STOPPING OVER-MEDICATION OF PEOPLE WITH LEARNING DISABILITIES

(STOMPwLD) 2016
We all need to make it a priority to reduce and stop the use of inappropriate drugs, to reduce adverse side effects and potential drug interactions. This is vital to our patients' safety and their quality of care.

The goal is to improve the quality of life of people with a learning disability by reducing the potential harm of inappropriate psychotropic drugs that may be used wholly inappropriately, as a "chemical restraint" to control challenging behaviour, in place of other more appropriate treatment options. It is time for action, it is time for you to lead a medication review of all people with a learning disability, with a view to implementing a planned supervised dose reduction and stopping of inappropriate psychotropic drugs.

Aim of this document
Multiple psychotropic drug use often starts at a specialist level which is then passed onto primary care with or without follow up. Many GPs are overseeing the management and prescribing long term. Following the Banerjee report (2009) and the national drive to reduce inappropriate use of antipsychotic drugs in dementia to save lives, confidence has grown amongst GPs and care teams to review prescribing. This document aims to provide support to begin the process of challenging continued need in people with a learning disability.

Why reduce the use of psychotropic drugs in people with a learning disability?
Glover et al. (2015) has shown that among adults known to their GP to have a learning disability, (excluding only those in hospital as inpatients) on any average day:
- 17.0% were being prescribed antipsychotic drugs,
- 16.9% antidepressants,
- 7.1% drugs used in mania and hypomania,
- 4.2% anxiolytics, and
- 2.7% hypnotics.

It is estimated that on an average day in England, between 30,000 and 35,000 adults with a learning disability are being prescribed an antipsychotic, an antidepressant or both without appropriate clinical indications (psychosis or affective/anxiety disorder). A substantial proportion of people with a learning disability who are prescribed psychotropic drugs for behavioural purposes can safely have their drugs reduced or withdrawn.
Challenging behaviour has been described as behaviour which puts an individual or others at risk in any social situation and limits their access to services. Causes tend to be personal factors such as communication difficulties and physical health issues and/or environmental factors such as abusive or restrictive social environments. Assessment usually requires observation and a physical assessment to exclude physical causes with the development of a behavioural support plan and referral to secondary care services.

National Institute for Health and Social Care Excellence advises that specialists consider prescribing antipsychotic medication to manage behaviours that challenge only if:

- Psychological or other interventions alone do not produce change within an agreed time or
- Treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or
- The risk to the person or others is very severe (for example, because of violence, aggression or self-injury)

If the psychotropic drug is prescribed for a mental illness there is the expectation that the drug treatment will follow the recommendations of the relevant NICE guidance. If the person with a learning disability has been symptom free for some time maintenance may not be the best course and may need referral to the specialist person with a learning disability team.

APPENDIX 1
Algorithm for the review, reduction or stopping of psychotropic drugs in People with a Learning Disability

**Undertake a drug review**

Could any of the psychotropic drugs be stopped?

- Consider which psychotropic drug could be most easily reduced or stopped and agree a schedule of dose reductions.

  - Make first reduction

  - Is the person settled after 4 weeks?

  - Make further reductions of dose at agreed time intervals

  - Review every 4 weeks

  - Non-pharmacological approaches put in place and response noted

  - Person unsettled with evidence of re-emergence of problem behaviours, affective or psychotic symptoms

  - Mild to moderate behavioural problems manageable in current setting
    - Advise care giver to commence Antecedent, Behaviour, Consequence charts to identify the cause if possible
    - Care plan formulated accordingly
    - Put behavioural interventions in place
    - Continue with lowered dose of the psychotropic drug and delay further reductions
    - Monitor use of PRN’s (if prescribed)

  - Severe behavioural symptoms un-manageable in current setting
    - Increase the psychotropic drug to the original dose
    - Contact LD Psychiatry services for advice

  - If withdrawal successful consider reduction of other psychotropic drug(s)

  - If settled at next review:
    - Observe for 4 weeks
    - Consider reducing the dose by further agreed amount
    - Proceed stepwise to stopping the drug completely if remains settled

  - Document rationale for continuing the psychotropic drug(s) including evidence of risk/benefit/best interest discussion

  - Consider time scale for next review

  - If withdrawn: successful consider reduction of other psychotropic drug(s)
1. Undertake medicines reconciliation

   1. Undertake a drug review and find out when psychotropic drugs in an individual with a learning disability in General Practice.
   2. Share the results with the practice team, the people with a learning disability specialist teams and others who can help.
   3. Together develop an agreement about a programme of reviews with their named teams and others who can help.

Suggested steps for your GP practice

Appendix 2

1. Have a meeting to discuss the issue and appoint a GP lead.
2. Organise for a practice team member to interrogate the practice prescribing system or work with the CCG Pharmacy team to obtain details of all people with a learning disability on psychotropic drugs.
3. Share the results with the practice team, the people with a learning disability specialist teams and others who can help.
4. Together develop an agreement about a programme of reviews with their named teams and others who can help.

