Psychotropic Polypharmacy and Tapering Medications

By Elaine Gottlieb

In recent years, the number of children and adolescents taking multiple psychotropic medications for psychiatric conditions – a practice known as polypharmacy -- has increased significantly. According to an article published in the October 2010 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, the percentage of child visits in which psychotropic medications from at least two classes were prescribed increased from 14.3 percent to 20.2 percent from 1996 to 2007.

Possible reasons for this increase include greater patient, parent or physician emphasis on symptom reduction, diminishing concerns regarding polypharmacy, limited availability of psychosocial interventions, and the increasing severity of illnesses or comorbidities in the pediatric population.¹ Pediatric polypharmacy is associated with older patient age, mental disorder diagnoses, multiple mental disorder diagnoses and public insurance coverage.² “If a patient is on a polypharmacy regimen, they don’t have a simple disorder,” says John Straus, MD, pediatrician and executive director, MCPAP.

The most commonly reported combinations of psychotropic medications in the pediatric population are a stimulant with an antidepressant and an antidepressant with an antipsychotic.³

“In my practice, the patients most likely to be on multiple medications are kids with ADHD and depression or anxiety, which represents a good number of patients,” says Michael Posner, MD, a pediatrician at Pediatric Associates in West Springfield, Mass.

Rational and Irrational Polypharmacy
In treating mental health conditions, polypharmacy generally refers to concurrent prescription of two or more psychotropic medications from across medication classes. While the use of multiple medications can increase the risk of adverse effects and drug interactions; in some cases it is necessary. "Rational" polypharmacy might, for example, involve using "two antidepressants with two different mechanisms of action or an antidepressant and an antipsychotic to treat severe depression or prescribing an additional medication to treat a side effect, such as a sleep problem resulting from stimulants used to treat ADHD.

When we use multiple medications, we are trying to tailor the treatment to the individual patient. "We treat patients, not diagnoses," says Jefferson Prince, MD, director, Child Psychiatry, Mass General for Children at North Shore Medical Center, and medical director of the MCPAP Northeast regional team.

"Irrational" polypharmacy, on the other hand, can involve prescribing two or more medications from the same class, such as antipsychotics or antidepressants, for the same condition without a sound clinical reason. Few controlled studies have been done on the safety and efficacy of polypharmacy in pediatric patients; the studies that have evaluated multi-class psychotropic treatment in the pediatric population show little evidence of improved outcomes over monotherapy regimens. "We don’t have a database of which medications work well together. Sometimes we overestimate what we can accomplish with medications," says Dr. Prince.

In testimony before the U.S. House Subcommittee on Income Security and Family Support, American Academy of Child and Adolescent Psychiatry (AACAP) representative Christopher Bellonci, MD, a child and adolescent psychiatrist in Needham, Mass. and former MCPAP child psychiatry consultant, said that the prescribing physician should provide an explanation when a child is taking more than three psychotropic medications and when a child is taking more than one medication from the same class. He advised against the practice of polypharmacy.

**Monitoring Patients on Polypharmacy**

When a child or adolescent is taking multiple psychotropic medications, it is the pediatrician’s role to understand what polypharmacy is, monitor the treatment, and, in some instances, also monitor side effects (see guidance below). Some of these patients may have been placed on polypharmacy regimens during inpatient treatment, which can further complicate care. Since pediatricians are not usually the prescriber, they “need to be advocates for children on multiple medications and feel comfortable speaking with the specialist,” says Dr. Straus.

"It’s important that we as clinicians think of the medical treatment as the beginning of a process and a conversation. How well the patient tolerates the combination of medications and their effectiveness should guide how long patients take them,” says Dr. Prince. “The pediatrician can ask the psychiatrist whether the child needs to be on multiple medications or can be tapered off.”
Often, patients are placed on a new medication without transitioning from the old medication for fear of a negative outcome. “There’s always a feeling that if you take a medication away, the condition will get a lot worse but we don’t know that. If clinicians taper the old medicine once the new medicine is on board, we would never have polypharmacy that didn’t meet a proven need,” says Dr. Straus.

Discussing the child’s medication regimen with his or her parents is also important. “Ask the parents whether the psychiatrist has tried to simplify the regimen, particularly if the child has been taking multiple medications for an extended period of time without change,” says Dr. Straus.

**Tapering Off Polypharmacy**

The decision to taper a patient off psychotropic medications should be made carefully; some patients, such as those with severe depression, severe mood disorders or bipolar disorder, may need to be on multiple medications. “These conditions are chronic and aren’t going to go away. For some children, taking multiple medications keeps them out of the hospital,” says Dr. Prince.

When the decision is made to taper off a medication, it should be done gradually to avoid withdrawal or rebound side effects. “Just as we ‘start low and go slow’ when starting new medications, we should taper patients off in a modest, slow fashion. If a patient has been on SSRIs for two years, it can take six months to taper off,” says Dr. Prince. Best practices for tapering off medications in the pediatric population have yet to be established.

“When a child with ADHD has been doing well on antidepressant or antianxiety medication for seven or eight months and is working with a counselor, it’s perfectly reasonable to try to taper off. With antidepressants, I try to use fluoxetine which doesn’t need tapering. If a child gets anxious about getting off the medication, I taper more slowly and drop down the dose 10 percent a week for a month. Other antidepressants, such as sertraline or citalopram, need to be tapered slowly especially if the child has been on them for a long time. If I were tapering a medication I wasn’t familiar with, I would coordinate with MCPAP. I couldn’t prescribe psychotropic medications without them,” says Dr. Posner.

Patients and families need to be educated about the tapering off process. “Patients should be aware that they may be uncomfortable during the tapering period and be vigilant about monitoring physical and psychological symptoms. Having symptoms is not a harbinger of problems; if they become a problem, the tapering can be extended,” says Dr. Prince.

Judicious use of psychotropic medications can be beneficial in treating a variety of psychiatric conditions. However, the use of multiple medications should be a red flag to question the treatment regimen and consult with parents and prescribers to ensure that it is truly necessary.
Guidance for Pediatricians/Family Practitioners in Addressing Polypharmacy

Most common polypharmacy regimens:

- A stimulant with an antidepressant
- An antidepressant with an antipsychotic

When a patient is on a polypharmacy regimen:

- Consider whether the regimen is “rational” or “irrational” (see accompanying article for examples)
- Discuss the regimen with the parents or caregiver and ask if the prescriber has tried to simplify it
- Discuss the reason for prescribing multiple medications and the possibility of simplifying the regimen with the prescriber

When to consider tapering off a polypharmacy regimen:

- When there isn’t a sound rationale for the regimen, such as prescribing two medications from the same class for the same condition
- When the patient’s condition has stabilized for six months or more

Addressing medication side effects

- The following MCPAP articles discuss risks associated with antidepressants and atypical antipsychotics.

Consult MCPAP
If you are a MCPAP enrolled primary care clinician and you need help dealing with any issues related to polypharmacy regimens, contact your local MCPAP regional hub.

**Hospitals are required by insurers to coordinate outpatient care before discharge from the hospital.** However, this system may not always be seamless. MCPAP-enrolled primary care clinicians: Do you find yourself responsible for refilling a prescription for a patient recently discharged from the hospital? Are these patients currently on a polypharmacy or any other regimen that you are uncomfortable with? If so, please contact your local MCPAP regional hub for assistance.

©MBHP October 2012