INPATIENT PRACTICE

# Avoiding Antipsychotic Polypharmacy

Some psychiatrists who work on inpatient units are concerned about the practice of discharging patients who are on multiple antipsychotics. The Joint Commission tried to provide guidance on this issue through its measure on hospital-based inpatient psychiatric services, which went into effect Oct. 1.

This month, CLINICAL PSYCHIATRY NEWS speaks with Dr. Michael J. Serby about the Joint Commission's new measure and its implications for inpatient practice. Dr. Serby helped CLINICAL PSYCHIATRY NEWS launch the Inpatient Practice column 2 years ago with a discussion about medical-psychiatric units (CLINICAL PSYCHIATRY NEWS, October 2006, p. 71). He serves as associate chairman of psychiatry and behavioral sciences at Beth Israel Medical Center, and professor of clinical psychiatry at the Albert Einstein College of Medicine, both in New York.

**CLINICAL PSYCHIATRY NEWS:** How widespread is the practice of antipsychotic polypharmacy?

**Dr. Serby:** The use of multiple antipsychotic agents in a single patient is a widespread and growing practice worldwide. The prevalence of this approach cannot be precisely estimated, because some figures refer to percentages of patients with schizophrenia, while other data represent the use of two or more antipsychotics in patients with any psychiatric disorder. Numbers may also differ between inpatient and outpatient settings. Nevertheless, there is now a body of literature that documents the extent of this practice.

International figures reporting the use of antipsychotic polypharmacy range from 13% to a high of 47% (Austria). This clinical custom is increasing over time. In the United States, it is reported in up to 25% of outpatients and 50% of inpatients on these drugs. The combinations may consist of two (or more) atypical antipsychotics, or an atypical paired with a first-generation agent. A recent study noted that 3.7% of "new users" were started on multiple atypical antipsychotics, pointing to an expanding acceptance of this approach among prescribers.

**CPN:** What are the theoretical underpinnings of the choice to use multiple antipsychotics?

**Dr. Serby:** A high rate of nonresponse in various psychotic disorders is a significant problem for psychiatry. Disorganized and agitated inpatients who do not improve are of particular concern. Adequate serial trials of different antipsychotic medications are time consuming and may be unsuccessful. The use of clozapine is reserved for treatment-resistant cases, but this drug also might be ineffective or only partly effective.

This background has led many clinicians to prescribe courses of two or more antipsychotics together. Often, this occurs in the context of a crossover from one medication to another. If the patient improves midway through, both drugs may be maintained indefinitely. In many other situations, a decision is simply made to add one antipsychotic to another. This may be justified by a scientific rationale invoking contrasting receptor effects of the two drugs (for example, different receptor blockade profiles, or the concomitant use of a pure receptor blocker with a mixed agonist/antagonist).

An alternative rationale is the specific targeting of individual symptoms by the use of multiple drugs (for example, one medication to improve negative symptoms, and another to enhance relaxation and sleep).

**CPN:** What factors, including the Joint Commission's stance on polypharmacy, might affect the decision to treat with multiple antipsychotics?

**A recent study noted that 3.7% of 'new users' were started on multiple atypicals.**

**DR. SERBY**

**Dr. Serby:** The Joint Commission's new measures for hospital-based inpatient psychiatric services refer to the number of patients discharged on multiple antipsychotic medications, and address whether such discharges have "appropriate justification." The major justification the commission cites is three or more failed trials of monotherapy. The commission believes that the practice of antipsychotic polypharmacy must be policed and reduced.

**CPN:** Do you see multiple antipsychotics in use in patients with nonpsychotic disorders?

**Dr. Serby:** There is an increasing tendency to use antipsychotic medications as anxiolytics, mood stabilizers, and/or soporifics in patients with anxiety disorders, mood disorders, personality disorders, and substance use disorders. Despite black box warnings against their use in dementia, the prescription of antipsychotics for agitation in dementia is still fairly common. The use of multiple agents in these cases is unusual. But there may be reason for concern that if antipsychotic polypharmacy prevails in the treatment of psychosis, it might be thought of as useful in some of these other conditions.

