Topic 9b re-audit report

Antipsychotic prescribing in people with a learning disability

Trust: Coventry and Warwickshire Partnership Trust
Date: February 2011
Please use the following to cite this report:

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 re-audit for Topic 9b, a quality improvement programme addressing the use of antipsychotic medication in people with a learning disability. Data are presented at national and Trust level.

Audit 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 4 aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia (NICE schizophrenia guideline update CG82, 2009).

Sample
One hundred and seventy-four clinical teams from forty specialist mental health Trusts participated in the re-audit, submitting data for 2387 patients, all of whom had a diagnosis of learning disability and were prescribed one or more antipsychotics. Antipsychotic treatment had been initiated within the last year in 334 patients; and initiated over 12 months ago in 2053 patients. The baseline sample and this re-audit represent the largest audits of antipsychotic prescribing in people with a learning disability that have been conducted to date; and thus provide the most generalisable picture of such prescribing nationally.
### Key findings at re-audit

1. For patients in whom antipsychotic treatment was initiated less than 12 months ago (n=334), the indication for treatment was clearly described in 93% of the clinical records.

2. Of those patients in whom antipsychotic treatment was initiated more than 12 months ago (n=2053), 97% had their continuing need for antipsychotic medication reviewed in the last year.

3. The most common indications for antipsychotic prescribing in the total national sample (n=2387) for the first antipsychotic prescribed were psychotic disorder (39%), followed by anxiety and agitation (41%), and overt aggression (43%).

4. Oral risperidone was the most commonly used antipsychotic, being prescribed for 41% of the total national sample. Olanzapine was prescribed for 20% of patients, and quetiapine, haloperidol and chlorpromazine for 10%, 9% and 8% of patients respectively.

5. Only 6% of the total national sample were prescribed a high dose antipsychotic, and 14% were prescribed a combination of antipsychotics.

6. In addition to an antipsychotic, almost three quarters (71%) of patients were prescribed at least one other drug for the treatment of mental illness, behavioural problems or epilepsy.

7. For those patients in whom antipsychotic treatment was initiated more than 12 months ago (n=2053), documented evidence of side effect assessment (either recorded measure or reference to monitoring): see also Figure 1 was as follows:
   - Blood glucose: 70% of patients (range across Trusts 9-100%)
   - Lipid profile: 69% of patients (9-100%)
   - Weight/BMI: 68% of patients (0-100%)
   - Extrapyramidal (motor) side effects: 57% of patients (15-100%)
   - Blood pressure: 51% of patients (0-100%)

8. Of the side effect assessments listed in Point 7 above, 11% of patients had no documented evidence of any of them being conducted in the last year. Ten percent of patients had evidence of one assessment, 12% had evidence of two, and 67% had evidence of three or more.
Figure 1: Summary radar diagram against the audit standards at baseline and re-audit for Trust 40 and in the total national sample (TNS).

NB. “Treatment indications documented” refer to those for whom antipsychotic medication was prescribed for less than 12 months.

Conclusions: comparisons of baseline and re-audit findings

As at baseline;

- The indications for prescribing antipsychotic medication were clearly documented in the vast majority of clinical records.
- The continuing need for antipsychotic medication was regularly reviewed and documented in almost all patients in this sample. The high proportion of patients having medicines changed at review suggests thoughtful and thorough practice in this area.
High doses and combinations of antipsychotics are prescribed less commonly than in adult mental health services\(^1\) \(^2\).

In just under three-quarters of patients, a general statement regarding the presence or absence of side effects had been documented in the last year; however, documented evidence of systematic monitoring across a range of side effects was far less common. Potentially remediable physical health problems may therefore not be detected.

Compared to the baseline audit, there was an improvement across all side effect assessment measures. While half of patients had evidence of assessment of three or more at baseline, at re-audit the corresponding proportion was three-quarters.

**What happens next?**

1. In addition to this benchmarked report, POMH will provide bespoke change interventions to be provided to each participating Trust, including:
   - PowerPoint slide sets summarising the benchmarked findings, customised for each participating Trust;
   - Opportunities for sharing good practice.

2. A supplementary audit will be conducted in January 2013.

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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’).

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

How to use this report

<table>
<thead>
<tr>
<th>Data from each clinic or Trust are presented by code only.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The POMH-UK Central Project Team does not know the identity of individual teams.</td>
</tr>
<tr>
<td>Only the Local Project Team lead for your Trust has the key to team codes for your Trust. You should contact this person if you need to identify data for your own particular team.</td>
</tr>
</tbody>
</table>

Clinical background

Please refer to the baseline report for the clinical background. This can also be found in the ‘member’s area’ of the POMH website: (www.rcpsych.ac.uk/pomh/members).

Further analysis of your Trust’s data

Ownership of data submitted to POMH-UK is retained by the Trust that provided it. See Appendix A for further information on data ownership. An Excel file containing the data submitted by your Trust has been made available to your Local Project Team lead. Please contact this person if you wish to conduct further analyses on your data.
Audit standards

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

Audit 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 4 aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.
Method

The Prescribing Observatory for Mental Health (POMH-UK) invited all National Health Service (NHS) Trusts in the United Kingdom providing specialist mental health services to participate in a project to benchmark the use of antipsychotics in people with a learning disability. Each Trust that formally agreed to take part was asked to form a ‘Local Project Team’ (LPT), with minimum core membership of a senior psychiatrist, a senior pharmacist, and a member of the clinical audit/clinical effectiveness team. It was suggested that nurses, other clinicians and service users be co-opted from relevant services to advise on this topic. Local Project Teams were invited to attend one of six regional introductory workshops to discuss and review the aims, objectives and methodology of the proposed audit at baseline. Comment and discussion at the workshops led to refinements of the audit methodology and data collection tool.

All Trusts and clinical teams were self-selected in that they chose to participate. All participating Trusts/health care organisations are listed in alphabetical order in Appendix B.

A case note audit of the use of antipsychotic medication in people with a learning disability was conducted. A questionnaire/audit tool was sent to Trusts with instruction that copies should be made available to allow clinical teams to audit either a sub-sample, or all the patients on an LD Consultant’s current caseload who were currently prescribed an antipsychotic.