Additional actions for consideration

1. Make reductions stepwise and realistic, keeping specialists involved. Generally withdraw or reduce one drug at a time. Choose the drug with the least evidence of benefit first.
2. The rate of reduction should depend on an agreement between the carers, and if possible the patient and the prescriber. This should be informed by the level of concern of the carers, the history of the behaviours associated with the introduction of the drugs, the duration of exposure, dose of drug, half-life of drug, previous response to such reduction / discontinuation and the availability of other strategies and support for the carers to deal with re-emergent behaviours.
3. For drugs with a long half-life (fluoxetine) or antidepressants most SSRI and other antidepressants, it is better to slow down the rate of reduction rather than sticking to a rigid plan if there are concerns about the behaviours.

Some potential problems

Accept that the reduction may take some time and will be difficult from time to time.

a. Sometimes if behaviours deteriorate it can be difficult to judge whether it is a withdrawal effect (usually occurs within the first week) or a return of the behaviours for which the drug(s) was prescribed or the person is just more alert and the carers have difficulty with this impacting on their working practice. Observe PRN usage in these circumstances.

b. It is better to slow down the rate of reduction rather than sticking to a rigid plan if there are concerns about the behaviours.

Be aware of drug discontinuation effects (see table below). These are usually mild and self-limiting but may be difficult to elicit in people with a learning disability.

Discontinuation effects management

<table>
<thead>
<tr>
<th>Psychotropic drug class</th>
<th>Discontinuation effects</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td></td>
<td>Slow down rate of reduction</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Most SSRIs and other antidepressants are associated with discontinuation effects. Flu-like symptoms, dizziness, insomnia and irritability are common</td>
<td>If mild – reassurance and individual support. If severe – reintroduce antidepressant</td>
</tr>
<tr>
<td>Benzodiazepines and Z drugs</td>
<td>At least 1/3 of long term users suffer discontinuation problems – stiffness, weakness and flu-like symptoms</td>
<td>Minimal intervention and reduce slowely. Consider switch to diazepam</td>
</tr>
<tr>
<td>Mood stabilisers</td>
<td>Rapid withdrawal of anticonvulsants has been associated with seizures</td>
<td>Slow down rate of reduction</td>
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</tbody>
</table>
In Salford they are reviewing 150 people who are seen by the people with a learning disability pharmacy team and are prescribed PRN psychotropic drugs. This review will involve either face to face or telephone review. They are firstly exploring the frequency of use of PRN psychotropic drugs, and then devising a plan to reduce any that have not been used for a number of months. This reduction will be done in partnership with the individual and a responsive action plan devised if for any reason a deterioration is reported. They are also updating the local policy for staff teams to follow. It is part of the wider Positive Behaviour Support Policy.

NHS Newcastle Gatehead Clinical Commissioning Group (CCG) and NHS North Tyneside CCG are collaborating with the Newcastle Upon Tyne Foundation Trust on a psychotropic drug review pilot. The overall aim of the pilot is to provide high quality, evidence based services for people with a learning disability and to understand the resources needed to keep patients and carers involved and safe while psychotropic drugs and alternative therapies are considered in the community. A key principle in this work is that people with complex needs will have their care led by specialists.

Through a data sharing agreement, the CCGs identified the number of people with a learning disability and to understand the resources needed to keep patients and carers involved and safe while psychotropic drugs and alternative therapies are considered in the community. A key principle in this work is that people with complex needs will have their care led by specialists.

A sample of GP practices then carried out a desk-top case review of people in this group and the GP people with a learning disability register agreed to try reducing it slowly with support. The dose was reduced to 100mg every 4 weeks for approximately 30mg (depression) and mirtazapine 30mg (depression). He was monitored by the pharmacy team and was monitored by the pharmacy team. No signs of akathisia. Placement is secure and stable but without a serious mental health diagnosis. Period of reduction was twelve months. Currently using 200mg daily only. No signs of akathisia. Placement is secure and stable but without a serious mental health diagnosis. Period of reduction was twelve months. Currently using 200mg daily only. No signs of akathisia. Placement is secure and stable but without a serious mental health diagnosis. Period of reduction was twelve months. Currently using 200mg daily only. No signs of akathisia. 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This document has been endorsed by the Royal College of General Practitioners, the Royal Pharmaceutical Society, the Royal College of Nursing, the Royal College of Psychiatrists and the Challenging Behaviour Foundation.

This document can be made available in alternative formats such as large print, and may be available in alternative languages, upon request. Please contact Joanne Coleman at joanne.coleman6@nhs.net. Other resources are available for people with a learning disability, their family or carer.