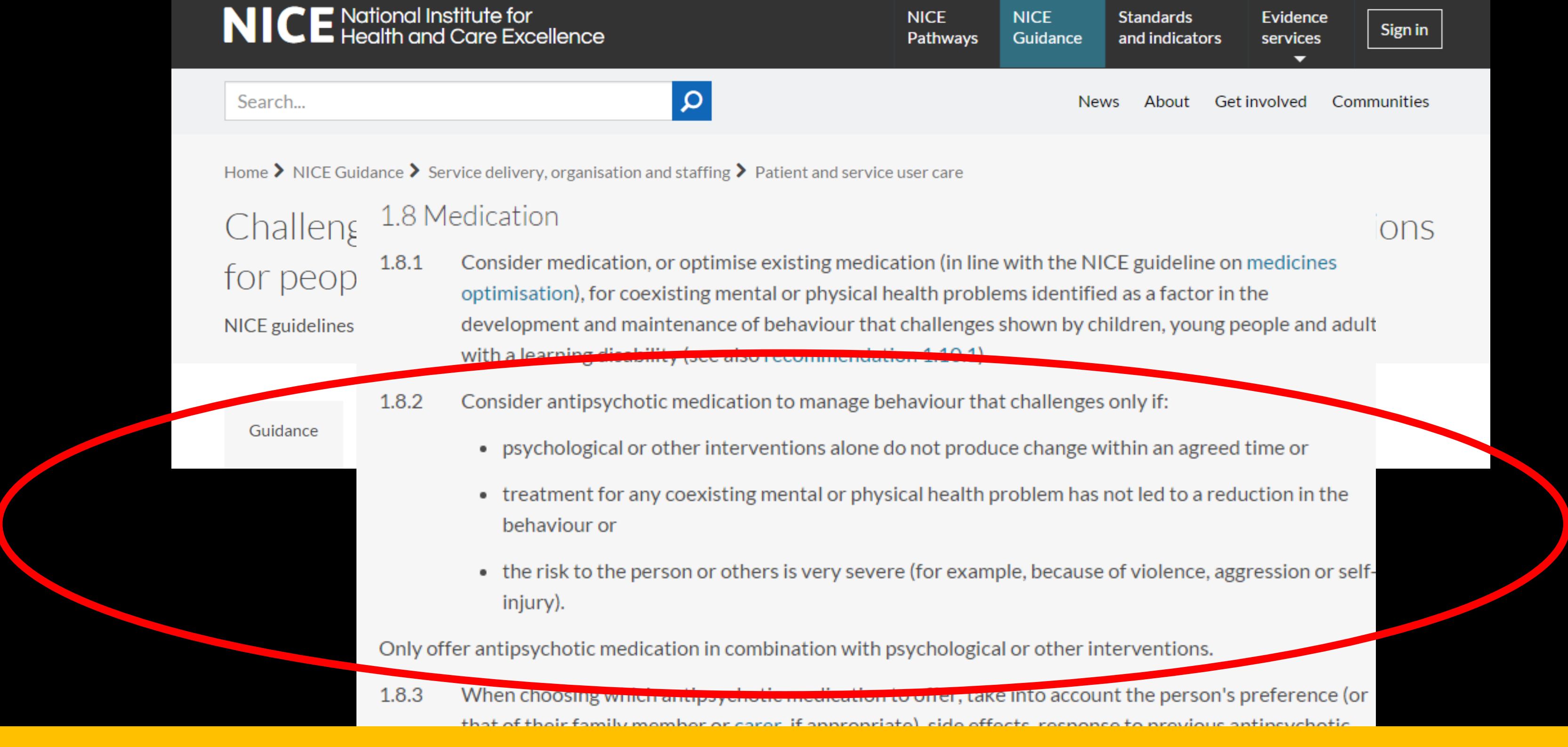

Strength of evidence for medication and psychological interventions, not very different!

