



The Deprescribing of Psychotropic Medication in Service Users (Patients) with Learning Disability

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Aims

- Reflect on issues of consent in people with learning disability
- Discuss how the STOMP programme can be implemented safely from a clinical perspective
- Consider the possible consequences of withdrawing psychotropic medication prescribed for the management of behaviour that challenges focussing on antipsychotics



Deprescribing

- Deprescribing refers to the reduction of dose or the withdrawal of a medicine
- We give patient information leaflets when prescribing but what about when we deprescribe?
- Clinical guidelines tend to focus on prescribing rather than deprescribing



Why do we need to review psychotropics ?

- Risk vs Benefit
- Side effect monitoring
- Off label prescribing
- Evidence base
- Reviewing diagnosis
- Expectation – NHS bodies, service users (SUs) and their support
- National projects to reduce prescribing - STOMP



The deprescribing process

- Timing of the deprescribing
- Expectations
- Informed consent – material risks, alternatives
- Clinical issues
- Accessible information for patients and their carers / relatives
- Level of support for the person with learning disability (PwLD)



Communication - Management of expectation

- What?
- Review continued need for prescription for psychotropic medication
- Why?
- Some people take medicines that they no longer require
- Take care not to “demonise” antipsychotics – be mindful that a trial reduction in dose or complete withdrawal may not be permanent and antipsychotic may have to be restarted or dose increased again in the future
- Who?
- Psychiatrist ? GP?
- When?
- For a PwLD who has remained stable with challenging behaviour being managed by medication, concept of reduction may be daunting. consider timing eg before Christmas
- How ?
- Involvement of PwLD, support workers, carers, family, nurses



Legal aspects

- Patient engagement
- Informed consent to treatment which may involve deprescribing
- People with learning disability who have capacity regarding medication (under the MCA) should be treated just as anyone else who does not have LD.
- Consider the application of the Montgomery Judgement



Legal aspects

- Information for patients to comply with Accessible Information Standard.
 - In general easy read material may be of variable quality. Need to check author and date.



STOMP

- Stopping the over prescribing of medication in people with learning disability, autism or both
- Evidence shows:
 - Psychotropic medicines are being prescribed long term
 - Without adequate review or monitoring
 - In people with learning disability who do not have a documented diagnosis of a mental illness



Consider the possible consequences of withdrawing psychotropic medication prescribed for the management of behaviour that challenges focussing on antipsychotics



- For SUs on several different psychotropic medicines ideally reduce one at a time
- As doses are reduced monitor for the re emergence of behaviour that challenges
- What are the implications of subsequently reducing the side effects?



Discontinuing psychotropic medication

- **Discontinuation symptoms**
- Discontinuation symptoms are symptoms experienced on stopping prescribed drugs that are not drugs of dependence.
- It differs from the term “withdrawal” which implies addiction
- May be mistaken for a relapse of illness or emergence of a new physical or mental illness
- SUs who have experienced these symptoms may consider antidepressants to be addictive and may be reluctant to accept future treatment
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Discontinuing antidepressants

- **Discontinuation symptoms**
- Can start within 5 days of stopping - most common with paroxetine and venlafaxine due to short half life. Reduce over a four week period to reduce risk. The symptoms usually resolve within two to four weeks.
- Symptoms:
 - Flu like symptoms- fever, nausea, vomiting, insomnia, headache, sweating
 - Anxiety
 - Agitation
 - In addition for SSRIs : dizziness, vertigo, paraesthesiae, numbness and electric shocks



Discontinuing antipsychotics

- In general population stopping an antipsychotic has three main risks:
- Discontinuation syndrome
- Withdrawal / rebound psychosis
- Relapse of symptoms

- Discontinuing gradually reduces these risks



Discontinuing antipsychotics

- **Withdrawal / rebound psychosis**
- The **rebound effect**, or **rebound phenomenon**, is the emergence or re-emergence of symptoms that were either absent or controlled while taking a medication, but appear when that same medication is discontinued, or reduced in dosage. In the case of re-emergence, the severity of the symptoms is often worse than pretreatment levels



Discontinuing antipsychotics

- Cholinergic rebound from abrupt withdrawal
 - Headache, restlessness, nausea, vomiting, diarrhoea, rhinorrea, myalgia and insomnia



Management of side effect reduction in antipsychotics

- Not all adverse effects are dose related
- Manage the patient's expectation
- **Weight gain**
- A reduction in dose may not necessarily lead to weight reduction
- A reduction in dose does not mean SU can return to eating unhealthy diet



Management of side effect reduction in antipsychotics

- **Sedation**
- A reduction in dose may well lead to a reduction in sedation.
- Advantage or disadvantage?
- As the antipsychotic is reduced /withdrawn may have an impact on sleeping at night – what are the options? sleep hygiene measures, does SU have a prescription for temazepam or Z drug prn? If so monitor usage
- Positive effect of SU being more alert and able to engage with activities, however are these activities in place?



