Long term antipsychotic polypharmacy is common among Medicaid recipients with schizophrenia


Q How prevalent is antipsychotic polypharmacy in people with schizophrenia?

**METHODS**

- **Design:** Retrospective longitudinal study.
- **Setting:** California and Georgia Medicaid systems, USA; database records for January 1998 to December 2000 analysed.
- **Population:** 31,435 adults (over 16 years of age) with a primary diagnosis of schizophrenia (ICD-9-CM) identified using the Georgia Medicaid claims database, plus state psychiatric hospital databases and a database of a random sample of 20% California Medicaid claims.
- **Assessment:** Information on antipsychotic use (type of antipsychotic, mode of administration, date prescriptions were filled, duration of prescribed treatment) were obtained from claims databases. Polypharmacy episodes were defined as simultaneous treatment with at least two different antipsychotics, overlapping for a minimum of 2 weeks, with any breaks in treatment lasting less than 31 days. Long term antipsychotic polypharmacy was defined as lasting at least 61 days (corresponding with the Journal of Clinical Psychiatry recommended guideline for maximum duration of antipsychotic polypharmacy).
- **Outcomes:** Prevalence and duration of antipsychotic polypharmacy.
- **Follow up period:** 3 years [retrospective].

**MAIN RESULTS**

Between 1998 and 2000, the overall prevalence of antipsychotic polypharmacy was 40%, and the average duration of polypharmacy was 149 days. The prevalence of antipsychotic polypharmacy increased significantly over the 3 year period (32% in 1998 to 41% in 2000; p<0.0001). The overall prevalence of long term antipsychotic polypharmacy episodes was 23%. People who had long term polypharmacy episode(s) had on average 2.1 episodes, lasting 235.9 days each. Long term clozapine based polypharmacy episodes were longer on average than non-clozapine based episodes (300.6 days vs 225.3 days).

**CONCLUSIONS**

Antipsychotic polypharmacy is common in Medicaid recipients with schizophrenia and is prescribed for long periods exceeding Journal of Clinical Psychiatry recommended guidelines.

**NOTES**

The data used in this study were obtained retrospectively from database analysis and were not independently verified. The databases used were based on Medicaid claims and therefore could be incomplete representations of prescription drug usage if claims were not made for reimbursement. The databases used do not include data on antipsychotic usage during periods of hospitalisation.

**Commentary**

There has been little research into the efficacy or adverse effects of antipsychotic polypharmacy in people with schizophrenia, therefore use should be limited to the short term. However, Ganguly et al report that almost a quarter of schizophrenics sampled in the USA have received long term antipsychotic polypharmacy.

How reliable is this estimate? The limitations of this study include the reliance on retrospective analysis of Medicaid claims databases to identify people with schizophrenia and cases of polypharmacy, without any verification of the findings by direct patient or physician contact. The Medicaid eligible population may be enriched for patients with more severe schizophrenia. The survey included only two state databases, and they varied significantly in the incidence of long term antipsychotic polypharmacy (29.3% in California vs 18.1% in Georgia). Therefore, care should be taken in generalising these findings.

It is likely that the use of antipsychotic polypharmacy is driven by limited resources and drug resistance. The lack of state hospital beds and community psychiatric resources result in only the most severe cases being admitted to the system. For example, in Los Angeles County there are 240 state hospital beds for about 3 million people. Therefore, physicians may feel that polypharmacy is the only option available to them in patients showing limited response to monotherapy, even though they know it may not work.

The findings of Ganguly et al will have limited impact on clinical practice, as physicians will still have to deal with the problem of drug resistance. High quality randomised controlled trials are needed to test the efficacy and safety of antipsychotic polypharmacy, especially in monotherapy resistant patients.

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