Approaches to prescribing

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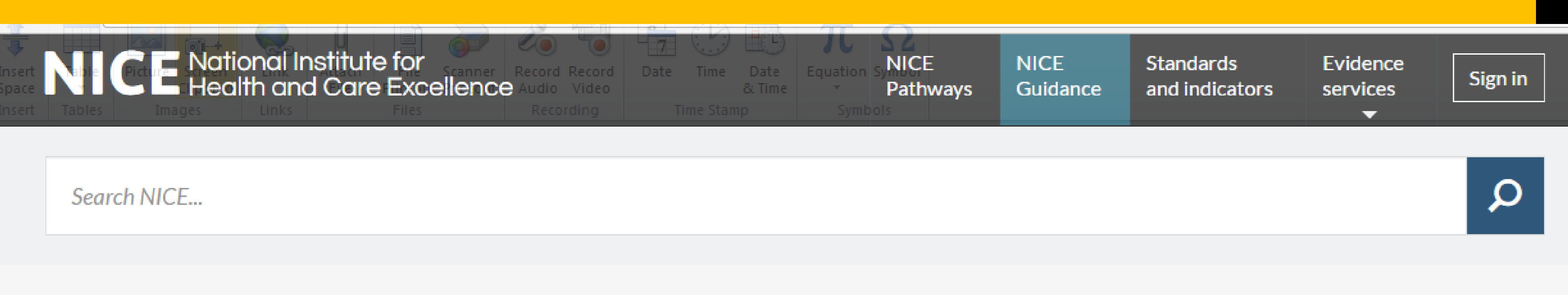
- Treat the mental illness
- The judgment on doses



Approaches to prescribing

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- **Problems with recording a clear diagnosis in ID (and elsewhere too)**

- There are categories for atypical presentations in all diagnostic systems- ICD, DSM, DMID or DC-LD
- The narrative account of the symptoms and symptom clusters is important.
- Any prescribing should be based on that narrative account- whether it be syndromal or symptom specific.

Cognitive perceptual

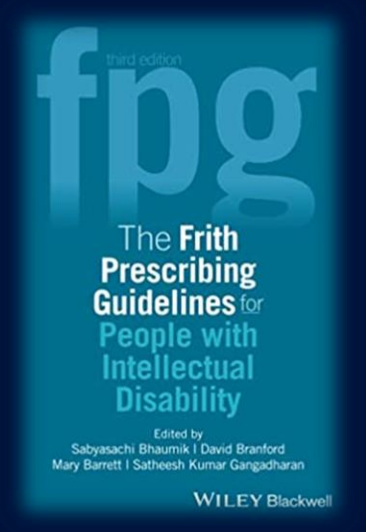
Affective dysregulation

Anxiety

5 symptom clusters

Aggression (sub types)

Self injury (sub types)



Off label prescribing

- Part of mainstream medical practice
- Supported, suppositional and investigational (Largent et al 2013) (Glover et al 2014)
- Examples from paediatrics (Mason et al 2012)
- Anticancer drugs
- The NICE guidelines on delirium (www.nice.org)

In many of the conditions described earlier

- Preci
- Dia
- Le
- De

Responsibilities of the prescriber (Good practice in prescribing and managing medicines and devices, GMC 2013)

- Overseeing all aspects of treatment
- Record usage carefully
- Inform parents and carers fully

- Explanation to patients
- Explanation to families and/or carers
- Easy read leaflets and reasonable adjustments

Does your treatment work?

