

Workshop: Getting Medication Use Right

Workshop facilitator: Rory Sheehan – NIHR Doctoral Research Fellow in Psychiatry of Intellectual Disabilities, UCL

The **aim** of this workshop was to consider the major barriers and facilitators to getting psychotropic medication use right for people with intellectual disability, both in the short-term (when new medication is first prescribed) and in the longer-term (when existing medication is reviewed).

The **objectives** were to:

- Review psychotropic medication prescribing for people with intellectual disability and the case for change
- Identify and discuss key points in the pathway of medication prescribing and continuing medication use
- Explore ways of promoting collaborative working between different stakeholders to ensure that psychotropic medication is used in the best possible way

Background

There has been debate around the use of psychotropic medication for people with intellectual disability and a national programme to reduce inappropriate medication use has been established. Best practice guidance on psychotropic prescribing has been produced, but challenges remain in ensuring that the views of all stakeholders are considered and medication is used in the most appropriate way. There are particular issues involved in how medication prescribing decisions are initially made and how existing medication prescriptions are reviewed.

Workshop Discussion

The group first discussed prescribing in relation to the Mental Capacity Act (MCA) and how the Act could be used to support people with learning disability and their carers, for example, by having a best interests meeting before medication is prescribed. The group suggested that prescribing medication is often the 'default' position and that evidence should be required that medication is the least restrictive option. It was raised that GPs don't always appear to follow the MCA and whether they are aware of their responsibilities. There was a positive example of how care staff had used the MCA to combat pressure from professionals to prescribe, the MCA had helped them to step back and consider the best option for the person. An issue was raised that best interest meetings don't always involve the right people and that a wider meeting should be held before this point to address anything that is going wrong for the individual. There was recognition that medication use is only part of the wider pathway of supporting someone with challenging behaviour and other interventions need to be available when required. The value of intervening early to prevent the onset of challenging behaviour was highlighted.

Discussion moved on to the role of the GP and decision making processes. People should not have to prove that they do not need medication in order to have their medication reduced. The issue was also highlighted that GPs often only have medication available to them as a solution in the absence of other options. Some group members felt that this was especially the case if someone had a dual diagnosis of a learning disability and a mental

health issue, as there is a lack of joint support. There is often confusion over who is the decision maker about medication as GPs prescribe on the basis of a psychiatrist's views and may have had little input into the decision. GPs may find themselves in a difficult position as they often do not see themselves as experts in prescribing and monitoring of psychotropic medication and might have little confidence to make medication changes.

Group members emphasised that mental wellness should be focused on rather than mental distress, which relates to the need to have wider meetings to address emerging issues and focus on maintaining mental wellbeing. Suggestion that the Local Authority should take over the role of the first point of call from GP's as they might be able to address some of the systemic determinants of challenging behaviour more easily (e.g. ensuring the right level of support and social opportunities). This would add an extra step before prescription and act as a signposting service to more appropriate interventions. This was added to with the contribution that medication is often prescribed from a crisis situation and the steps before medication need to be reinforced rather than just turning to prescribing. An additional suggestion on this point was to develop a checklist for psychiatrists and GPs of things they should have tried before prescribing medication. This should include using the MCA if necessary and alternative interventions, among other checks.

An example was given about PRN medication where the care staff become decision makers, which can result in unmonitored PRN administration becoming regular. Group members felt that this related to the medicalisation of a social problem in many cases, but that care staff can be in a similar position to GPs, where the only intervention they have available is medication. Prescribers should be aware of how often PRN medication is being used, for example, by checking how often the prescription is requested.

The need to take into account of the individual's views was raised and that medication should be a last resort, but is often the first option considered. This was related to the 'doctor knows best view' and a prevailing medical model that would need to be overcome for someone with a learning disability and their family members to make a meaningful contribution to decisions about medication.

The group agreed that the individual should be the starting point for any decision about medication. The point was also raised that psychiatrists should be seen as helpful for more than just prescribing and their expertise should be used more effectively, for example, in co-ordinating the MDT response to challenging behaviour and supporting the use of psycho-social interventions.

Actions

Action	Who?	When?
1. Make sure information about the Mental Capacity Act gets to families, care staff and prescribers so that it can be used as a tool to ensure prescribing is in the best interests of the individual	Camilla Parker to send information about the MCA. CBF to disseminate to families. Mencap to promote through social media links. ARC to disseminate to providers.	September 2017
2. Checklist for prescribers of other options that should be tried (or at least considered)	Dave Branford – Alerts on GP systems Other partners	

before medication is prescribed.		
3. Write to Peter Pratt (pharmacist at NHS England and NHS Improvement) about the potential for pharmacists to be routinely involved in care and medication reviews. Also about the role of the pharmacist as an advocate in prescribing decisions and decisions to stop or reduce medication	CBF and Peter Pratt	September 2017

Further information/guidance/ background reading

Sheehan, R. & Hassiotis, A. **Reduction or discontinuation of antipsychotics for challenging behaviour in adults with intellectual disability: a systematic review.** *Lancet Psychiatry* 2017;4(3):238-56. Abstract available at: <http://www.sciencedirect.com/science/article/pii/S2215036616301912>

Sheehan, R. & Hassiotis, A. **Psychotropic medication: finding ways forward for adults with intellectual disabilities.** The Learning Disabilities Elf. Available at: <https://www.nationalelfservice.net/treatment/antipsychotics/psychotropic-medication-finding-ways-forward-for-adults-with-intellectual-disabilities-rsmpsychotropics/>

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guideline [NG11]. Available at: <https://www.nice.org.uk/guidance/ng11>

Royal College of Psychiatrists **Practice Guidelines: Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge.** Available at: http://www.rcpsych.ac.uk/pdf/FR_ID_09_for_website.pdf