**CPN:** What therapeutic measures can be implemented in lieu of adding a second antipsychotic?

**Dr. Serby:** Several drugs that affect the glutamatergic system have yielded preliminary positive results as augmenters of antipsychotic drugs in schizophrenia. Lamotrigine has received the most attention; other agents include glycine, D-alanine, and sarcosine.

Testosterone recently was found to have beneficial effects against negative symptoms in patients on antipsychotics. Symptoms of depression, insomnia, and anxiety should be treated with classically indicated medications rather than another antipsychotic.

**CPN:** How do you teach physicians to avoid antipsychotic polypharmacy?

**Dr. Serby:** The accumulation of an evidence base is critical. The combination of negative studies for polypharmacy, an appreciation of excessive side effects, and positive results with other potential augmenters should give clinicians pause.

The Joint Commission's emphasis on this matter has led to greater scrutiny. All of this should be reviewed by clinicians who treat psychotic patients. Appropriate forums for discussion include departmental meetings, such as grand rounds, and morbidity/mortality conferences. Supervision of residents should focus on the totality of the scientific and clinical evidence. ■

*By Gina L. Henderson, Publication Editor. Share your thoughts and suggestions at cpnews@elsevier.com.*

## *Commission in Transition*

The Joint Commission, which provides the standard in hospital accreditation in the United States, will soon be subjected to greater federal oversight.

Congress has eliminated the Joint Commission's "unique deeming authority" for hospitals as part of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331), which was enacted over the summer.

That means that the Joint Commission will need to apply to the Centers for Medicare and Medicaid Services in order for its accredited hospitals to be deemed to have met the conditions of participation in Medicare.

Previously, the Joint Commission's deeming authority had been automatic and was not subject to oversight by the CMS.

Officials at the Joint Commission supported the intention of the change, and plan to apply to CMS for hospital-deeming authority. The Joint Commission and other accrediting bodies already apply to CMS for deeming authority in other areas, such as home care programs.

Under the new law, the Joint Commission will have 24 months to apply to CMS for deeming authority and to be recognized.

During the transition period, accredited hospitals will not be affected by this change, according to the Joint Commission.

In 2004, the U.S. Government Accountability Office (GAO) issued a report that called on Congress to consider giving the CMS greater authority over the Joint Commission's hospital accreditation program. GAO investigators examined state agency validation surveys for 500 hospitals accredited by the commission and found that it had missed most of the serious deficiencies picked up during the state reviews.

**—Mary Ellen Schneider**

## Report Backs Standardizing Criteria For Diversion Across Hospitals

BY ALICIA AULT
*Associate Editor, Practice Trends*

Standardizing criteria across hospitals could help reduce the practice of ambulance diversion, as could reductions in emergency department boarding and increased coverage of uninsured patients, a new report suggests.

Currently, hospitals in most areas decide on their own when and how often to go on diversion, which leads to a chaotic system and poses health risks to patients who may be delayed in getting needed care, said Dr. Guy Clifton, professor of neurosurgery at the University of Texas, Houston.

Dr. Clifton coauthored the report, "Ambulance Diversions: What They Are, Why We Care, and What to Do," for the New America Foundation, a Washington, D.C.–based public policy institute.

Covering uninsured patients also would help curb diversion, because it would reduce the number of nonurgent cases contributing to emergency department crowding, he said in an interview.

Before joining the foundation, Dr. Clifton was a Robert Wood Johnson Foundation Health Policy Fellow in the office of Sen. Orrin Hatch (R-Utah). He also wrote the forthcoming book "Flatlined: Resuscitating American Medicine" (Piscataway, N.J.: Rutgers University Press, 2009), which takes on the issues raised by the huge number of uninsured Americans.

According to the report, about half of hospitals and 70% of urban hospitals reported at least some time on diversion in 2004. The diversion picture is a bit fuzzy, he said.

Dr. Clifton said that because there is a shortage of primary care providers, many people, even those with insurance, are receiving less preventive care. When they come to the emergency department, they are not seeking nonurgent help, and are often sick enough that they require admission.

Diversion standards, data collection, and public reporting should be instituted nationally, he said. ■

*For a copy of the report, visit www.newamerica.net/files/Ambulance%20Diversions.pdf.*