FR/ID/09

Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines

Faculty of Psychiatry of Intellectual Disability

FACULTY REPORT

- **Narrative accounts of improvement alone may not be enough.**

- **Supplement with standardised measures: eg: CGI - easy to administer, quick, can have multiple raters, can capture balance between effects and side effects**

CLINICAL GLOBAL IMPRESSIONS SCALE (Date:)

1. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to his condition at admission to the project, how much has he changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

Score:

2. **Efficacy index:** Rate this item on the basis of **drug effect only**. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms	**01**	**02**	**03**	**04**
Moderate	Decided improvement. Partial remission of symptoms	**05**	**06**	**07**	**08**
Minimal	Slight improvement which doesn't alter status of care of patient	**09**	**10**	**11**	**12**
Unchanged or worse		**13**	**14**	**15**	**16**

Score:

- Reviewing
- Rationalising
- Increasing
- Reducing
- Stopping

- The self assessment framework
- Examples of case note entries for medication reviews

FR/ID/09

Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines

Faculty of Psychiatry of Intellectual Disability

FACULTY REPORT

Evidence Base and the problem with RCTs

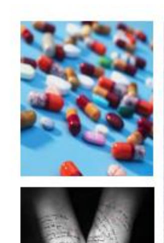
- Very few and limited sample sizes: NACHBID study (Tyrer et al 2008), Discontinuation studies (Ahmed et al 2000, De Kuijper et al 2014, Shankar et al 2019)
- Ethical issues and the psychotropic medication paradox in ID research
- The discrepancy between research samples and patients in your practice.

Some new data from secondary care

http://www.rcpsych.ac.uk/pdf/10-year%20report.pdf

The Prescribing Observatory for Mental Health 10-year report

Supporting rational, effective and safe prescribing in mental health services



Some new data from secondary care

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Overview

Over the 6 years of this quality improvement programme (2009–2015), there were some improvements in the proportion of patients prescribed antipsychotic medication for more than 12 months who had documented evidence in their clinical records of the assessment of body weight and monitoring of blood pressure.

The practice standard 1 (see below) was met in almost all cases, with treatment being documented for 98% of patients who started treatment in the past 12 months and 97% for those who had been prescribed antipsychotic medication for more than 12 months. The clinical indications for antipsychotic treatment were similar at each audit with the exception of self-harm and self-injurious behaviour which were more frequent targets at the supplementary audit. In total, 64% of people with learning disability were prescribed an antipsychotic at supplementary audit, 49% of whom had a comorbid psychotic illness and 36% of whom exhibited behaviours noted by NICE to be potentially legitimate targets for such treatment.

Foreword
Introducti
QIP 1 & 3
QIP 2. Sc
QIP 4. Pre
QIP 6. As
QIP 7. Mc
QIP 8. M
QIP 9. An
QIP 10. P
QIP 11. Pr
QIP 12. P
QIP 13. P
QIP 14. Prescribing for substance misuse: alcohol detoxification
QIP 15. Prescribing valproate for bipolar disorder
Upcoming QIP: Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour
International developments
Appendix I

- Maintaining progress in secondary care consistently
- Working with primary care to replicate this there.

Key message 1

THE RESPONSIBILITY IS THE PRESCRIBERS'.

Key message 2

JUST WRITING "CHALLENGING BEHAVIOUR" MAY NOT BE PRECISE ENOUGH AS A RECORDED INDICATION FOR PRESCRIBING

Key message 3

RECORD ALL DIAGNOSES SYSTEMATICALLY AND

THE NARRATIVE THAT UNDERPINS IT.

Key message 4

RECORD TARGET SYMPTOMS/ SYNDROMES, HAVE PROVISIONAL TIMEFRAMES FOR EVALUATION AND COMMUNICATE THAT TO ALL CONCERNED.

Key message 5

OFF LABEL PRESCRIBING IS NOT INAPPROPRIATE, UNLAWFUL OR UNETHICAL. HOWEVER, IF NOT DONE PROPERLY, IT CAN BE.

Key message 6

USE A STANDARDISED OUTCOME MEASURE THAT CAN BE RECORDED QUICKLY AND IMPLEMENTED WIDELY

Key message 7

PRESCRIBE RATIONALLY. REDUCING AND STOPPING MAY BE PART OF THAT PROCESS

Key message 8

LARGE SCALE NATURALISTIC STUDIES/ NATIONAL AUDITS ARE URGENTLY NEEDED

Contact details

regialexander@nhs.net

http://radiant.nhs.uk