Combined antipsychotic use in a community rehabilitation psychiatric service

Tunde Apantaku-Olajide, Abid Khattak, Peter Whitty

Ir J Psych Med 2010; 27(3): 138-140

Abstract

Objectives: Despite the clinical guidelines regarding the use of combined antipsychotics and the limited evidence for its benefits, use remains high in psychiatric practice. The aim of this study was to examine prescribing practices and investigate reasons for initiating and continuing combined antipsychotics in stable psychiatric illnesses.

Method: A cross-sectional case record survey of antipsychotic prescribing practices in a community psychiatric rehabilitation service. A total sample (n = 75) of patients with chronic and enduring psychiatric illnesses was studied. The age, gender, diagnosis and prescribed antipsychotics were examined. The proportional prevalence and documented reasons for combined antipsychotic prescribing were analysed.

Results: Seventy-three of the 75 patients were prescribed antipsychotic mediations. Of these, 44 (60%) received a combination of two or more antipsychotics. The most common reason for combined prescribing was a switch of antipsychotic (n = 18; 41%). No reason was documented in 19 cases (43%).

Conclusions: In this study, slow cross-tapering or incomplete switch process of antipsychotics contributed to the prolonged period of combined antipsychotics treatment. Adequate documentation regarding indication and review of medications cannot be overemphasized.

Key words: Combined antipsychotics; Psychiatric; Community rehabilitation.

Introduction

In spite of clinical guidelines regarding the use of combined antipsychotics and the limited evidence for its benefits, the use has become a norm rather than the exception.[1] A national survey conducted by Schizophrenia Ireland in 2002 found that over 65% of patients were on two or more medications; over 30% were on three or more and 13% on four or more medications for mental health problems.[2]

Various reasons have been offered for the combination of antipsychotics in clinical practice such as improving efficacy in refractory illness, achieving rapid control of symptoms, minimising adverse effects of initial medication and augmenting an initial medication for which maximal dosages have been reached.[3,4]

However the use of combined antipsychotics is associated with an increased risk of adverse effects and of drug to drug interactions. Combined antipsychotic prescribing can lead to higher rates of noncompliance due to complex treatment regimes. Further, there is an increased cost associated with combining medications and the practice can also confound clinicians' ability to identify helpful from unhelpful medications.[5-7]

Many studies have investigated prescribing practices in outpatient, day-hospital and inpatient settings. However, few studies have involved patients attending a rehabilitation service and yet the prevalence of combined antipsychotic use might be higher in this group for a number of reasons. A high number of such patients suffer from severe and enduring mental illnesses that require intensive biological treatments. Further, many are on a long term treatment programme and have other aspects of their care optimised, yet continue to display treatment resistant symptoms.

We evaluated patients residing within a community rehabilitation facility to investigate the use of combined antipsychotics use in stable chronic psychiatric illnesses. We examined the demographic and clinical characteristics of these patients and identified the reasons why the combination of antipsychotics was initiated.

Methods

This is a cross-sectional case record survey of antipsychotic prescribing practices within an Irish psychiatric rehabilitation service. This rehabilitation service consists of seven community hostels and a 22 bed inpatient unit. For the purposes of the study, we included patients living in community hostel placements only as these were the most stable group of patients and excluded those from the inpatient unit. The community hostels have 86 beds in total. Patients receive varying levels of nursing supervision ranging from working-hour nursing care to a 24-hour care. The general adult psychiatric clinics are responsible for reviewing and prescribing patients' medications.

We examined the case records of all patients residing in the community hostels on a given day in October 2007. Data was obtained on age, gender, diagnosis and prescribed medications. We limited our analysis to regular antipsychotic medications and excluded pro re nata (PRN) or 'as required' prescriptions. The proportional prevalence and documented reasons for combined antipsychotic use was analysed. We also examined the site where the combined prescribing

***Tunde Apantaku-Olajide**, Registrar in General Adult Psychiatry, Dublin University Psychiatry Rotational Training Programme, Dublin. Email: tunyapans@yahoo.com
Abid Khattak, MB, MRCPsych, Consultant, Psychiatric Rehabilitation and Recovery Unit, St. Loman's Hospital, Dublin.
Peter Whitty, MD, MRCPsych, Consultant, Department of Psychiatry, Adelaide & Meath Hospital, Tallaght, Dublin 24, Ireland.
**Correspondence*

SUBMITTED: AUGUST 4, 2009. ACCEPTED: JANUARY 8, 2010.

was initiated. All data was analysed using EPI-INFO 2007 version.

Results

Patients' demographic and clinical characteristics

A total of 75 psychiatric patients were residing in the service at the time of survey. Of these, 46 (61%) were male and 29 (39%) were female. Their mean age was 56 years (sd = 8.0) and their mean duration in treatment was 14.9 years (sd = 6.9). The mean outpatient clinic review interval was 16.4 weeks (sd =12.6).

