# Workshop: Reducing over prescribing of psychotropic medicine in people with Learning Disabilities

**Co-facilitators:** Danielle Adams - Principle Clinical Pharmacist Mental Health, Hertfordshire Partnership University NHS Foundation Trust

Lorna Walker Bryan - Family Carer

The **aim** of this workshop was to consider the issues surrounding de-prescribing psychotropic medication and strategies to address these, ensuring any de-prescribing is supportive and effective.

The **objectives** were to:

- Consider the issues in de-prescribing psychotropic medication
- Discuss strategies that need to be in place to ensure reduction of over prescribing is supportive and effective
- Discuss how consideration can be given to engaging the person, their carers and relatives in the process

## Background

The issues of overprescribing people with a learning disability refer to the long term prescribing of psychotropic medicines in the absence of a mental health diagnosis and without adequate review of clinical need and without adequate monitoring of side effects. The levels of prescribing of these medicines are higher for people with a learning disability than in the general population.

It appears that these medicines and especially the antipsychotics are initiated to manage behaviour that challenges. Behaviour that challenges is a symptom not a diagnosis. Antipsychotics are not licensed to treat behaviour that challenges in adults and exposes people to a variety of adverse effects affecting quality of life and increasing risk of diabetes and heart disease.

This workshop will consider the issues which can arise when psychotropic medication is reduced, and how best to support this process.

## Workshop Discussion

Identify issues in reducing over prescribing

- There is not always a specific aim for the use of medication.
- Often there is a lack of multi-disciplinary approach and/or the opinion of one professional overrides others.
- Second opinion doctors seem to view their relationship with colleagues as more important than the person being prescribed medication.
- Change of provider, manager or psychiatrist can lead to change in prescribing. Too much influence of personal opinions.
- Conflicts of interest. Psychiatrists are often shareholders of the hospitals.
- There is a lack of consequences for prescribers, e.g. the TT SCR and GMC not investigating.

- Sometimes it is care providers and families asking for medication for the person.
- Cause of death is not recorded as medication, but other health complications. Will the mortality review look at this and draw out enough data?
- CQC inspections looking at mediation depends on the knowledge and experience of the inspectors.

Consider strategies to support the reduction of over prescribing

- If there was more focus on the evidence of the need for medication and evidence of benefit or detriment, then professionals have something with which to challenge the prescriber and the decision making. Evidence liberates people from 'opinion'.
- Monitoring benefit/harm, behaviour and side effects in details provides evidence.
- Understand prescribers in order to change their behaviour.
- A standardised medication withdrawal process.
- There is a personal risk to a doctor prescribing above the licensed limit; they must show it is beneficial and they are not negligent.

Discuss how to engage the person and family carers in the process.

- Need to understand prescribers and work in partnership with them. Family carers and other professionals should try to be more tactful and positive so prescribers do not become defensive. Build relationships and work together.

**Actions**

| Action | Who? | When? |
|---|---|---|
| 1. Build a relationship between family carers and psychiatrist (don't make the psychiatrist defensive). Need pan-disciplinary meetings with humanity | Link with Empowering Families action to improve how professionals and families work together. | Empowering Families action – 4th September 2017 |
| 2. Families need expected outcomes and timeframe at the point of prescribing – evidence is needed for medication and evidence of benefit/side effects. Baseline is essential. | Ashok – are psychiatrists doing this and sharing the information with others.<br>CQC to inspect on medication prescription standards and outcomes related to medication<br><br>CBF Family Carer resource. | September 2017 |

**Further information/guidance/ background reading**

Public Health England. (2015). Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England. http://webarchive.nationalarchives.gov.uk/20160704150527/http:/improvinghealthandlives.or

g.uk/securefiles/160704_1723/Psychotropic%20medication%20and%20people%20with%20learning%20disabilities%20or%20autism.pdf

Royal College of Psychiatrists. (2016). Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guideline. www.rcpsych.ac.uk/pdf/FR_ID_09_for_website.pdf