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 Local Project Team 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 SNAP (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@cru.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

Forty specialist mental health Trusts (listed in Appendix B) within the UK participated in the baseline audit of this quality improvement programme to address the use of antipsychotic medication in people with a learning disability. Data were submitted for 2387 patients from 174 clinical teams.

The analyses presented in this section of the report were conducted on the total national sample (n=2387)

Audit 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

Table 1: Clinical and demographic characteristics of the total patient sample and LD severity subsamples at re-audit.

<table>
<thead>
<tr>
<th>Key demographic characteristics</th>
<th>Total sample N=2387</th>
<th>Mild/borderline N=1152</th>
<th>Moderate N=711</th>
<th>Severe/profound N=524</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1466 (61%)</td>
<td>682 (59%)</td>
<td>460 (64%)</td>
<td>324 (62%)</td>
</tr>
<tr>
<td>White/White British</td>
<td>2017 (84%)</td>
<td>978 (85%)</td>
<td>605 (85%)</td>
<td>434 (83%)</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>77 (3%)</td>
<td>35 (3%)</td>
<td>22 (3%)</td>
<td>20 (4%)</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>76 (3%)</td>
<td>33 (3%)</td>
<td>20 (3%)</td>
<td>23 (4%)</td>
</tr>
<tr>
<td>Mixed or other</td>
<td>217 (9%)</td>
<td>106 (9%)</td>
<td>64 (9%)</td>
<td>47 (9%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age in years (SD)</td>
<td>43 (14.2)</td>
<td>42 (14.3)</td>
<td>44 (14.3)</td>
<td>43 (13.9)</td>
</tr>
<tr>
<td>16-25 years</td>
<td>346 (14%)</td>
<td>173 (15%)</td>
<td>88 (12%)</td>
<td>85 (16%)</td>
</tr>
<tr>
<td>26-35 years</td>
<td>402 (17%)</td>
<td>208 (18%)</td>
<td>116 (16%)</td>
<td>78 (15%)</td>
</tr>
<tr>
<td>36-45 years</td>
<td>541 (23%)</td>
<td>273 (24%)</td>
<td>163 (23%)</td>
<td>105 (20%)</td>
</tr>
<tr>
<td>46-55 years</td>
<td>624 (26%)</td>
<td>289 (25%)</td>
<td>180 (25%)</td>
<td>135 (30%)</td>
</tr>
<tr>
<td>56-65 years</td>
<td>327 (14%)</td>
<td>138 (12%)</td>
<td>112 (16%)</td>
<td>77 (15%)</td>
</tr>
<tr>
<td>66 years and over</td>
<td>147 (6%)</td>
<td>71 (6%)</td>
<td>52 (7%)</td>
<td>24 (5%)</td>
</tr>
<tr>
<td><strong>Antipsychotic prescribing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiated within 12 months</td>
<td>334 (14%)</td>
<td>184 (15%)</td>
<td>97 (14%)</td>
<td>53 (10%)</td>
</tr>
<tr>
<td>Over 12 months</td>
<td>2053 (86%)</td>
<td>968 (84%)</td>
<td>614 (86%)</td>
<td>471 (90%)</td>
</tr>
<tr>
<td><strong>Documented psychiatric diagnoses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>269 (11%)</td>
<td>69 (6%)</td>
<td>100 (14%)</td>
<td>100 (19%)</td>
</tr>
<tr>
<td>One</td>
<td>1702 (71%)</td>
<td>847 (74%)</td>
<td>503 (71%)</td>
<td>352 (67%)</td>
</tr>
<tr>
<td>Multiple</td>
<td>416 (17%)</td>
<td>236 (20%)</td>
<td>108 (15%)</td>
<td>72 (14%)</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>487 (20%)</td>
<td>168 (15%)</td>
<td>158 (22%)</td>
<td>161 (31%)</td>
</tr>
<tr>
<td>F00-F09</td>
<td>61 (3%)</td>
<td>17 (1%)</td>
<td>36 (5%)</td>
<td>8 (2%)</td>
</tr>
<tr>
<td>F10-F19</td>
<td>24 (1%)</td>
<td>24 (2%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>F20-F29</td>
<td>631 (26%)</td>
<td>433 (38%)</td>
<td>164 (23%)</td>
<td>34 (6%)</td>
</tr>
<tr>
<td>F30-F39</td>
<td>632 (26%)</td>
<td>341 (30%)</td>
<td>188 (26%)</td>
<td>103 (20%)</td>
</tr>
<tr>
<td>F40-F48</td>
<td>173 (7%)</td>
<td>104 (9%)</td>
<td>49 (7%)</td>
<td>20 (4%)</td>
</tr>
<tr>
<td>F50-F59</td>
<td>19 (1%)</td>
<td>9 (1%)</td>
<td>1 (&lt;1%)</td>
<td>9 (2%)</td>
</tr>
<tr>
<td>F60-F69</td>
<td>111 (5%)</td>
<td>88 (8%)</td>
<td>15 (2%)</td>
<td>8 (2%)</td>
</tr>
<tr>
<td>F80-F89</td>
<td>674 (28%)</td>
<td>233 (20%)</td>
<td>208 (29%)</td>
<td>233 (44%)</td>
</tr>
<tr>
<td>F90-F98</td>
<td>143 (6%)</td>
<td>60 (5%)</td>
<td>33 (5%)</td>
<td>50 (10%)</td>
</tr>
<tr>
<td>F99</td>
<td>7 (&lt;1%)</td>
<td>3 (&lt;1%)</td>
<td>-</td>
<td>7 (&lt;1%)</td>
</tr>
<tr>
<td>Not known</td>
<td>119 (5%)</td>
<td>38 (3%)</td>
<td>43 (6%)</td>
<td>38 (7%)</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; F80-F89 – 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.
Approximately half of the total national sample (48%) had borderline/mild learning disability, 30% moderate and 22% severe/profound. No major differences were seen between these subgroups with regard to the demographic variables collected: gender, age or ethnicity. As at baseline, consistent with clinical expectations, the proportion of patients with a diagnosis of a schizophrenia spectrum disorder decreases with the severity of the learning disability, while the proportion with epilepsy or a disorder of psychological development (F80-89) increases.

### 1.2: Initiation of treatment with antipsychotic medication

**Table 2: Origin of antipsychotic treatment initiation where this occurred within the last year across mild/borderline, moderate and severe/profound LD subsamples at baseline and re-audit.**

<table>
<thead>
<tr>
<th>Antipsychotic treatment initiation</th>
<th>Total</th>
<th>Mild/borderline</th>
<th>Moderate</th>
<th>Severe/profound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline N=328</td>
<td>Re-audit N=334</td>
<td>Baseline N=176</td>
<td>Re-audit N=184</td>
</tr>
<tr>
<td>Independently initiated by primary care</td>
<td>12 (4%)</td>
<td>21 (6%)</td>
<td>5 (3%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>Initiated by primary care on recommendation from secondary care</td>
<td>64 (20%)</td>
<td>59 (18%)</td>
<td>25 (14%)</td>
<td>23 (13%)</td>
</tr>
<tr>
<td>Independently initiated by secondary care</td>
<td>246 (75%)</td>
<td>251 (75%)</td>
<td>143 (81%)</td>
<td>153 (83%)</td>
</tr>
<tr>
<td>Unclear</td>
<td>6 (2%)</td>
<td>3 (1%)</td>
<td>3 (2%)</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

Between baseline and re-audit, there was very little change, although there was a modest increase in the proportion of patients with moderate and severe learning disability whose antipsychotic treatment was initiated by primary care (although the numbers involved are small).
1.3: Indications for treatment with antipsychotic medication

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

Table 3: The most common indications* for antipsychotic prescribing where this was initiated within the last 12 months reported at baseline and re-audit.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Baseline N=328</th>
<th>Re-audit N=334</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychotic disorder</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>2. Overt aggression</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>3. Agitation and anxiety</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>4. Threatening behaviour</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>5. Self harm</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>6. Obsessive behaviour</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Note that individual patients may have been prescribed antipsychotic medication for more than one indication.

At re-audit, in relation to audit standard 1, the rationale for initiating treatment with an antipsychotic was clearly documented in the clinical records in 311 (93%) cases. Seven percent of patients did not have any indication documented in the clinical records.

Table 4: The most common indications* for antipsychotic prescribing where this was initiated more than 12 months ago reported at baseline and re-audit.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Baseline N=1991</th>
<th>Re-audit N=2053</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overt aggression</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td>2. Agitation and anxiety</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>3. Psychotic disorder</td>
<td>42%</td>
<td>39%</td>
</tr>
<tr>
<td>4. Threatening behaviour</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>5. Self harm</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>6. Obsessive behaviour</td>
<td>13%</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Note that individual patients may have been prescribed antipsychotic medication for more than one indication.

At re-audit, a clear reason for prescribing antipsychotic treatment was documented in the clinical records for 97% of those patients who had started antipsychotic medication more than 12 months ago. Three percent of patients did not have any indication documented in the clinical records.

The profile of clinical indications for antipsychotic treatment was similar at baseline and re-audit.
Table 5: Documented clinical indications for prescribing antipsychotic medication at re-audit; co-occurrence in patients whose treatment was initiated in the previous 12 months.

The boxes with the white background show the total proportion of patients for whom each indication for use was documented, and the boxes with the lilac background show the proportion for whom each combination of indications was documented. Bear in mind that these combinations are not mutually exclusive: if there were three indications in a particular case, this case would be counted in two blue cells.

Table 6: Documented clinical indications for prescribing antipsychotic medication at re-audit; co-occurrence in patients whose treatment was initiated more than 12 months ago.

Comparison of the two tables suggests that clinical indications of overt aggression and, threatening behaviour are less likely to be associated with a psychotic disorder in those patients for whom treatment was initiated less than a year ago compared to those in whom treatment was initiated more than a year ago.
As at baseline, the number of documented indications for antipsychotic treatment increases with the degree of learning disability, reflecting the known increase in the prevalence of behavioural problems with lower IQ. The number of indications were also greater in those who were prescribed combined antipsychotics than in those who were prescribed a single antipsychotic; this suggests that combined antipsychotics may be targeted towards those patients with more complex problems.
Figure 2: Proportion of people with psychiatric diagnoses, across mild/borderline, moderate and severe/profound diagnostic subsamples at re-audit (n=2387).

The majority of patients overall had at least one psychiatric diagnosis.

The five most frequent psychiatric diagnoses in the total national sample are listed below in order of frequency:

1. Disorders of psychological development (F80-89): n=674; 28% of TNS
2. Schizophrenia, schizotypal and delusional disorders (F20-29): n=632; 26%
3. Mood [affective] disorders (F30-39): n=631; 26%
4. Neurotic, stress-related and somatoform disorders (F40-F48): n=173; 7%
5. Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-98): n=143; 6%

See Table 1, page 19 for a more detailed breakdown of psychiatric diagnoses across the LD severity subsamples.

The slightly higher proportion of patients in the severe/profound group with no psychiatric diagnoses may reflect the difficulty in making a formal diagnosis.
1.4: Antipsychotic prescribing practice

The prevalence of high-dose and combined antipsychotic prescribing identified in this re-audit is notably lower than in general adult psychiatry (Paton et al, 2008). Only 6% of the TNS were prescribed a high dose, and 14% prescribed a combination of antipsychotics. As at baseline, risperidone was the most commonly prescribed antipsychotic at re-audit.

Antipsychotics prescribed for more than 50 patients in the total national sample, in descending order

1. Risperidone (n=983, 41%)
2. Olanzapine (n=487, 20%)
3. Quetiapine (n=235, 10%)
4. Haloperidol (n=209, 9%)
5. Chlorpromazine (n=198, 8%)
6. Zuclopenthixol (n=164, 7%)
7. Aripiprazole (n=160, 7%)
8. Clozapine (n=71, 3%)
9. Amisulpride (n=69, 3%)

Table 8: Dosing details for the most 5 most commonly prescribed antipsychotics at re-audit.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use: n (%)</th>
<th>Dose: Median (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monotherapy</td>
<td>Combination</td>
</tr>
<tr>
<td>Risperidone</td>
<td>859 (87%)</td>
<td>124 (13%)</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>390 (80%)</td>
<td>97 (20%)</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>187 (80%)</td>
<td>48 (20%)</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>103 (49%)</td>
<td>106 (51%)</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>98 (50%)</td>
<td>100 (51%)</td>
</tr>
</tbody>
</table>
1.5: The use of other medicines to treat mental illness, behavioural problems or epilepsy

The majority of patients in the total national sample (with a learning disability and prescribed an antipsychotic) were also prescribed one or more other regular medication(s) for mental illness, behavioural problems or epilepsy. The most common co-prescriptions were for antidepressants or anticonvulsants/mood stabilisers, suggesting that mood disorder is a common problem for which a pharmacotherapeutic remedy is sought.

Table 9: Proportion of patients in the total national sample prescribed additional medication (n=2387) at re-audit.

<table>
<thead>
<tr>
<th>Other drugs prescribed in addition to an antipsychotic</th>
<th>Total sample n=2387</th>
<th>Diagnosis of epilepsy n=487</th>
<th>Mild/ borderline n=1152</th>
<th>Moderate n=711</th>
<th>Severe/ profound n=524</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant - SSRI</td>
<td>642 27%</td>
<td>93 19%</td>
<td>364 32%</td>
<td>173 24%</td>
<td>105 20%</td>
</tr>
<tr>
<td>Antidepressant – other</td>
<td>185 8%</td>
<td>33 7%</td>
<td>96 8%</td>
<td>59 8%</td>
<td>30 6%</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>356 15%</td>
<td>195 40%</td>
<td>114 10%</td>
<td>127 18%</td>
<td>115 22%</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>280 12%</td>
<td>79 16%</td>
<td>103 9%</td>
<td>88 12%</td>
<td>89 17%</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>322 13%</td>
<td>68 14%</td>
<td>136 12%</td>
<td>104 15%</td>
<td>82 16%</td>
</tr>
<tr>
<td>Valproate</td>
<td>404 17%</td>
<td>171 35%</td>
<td>177 15%</td>
<td>133 19%</td>
<td>94 18%</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>120 5%</td>
<td>93 19%</td>
<td>49 4%</td>
<td>38 5%</td>
<td>33 6%</td>
</tr>
<tr>
<td>Lithium</td>
<td>118 5%</td>
<td>12 2%</td>
<td>62 5%</td>
<td>44 6%</td>
<td>12 2%</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>77 3%</td>
<td>74 15%</td>
<td>26 2%</td>
<td>21 3%</td>
<td>30 6%</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>21 1%</td>
<td>21 4%</td>
<td>11 1%</td>
<td>6 1%</td>
<td>4 1%</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>31 1%</td>
<td>11 2%</td>
<td>11 1%</td>
<td>10 1%</td>
<td>10 2%</td>
</tr>
<tr>
<td>Melatonin</td>
<td>46 2%</td>
<td>12 2%</td>
<td>12 1%</td>
<td>13 2%</td>
<td>21 4%</td>
</tr>
<tr>
<td>Topiramate</td>
<td>26 1%</td>
<td>26 5%</td>
<td>9 1%</td>
<td>9 1%</td>
<td>8 2%</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>15 1%</td>
<td>2 &lt;1%</td>
<td>9 1%</td>
<td>3 &lt;1%</td>
<td>3 1%</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>15 1%</td>
<td>12 2%</td>
<td>10 1%</td>
<td>3 &lt;1%</td>
<td>2 &lt;1%</td>
</tr>
<tr>
<td>Phenobarbital or Primidone</td>
<td>12 1%</td>
<td>11 2%</td>
<td>6 1%</td>
<td>3 &lt;1%</td>
<td>3 &lt;1%</td>
</tr>
<tr>
<td>Omega 3</td>
<td>2 &lt;1%</td>
<td>-</td>
<td>-</td>
<td>1 &lt;1%</td>
<td>1 &lt;1%</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>2 &lt;1%</td>
<td>1 &lt;1%</td>
<td>1 &lt;1%</td>
<td>1 &lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Oxycarbazepine</td>
<td>7 &lt;1%</td>
<td>5 1%</td>
<td>4 &lt;1%</td>
<td>2 &lt;1%</td>
<td>1 &lt;1%</td>
</tr>
<tr>
<td>Ethosuximide</td>
<td>4 &lt;1%</td>
<td>4 1%</td>
<td>-</td>
<td>4 &lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Other drug, not specified above</td>
<td>163 7%</td>
<td>45 9%</td>
<td>79 7%</td>
<td>51 7%</td>
<td>33 6%</td>
</tr>
<tr>
<td>Prescribed any of the above drugs</td>
<td>1706 71%</td>
<td>449 92%</td>
<td>811 70%</td>
<td>518 73%</td>
<td>377 72%</td>
</tr>
</tbody>
</table>

Of those patients prescribed an antipsychotic with a diagnosis of epilepsy, almost all were also prescribed a drug for mental health problems, behavioural problems or epilepsy; however, as can be seen from the Table, these patients do not account for all anticonvulsant prescribing in the sample.
1.6: Reviewing medicines and side effects

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

1.6.1: Medicine review

The clinical need for continued treatment with an antipsychotic should be reviewed at least once a year. Within this review, the decision to either maintain the treatment or make a change to the drug/dose or frequency should be documented.

Of those patients receiving antipsychotic treatment for over 12 months (n=2053), 1,983 (97%) had a documented medication review in the last year; in 100% of these cases there was a record of the clinical decision as to whether the medication was to remain the same or change.

For those with such a documented decision, the rationale for either keeping the medicine the same or changing was documented in 91% of cases.

Figure 3: Documentation of decision at medication review conducted within the last 12 months.

At baseline and re-audit, the proportion of patients for whom a clinical medication review had been documented in the previous year is very close to the standard, and higher than that seen in general adult psychiatry (POMH 2008a).
1.6.2: Side effect monitoring

**Audit 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 4 aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

In relation to audit standard 3, this section gives details about the prevalence of documented side-effect monitoring in the subgroup of patients who had been prescribed antipsychotic treatment for over a year.

**Table 10: Nature of documented evidence in the clinical records of clinical assessment of side effects in the last year at baseline and re-audit.**

<table>
<thead>
<tr>
<th></th>
<th>Baseline N=1991</th>
<th>Re-audit N=2053</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>General statement that side effects are present</td>
<td>424 (21%)</td>
<td>379 (18%)</td>
</tr>
<tr>
<td>General statement that side effects are not present</td>
<td>954 (48%)</td>
<td>1211 (59%)</td>
</tr>
<tr>
<td>No statement about side effects</td>
<td>613 (31%)</td>
<td>463 (23%)</td>
</tr>
</tbody>
</table>

In just over two-thirds of patients at baseline, a general statement regarding the presence or absence of side effects had been documented in the last year. At re-audit, the corresponding figure was over three-quarters. This represents a modest improvement since baseline.

**Table 11: Documented evidence in the clinical records of clinical assessment of side effects in the last year at re-audit (n=2053) across mild/borderline, moderate and severe/profound subsamples.**

<table>
<thead>
<tr>
<th></th>
<th>Mild/borderline N=968</th>
<th>Moderate N=614</th>
<th>Severe/profound N=471</th>
</tr>
</thead>
<tbody>
<tr>
<td>General statement that side effects are present</td>
<td>192 (20%)</td>
<td>117 (19%)</td>
<td>70 (15%)</td>
</tr>
<tr>
<td>General statement that side effects are not present</td>
<td>555 (57%)</td>
<td>364 (59%)</td>
<td>292 (62%)</td>
</tr>
<tr>
<td>No statement about side effects</td>
<td>221 (23%)</td>
<td>133 (22%)</td>
<td>109 (23%)</td>
</tr>
</tbody>
</table>
Antipsychotic drugs, particularly the first generation agents, are associated with extrapyramidal (EPS) side effects. These side effects can be subjectively unpleasant (e.g. akathisia, dystonia), interfere with the ability to undertake routine daily tasks (e.g. tremor) and be stigmatising (e.g. tardive dyskinesia). They can also confound clinical assessment; akathisia for example may be mistaken for anxiety or agitation. Antipsychotic drugs can also cause weight gain and have been associated with impaired glucose control and dyslipidaemia. The NICE guideline for schizophrenia recommends that all patients who are prescribed antipsychotic drugs should be regularly assessed for side effects including those that increase cardiovascular risk.

The prevalence and pattern of documented side effect assessment is shown in Tables 12 and 13 below.

**Table 12: Proportions of patients with documented evidence in their clinical records of EPS and weight gain assessment in the last year at baseline and re-audit.**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Re-audit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EPS n (%)</td>
<td>EPS n (%)</td>
</tr>
<tr>
<td>Evidence of formal assessment</td>
<td>116 (6%)</td>
<td>295 (14%)</td>
</tr>
<tr>
<td>Statement side effect present</td>
<td>158 (8%)</td>
<td>143 (7%)</td>
</tr>
<tr>
<td>Statement side effect not present</td>
<td>552 (28%)</td>
<td>724 (35%)</td>
</tr>
<tr>
<td>No documented evidence of assessment</td>
<td>1165 (59%)</td>
<td>891 (43%)</td>
</tr>
<tr>
<td></td>
<td>Weight/BMI/waist circumference n (%)</td>
<td>Weight/BMI/waist circumference n (%)</td>
</tr>
<tr>
<td>Evidence of formal assessment</td>
<td>510 (26%)</td>
<td>734 (36%)</td>
</tr>
<tr>
<td>Statement side effect present</td>
<td>237 (12%)</td>
<td>226 (11%)</td>
</tr>
<tr>
<td>Statement side effect not present</td>
<td>361 (18%)</td>
<td>441 (21%)</td>
</tr>
<tr>
<td>No documented evidence of assessment</td>
<td>883 (44%)</td>
<td>652 (32%)</td>
</tr>
</tbody>
</table>

The data in table above indicate a moderate improvement from baseline to re-audit in the proportion of patients in whom EPS and obesity were assessed in the previous year.
Table 13: Proportion of patients with documented evidence in their clinical records of monitoring blood pressure, blood glucose and lipid profile in the last year at baseline and re-audit.

<table>
<thead>
<tr>
<th>Test result recorded</th>
<th>Baseline</th>
<th></th>
<th>Re-audit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood pressure n (%)</td>
<td>Blood glucose n (%)</td>
<td>Lipid profile n (%)</td>
<td>Blood pressure n (%)</td>
</tr>
<tr>
<td>Test result recorded</td>
<td>424 (21%)</td>
<td>729 (37%)</td>
<td>696 (35%)</td>
<td>546 (27%)</td>
</tr>
<tr>
<td>Reference to monitoring, no test result</td>
<td>310 (16%)</td>
<td>471 (24%)</td>
<td>447 (23%)</td>
<td>494 (24%)</td>
</tr>
<tr>
<td>No documented evidence of monitoring</td>
<td>1257 (63%)</td>
<td>791 (40%)</td>
<td>848 (43%)</td>
<td>1013 (49%)</td>
</tr>
</tbody>
</table>

Figures in this table indicate a consistent increase from baseline to re-audit in the proportion of patients for whom blood pressure, blood glucose and lipid profile had been assessed in the last year.

Of the side effect assessments identified in Table 12 and 13, 11% of patients had no documented evidence of any of them being conducted in the last year. Ten percent of patients had evidence of one assessment, 12% had evidence of two, and 67% had evidence of three or more.
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

Audit 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 4 aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.
2.1: Patient demographic and clinical characteristics

Table 14: Number of clinical teams and patient records submitted by each participating Trust at baseline and re-audit.

<table>
<thead>
<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Re-audit</td>
</tr>
<tr>
<td>02</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>03</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>05</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>06</td>
<td>7</td>
<td>15</td>
</tr>
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<td>08</td>
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<td>09</td>
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<td>19</td>
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<td>5</td>
</tr>
<tr>
<td>91</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>92</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>93</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>94</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145</strong></td>
<td><strong>174</strong></td>
</tr>
</tbody>
</table>
Thirty-seven Trusts participated in the baseline audit with 40 Trusts in the re-audit. Due to changes in organisational structures (e.g. Trusts merging) it is difficult to ascertain exactly which Trusts and/or services participating in this re-audit also participated in the baseline, as new POMH Trust codes may have been issued to some newly merged Trusts. POMH recommends that local project team leads (LPTLs) familiarise themselves with the baseline and re-audit reports and advise local services if they may have participated previously under a different Trust or team code.
Figure 4: Proportion of males and females for each Trust and the total national sample at re-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 5: Distribution of the three most common ethnic groups by Trust and in the total national sample at re-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 6: Patients’ learning disability severity by Trust and in the total national sample at re-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 7: Patients’ psychiatric diagnoses by Trust and in the total national sample at re-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.
This Figure relates to **audit standard 1**: The indication for treatment with antipsychotic medication should be documented in the clinical records.

**Figure 8**: Proportion of patients in each Trust for whom antipsychotics were prescribed for less than 12 months and for whom the indication for antipsychotic prescribing is clearly documented at baseline and re-audit.

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

**Figure 9**: Proportion of patients in each Trust for whom antipsychotics were prescribed for more than 12 months and for whom the continuing need for antipsychotic medication was reviewed at baseline and re-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 Trust with the lowest proportion on the right.
The following six Figures all relate to **audit 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 4 aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia.

**Figure 10**: 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 baseline and re-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 Trust with the lowest proportion on the right.
Figure 11: 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 EPS at baseline and re-audit.

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 Trust with the lowest proportion on the right.

The majority of Trusts participating at both baseline and re-audit, showed an improvement in the proportion of patients in whom there was documentation of EPS assessment.
Figure 12: 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 weight change at baseline and re-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 Trust with the lowest proportion on the right.

The majority of Trusts participating at both baseline and re-audit, showed an improvement in the proportion of patients in whom there was documentation of assessment of body weight.
**Figure 13:** 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 baseline and re-audit.

The Trusts with the highest proportion of patients having had a review of blood pressure in the last year with a documented measure in the last year are on the left hand side of the Figure and the Trust with the lowest proportion on the right. The diamond indicates the baseline figure for this criterion; it is not directly comparable with Figure 1 in the Executive summary (page 4). This is also the case for Figures 14 and 15.

The majority of Trusts participating at both baseline and re-audit, showed an improvement in the proportion of patients in whom there was documentation of assessment of blood pressure.
Figure 14: 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 baseline and re-audit.

The Trusts with the highest proportion of patients having had a review of blood glucose in the last year are on the left hand side of the Figure and the Trust with the lowest proportion on the right.

Between baseline and re-audit although there was a modest improvement overall in the proportion of patients with a recorded test result for blood glucose, there was marked variation across Trusts.
Figure 15: 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 baseline and re-audit.

The Trusts with the highest proportion of patients having had a review of lipid profile in the last year are on the left hand side of the Figure and the Trust with the lowest proportion on the right.

Between baseline and re-audit although there was a modest improvement overall in the proportion of patients with a recorded test result for lipids, there was marked variation across Trusts.
POMH-UK (2011) Topic 9b re-audit report – Antipsychotic prescribing in people with learning disabilities
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 Project Team 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 16: Proportion of patients receiving antipsychotic treatment for less than a year (n=9) in each team for whom the indication for antipsychotic prescribing is clearly documented at re-audit.

The team with the highest proportion of patients with clear documentation of the indication is on the left hand side of the Figure and the team with the lowest proportion on the right. In this Figure, and all such subsequent Figures, the proportions in the Trust and TNS are shown on the far right of the Figure.

Figure 17: Proportion of patients receiving antipsychotic treatment for more than a year (n=95) in each team for whom the continuing need for antipsychotic medication was reviewed in the last year at re-audit.

The team with the highest proportion of patients having a medicines review in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.
Figure 18: 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 re-audit.

The team with the highest proportion of patients having a general assessment of side effects in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.

Figure 19: 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 re-audit.

The team with the highest proportion of patients having an assessment of EPS in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.
Figure 20: Proportion of patients in each team and the total national sample with documented evidence in their clinical records of assessment of **weight change** in the last year at re-audit.

The team with the highest proportion of patients having an assessment of weight change in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.

Figure 21: 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 re-audit.

The team with the highest proportion of patients having an assessment of blood pressure in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.
Figure 22: 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 re-audit.

The team with the highest proportion of patients having an assessment of blood glucose in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.

Figure 23: 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 re-audit.

The team with the highest proportion of patients having an assessment of lipid profile in the last year is on the left hand side of the Figure and the team with the lowest proportion on the right.
POMH-UK (2011) Topic 9b re-audit report – Antipsychotic prescribing in people with learning disabilities
Appendix A: Data Ownership

As outlined in the original memorandum of understanding, the following statement outlines the agreement between POMH-UK and Trusts regarding ownership of data.

‘Data collected by a Local Project Team will belong to that Trust. These Trust data will be made available to POMH-UK in a way that is anonymous with the exception of the identity of the source Trust. The national data will be analysed by POMH-UK and a report summarising the audit results will be returned to each Trust. In this report all data will be anonymous except that of the receiving Trust. However, it will allow for benchmarking with comparable Trusts. There is a publication strategy allowing POMH-UK to publish the anonymous aggregated data on its web site and in appropriate scientific journals. Any requests from other organisations for audit data will be referred to the POMH-UK reports in the public domain or provided with a list of member Trusts and asked to approach individual Trusts directly.’
Appendix B: Participating Trusts

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

5 Boroughs Partnership NHS Foundation Trust
Avon & Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield & Haringey Mental Health Trust
Berkshire Healthcare NHS Foundation Trust
Bradford District Care Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Central and North West London NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Coventry and Warwickshire Partnership Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership Trust
Dorset Healthcare University NHS Foundation Trust
Forensic Network (Scotland)
Greater Manchester West Mental Health NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Humber NHS Foundation Trust
Hywel Dda Health Board
Kent and Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Leeds Partnership Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
North East London NHS Foundation Trust
Northamptonshire Healthcare NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Oxleas NHS Foundation Trust
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
Sheffield Health & Social Care NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South Staffordshire & Shropshire Healthcare NHS Foundation Trust
South West London and St George’s Mental Health Trust
South West Yorkshire Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
West London Mental Health NHS Trust
Worcestershire Mental Health Partnership NHS Trust
Appendix C: Audit data collection guide and form

POMH-UK Topic 9b: Antipsychotic prescribing in people with learning disabilities

This tool is intended as part of the POMH-UK Topic 9b re-audit only (January 2011) and may not be suitable for other uses.

Complete a separate form for each patient - ONLY include patients with a learning disability who are currently prescribed antipsychotic medication.

To help you complete this audit please use the patient's clinical records - these include all notes and records that are available to you and the clinical team, both paper and electronic.

PLEASE REFER FIRST TO THE GUIDANCE NOTES LOCATED AT THE END OF THIS QUESTIONNAIRE.

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Q8 * Patient's self-assigned ethnicity as recorded in the clinical records (see guidance notes for further information)
- White
- Black/Black British
- Chinese
- Other ethnic group
- Not stated/refused

Q9 * Does the patient have mild/borderline, moderate or severe/profound learning disabilities? (ICD-10 category F70-F79 or DC-LD equivalent) (see guidance notes for further information)
- Mild/borderline
- Moderate
- Severe/profound

Q10 * Please select all applicable co-morbid psychiatric diagnoses for this patient (ICD-10 category or DC-LD equivalent on axis 3). (see guidance notes for further information)
- F00-F09
- F10-F19
- F40-F49
- F80-F89
- F90-F98
- None of the above apply

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

Q12 * Is this patient currently on:
- Outpatient (incl. community mental health teams)
- Inpatient - general adult acute ward
- Inpatient - specialist LD assessment and treatment ward (incl. low secure)
- Inpatient - forensic medium or high secure ward
- Inpatient - continuing care (core houses/long stay)

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Antipsychotic prescribing

* Complete below for each oral or short-acting IM antipsychotic currently prescribed. (see guidance notes for further information)

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

Q13

- Amisulpride: regular oral daily mg
- Amisulpride: PRN oral max daily mg
- Aripiprazole: regular oral daily mg
- Aripiprazole: PRN oral max daily mg
- Aripiprazole: regular IM daily mg
- Aripiprazole: PRN IM max daily mg
- Asenapine: regular oral daily mg
- Asenapine: PRN oral max daily mg
- Benzepindole: regular oral daily mg
- Benzepindole: PRN oral max daily mg
- Chlorpromazine: regular oral daily mg
- Chlorpromazine: PRN oral max daily mg
- Chlorpromazine: regular IM daily mg
- Chlorpromazine: PRN IM max daily mg
- Clozapine: regular oral daily mg
- Clozapine: PRN oral max daily mg
- Flupentixol: regular oral daily mg
- Flupentixol: PRN oral max daily mg
- Fluphenazine regular oral daily mg
- Fluphenazine: PRN oral max daily mg
- Haloperidol: regular oral daily mg
- Haloperidol: PRN oral max daily mg
- Haloperidol: regular IM daily mg
- Haloperidol: PRN IM max daily mg

- Levomepromazine: regular oral daily mg
- Levomepromazine: PRN oral max daily mg
- Levomepromazine: regular IM daily mg
- Levomepromazine: PRN IM max daily mg
- Olanzapine: regular oral daily mg
- Olanzapine: PRN oral max daily mg
- Olanzapine: regular IM daily mg
- Olanzapine: PRN IM max daily mg
- Paliperidone: regular oral daily mg
- Paliperidone: PRN oral max daily mg
- Paliperidone: regular IM daily mg
- Paliperidone: PRN IM max daily mg
- Perazine: regular oral daily mg
- Perazine: PRN oral max daily mg
- Perazine: regular IM daily mg
- Perazine: PRN IM max daily mg
- Pimozide: regular oral daily mg
- Pimozide: PRN oral max daily mg
- Pimozide: regular IM daily mg
- Pimozide: PRN IM max daily mg
- Promazine: regular oral daily mg
- Promazine: PRN oral max daily mg
- Promazine: regular IM daily mg
- Promazine: PRN IM max daily mg
- Quetiapine: regular oral daily mg
- Quetiapine: PRN oral max daily mg
- Risperidone: regular oral daily mg
- Risperidone: PRN oral max daily mg
- Risperidone: regular IM daily mg
- Risperidone: PRN IM max daily mg
- Sertindole: regular oral daily mg
- Sertindole: PRN oral max daily mg
- Sertindole: regular IM daily mg
- Sertindole: PRN IM max daily mg
- Thioridazine: regular oral daily mg
- Thioridazine: PRN oral max daily mg
- Zotepine: regular oral daily mg

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* Complete below for each depot or long-acting antipsychotic prescribed for administration within the last 4 weeks. If the prescription has changed in the last 4 weeks, enter the most recently prescribed dose only.

Q14

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Single or total dose (mg)</th>
<th>Weekly Injection Interval (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziprasidone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paliperidone</td>
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<td>Paliperidone</td>
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<tr>
<td>Risperidone</td>
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<td></td>
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<tr>
<td>Risperidone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q15a

* For the 1st drug selected above, please discuss with the doctors-prescribers in the team what the main indications for antipsychotic prescribing are for this patient.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-morbid psychotic disorder</td>
<td>Motor stereotypes, mannerisms or tics</td>
</tr>
<tr>
<td>Overt aggressive behaviour (directed towards others or property)</td>
<td>Inappropriate sexual behaviours</td>
</tr>
<tr>
<td>Threatening behaviour (including verbal aggression or intimidating behaviour)</td>
<td>Oppositional or defiant behaviours</td>
</tr>
<tr>
<td>General agitation / anxiety or hyperactivity</td>
<td>Social withdrawal or isolation</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Unclear</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Other</td>
</tr>
<tr>
<td>Self-injurious or self harming behaviours</td>
<td>Other</td>
</tr>
</tbody>
</table>

Q15b

If a 2nd antipsychotic drug was selected above, please discuss with the doctors-prescribers in the team what the main indications for prescribing that antipsychotic are for this patient.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-morbid psychotic disorder</td>
<td>Motor stereotypes, mannerisms or tics</td>
</tr>
<tr>
<td>Overt aggressive behaviour (directed towards others or property)</td>
<td>Inappropriate sexual behaviours</td>
</tr>
<tr>
<td>Threatening behaviour (including verbal aggression or intimidating behaviour)</td>
<td>Oppositional or defiant behaviours</td>
</tr>
<tr>
<td>General agitation / anxiety or hyperactivity</td>
<td>Social withdrawal or isolation</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Unclear</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Other (e.g. emotional/affective instability)</td>
</tr>
<tr>
<td>Self-injurious or self harming behaviours</td>
<td>Other</td>
</tr>
</tbody>
</table>

Q15d

If a 3rd antipsychotic drug was selected above, please discuss with the doctors-prescribers in the team what the main indications for prescribing that antipsychotic are for this patient.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-morbid psychotic disorder</td>
<td>Motor stereotypes, mannerisms or tics</td>
</tr>
<tr>
<td>Overt aggressive behaviour (directed towards others or property)</td>
<td>Inappropriate sexual behaviours</td>
</tr>
<tr>
<td>Threatening behaviour (including verbal aggression or intimidating behaviour)</td>
<td>Oppositional or defiant behaviours</td>
</tr>
<tr>
<td>General agitation / anxiety or hyperactivity</td>
<td>Social withdrawal or isolation</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Unclear</td>
</tr>
<tr>
<td>Obsessive behaviours (including rituals)</td>
<td>Other (e.g. emotional/affective instability)</td>
</tr>
<tr>
<td>Self-injurious or self harming behaviours</td>
<td>Other</td>
</tr>
</tbody>
</table>
POMH-UK (2011) Topic 9b: Antipsychotic prescribing in people with learning disabilities

Guidance Notes

Q1: Trust code
You will see that this code has been pre-entered on your data collection forms. Your code is known only to your trust and the POMH-UK Central Project Team. It will allow you to identify your own data in national reports but remain anonymous to others viewing the data. Please ensure the clinical team code is in the format xxxxx, where the first five digits are the Trust code and the 6th digit identifies your team.

Q2: Clinical team code
You will see that this code has been pre-entered on your data collection forms. Your clinical team code is known only to your Local Project Team and yourselves, allowing you to identify individual teams from data presentations whilst they remain anonymous to others viewing the data. Please ensure the clinical team code is in the format xxxx, where the first two digits are the Trust code and the 2nd and 3rd digits identify your team.

Q3: Optional extra identifier
This field gives your team the option of identifying data by site, clinical team, lead consultant, or any other variable you wish. You can decide as a team whether or not to use this field. Enter any numerical code you like in this field and keep a record of yourselves of what it means but do not tell us what this code means. If you choose to use this field we can seed you your local data file for further analyses by this code. If you don’t want to use an additional identifier simply leave this field blank.

Q4: Details of data collector
Enter your own initials in this field (e.g. MC). This will enable your team to identify should we need to query something about the data collection.

Q5: Patient code
Please assign a numerical code to each patient on whom data is collected, for example Joe Bloggs=1, Jane Bloggs=2. Enter the relevant code in the ‘folder’ on every data collection form. Keep a record of these codes so you can follow up on patients for whom auditing data is required. We will refer to individual patient data only and will not be able to identify actual patients ourselves.

Q6: Patient’s self-assigned ethnicity
The categories shown map onto the national census data. Further information on the ethnic groups within some of the categories is provided below.

White British/White Other
Black (Black British, Black Caribbean, Black African, & other black)
Asian (Asian British, Indian, Pakistani, Bangladeshi & other Asian)
Chinese
Mixed (Asian & Black / Asian & White / Black & White / other mixed)
Other ethnic group (any ethnicity that does not fit a category above)

Q8: Outward: Clinical records
The term ‘clinical records’ includes all notes and records that are available to the team, both paper and electronic.

Q9: Mild, moderate, severe/profound ID (ICD10 category)

Mild
- 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
- 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
- IQ range of 20 to 34. Likely to result in continuous need of support or IQ under 20. Requires in severe limitation in self-care, continence, communication and mobility.

Q10: Comorbidity 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. personality disorder
F80-F89 disorders of psychological development
F90-F98 behavioural & emotional disorders with onset occurring in childhood & adolescence
F98 unclassified mental disorder
Not known: the clinical team has not yet reached a diagnosis

Q12 & 14: Drug names
Please refer to the British National Formulary (BNF) for details of generic and brand names of drugs.

Q15: 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, please write the name of the drug in the box provided. Please note that the 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).

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”, “Asks X about 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”.

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Appendix D: References


NICE schizophrenia guideline CG82 (updated March 2009) www.nice.org.uk/guidance/CG82


POMH-UK (2011) Topic 9b re-audit report – Antipsychotic prescribing in people with learning disabilities
Appendix E: POMH-UK Topic 9b Advisory Group

Topic 9b Advisory Group

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Sumera Bhatti (POMH-UK)
Dr Sabyasachi Bhaumik (Special advisor)
Dr Andrew Flynn (Special advisor)
Steven Hardy (Special advisor)
Samantha McIntyre (POMH-UK)
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Dr Jill Rasmussen (Special advisor)
Krysia Zalewska (POMH-UK)