By using the ICD-10 diagnostic criteria, we identified 55 patients (73%) with a diagnosis of schizophrenia; 14 (19%) with bipolar affective disorder; two (3%) with a learning disability; three (4%) had an emotionally unstable personality disorder, and one patient (1%) had fronto-temporal dementia.

Pattern of antipsychotic prescriptions

Antipsychotic medication was prescribed for 73 (97%) of the 75 patients *(see Table 1)*. Oral medication alone was prescribed for 54 of these 73 patients (74%), two patients (3%) were on depot medication alone, while the remaining 17 patients (23%) were on a combination of oral and depot preparations.

In terms of the class of antipsychotic, 64 patients (88%) were prescribed a first-generation antipsychotic (FGA) and 59 patients (81%) received a second-generation antipsychotic (SGA). A total of 19 patients (26%) were prescribed clozapine.

Most patients (n = 44; 60%) were prescribed more than one antipsychotic at the time of the study. The most common combination was of a FGA and SGA (n = 29). A further 10 patients were prescribed a combination of SGAs; while the remaining five patients were prescribed a combination of FGAs. Nine of the 44 patients were also on clozapine at the time of survey, while two patients had failed trial of clozapine in the past.

Table 2 gives the documented reasons for prescribing combinations of antipsychotics among the 44 patients in this sample. The most frequent reason was a switch from one antipsychotic to another. At the time of survey, 18 patients (41%) were undergoing a switch and the mean period of the switch process was 455 days (sd = 61) from the date of initiation. In the case of 19 patients (43%), there were no documented reasons for combined antipsychotic use.

Most patients (n = 28, 64%) had their combination initiated during an acute admission, with the remainder (n = 16, 36%) initiated during outpatient reviews.

Table 1: Pattern of antipsychotic prescriptions

	n = 73	Percentage of total sample
Single antipsychotic	29	40%
Combined antipsychotics	44	60%
2 antipsychotics	18	24%
≥ 3 antipsychotics	26	36%

Table 2: Documented reasons for combining antipsychotics

Primary reason for combined antipsychotic treatment	Number of patients	Percentage of patients on combination
No reason documented	19	43%
Switching of antipsychotics	18	41%
Lack of efficacy of monotherapy at maximal dosage	4	9%
Poor compliance with oral medication	2	5%
History of violence and aggression; Safety concerns	1	2%

Discussion

This study was a descriptive, cross-sectional survey to investigate the use of combined antipsychotics and the indication of such prescriptions in a community rehabilitation psychiatric service.

The main finding was that almost two thirds of patients receiving antipsychotic treatment in the study population were prescribed a combination of antipsychotics. This finding is similar to the results reported in other studies.[2,8,9]

In rehabilitation psychiatry, the patients are fairly stable and suffer from chronic refractory psychiatric conditions. It is therefore expected that they would be on a variety of pharmacotherapy including combination therapy, however the use of combined antipsychotics could be minimised.

In this study, 41% of cases on combined antipsychotic treatment were undergoing a switch process. Typically the clinicians responsible for reviewing medications are consultant psychiatrists and non-consultant medical personnel. The mean outpatient review interval of 16.4 weeks could have increased the chances of different clinicians assessing patients at each outpatient reviews. The non-consultant medical personnel rotate through various mental health service sectors every six months, such that longer intervals between outpatient reviews may be associated with slower or incomplete switch process and might have contributed to the high level of combined antipsychotic prescribing in this study.

A total of 64% of the cases had the combination process commenced during acute psychiatric admission; a further explanation might be that patients become stable on the combination and there is reluctance by the clinician to complete the switch process.

In this study, the mean period of combination therapy initiated primarily for the purpose of switching antipsychotics was 455 days. A prolonged combination is defined by a period of more than 60 consecutive days of combined antipsychotic treatment.[11] One study recommended a crossover period of between one and four weeks.[12]

Two other studies has utilised a seven-day cross-titration period followed by an 11-week flexible dose period during which patients received the post-switch antipsychotic, and reported favourable outcomes irrespective of their previous medication or indication for switch.[13,14]

Furthermore, estimating the desired target dose of post-

https://doi.org/10.1017/S0790966700001324 Published online by Cambridge University Press

switch antipsychotic using the current dose of patient's pre-switch antipsychotic as a guide is advisable prior to commencing a cross-taper strategy.[12] The responsibility ultimately rests with clinicians to ensure the switching is complete and that patients are not continued on a combination of antipsychotics indefinitely.

We also found a low level of documentation for prescribing more than one antipsychotic. The burden of paperwork and restrictions in professional freedom are some reasons for low levels of documentation in clinical practice.[10]

In the past, psychiatrists would have been the sole source of authority and legitimacy in the clinical decision-making process. Today, the psychiatrist-patient relationship is influenced by the outside world including family, caregivers and legal representatives, but psychiatrists carry the ultimate responsibility for the delivery of patients' care and make certain decisions, which maybe unsupported by scientific evidence;[15] such that there is the need for psychiatrists to monitor and assess patients' treatment progress objectively by documenting treatment indications and outcomes.

The importance of clear documentation can not be overstated in terms of delivering a high quality of care. One way that documentation could have been enhanced was through the use of care plans which were not used routinely during the study. Such care plans should include reviews of medication and responsible clinician; this might have helped with documenting the reason for combined antipsychotic use.

Limitations

Several limitations to this present study need to be noted. First, this was a descriptive study of one psychiatric service; the results may not be generalisable to other community rehabilitation settings. The lack of analysis for correlation between the patients' demographic and clinical characteristics and the prescription patterns is a limitation.

Secondly, our cross-sectional design limits investigation for changes in dose or symptom ratings that might have occurred in response to use of combined antipsychotics. We therefore suggest need for longitudinal studies examining patients' subjective outcome, side effects, tolerability and quality of life, all of which may be helpful in determining the benefits of combined prescribing. Thirdly, we could not investigate the role of rotating non-consultant medical personnel in the prescribing practice because the information was unavailable in the data set.

Conclusion

The results from this study suggest that in stable chronic psychiatric patients slow cross-tapering or incomplete switch processes contribute to prolonged periods of antipsychotic combinations. Proper documentation of indication and review of medications using treatment care plans maybe helpful in minimising this.

Declaration of Interest: None.

References

1. Patrick V, Schleifer SJ, Nurenberg JR, Gill KJ. Best practices: An initiative to curtail the use of antipsychotic polypharmacy in a state psychiatric hospital. Psychiat Serv 2006, 57: 21-23.
2. Schizophrenia Ireland. Quality of Choice: Survey of Service Users Experience of Mental Healthcare Treatment. Dublin: SI, 2002.
3. Sim K, Su A, Fuji S et al. Antipsychotic polypharmacy in patients with schizophrenia: a multicentre comparative study in East Asia. Br J Clin Pharmacol 2004; 58: 178-183.
4. Sernyak MJ, Rosenheck R. Clinicians' reasons for antipsychotics co prescribing. J Clin Psychiat 2004; 65: 1597-1600.
5. Miller AL, Craig CS. Combination antipsychotics: pros, cons, and questions. Schiz Bull 2002; 28: 105-109.
6. Loosbrock DL, Zhao Z. Antipsychotic medication use patterns and associated costs of care for individuals with schizophrenia. J Ment Health Pol Econ 2003; 6: 67-75.
7. Jaffe AB, Levine J. Antipsychotic medication co-prescribing in a large state hospital system. Pharmacoepidemiol Drug Saf 2003; 12: 41-48.
8. Faries D, Ascher-Svanum H, Zhu B, Correll C, Kane J. Antipsychotic monotherapy and polypharmacy in the naturalistic treatment of schizophrenia with atypical antipsychotics. BMC Psychiatry 2005 May 27; 5: 26
9. Schumacher JE, Makela EH, Griffin HR. Multiple antipsychotic medication prescribing patterns. Ann Pharmacother 2003, 37: 951-955.
10. Kissling W, Seemann U, Piwernetz K. Quality management in psychiatry. Int Clin Psychopharmacol 2001; 16(Suppl 3); S15-S24.
11. The expert consensus guideline series. Treatment of schizophrenia. J Clin Psychiat 1999: 3-80.
12. Weiden PJ: Switching antipsychotics: an up-dated review with a focus on quetiapine. J Psychopharmacol 2006; 20: 104
13. De Nayer A, Windhager E, Irmansyah et al. Efficacy and tolerability of quetiapine in patients with schizophrenia switched from other antipsychotics. Int J Psychiatry Clin Pract 2003, 7: 59-66.
14. Gillain B, Van Peborgh P, De Brueeker G, Peuskens J. Quetiapine clinical use in real-life environment – the SECURE Study. Eur Neuropsychopharmacol 2002; 12 (Suppl. 3): S263, abs P.2.021.
15. McGrath BM, Tempier RP. Implementing Quality Management in Psychiatry: From Theory to Practice – Shifting focus from Process to Outcome. Can J Psychiat 2003; 48: 467-474.

Erratum re the case report by Tunde D. Apantaku-Olajide entitled *Treatment considerations in clozapine induced enuresis or incontinence*, Ir J Psychol Med 2010; 27(2): 99-100 published in the June issue of the Journal. The second author of this article is Yolande Ferguson, Consultant in General Adult Psychiatry, Adelaide and Meath Hospital, Tallaght, Dublin 24. Unfortunately her name was omitted at press.

https://doi.org/10.1017/S0790966700001324 Published online by Cambridge University Press