- **Metabolic syndrome**
- The Royal colleges of GPs and Psychiatrists refer to the work done by Professor Helen Lester published in 2013
- Although the Lester UK Adaptations are not specific for behaviour which challenges in LD, it may be a useful resource . Of course some of our SU do have psychotic illness which or may not have been diagnosed
- <http://rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf>



- **Metabolic syndrome**
- the service user postcard prompt
<http://rcpsych.ac.uk/pdf/LesterPostcardPrompt.pdf>



Management of side effect reduction in antipsychotics

- **Metabolic syndrome**
- Continue to monitor BP, lipids, weight gain and blood sugar
- If SU prescribed a statin for primary prevention to reduce vascular risk, this may need to be reviewed in the long term
- **EPSEs**
- If continues to be a problem consider investigating other causes



Management of side effect reduction in antipsychotics

- **Hyperprolactinaemia**
- May be dose related
- More likely with typicals and risperidone
- Less likely with aripiprazole, olanzapine, clozapine and quetiapine
- Also can occur with hypothyroidism
- Is reduction in prolactin levels to near normal an Advantage or disadvantage?



Management of side effect reduction in antipsychotics

- **Reduction of prolactin levels in women**
- Female SUs who have been on antipsychotics for many years may experience amenorrhoea – may be viewed as an advantage
- Need to alert SU and their support that periods may return.
- Issues of supporting SU with menstrual cycle and being alert to possible PMT which can adversely effect mood



Management of side effect reduction in antipsychotics

- **Reduction in prolactin levels in women**
- Increase in fertility
- Advantage or disadvantage?
- In sexually active women who are not planning a pregnancy ensure SU has access to appropriate contraceptive advice and services.



Management of side effect reduction in antipsychotics

- Hyperprolactinaemia and dopamine blockade can cause sexual dysfunction eg reduced libido
- Advantage or disadvantage?
- In SUs displaying inappropriate sexual behaviour the adverse effect of reduced libido may possibly be helpful. If antipsychotic is withdrawn these behaviours may begin to surface again



Management of side effect reduction in antidepressants

- **Sexual dysfunction**
- All antidepressants can cause sexual dysfunction, particularly SSRIs and venlafaxine.
- Advantage or disadvantage?
- As with antipsychotics, in SUs displaying inappropriate sexual behaviour the adverse effect of reduced libido may possibly be helpful. If antidepressant is withdrawn these behaviours may begin to surface again



Miscellaneous

- SUs may consider replacing psychotropic meds with complementary therapies - Risk of serotonin syndrome with St Johns Wort and SSRIs
- SUs who are having trouble sleeping may take hypnotics too frequently leading to dependence.
- Care/support staff may give oral lorazepam prn more often if they consider behaviour is challenging. This needs to be monitored.
- Consider implications for re emergence of behaviour which challenges



Miscellaneous

- Be alert to medication prescribed to counteract adverse effects of antipsychotics that may no longer be required eg laxatives or statins
- Anticholinergic medicines prescribed to treat extrapyramidal effects will need to be reviewed as antipsychotics are withdrawn.
- Please note that procyclidine has the potential for abuse.



What are we doing in HPFT re STOMP?

- Developed a fact sheet for Psychiatrists and GPs re deprescribing antipsychotics in people with learning disability but without a mental health diagnosis
- Set up a database in order that we track our patients within HPFT
- Together with Consultant psychiatrists I am part of a primary care review group to look at how STOMP can be implemented by GP practices



STOMP database

- Fields
- Patient demographics
- Mental health diagnoses
 - ICD 10 F
 - Is Challenging behaviour primary diagnosis?
 - Is there a diagnosis of epilepsy?
- Is service user prescribed any of the following medication?
 - Lithium, Mood stabiliser, Antidepressant, anti epileptic drugs, antidepressants, benzos, antipsychotic, PRN
- Capacity and Consent
- Is service user (SU) currently undergoing a reduction in their antipsychotic?



Reducing Medication incidents

- Interface between primary and secondary care – increased risk of medication incidents
- Empowerment and engagement of SUs
- Autistic Spectrum Conditions – changes in medication
- Management of the dispensing of medication that is being frequently changed- dosette boxes, MARS
- Is the deprescribing happening in primary care or under psychiatry in a Mental Health Trust?



Any Questions?

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Useful Resources

- Adams D, Shah C Reducing antipsychotic prescribing in people with learning disabilities Clin Pharm 2016
- Adams D, Shah C Prescribing of psychotropic medicines: the role of learning disability nurses. Learning Disability Practice 2016; 19, 8, 21-25
- Adams D, Sawhney I. Deprescribing of psychotropic medication in a 30-year-old man with learning disability. Eur J Hosp Pharm 2017;24:63-64



Useful Resources

- NHS England STOMP <https://www.england.nhs.uk/learning-disabilities/stomp/>
- NHS England Transforming Care 2017 <https://www.england.nhs.uk/learning-disabilities/caretransformed/>
- NICE guidance NG11 May 2015 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges <https://www.nice.org.uk/guidance/ng11>
- Public Health England 2017 <https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities>