Antipsychotic prescribing in people with a learning disability

POMH-UK Quality Improvement Programme. Topic 9c: supplementary audit
Prepared by the Prescribing Observatory for Mental Health-UK for
Coventry and Warwickshire Partnership Trust

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Data control statement for POMH-UK quality improvement programme 9c: Antipsychotic prescribing in people with learning disabilities

Data ownership and control

In line with the original memorandum of understanding between POMH-UK and member healthcare organisations (predominantly mental health NHS Trusts), the following statement outlines the agreement regarding ownership of the audit data in this quality improvement programme:

Control of the local data submitted to POMH-UK is retained by the healthcare organisation that submitted them. These data have been made available to POMH-UK in a way that is anonymous, with the exception of the identity of the source organisation. The aggregate data from all participating organisations have been analysed by POMH-UK, to produce this customised report. This report summarises the national results, and local results at organisation and clinical team level, benchmarked anonymously against the other organisations taking part.

Data Sharing

There is a publication strategy allowing POMH-UK to publish the anonymous aggregated data on its web site and/or in appropriate scientific journals. Any organisations requesting these audit data will be referred to the POMH-UK reports appearing in the public domain or provided with a list of member healthcare organisations and asked to approach them individually. It is each organisation’s decision whether, and with whom, to share their data.

Data for Quality Improvement

Given that the data are collected for the purpose of quality improvement they are not necessarily representative of performance across the Trust. The use of data for ranking or judgement at an organisational level may therefore not be appropriate. Participation in POMH QIPs can be considered to indicate engagement in quality improvement. Relative and absolute performance against the practice standards should always be considered with the above caveats in mind.

Reflection by clinical teams on their benchmarked performance is perhaps the most potent element of POMH-UK programmes. In addition to performance against the clinical standards, the audit data include demographic, diagnostic and other relevant clinical information that provide a context for interpretation and understanding of practice, which can inform local strategies and systems to achieve improvement. The data collected are designed to be suitable for this clinical purpose, and not for objective ranking of healthcare organisations, for which they are untested and would not necessarily be appropriate.
How to read this report

The term ‘Trust’ has been used throughout this report to refer to all healthcare organisations that participated.

Executive summary
An executive summary of this report starts on page 4. This provides an overview of national performance against the practice standards and how your Trust compares. It also provides some broader observations relating to national prescribing practice (page 9) that may usefully prompt local reflection and discussion.

Practice standards
Page 17 of this report outlines the standards against which prescribing practice was measured in this quality improvement programme (QIP). These practice standards were derived from evidence-based guidelines and agreed by an expert clinical advisory group.

Method
Page 18 provides an outline of the methodology of the QIP. This includes the nature of the clinical audit data collected and how these were cleaned.

National level results
The section beginning on page 19 describes the demographic and clinical characteristics of the total patient audit sample. The findings of the data analysis are presented in graphs and tables, primarily to show the extent to which clinical prescribing across the participating services is meeting the practice standards.

Trust level section
The analyses presented in this section, starting on page 39, allow Trusts to compare the quality of their local practice, in absolute terms, with the practice standards and, in relative terms, with that of the other, anonymous, participating Trusts.

Each of the benchmarked graphs in this section provides evidence of performance on a particular aspect of prescribing practice across all Trusts individually and the total national sample (TNS). In each figure, the Trust(s) on the left hand side is closest to meeting the relevant standard while the Trusts on the right are further away from meeting the standard.

Team level results
This section starts on page 51. The figures allow individual clinical teams in each Trust to compare their practice with each other and against the national data. For each figure, the team(s) on the left hand side is closest to meeting the standard. The bar on the far right shows the total national sample (TNS) and the bar next to this shows the overall Trust performance.
Executive Summary

Background
The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based quality improvement programmes open to all specialist mental health services in the UK. The aim is to help mental health services improve prescribing practice in discrete areas (‘Topics’).

This report presents the results of the supplementary audit for a quality improvement programme (Topic 9c), addressing the use of antipsychotic medication in people with a learning disability. Data are presented at national and Trust level.

The Winterbourne View report, published in 2012, raised concerns about the over-use of psychotropic medicines in people with learning disability. The report recommended (section 7.31) that ‘health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient…. Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management…’

For this supplementary audit, the eligibility criteria have therefore been expanded to include all patients with a learning disability under the care of mental health services, regardless of whether or not they are prescribed antipsychotic medication. This will allow the prevalence of prescribing of different categories of psychotropic drugs to be benchmarked across services while also retaining the original focus of this QIP on the quality of prescribing of antipsychotic medication.

Practice standards

1. The indication for treatment with antipsychotic medication should be documented in the clinical records (Deb, 2006).

2. The continuing need for antipsychotic medication should be reviewed at least once a year (Deb, 2006).

3. Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of extrapyramidal side effects (EPS), and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia (NICE schizophrenia guideline update CG82, 2009).

Compliance with NICE guideline
The original derivation of these practice standards can be found on page 17. While this report was being prepared, NICE published a guideline entitled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disability whose behaviour challenges’ (NG11, May 2015). Practice standard 1 is consistent with recommendations 1.8.4 and 1.8.5. Practice standards 2 and 3 address aspects of NICE recommendations 1.8.4, 1.8.5 and 1.8.6.
Supplementary audit sample

Three hundred and thirty-eight teams from 54 specialist mental health Trusts participated in this supplementary audit, submitting data for 5,654 patients, all of whom had a diagnosis of a learning disability. At baseline (2009), 39 Trusts participated, 145 teams submitting data for 2,319 patients. At re-audit (2011), 174 teams with 40 Trusts submitted data for 2,387 patients.

- Compared with the baseline and re-audit samples, a higher proportion of the supplementary audit sample was under the care of forensic services (8% v 1% at baseline and re-audit), had a mild/borderline learning disability (see Table 1) and had no diagnosed co-morbid mental illness (24% v 12%). A lower proportion had a diagnosis of schizophrenia spectrum disorder. These differences are likely to be due to the changes made to the eligibility criteria on this occasion; that is, all patients with a diagnosis of learning disability (LD) could be included, rather than, as in the earlier audits, only those patients with a diagnosis of LD who were prescribed an antipsychotic.

- When compared with the baseline and re-audit samples, the demographic and clinical characteristics of the supplementary audit subsample of those prescribed an antipsychotic are very similar (see Tables 1 and 2). The exception to this is the increased number of multiple documented psychiatric diagnoses at supplementary audit (25% v 17% at baseline and re-audit). This difference, and the different sampling methods used, should be borne in mind when considering the data, particularly when looking at change over time.
Prevalence of prescribing antipsychotic medication and clinical rationale

Subsequent to the Winterbourne View report, NICE published a guideline entitled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disability whose behaviour challenges’ (NG11, May 2015). This guideline includes recommendations that treatment for co-morbid mental illness should be optimised (1.8.1) and that antipsychotic medication should only be considered for the management of ‘behaviour that challenges’ if other strategies have failed and/or the risk to the person or others is severe, for example violence, aggression or self-injury (1.8.2).

Figure 1 below reflects clinical practice in the total national sample and your Trust in relation to these recommendations. The Figure shows the proportion of patients prescribed an antipsychotic who have a co-morbid psychiatric diagnosis that is a potentially legitimate target for such treatment, the proportion where antipsychotic medication was prescribed as part of the treatment for the NICE target symptoms mentioned above (violence, aggression or self-injury) and the proportion where neither of these reasons were documented.

Figure 1: Prevalence and nature of antipsychotic prescribing in people with a learning disability in the total national sample (TNS) and your Trust
National and Trust performance against the clinical practice standards

Figure 2 relates to **practice standard 1**: The indication for treatment with antipsychotic medication should be documented in the clinical records.

Practice standard 1 was met in almost all cases, with the clinical indication for antipsychotic treatment documented for 98% of patients who started treatment in the last 12 months and 97% of patients who had been prescribed antipsychotic medication for more than 12 months.

**Figure 2**: Documentation in the clinical records of the reasons for prescribing antipsychotic medication where this was prescribed within the last 12 months

In the TNS, 97% of those patients prescribed antipsychotic medication for 12 months or more had their medication reviewed in the last year. The respective proportion for your Trust is 99%. Figure 3 below compares your Trust with the TNS on the documented outcomes of medication review where antipsychotic medication was prescribed for 12 months or more.

**Figure 3 relates to practice standard 2**: The continuing need for antipsychotic medication should be reviewed at least once a year.

**Figure 3**: Documentation of decisions at medication review for patients prescribed antipsychotic medication

**Figure 3** relates to practice standard 2: The continuing need for antipsychotic medication should be reviewed at least once a year.

The indication for treatment with antipsychotic medication should be documented in the clinical records.
Practice standard 3: Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

Figure 4: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of assessment of extrapyramidal side effects (EPS) and weight measurement in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Figure 5: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of monitoring of blood pressure, blood glucose and lipid profile in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Practice standard 3: Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

Figure 4: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of assessment of extrapyramidal side effects (EPS) and weight measurement in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Figure 5: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of monitoring of blood pressure, blood glucose and lipid profile in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Practice standard 3: Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

Figure 4: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of assessment of extrapyramidal side effects (EPS) and weight measurement in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Figure 5: Proportions of patients prescribed antipsychotic medication with documented evidence in their clinical records of monitoring of blood pressure, blood glucose and lipid profile in the last year at baseline, re-audit and supplementary audit in the total national sample and your Trust

Practice standard 3: Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.
Broader observations of prescribing in LD services, to prompt local reflection and discussion

1. The vast majority of antipsychotic prescribing for people with LD under the care of mental health services is for a potentially legitimate target for such treatment: either a co-morbid mental illness or target symptoms/behaviours recognised by NICE.

2. In the new NICE guideline (NG11), it is recommended (1.8.4) that antipsychotic medication should only be initiated and monitored by a specialist. The data in Table 6 suggest that antipsychotic medication is initiated independently of secondary care services in only a minority of patients.

3. The Winterbourne view report recommended that 'health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient...'. With respect to people with LD under the care of mental health services, active medication review would seem to be part of routine clinical practice for virtually all patients.

4. Most antipsychotic medicines lower the seizure threshold and the lower prevalence of prescribing in patients with epilepsy suggests that clinicians use these medicines cautiously in this population.

5. Antipsychotic medicines are known to increase morbidity and mortality in people with dementia. The pattern of prescribing suggests that clinicians in LD services generally avoid antipsychotics in people with LD who also have dementia.

6. Antipsychotic medicines are used in clinical practice to ameliorate some forms of behavioural disturbance in patients with autistic spectrum disorders. That those patients with autistic spectrum disorders are overrepresented amongst people with LD prescribed antipsychotic medicine is consistent with clinical expectations.

7. Anticonvulsant (antiepileptic) medication would seem to be commonly prescribed for those with severe/profound LD, which is consistent with the increased prevalence of epilepsy in this subsample of patients.

A summary of the key findings from this supplementary audit can be found on page 37.
What happens next?

- We hope that the data presented in this report, and any evident change in prescribing practice in your Trust over the successive audits, will generate local review and discussion of prescribing practice for patients with a learning disability. In order to facilitate this, Trusts should consider local practice and systems with respect to aspects of care which their POMH-UK data indicate fall short of the standards, or where the Trust, or teams within the Trust, appear to be outliers in terms of their practice.

- Customised PowerPoint slide sets will be generated for each participating Trust, summarising the benchmarked findings of this audit. This is to help ensure that all participating clinical teams have access to the audit findings relating to their own practice.

- Clinicians who reflect on their performance data and generate and implement action plans as appropriate should be encouraged to submit evidence of this process as part of their CPD, to inform their appraisal and to support revalidation.
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Introduction

POMH-UK
The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based quality improvement programmes open to all specialist mental health services in the UK. The aim is to help mental health services improve prescribing practice in discrete areas ('Topics').

Those interested in learning more about the role of POMH-UK should visit the website: http://www.rcpsych.ac.uk/pomh. There are also reviews of the POMH-UK quality improvement methodology in the following publications:

Barnes TRE, Paton C. The role of the Prescribing Observatory for Mental Health (Editorial). British Journal of Psychiatry 2012; 201: 428-429

Barnes TRE, Paton C. Improving prescribing practice in psychiatry. International Review of Psychiatry 2011; 23: 328-335

This report presents the supplementary audit results for a quality improvement programme (Topic 9c) addressing the use of antipsychotic medication in people with a learning disability.

Clinical background

Please refer to the baseline report (9a) for the clinical background. This can also be found in the ‘member's area’ of the POMH website: (www.rcpsych.ac.uk/pomh/members). Log-in details can be obtained from your Trust POMH-UK lead.
Practice standards for audit

Whilst there has been a lack of NICE guidance in this area, practice standards were presented in “Using medication to manage behaviour problems among adults with a learning disability” by Deb and colleagues (University of Birmingham, September 2006). The practice standards used in this report were originally derived from these, and the third standard was also supported by the NICE clinical guideline for the management of schizophrenia CG82 (2009).

**Practice standards**

1. The indication for treatment with antipsychotic medication should be documented in the clinical records.

2. The continuing need for antipsychotic medication should be reviewed at least once a year.

3. Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

**Compliance with NICE guidelines**

While this report was being prepared, NICE published a guideline entitled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disability whose behaviour challenges’ (NG11, May 2015).

Practice standard 1 is consistent with recommendations 1.8.4 and 1.8.5. Practice standards 2 and 3 address aspects of NICE recommendations 1.8.4, 1.8.5 and 1.8.6.

In addition, NICE recommends that treatment for co-morbid mental illness should be optimised (1.8.1) and that antipsychotic medication should only be considered if the risk to the person or others is severe, for example violence, aggression or self-injury (1.8.2). Where the data allow, we have included tables or figures that show clinical practice in relation to these recommendations.
Method

The Winterbourne View report, published in 2012, raised concerns about the over-use of psychotropic medicines in people with learning disability. The report recommended (section 7.31) that 'health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient.... Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management.'

For this supplementary audit, the eligibility criteria have therefore been expanded to include all patients with a learning disability under the care of mental health services, regardless of whether or not they are prescribed antipsychotic medication. This will allow the prevalence of prescribing of different categories of psychotropic drugs to be benchmarked across services while also retaining the original focus of this QIP on the quality of prescribing of antipsychotic medication.

All Trusts and clinical teams were self-selected in that they chose to participate. All participating Trusts are listed in alphabetical order in Appendix A.

A case record audit of the use of antipsychotic medication in people with a learning disability was conducted. A questionnaire/audit tool was sent to Trusts with instructions that copies should be made available to allow clinical teams to audit a sample of patients with a diagnosis of a learning disability (see Appendix C).

The following data were collected:
- Age, gender, ethnicity, severity of learning disability, co-morbid psychiatric diagnoses and care setting
- Diagnosis of epilepsy
- The dose of each oral/short-acting IM and depot/long-acting antipsychotic currently prescribed
- The main indications for antipsychotic prescribing
- Other medications for mental health, behavioural problems or epilepsy
- Evidence of side effect monitoring.

The POMH-UK Lead for each participating Trust will be sent an Excel dataset containing their Trust’s data. This allows Trusts to conduct further analyses on their own data should they wish.

Data cleaning

Data were collected using FUSION (electronic survey software), and stored and analysed using SPSS.

Data were cleaned to correct instances of obvious data entry error. Details of corrections are held on file by POMH-UK; please contact pomh-uk@rcpsych.ac.uk if you wish to examine these.

All figures presented are rounded to zero decimal places for simplicity. Therefore, the total percentages for some charts or graphs add up to 99% or 101%.
1. National level results

Fifty-four specialist mental health Trusts (listed in Appendix A) within the UK participated in the supplementary audit of this quality improvement programme to address the use of antipsychotic medication in people with a learning disability. Data were submitted for 5,654 patients from 338 clinical teams.

The analyses presented in this section of the report were conducted on the total national sample (TNS=5,654)

Practice standards

1. The indication for treatment with antipsychotic medication should be documented in the clinical records.

2. The continuing need for antipsychotic medication should be reviewed at least once a year.

3. Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.
1.1: Patient demographic and clinical characteristics

Compared with the baseline and re-audit samples, a higher proportion of the supplementary audit sample was under the care of forensic services (8% v 1% at baseline and re-audit), had a mild/borderline learning disability (see Table 1) and had no diagnosed co-morbid mental illness (24% v 12%). A lower proportion had a diagnosis of schizophrenia spectrum disorder. These differences are likely due to the changes made to the eligibility criteria on this occasion; that is, all patients with a diagnosis of LD could be included, rather than only those patients with a diagnosis of LD who were prescribed an antipsychotic as on previous occasions.

The figures in Table 1 that are in bold font reflect clinical characteristics of this supplementary audit sample that differ from the baseline and re-audit samples.
Table 1: Clinical and demographic characteristics of the total patient samples at baseline (n=2,319), re-audit (n=2,387) and supplementary audit (n=5,654)

<table>
<thead>
<tr>
<th>Key demographic characteristics</th>
<th>Baseline 2009 TNS N=2,319</th>
<th>Re-audit 2011 TNS N=2,387</th>
<th>Supplementary audit 2015 TNS N=5,654</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
<td>1,385 (60%)</td>
<td>2,017 (84%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>White/White British</td>
<td>1,957 (84%)</td>
<td>1,666 (61%)</td>
</tr>
<tr>
<td></td>
<td>Black/Black British</td>
<td>59 (3%)</td>
<td>77 (3%)</td>
</tr>
<tr>
<td></td>
<td>Asian/Asian British</td>
<td>84 (4%)</td>
<td>76 (3%)</td>
</tr>
<tr>
<td></td>
<td>Mixed or other</td>
<td>221 (10%)</td>
<td>217 (9%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Mean age in years (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less than 16 years</td>
<td>44 (14.2)</td>
<td>43 (14.2)</td>
</tr>
<tr>
<td></td>
<td>16-25 years</td>
<td>282 (12%)</td>
<td>346 (14%)</td>
</tr>
<tr>
<td></td>
<td>26-35 years</td>
<td>400 (17%)</td>
<td>402 (17%)</td>
</tr>
<tr>
<td></td>
<td>36-45 years</td>
<td>586 (25%)</td>
<td>541 (23%)</td>
</tr>
<tr>
<td></td>
<td>46-55 years</td>
<td>561 (24%)</td>
<td>624 (26%)</td>
</tr>
<tr>
<td></td>
<td>56-65 years</td>
<td>345 (15%)</td>
<td>327 (14%)</td>
</tr>
<tr>
<td></td>
<td>66 years and over</td>
<td>147 (6%)</td>
<td>147 (6%)</td>
</tr>
<tr>
<td><strong>Severity of learning disability</strong></td>
<td>Mild/borderline</td>
<td>1,101 (47%)</td>
<td>1,152 (48%)</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>672 (29%)</td>
<td>711 (30%)</td>
</tr>
<tr>
<td></td>
<td>Severe/profound</td>
<td>546 (24%)</td>
<td>524 (22%)</td>
</tr>
<tr>
<td><strong>Clinical setting: outpatient</strong></td>
<td>General adult community</td>
<td>1,826 (79%)</td>
<td>1,995 (84%)</td>
</tr>
<tr>
<td></td>
<td>LD community team</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>General adult acute ward</td>
<td>14 (1%)</td>
<td>10 (&lt;1%)</td>
</tr>
<tr>
<td></td>
<td>Specialist LD assessment</td>
<td>339 (15%)</td>
<td>310 (13%)</td>
</tr>
<tr>
<td></td>
<td>and treatment award</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forensic low, medium or high secure</td>
<td>22 (1%)</td>
<td>31 (1%)</td>
</tr>
<tr>
<td><strong>Clinical setting: inpatient</strong></td>
<td>Continuing care/rehabilitation</td>
<td>118 (5%)</td>
<td>41 (2%)</td>
</tr>
<tr>
<td><strong>Other current psychiatric diagnoses within ICD-10(^1) categories</strong></td>
<td>F00-F09</td>
<td>69 (3%)</td>
<td>61 (3%)</td>
</tr>
<tr>
<td></td>
<td>F10-F19</td>
<td>14 (1%)</td>
<td>24 (1%)</td>
</tr>
<tr>
<td></td>
<td>F20-F29</td>
<td>615 (27%)</td>
<td>631 (26%)</td>
</tr>
<tr>
<td></td>
<td>F30-F39</td>
<td>629 (27%)</td>
<td>632 (26%)</td>
</tr>
<tr>
<td></td>
<td>F40-F48</td>
<td>169 (7%)</td>
<td>173 (7%)</td>
</tr>
<tr>
<td></td>
<td>F50-F59</td>
<td>20 (1%)</td>
<td>19 (1%)</td>
</tr>
<tr>
<td></td>
<td>F60-F69</td>
<td>172 (7%)</td>
<td>111 (5%)</td>
</tr>
<tr>
<td></td>
<td>F80-F89</td>
<td>482 (21%)</td>
<td>674 (28%)</td>
</tr>
<tr>
<td></td>
<td>F90-F98</td>
<td>201 (9%)</td>
<td>143 (6%)</td>
</tr>
<tr>
<td></td>
<td>F99</td>
<td>4 (&lt;1%)</td>
<td>7 (&lt;1%)</td>
</tr>
<tr>
<td></td>
<td>Not known</td>
<td>110 (5%)</td>
<td>119 (5%)</td>
</tr>
<tr>
<td><strong>Documented psychiatric diagnoses</strong></td>
<td>None</td>
<td>273 (12%)</td>
<td>269 (11%)</td>
</tr>
<tr>
<td></td>
<td>One</td>
<td>1,652 (71%)</td>
<td>1,702 (71%)</td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td>396 (17%)</td>
<td>416 (17%)</td>
</tr>
</tbody>
</table>

\(^1\) ICD-10 codes and diagnoses: F00-F09 – Organic, including symptomatic, mental disorders; F10-F19 – Mental and behavioural disorders due to psychoactive substance use; F20-F29 – Schizophrenia, schizotypal and delusional disorders; F30-F39 – Mood (affective) disorders; F40-F48 – Neurotic, stress-related and somatoform disorders; F50-F59 – Behavioural syndromes associated with physiological disturbances and physical factors; F60-F69 – Disorders of adult personality and behaviour; F80-F89 – Disorders of psychological development; F90-F98 – Behavioural and emotional disorders with onset occurring in childhood and adolescence; F99 – Unspecified mental disorder.
When compared with the baseline and re-audit samples, the supplementary audit subsample of those prescribed an antipsychotic is very similar (see Tables 1 and 2). The exception to this is the increased number of multiple documented psychiatric diagnoses at supplementary audit (25% v 17% at baseline and re-audit). This difference, and the different sampling methods used, should be borne in mind when considering the data, particularly when looking at change over time.

Compared with those patients who were not prescribed an antipsychotic, those who were prescribed an antipsychotic were less likely to have a diagnosis of epilepsy or dementia (F00-F09) but more likely to have a diagnosis of a schizophrenia spectrum disorder (F20-29), an affective disorder (F30-39) or an autistic spectrum disorder (F80-89). The relevant figures in Table 2 are in bold font to draw attention to these differences.

### Table 2: Clinical and demographic characteristics of the total patient sample and subgroups prescribed and not prescribed antipsychotic medication at supplementary audit (n=5,654)

<table>
<thead>
<tr>
<th>Key demographic characteristics</th>
<th>Total sample N=5,654</th>
<th>Subsample prescribed an antipsychotic N=3,628</th>
<th>Subsample not prescribed an antipsychotic N=2,026</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3,445 (61%)</td>
<td>2,237 (62%)</td>
<td>1,208 (60%)</td>
</tr>
<tr>
<td>White/White British</td>
<td>4,590 (81%)</td>
<td>2,933 (81%)</td>
<td>1,657 (82%)</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>194 (3%)</td>
<td>141 (4%)</td>
<td>53 (3%)</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>273 (5%)</td>
<td>179 (5%)</td>
<td>94 (5%)</td>
</tr>
<tr>
<td>Mixed or other</td>
<td>597 (10%)</td>
<td>375 (10%)</td>
<td>222 (11%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age in years (SD)</td>
<td>41.2 (15.3)</td>
<td>42.3 (15.2)</td>
<td>41 (15.6)</td>
</tr>
<tr>
<td>Less than 16 years</td>
<td>44 (1%)</td>
<td>13 (&lt;1%)</td>
<td>31 (2%)</td>
</tr>
<tr>
<td>16-25 years</td>
<td>1,004 (18%)</td>
<td>583 (16%)</td>
<td>421 (21%)</td>
</tr>
<tr>
<td>26-35 years</td>
<td>1,262 (22%)</td>
<td>821 (23%)</td>
<td>441 (22%)</td>
</tr>
<tr>
<td>36-45 years</td>
<td>946 (17%)</td>
<td>626 (17%)</td>
<td>320 (16%)</td>
</tr>
<tr>
<td>46-55 years</td>
<td>1,234 (22%)</td>
<td>821 (23%)</td>
<td>413 (20%)</td>
</tr>
<tr>
<td>56-65 years</td>
<td>785 (14%)</td>
<td>511 (14%)</td>
<td>274 (14%)</td>
</tr>
<tr>
<td>66 years and over</td>
<td>379 (7%)</td>
<td>253 (7%)</td>
<td>126 (6%)</td>
</tr>
<tr>
<td><strong>Epilepsy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis documented</td>
<td>1,328 (24%)</td>
<td><strong>724 (20%)</strong></td>
<td><strong>604 (30%)</strong></td>
</tr>
<tr>
<td><strong>Clinical setting: outpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General adult community team</td>
<td>209 (4%)</td>
<td>152 (4%)</td>
<td>57 (3%)</td>
</tr>
<tr>
<td>LD community team</td>
<td>4,495 (80%)</td>
<td>2,807 (77%)</td>
<td>1,688 (83%)</td>
</tr>
<tr>
<td><strong>Clinical setting: inpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General adult acute ward</td>
<td>23 (&lt;1%)</td>
<td>20 (1%)</td>
<td>3 (&lt;1%)</td>
</tr>
<tr>
<td>Specialist LD assessment and treatment award</td>
<td>403 (7%)</td>
<td>299 (8%)</td>
<td>104 (5%)</td>
</tr>
<tr>
<td>Forensic low, medium or high secure</td>
<td>458 (8%)</td>
<td>302 (8%)</td>
<td>156 (8%)</td>
</tr>
<tr>
<td>Continuing care/rehabilitation</td>
<td>66 (1%)</td>
<td>48 (1%)</td>
<td>18 (1%)</td>
</tr>
<tr>
<td><strong>Other current psychiatric diagnoses within ICD-10 categories</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F00-F09</td>
<td>257 (5%)</td>
<td><strong>105 (3%)</strong></td>
<td><strong>152 (8%)</strong></td>
</tr>
<tr>
<td>F10-F19</td>
<td>138 (2%)</td>
<td>104 (3%)</td>
<td>34 (2%)</td>
</tr>
<tr>
<td>F20-F29</td>
<td>1,005 (18%)</td>
<td><strong>970 (27%)</strong></td>
<td><strong>35 (2%)</strong></td>
</tr>
<tr>
<td>F30-F39</td>
<td>1,332 (24%)</td>
<td>917 (25%)</td>
<td>415 (20%)</td>
</tr>
<tr>
<td>F40-F48</td>
<td>566 (10%)</td>
<td>345 (10%)</td>
<td>221 (11%)</td>
</tr>
<tr>
<td>F50-F59</td>
<td>29 (1%)</td>
<td>19 (1%)</td>
<td>10 (&lt;1%)</td>
</tr>
<tr>
<td>F60-F69</td>
<td>355 (6%)</td>
<td>234 (6%)</td>
<td>121 (6%)</td>
</tr>
<tr>
<td>F80-F89</td>
<td>1,592 (28%)</td>
<td><strong>1,152 (32%)</strong></td>
<td><strong>440 (22%)</strong></td>
</tr>
<tr>
<td>F90-F98</td>
<td>378 (7%)</td>
<td>230 (6%)</td>
<td>148 (7%)</td>
</tr>
<tr>
<td>F99</td>
<td>11 (&lt;1%)</td>
<td>9 (&lt;1%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td><strong>Documented psychiatric diagnoses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1,376 (24%)</td>
<td>606 (17%)</td>
<td>770 (38%)</td>
</tr>
<tr>
<td>One</td>
<td>3,061 (54%)</td>
<td>2,103 (58%)</td>
<td>958 (47%)</td>
</tr>
<tr>
<td>Multiple</td>
<td>1,217 (21%)</td>
<td>919 (25%)</td>
<td>298 (15%)</td>
</tr>
</tbody>
</table>

©2015 The Royal College of Psychiatrists.
Most antipsychotic medicines lower the seizure threshold and the lower prevalence of prescribing in patients with epilepsy suggests that clinicians use these medicines cautiously in this population.

Antipsychotic medicines are known to increase morbidity and mortality in people with dementia. The pattern of prescribing in Table 2 suggests that clinicians generally avoid antipsychotics in people with LD who also have dementia (F00-F09).

Antipsychotic medicines are used to ameliorate some forms of behavioural disturbance in patients with autistic spectrum disorders. That those patients with autistic spectrum disorders (F80-89) are over-represented in the sub-group prescribed antipsychotic medicine is consistent with clinical expectations.
1.2: All patients prescribed antipsychotic medication

Figure 6: Psychiatric co-morbidity in patients prescribed antipsychotic medication, across mild/borderline, moderate and severe/profound learning disability subsamples at baseline (n=2,316), re-audit (n=2,387) and supplementary audit* (n=3,628)

*Note that for this figure, the data shown at supplementary audit relate only to those prescribed antipsychotic medication. This is to allow comparison with the baseline and re-audit samples.

Compared with baseline and re-audit, a higher proportion of those patients with mild/borderline LD in the supplementary audit sample had multiple psychiatric diagnoses.
1.3: Antipsychotic prescribing practice

The proportion of patients in the total national sample (TNS) who were prescribed an antipsychotic was 64% (n=3,628). Five percent of this subsample was prescribed a high dose and 12% a combination of antipsychotics.

Table 3: Dosing details for the five most commonly prescribed antipsychotics at supplementary audit.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Monotherapy</th>
<th>Combination</th>
<th>PRN</th>
<th>Daily dose: median (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use: n (%)</td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td>Risperidone</td>
<td>1,407 (91%)</td>
<td>146 (9%)</td>
<td>98 (7%)</td>
<td>2mg (0.25-14mg)</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>536 (83%)</td>
<td>113 (17%)</td>
<td>48 (8%)</td>
<td>10mg (2.5-30mg)</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>289 (77%)</td>
<td>84 (23%)</td>
<td>20 (6%)</td>
<td>300mg (10-800mg)</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>255 (75%)</td>
<td>85 (25%)</td>
<td>2 (1%)</td>
<td>10mg (1-35mg)</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>137 (49%)</td>
<td>142 (51%)</td>
<td>116 (55%)</td>
<td>4.75mg (0.3-30mg)</td>
</tr>
</tbody>
</table>

There was no change in the three most commonly prescribed antipsychotics over the three audits in this quality improvement programme. As on previous occasions, haloperidol was the antipsychotic most likely to be prescribed PRN.

On this occasion, risperidone was prescribed for 1,553 (43%) patients; olanzapine 649 (18%) patients, quetiapine 373 (10%) patients, aripiprazole 340 (9%) patients and haloperidol 279 (8%) patients. Other antipsychotics prescribed for more than 100 patients were zuclopenthixol (n=223, 6%), chlorpromazine (n=182, 5%), clozapine (n=166, 5%) and amisulpride (n=112, 3%).
Practice standard 1: The indication for treatment with antipsychotic medication should be documented in the clinical records.

This standard was met in almost all cases, with the clinical indication for antipsychotic treatment documented for 98% of patients who started treatment in the last 12 months, and 97% of patients who had been prescribed antipsychotic medication for more than 12 months.

The clinical indications for antipsychotic treatment were similar at each audit, with the exception of self-harm and self-injurious behaviour which were more frequent targets at the supplementary audit.

Table 4: The most common indications for antipsychotic prescribing at baseline, re-audit and supplementary audit

<table>
<thead>
<tr>
<th>Common indications for prescribing</th>
<th>Antipsychotic prescribing initiated within the last 12 months</th>
<th>Antipsychotic prescribing initiated more than 12 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline N=328</td>
<td>Re-audit N=334</td>
</tr>
<tr>
<td>1. Agitation and anxiety</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>2. Overt aggression</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>3. Psychotic disorder</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>4. Threatening behaviour</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>5. Self-harm/self-injurious behaviour*</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>6. Obsessive behaviour</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

*The clinical indications self-harm and self-injurious behaviour were collected separately in the supplementary audit whereas at baseline and re-audit these indications were grouped together.
In those patients with severe/profound learning disability, the indication for antipsychotic treatment was less likely to be a diagnosed psychotic illness and more likely to be overt aggression or self-injurious behaviour (see figures in bold font in Table 5).

Table 5: The most common indications for antipsychotic prescribing where this was initiated more than 12 months ago at supplementary audit by severity of LD (n=3,163)

<table>
<thead>
<tr>
<th>Common indications for prescribing</th>
<th>Mild/borderline N=1,621</th>
<th>Moderate N=883</th>
<th>Severe/profound N=659</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic disorder</td>
<td>55%</td>
<td>37%</td>
<td><strong>15%</strong></td>
</tr>
<tr>
<td>Agitation and anxiety</td>
<td>32%</td>
<td>48%</td>
<td><strong>51%</strong></td>
</tr>
<tr>
<td>Overt aggression</td>
<td>27%</td>
<td>42%</td>
<td><strong>48%</strong></td>
</tr>
<tr>
<td>Threatening behaviour</td>
<td>28%</td>
<td>35%</td>
<td><strong>28%</strong></td>
</tr>
<tr>
<td>Self-harm/self-injurious behaviour*</td>
<td><strong>4% / 7%</strong></td>
<td><strong>3% / 15%</strong></td>
<td>**8% / <strong>31%</strong></td>
</tr>
<tr>
<td>Obsessive behaviour</td>
<td>7%</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

*The clinical indications self-harm and self-injurious behaviour were collected separately in the supplementary audit whereas at baseline and re-audit these indications were grouped together.
1.4: Initiation of treatment with antipsychotic medication

In the new NICE guideline (NG11), it is recommended (1.8.4) that antipsychotic medication should only be initiated and monitored by a specialist. The data in Table 6 suggest that in only a small minority of patients is antipsychotic medication initiated independently of secondary care services.

### Table 6: Service where antipsychotic treatment was initiated where this occurred within the last 12 months across mild/borderline, moderate and severe/profound LD subsamples at supplementary audit

<table>
<thead>
<tr>
<th>Antipsychotic treatment initiation</th>
<th>Total N=465</th>
<th>Mild/borderline N=252</th>
<th>Moderate N=139</th>
<th>Severe/profound N=74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independently initiated by primary care</td>
<td>19 (4%)</td>
<td>5 (2%)</td>
<td>8 (6%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td>Initiated by primary care on recommendation from secondary care</td>
<td>82 (18%)</td>
<td>44 (17%)</td>
<td>24 (17%)</td>
<td>14 (19%)</td>
</tr>
<tr>
<td>Independently initiated by secondary care</td>
<td>351 (75%)</td>
<td>198 (79%)</td>
<td>102 (73%)</td>
<td>51 (69%)</td>
</tr>
<tr>
<td>Unclear</td>
<td>13 (3%)</td>
<td>5 (2%)</td>
<td>5 (4%)</td>
<td>3 (4%)</td>
</tr>
</tbody>
</table>
1.5: The use of medicines to treat mental illness, behavioural problems or epilepsy

The data in Table 7 suggest that antipsychotic medication is the most commonly prescribed psychotropic medication for people with LD under the care of mental health services, with antidepressants and anticonvulsants being the next most commonly prescribed groups of medication.

Anticonvulsant (antiepileptic) medication (indicated by *) was more commonly prescribed for those with severe/profound LD. This is consistent with the increased prevalence of epilepsy in this subsample of patients (15% in mild/borderline, 25% in moderate and 44% in severe/profound).

Table 7: Proportion of patients in the total national sample prescribed medication (n=5,654) across the LD subsamples at supplementary audit.

<table>
<thead>
<tr>
<th>Drugs prescribed</th>
<th>Total sample n=5,654</th>
<th>Mild/ borderline n=2,973</th>
<th>Moderate n=1,531</th>
<th>Severe/ profound n=1,150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic</td>
<td>3,628 64%</td>
<td>1,873 63%</td>
<td>1,022 67%</td>
<td>733 64%</td>
</tr>
<tr>
<td>Antidepressant - SSRI</td>
<td>1,616 29%</td>
<td>954 32%</td>
<td>439 29%</td>
<td>223 19%</td>
</tr>
<tr>
<td>Antidepressant – other</td>
<td>504 9%</td>
<td>326 11%</td>
<td>111 7%</td>
<td>67 6%</td>
</tr>
<tr>
<td>Carbamazepine*</td>
<td>699 12%</td>
<td>251 8%</td>
<td>190 12%</td>
<td>258 22%</td>
</tr>
<tr>
<td>Benzodiazepine*</td>
<td>799 14%</td>
<td>362 12%</td>
<td>227 15%</td>
<td>210 18%</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>582 10%</td>
<td>323 11%</td>
<td>141 9%</td>
<td>118 10%</td>
</tr>
<tr>
<td>Valproate*</td>
<td>1,125 20%</td>
<td>493 17%</td>
<td>316 21%</td>
<td>316 27%</td>
</tr>
<tr>
<td>Lamotrigine*</td>
<td>405 7%</td>
<td>154 5%</td>
<td>98 6%</td>
<td>153 13%</td>
</tr>
<tr>
<td>Levetiracetam*</td>
<td>251 4%</td>
<td>85 3%</td>
<td>63 4%</td>
<td>103 9%</td>
</tr>
<tr>
<td>Melatonin</td>
<td>185 3%</td>
<td>48 2%</td>
<td>67 4%</td>
<td>70 6%</td>
</tr>
<tr>
<td>Lithium</td>
<td>166 3%</td>
<td>88 3%</td>
<td>53 3%</td>
<td>25 2%</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>109 2%</td>
<td>64 2%</td>
<td>33 2%</td>
<td>12 1%</td>
</tr>
<tr>
<td>Pregabalin*</td>
<td>106 2%</td>
<td>50 2%</td>
<td>30 2%</td>
<td>26 2%</td>
</tr>
<tr>
<td>Topiramate*</td>
<td>102 2%</td>
<td>35 1%</td>
<td>29 2%</td>
<td>38 3%</td>
</tr>
<tr>
<td>Phenytoin*</td>
<td>56 1%</td>
<td>20 1%</td>
<td>16 1%</td>
<td>20 2%</td>
</tr>
<tr>
<td>Gabapentin*</td>
<td>26 1%</td>
<td>16 1%</td>
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<td>4 &lt;1%</td>
</tr>
<tr>
<td>Phenobarbital or Primidone*</td>
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<td>6 &lt;1%</td>
<td>5 &lt;1%</td>
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<tr>
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<td>6 &lt;1%</td>
<td>2 &lt;1%</td>
</tr>
<tr>
<td>Rufinamide*</td>
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<td>2 &lt;1%</td>
<td>6 1%</td>
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<td>Naltrexone</td>
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<tr>
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<td>-</td>
<td>4 &lt;1%</td>
</tr>
<tr>
<td>Omega 3</td>
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<td>2 &lt;1%</td>
<td>1 &lt;1%</td>
</tr>
<tr>
<td>Ethosuximide*</td>
<td>4 &lt;1%</td>
<td>2 &lt;1%</td>
<td>-</td>
<td>2 &lt;1%</td>
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<tr>
<td>Paraldehyde*</td>
<td>1 0%</td>
<td>1 0%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Prescribed any of the above drugs:

<table>
<thead>
<tr>
<th></th>
<th>Total sample n=5,654</th>
<th>Mild/ borderline n=2,973</th>
<th>Moderate n=1,531</th>
<th>Severe/ profound n=1,150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any of the above</td>
<td>4,962 88%</td>
<td>2,552 86%</td>
<td>1,368 89%</td>
<td>1,042 91%</td>
</tr>
</tbody>
</table>
Figure 7 takes a broader view of potentially comorbid diagnoses that could be legitimate targets for antipsychotic and antidepressant medication. In addition to diagnoses within F20-29 (schizophrenia spectrum disorders) and F30-39 (affective disorders) diagnostic groupings, respectively, the range of developmental disorders covered by F80-89 (for example, autism) are also included.

With respect to antipsychotic treatment, this is prescribed for just over 60% of people with LD (who are in contact with mental health services), irrespective of the severity of LD. The majority of this prescribing is for a comorbid psychiatric condition. Antidepressants are less commonly prescribed overall and the prevalence of such prescribing falls as the severity of LD increases.

**Figure 7: Proportion of patients prescribed antipsychotics and antidepressants with or without a relevant psychiatric diagnosis by severity of learning disability at supplementary audit.**
Table 8 shows that antipsychotics and antidepressants were more often prescribed for patients with one or more comorbid psychiatric diagnoses. Even in the 1,376 patients with no psychiatric diagnosis, over 2 in 5 were prescribed an antipsychotic and almost 1 in 5 an antidepressant. As can be seen in Table 4, the most common clinical indications for antipsychotic prescribing were psychosis, overt aggression, agitation/anxiety and threatening behaviour.

**Table 8: Medication prescribed for more than 5% of the total national sample (n=5,654) and comorbidity at supplementary audit.**

<table>
<thead>
<tr>
<th>Drugs prescribed (for ≥5% total national sample)</th>
<th>Total sample n=5,654</th>
<th>No other psychiatric diagnoses N=1,376</th>
<th>One psychiatric diagnosis N=3,061</th>
<th>Multiple psychiatric diagnoses N=1,217</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic</td>
<td>3,628 64%</td>
<td>606 44%</td>
<td>2,103 69%</td>
<td>919 76%</td>
</tr>
<tr>
<td>Antidepressant – SSRI</td>
<td>1,616 29%</td>
<td>208 15%</td>
<td>959 31%</td>
<td>449 37%</td>
</tr>
<tr>
<td>Antidepressant – other</td>
<td>504 9%</td>
<td>59 4%</td>
<td>295 10%</td>
<td>150 12%</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>699 12%</td>
<td>212 15%</td>
<td>367 12%</td>
<td>120 10%</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>799 14%</td>
<td>160 12%</td>
<td>426 14%</td>
<td>213 18%</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>582 10%</td>
<td>88 6%</td>
<td>333 11%</td>
<td>161 13%</td>
</tr>
<tr>
<td>Valproate</td>
<td>1,125 20%</td>
<td>279 20%</td>
<td>600 20%</td>
<td>246 20%</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>405 7%</td>
<td>166 12%</td>
<td>177 6%</td>
<td>62 5%</td>
</tr>
</tbody>
</table>

Of the 606 patients with no psychiatric diagnosis who were prescribed an antipsychotic, the clinical indications for such medication were overt aggression (n=303, 50%), threatening behaviour (n=225, 37%) or self-harm/self-injurious behaviour (n=161, 27%). These behaviours are recognised by NICE as a legitimate target for antipsychotic treatment where other strategies have failed (NG11; 1.8.2).
1.6: Reviewing medicines and side effects

**Practice standard 2:** The continuing need for antipsychotic medication should be reviewed at least once a year.

### 1.6.1: Medicine review

Of those patients receiving antipsychotic treatment for over 12 months (n=3,163), 3,066 (97%) had a documented *medication review* in the last year.

A change was made to medication in a third of cases suggesting that medication review was an active process (see Figure 8). Therapeutic response and carers views were considered at medication review more often than side effects or adherence to medication (see Figure 9).

Of those patients receiving drug treatments other than antipsychotics over the past 12 months (n=1,334), 1,191 (89%) had a documented medication review in the last year. Figures 8 and 9 show that such medication was less likely to be changed and review in general was less assiduous than that associated with antipsychotic medication.

**Figure 8: Documentation of decisions at medication review conducted within the last 12 months for those prescribed antipsychotic medication*, and those not prescribed antipsychotic medication but prescribed other psychotropic medication, for more than 12 months at supplementary audit.**

[Diagram showing percentages of medication maintained, dose changed, new medication prescribed, at least one medication withdrawn, and unclear, for prescribed antipsychotic medication and not prescribed antipsychotic medication but prescribed other psychotropic medication.]
Figure 9: Factors considered at medication review for those prescribed antipsychotic medication*, and those not prescribed antipsychotic medication but prescribed other psychotropic medication, for more than 12 months at supplementary audit.

*Note: Patients could be prescribed an antipsychotic alongside another psychotropic medication.
1.6.2: Side effect monitoring

**Practice standard 3:** Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

As can be seen in Figure 10, since baseline, the proportion of patients for whom there was no documented evidence of side effect assessment has reduced from 30% to 20%. Side effects were slightly less likely to be assessed in the severe/profound LD subsample (see Figure 11).

**Figure 10:** Nature of documented evidence in the clinical records of clinical assessment of side effects in patients prescribed antipsychotic medication in the last 12 months at baseline, re-audit and supplementary audit.

![Figure 10](image1)

**Figure 11:** Documented evidence in the clinical records of clinical assessment of side effects of antipsychotic medication in the last 12 months at supplementary audit (n=3,163) across mild/borderline, moderate and severe/profound LD subsamples.

![Figure 11](image2)
Since baseline there has been a modest increase in the proportion of patients for whom there was documented evidence that body weight (see Figure 13) and blood pressure (see Figure 14) were measured.
There has been a modest improvement in monitoring of blood pressure, blood glucose and blood lipids since the baseline audit in 2009.

Figure 14: Proportion of patients prescribed antipsychotic medication with documented evidence in their clinical records of monitoring of blood pressure, blood glucose and lipid profile in the last year at baseline, re-audit and supplementary audit.
Summary of key national findings at supplementary audit

What is the prevalence of antipsychotic prescribing?

- Almost two-thirds (64%) of patients (n=3,628) from the total national sample who were prescribed an antipsychotic. Five percent of this subsample were prescribed a high dose and 12% a combination of antipsychotics.

Which antipsychotics are prescribed?

- Risperidone was prescribed for 1,553 (43%) patients; olanzapine 649 (18%), quetiapine 373 (10%), aripiprazole 340 (9%) and haloperidol 279 (8%). Other antipsychotics prescribed for more than 100 patients were zuclopenthixol (n=223, 6%), chlorpromazine (n=182, 5%), clozapine (n=166, 5%) and amisulpride (n=112, 3%).
- There was no change in the three most commonly prescribed antipsychotics over the three audits conducted so far in this quality improvement programme. As on previous occasions, haloperidol was the antipsychotic most likely to be prescribed PRN.

Who is prescribed antipsychotic medication and why?

- Compared with those patients who were not prescribed an antipsychotic, those who were prescribed an antipsychotic were less likely to have a diagnosis of epilepsy or dementia (F00-F09) but more likely to have a diagnosis of a schizophrenia spectrum disorder (F20-29), affective disorder (F30-39) or autistic spectrum disorder (F80-89). The relevant figures in Table 2 are in bold to draw attention to these differences.
- As can be seen in Table 5, the most common clinical indications for antipsychotic prescribing were overt aggression, agitation, anxiety and threatening behaviour. The clinical indications for antipsychotic treatment were similar at each audit with the exception of self-harm and self-injurious behaviour which were more frequent targets at the supplementary audit.
- Antipsychotics and antidepressants were more often prescribed in patients with one or more comorbid psychiatric diagnoses (see Table 8). Of the subsample of patients with no psychiatric diagnosis, over 2 in 5 were prescribed an antipsychotic and almost 1 in 5 an antidepressant.

Who initiates treatment with antipsychotic medication?

- In the new NICE guideline (NG11), it is recommended (1.8.4) that antipsychotic medication should be initiated and monitored by a specialist. The data in Table 6 suggest that antipsychotic medication is initiated independently of secondary care services in only a minority of patients.
What is the nature and frequency of medication review?

- Of those patients receiving antipsychotic treatment for over 12 months (n=3,163), 3,066 (97%) had a documented medication review in the last year. A change was made to medication in a third of cases suggesting that medication review was an active process (see Figure 3 and 8). Therapeutic response and carer views were considered at medication review more often than side effects or adherence to medication (see Figure 9). Of those patients receiving drug treatments other than antipsychotics over the past 12 months (n=1,334), 1,191 (89%) had a documented medication review in the last year.

- Since baseline, the proportion of patients for whom there was no documented evidence of side-effect assessment reduced from 30% to 20% (see Figure 10). Side effects were slightly less likely to be assessed in the severe/profound LD subsamples (see Figure 11).

- Practice in relation to monitoring of EPS in people with a learning disability prescribed antipsychotics has improved modestly since baseline (Figure 4 and 12) but is inconsistent within and between Trusts (see Figure 19).

- There has been a modest improvement in monitoring of blood pressure, blood glucose and blood lipids since the baseline audit in 2009.
2. Trust level results

Analyses presented in this section were conducted for each Trust individually and for the total sample to allow benchmarking.

Data from each Trust are presented by code.

Your Trust code is 40

Practice standards

1. The indication for treatment with antipsychotic medication should be documented in the clinical records.

2. The continuing need for antipsychotic medication should be reviewed at least once a year.

3. Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.
Table 9: Number of clinical teams and patient records submitted by each participating Trust at baseline, re-audit and supplementary audit

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<tr>
<th>Trusts (by code)</th>
<th>Number of participating clinics/teams from each Trust</th>
<th>Total number of patient records submitted by each Trust</th>
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<td>05</td>
<td>3 2 5</td>
<td>44 28 87</td>
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<tr>
<td>06</td>
<td>7 15 20</td>
<td>184 272 359</td>
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<tr>
<td>08</td>
<td>6 6 16</td>
<td>28 35 90</td>
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<tr>
<td>09</td>
<td>8 9 7</td>
<td>64 72 111</td>
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<td>-</td>
</tr>
<tr>
<td>109</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145</strong></td>
<td><strong>174</strong></td>
</tr>
</tbody>
</table>

This guideline includes recommendations that treatment for co-morbid mental illness should be optimised (1.8.1) and that antipsychotic medication should only be considered for the management of ‘behaviour that challenges’ if other strategies have failed and/or the risk to the person or others is severe, for example violence, aggression or self-injury (1.8.2).

The Figure below reflects clinical practice in the total national sample and your Trust in relation to these recommendations. The Figure shows the proportion of patients prescribed an antipsychotic who have a co-morbid psychiatric diagnosis that is a potentially legitimate target for such treatment (as in Figure 1), the proportion where antipsychotic medication was prescribed as part of the treatment for recognised NICE target symptoms mentioned above and the proportion where neither of these reasons were documented.

**Figure 15: Prevalence of antipsychotic prescribing by Trust**
This Figure relates to **practice standard 1**: The indication for treatment with antipsychotic medication should be documented in the clinical records.

**Figure 16**: Proportion of patients in each Trust for whom antipsychotics were prescribed for less than 12 months and the indication for antipsychotic prescribing was clearly documented: re-audit and supplementary audit.

The Trusts with the highest proportion of patients for whom documented indications for antipsychotic treatment were clear are on the left hand side of the Figure and the Trusts with the lowest proportion are on the right.
This Figure relates to **practice standard 2**: The continuing need for antipsychotic medication should be reviewed at least once a year.

**Figure 17**: Proportion of patients in each Trust for whom antipsychotics were prescribed for more than 12 months and the continuing need for antipsychotic medication was reviewed: re-audit and supplementary audit.

The Trusts with the highest proportion of patients having had the need for antipsychotic medication reviewed in the last year are on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
The following six Figures all relate to **practice standard 3**: Side effects of antipsychotic medication should be reviewed at least once a year. This review should include assessment for the presence of EPS, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

**Figure 18**: Proportion of patients in each Trust and the total national sample for whom antipsychotics were prescribed for more than 12 months, with documented evidence in their clinical records of a general assessment of side effects at re-audit and supplementary audit.

The Trusts with the highest proportion of patients with a documented general statement regarding side effects in the last year are on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
The Trust with the highest proportion of patients having had an assessment of EPS in the last year is on the left hand side of the Figure and the Trusts with the lowest proportion on the right.

The data in this Figure suggest that practice in relation to monitoring of EPS in people with a learning disability prescribed antipsychotics is inconsistent within and between Trusts.
Figure 20: Proportion of patients in each Trust and the total national sample for whom antipsychotics were prescribed for more than 12 months, with documented evidence in their clinical records of assessment of body weight at re-audit and supplementary audit.

The Trust with the highest proportion of patients having had an assessment of weight/BMI in the last year is on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
Figure 21: Proportion of patients in each Trust and the total national sample for whom antipsychotics were prescribed for more than 12 months, with documented evidence in their clinical records of assessment of blood pressure at re-audit and supplementary audit.

The Trusts with the highest proportion of patients having had a blood pressure measurement recorded in the last year are on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
Figure 22: Proportion of patients in each Trust and the total national sample for whom antipsychotics were prescribed for more than 12 months, with documented evidence in their clinical records of assessment of blood glucose at re-audit and supplementary audit.

The Trusts with the highest proportion of patients having had a blood glucose measurement recorded in the last year are on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
Figure 23: Proportion of patients in each Trust and the total national sample for whom antipsychotics were prescribed for more than 12 months, with documented evidence in their clinical records of assessment of lipid profile at re-audit and supplementary audit.

The Trusts with the highest proportion of patients having had a measurement of lipid profile recorded in the last year are on the left hand side of the Figure and the Trusts with the lowest proportion on the right.
3. Clinical team level results

Analyses presented in this section were conducted for each clinical team from your Trust individually, for your total Trust sample and for the total national sample to allow benchmarking.

Data from each Trust clinical team are presented by code only.

The POMH-UK Central Project Team does not know the identity of individual teams.

Only the Local POMH lead for your Trust or organisation has the key to team codes. You should contact this person if you need to identify data for your own particular team.
Figure 24: Proportion of patients receiving antipsychotic treatment for less than a year (n=19) in each team for whom the indication for antipsychotic prescribing is clearly documented at supplementary audit.

Figure 25: Proportion of patients receiving antipsychotic treatment for more than a year (n=121) in each team for whom the continuing need for antipsychotic medication was reviewed in the last year.
Figure 26: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of a general assessment of side effects in the last year at supplementary audit.

Figure 27: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of assessment of EPS in the last year at supplementary audit.
Figure 28: Proportion of patients in each team and the total national sample with a documented measure of body weight in their clinical records in the last year at supplementary audit.

Figure 29: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of assessment of blood pressure in the last year at supplementary audit.
Figure 30: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of assessment of blood glucose in the last year at supplementary audit.

Figure 31: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of assessment of lipid profile in the last year at supplementary audit.
Appendix A: Participating Trusts

The Trusts that participated in this audit are listed below in alphabetical order.

5 Boroughs Partnership NHS Foundation Trust
Abertawe Bro Morgannwg University Health Board
Avon & Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield & Haringey MH NHS Trust
Belfast Health and Social Care Trust
Berkshire Healthcare NHS Foundation Trust
Betsi Cadwaladr University Health Board
Black Country Partnership NHS Foundation Trust
Bradford District Care Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Coventry Partnership NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership Trust
Dorset Healthcare University NHS Foundation Trust
East London NHS Foundation Trust
Forensic Network (Scotland)
Hertfordshire Partnership University NHS Foundation Trust
Humber NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Mersey Care NHS Trust
NAVIGO Health and Social Care CIC
Norfolk & Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Partnerships in Care
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber Mental Health Trust
Sheffield Health & Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South Essex Partnership University NHS Foundation
South London and Maudsley NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS
South West London and St George’s Mental Health Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
West London Mental Health NHS Trust
Worcestershire Health & Care Trust
Appendix B: Clinical and demographic characteristics of patient sample

**Figure 32:** Proportion of males and females for each Trust and the total national sample at supplementary audit.

The Trust that submitted data for the highest proportion of males is on the left hand side of the Figure and the Trust with the lowest on the right. In this Figure, and all such subsequent figures, the proportions in the TNS are shown on the far right of the Figure. This Figure allows Trusts to compare the demographic characteristics of their sample of patients against the total national sample.

**Figure 33:** Distribution of the three most common ethnic groups by Trust and in the total national sample at supplementary audit.

The Trusts with the highest proportion of White British/Irish patients are on the left hand side of the Figure and the Trust with the lowest proportion on the right. This Figure allows Trusts to compare the demographic characteristics of their sample of patients against the total national sample. Trust teams may like to compare the ethnic breakdown of their patients with those of their catchment area population.
Figure 34: Patients’ learning disability severity by Trust and in the total national sample at supplementary audit.

The Trusts with the highest proportion of patients with a borderline/mild learning disability are on the left hand side of the Figure and the Trust with the lowest proportion on the right. This Figure allows Trusts to compare the LD severity of their sample of patients against the total national sample.

Figure 35: Patients’ psychiatric diagnoses by Trust and in the total national sample at supplementary audit.

The Trust with the highest proportion of patients with no co-morbid diagnoses is on the left hand side of the Figure and the Trust with the lowest proportion on the right. This Figure allows Trusts to compare the diagnostic profile of their sample of patients against the total national sample.
Appendix C: Audit data collection guide and form

This data collection tool relates specifically to the following quality improvement programme:

**Antipsychotic prescribing in people with learning disabilities**

**Topic 9c**

**ELIGIBLE PATIENTS:** All patients with a diagnosis of learning disability, whether or not they are prescribed antipsychotic medication.

**COLLECTING DATA:** To complete this audit form you should refer to the patient’s clinical records.

Clinical records include all electronic and paper notes, letters, and other patient information available to the clinical team.

**SUBMITTING DATA:** If you realise that you have made a mistake with data submission, you are able to edit submitted data before the data entry period ends.

Please refer to the **DATA ENTRY GUIDANCE NOTES** for instructions on how to do this. You will not be able to correct your submitted data after the data entry period ends.

For further assistance, please email pomp-uk@rcpsych.ac.uk or call POMH-UK on 020 3701 2608.

Data should be submitted online to POMH-UK from 2 Mar to 27 Mar 2015.

This form is intended for use as part of the POMH-UK Topic 9 quality improvement programmes only and may not be suitable for other purposes.
Q10 Other current psychiatric diagnoses within the following ICD-10 categories: (see guidance notes for all that apply)
- F00-F09
- F10-F19
- F20-F29
- F30-F39
- F40-F48
- F50-F59
- None documented

*If ticked other above, please specify

Q11 Does this patient have a current diagnosis of epilepsy?
- Yes
- No

Q12 What is this patient’s current clinical setting?
- Outpatient - general adult community team
- Outpatient - LD community team
- Inpatient - general adult acute ward
- Inpatient - specialist LD assessment and treatment ward (incl. low secure)
- Inpatient - forensic low, medium or high secure ward
- Inpatient - continuing care/rehabilitation (core houses/long stay)

Medication prescribed other than antipsychotics (complete for all patients)
- Anticholinergic: Lamotrigine
- Antidepressant - SSRI: Levetiracetam
- Antidepressant - Other: Lithium
- Benzodiazepine: Methylphenidate
- Carbamazepine: Naltrexone
- Ethosuximide: Valproate
- Fosphenytoin: Omega 2
- Gabapentin: Oxcarbazepine
- None documented

Antipsychotic medication prescribed (complete for all patients)

NOTE: for PRN doses enter the prescribed max mg a day that could be administered

Amisulpride:
- Regular oral daily mg
- PRN oral max daily mg

Aripiprazole:
- Regular oral daily mg
- PRN oral max daily mg
- Regular IM daily mg
- PRN IM max daily mg

Asenapine:
- Regular oral daily mg
- PRN oral max daily mg

Biperidol:
- Regular oral daily mg
- PRN oral max daily mg
- PRN IM max daily mg

Chlorpromazine:
- Regular oral daily mg
- PRN oral max daily mg
- Regular IM daily mg
- PRN IM max daily mg

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Antipsychotic prescribing in people with learning disabilities

Lurasidone:
- regular oral daily mg
- PRN oral max daily mg

Olanzapine:
- regular oral daily mg
- PRN oral max daily mg
- regular IM daily mg
- PRN IM max daily mg

Paliperidone:
- regular oral daily mg
- PRN oral max daily mg

Pericyazine:
- regular oral daily mg
- PRN oral max daily mg

Perphenazine:
- regular oral daily mg
- PRN oral max daily mg

Pimozide:
- regular oral daily mg
- PRN oral max daily mg

Prochlorperazine:
- regular oral daily mg
- PRN oral max daily mg

Promazine:
- regular oral daily mg
- PRN oral max daily mg
- regular IM daily mg
- PRN IM max daily mg

Quetiapine:
- regular oral daily mg
- PRN oral max daily mg

Risperidone:
- regular oral daily mg
- PRN oral max daily mg

Sertindole:
- regular oral daily mg
- PRN oral max daily mg

Sulpiride:
- regular oral daily mg
- PRN oral max daily mg

Trifluoperazine:
- regular oral daily mg
- PRN oral max daily mg

Zotepine:
- regular oral daily mg
- PRN oral max daily mg

Zuclopenthixol:
- regular oral daily mg
- PRN oral max daily mg

Zuclopenthixol acetate:
- Single dose (mg)
- Regular IM (mg)
- Injection interval (weeks)

None of the above oral or short-acting IM antipsychotic medication currently prescribed (please note ticking this box will remove all values from the boxes in this question)
<table>
<thead>
<tr>
<th>Drug</th>
<th>Single or total dose (mg)</th>
<th>Regular IM (mg)</th>
<th>Injection interval (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flupentixol decanoate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol decanoate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>Single or total dose (mg)</th>
<th>Regular IM (mg)</th>
<th>Injection interval (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziprazone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paliperidone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

None of the above depot or long-acting antipsychotic medication in this question (please note ticking this box will remove any values from the boxes in this question)
Q16 Is this patient prescribed one or more of the antipsychotic medicines listed in Questions 14 or 15?

- Yes (go to 17)
- No (go to 25)

Reasons for prescribing an antipsychotic (complete for all patients who are prescribed an antipsychotic)

- Co-morbid psychiatric disorder
- Threatening behaviour (including verbal aggression or intimidating behaviour)
- Obsessive behaviours (including rituals)
- Self-injurious or self-harming behaviours
- Inappropriate sexual behaviours
- Social withdrawal or isolation
- Other (e.g. emotional/affective instability)*

*If other, please state:

Q17 For the antipsychotic medicine(s) prescribed for this patient, please discuss with the doctors/prescribers in the team what the main indications for this medicine are (please tick all that apply)

- Overt aggressive behaviour (directed towards others or property)
- General agitation / anxiety or hyperactivity
- Self-harm; deliberate/repeated
- Motor stereotypes, mannerisms or tics
- Oppositional or defiant behaviours
- Unclear

Duration of antipsychotic prescription (complete for all patients who are prescribed an antipsychotic)

Q18 When was antipsychotic prescribing initiated?

- Within the last 12 months (Go to Q19)
- More than 12 months ago (Go to Q21)

For antipsychotic prescriptions instigated within 12 months ONLY

Q19 By whom was the antipsychotic prescribing initiated?

- Independently initiated by Primary Care
- Independently initiated by Secondary Care
- Initiated by Primary Care on recommendation from Secondary Care
- Unclear

Q20 Is the indication for antipsychotic medication clearly described in the clinical records?

- Yes
- No

Side effect monitoring

For antipsychotic prescriptions initiated more than 12 months ago ONLY

Q21 Evidence of a general side effect assessment (see guidance notes for further information).

- General statement that side effects are not present
- General statement that side effects are present

Q22 Documented evidence of formal or informal clinical assessment of movement disorder (extrapyramidal side effects; EPS or EPSE) in the last year.

- None recorded
- General statement that movement disorders are not present
- General statement that movement disorders are present
- Formal evaluation of movement disorders documented

Q23 Documented evidence of assessment of weight and/or BMI and/or waist circumference in the last year.

- None recorded
- General statement regarding absence of weight gain
- General statement regarding presence of weight gain
- Weight and/or BMI and/or waist circumference - actual values recorded

Q24 Is there any evidence in the case notes of monitoring of the following in the last year?

- No evidence of monitoring found
- Some reference to monitoring or relevant observation mode, but no result or value recorded
- Test result or measurement is recorded

** Blood pressure
** HBA1C or Glucose tolerance test or blood glucose (random or fasting)
** Lipid profile (HDL and/or total cholesterol)
Q25 Is there documentation of a formal psychiatric review of medication in the last year in the clinical records?

- Yes
- No
- Not applicable (not prescribed any medication) - Go to next

Q26 In the most recent formal psychiatric review of medication for mental health or behavioural problems, is there documented evidence of the following decisions (tick all that apply):

- Medication to be maintained unchanged (i.e. exactly the same drugs, dosage and frequency of administration)
- New medication prescribed
- None of the above
- Dose of any medication changed
- At least one medication withdrawn/stopped

Q27 At this medication review, is there documented evidence that the following were taken into account (tick all that apply):

- Therapeutic response
- Adherence to medication
- Side effects
- Patient and/or carer’s view (care includes family member, friend, paid carer, etc.)
- None of the above

Thank you.

Data should be submitted online to POMH-UK from 2 Mar to 27 Mar 2015.

Please check you have entered all data correctly.

If you have made a mistake that you cannot correct or have a question, please email POMH at pomh-uk@rcpsych.ac.uk.
Q9: Mild, moderate, severe/profound LD (ICD10 category)

- Mild - Approximate IQ range of 50 to 69. Likely to result in some learning difficulties in school. Many adults will be able to work and maintain good social relationships and contribute to society.

- Moderate - Approximate IQ range of 35 to 49. Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults will need varying degrees of support to live and work in the community.

- Severe/profound - Approximate IQ range of 20 to 34. Likely to result in continuous need of support or IQ under 20. Results in severe limitation in self-care, continence, communication and mobility.

Q10: Co-morbid psychiatric diagnoses (ICD10 categories)
The conditions within each of the ICD-10 diagnostic categories are shown below. Please select as many as apply.

- F00-F09 organic, including symptomatic, mental disorders e.g. dementia
- F10-F19 mental and behavioural disorders due to psychoactive substance use
- F20-F29 schizophrenia, schizotypal & delusional disorders
- F30-F39 mood (affective) disorders e.g. bipolar affective disorder, recurrent depressive disorder
- F40-F48 neurotic, stress-related & somatoform disorders e.g. agoraphobia, panic disorder
- F50-F59 behavioural syndrome associated with physiological disturbance & physical factors e.g. anorexia
- F60-F69 disorders of adult personality & behaviour e.g. paranoid personality disorder
- F80-F89 disorders of psychological development
- F90-F98 behavioural & emotional disorders with onset during occurring in childhood & adolescence
- F99 unspecified mental disorder

Q13: Any other medication for a mental health problem
If the patient is regularly prescribed any other type of medication for a mental health problem, behavioural problem or epilepsy, please indicate which type of medication this is. If you know the name of the medication, but are not sure which category it belongs to, ask a pharmacist or doctor. Please note that this question is only intended to capture information about drugs prescribed for mental health problems, behavioural problems or epilepsy and should not be used to record drugs prescribed for physical health problems (e.g. insulin, statin).

Q14 & 15: Drug names
Please refer to the British National Formulary (BNF) for details of generic and brand names of drugs.

Q21: Evidence of a formal or systematic general side effect assessment
General statement that side effects are not present: Please select this option if there is a statement in the patient's case notes in the last 12 months that the patient was found to be, or reported being, free from side effects. The following are examples of general statements: No sign of side effects, no problems reported, No sign of abnormal movements observed.

General statement that side effects are present: Please select this option if a general statement is made in the patient's case notes to side effects that were found, or reported, to be present. The following are examples of statements referring to the presence of side effects: X complained that his medication was making it difficult for him to wake up in the morning and that he regularly felt drowsy in the afternoon; Y has put on weight since her medication was changed.