Increased Risk Among Older Veterans of Prescribing Psychotropic Medication in the Absence of Psychiatric Diagnoses

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Objective: *This study uses Veterans Health Administration (VHA) pharmacy and encounter claims to evaluate the use of psychotropic medications without a psychiatric diagnosis across age groups.* **Methods:** *National VHA administrative data for fiscal year 2010 (FY2010) were used to identify all veterans who filled a prescription for at least one psychotropic medication from VHA (N = 1.85 million). Bivariate and multivariate analyses were used to compare the proportion of these veterans without any psychiatric diagnosis, across age groups, adjusting for possible medical indications. Analyses were repeated for six different classes of psychotropic medications and comparing mental health utilizers and non−mental health utilizers. Comparisons were made to prescribing of HIV and diabetes medications without an indicated diagnosis.* **Results:** *Of all VHA patients prescribed a psychotropic medication in FY2010, 30% had no psychiatric diagnosis, with highest proportions among veterans ages 65−85. This practice was most frequent among nonmental health utilizers and far more prevalent for psychotropic medications than for HIV or diabetes medications. Logistic regression analysis found that age greater than 65 was the strongest predictor of being prescribed a psychotropic without a psychiatric diagnosis. Adjustment for possible medical use of psychotropics and overall medical comorbidity did not substantially alter these trends.* **Conclusion:** *Older veterans, especially those not using specialty mental healthcare, are more likely to be prescribed psychotropic medications in the absence of a psychiatric diagnosis, perhaps representing unnecessary use, under-diagnosis of mental illness, or incomplete documentation.* (Am J Geriatr Psychiatry 2014; 22:531−539)

Key Words: Psychotropic medication, pharmacoepidemiology, veterans

INTRODUCTION

Recent reports have generated concern by finding that certain classes of psychotropic medications are frequently prescribed in the absence of a psychiatric diagnosis.[1−7] Studies evaluating antidepressant prescribing have noted older patients are at increased risk for exposure to this practice.[1−3] In a cohort of

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noninstitutionalized older adults newly started on an antidepressant, anxiolytic, or antipsychotic, nearly half of the patients did not meet criteria for a mental health disorder.[5] Other reports have found that multiple classes of psychotropics are commonly prescribed without evidence of a psychiatric diagnosis but have not fully explored the association of this practice with older age (greater than 65 years).[7] In addition, the existing literature has not explored the risk to older patients of this phenomenon while considering the potential confounding effect of medical indications for psychotropic use (e.g., for pain, headache, seizures). Given older patients are more likely to have multiple medical comorbidities, accounting for this medical burden may help explain a portion of what has been reported previously in the literature as prescribing without a psychiatric diagnosis.

These prescribing practices are a concern for several reasons. First, over the past two decades the prescribing of psychotropic medications has expanded substantially,[8,9] with most prescribing coming from nonpsychiatric providers.[10–12] Older patients are more likely to receive their mental health treatment in primary care settings,[13] meaning a growing number of patients are potentially at risk for exposure to this practice. Second, elderly patients are at substantial risk of adverse events from psychotropic medications, particularly from anticholinergic effects (e.g., constipation, urinary retention, delirium), antihistaminic effects (e.g., sedation), and antiadrenergic effects (e.g., orthostatic hypotension).[14–16] Psychotropic medications are also associated with increased morbidity and mortality, particularly related to falls in the elderly.[17–20] Thus, unnecessary use of psychotropic medications in this population (i.e., use in the absence of a clear diagnostic indication) may pose a potential risk to health.

This study uses national data from administrative records of outpatients treated by the Veterans Health Administration (VHA) to determine rates of psychotropic medication prescribing in the absence of psychiatric diagnosis across age groups. We aim to fill several gaps in the current literature: (1) to provide analyses with more granular older age groups and across six broad classes of psychotropics, (2) to include medical indications and severity of comorbid general medical illness in our analyses, and (3) to evaluate a large sample from a health system where economic incentives and considerations for not giving a psychiatric diagnosis are not at issue. Additionally, we examined prescribing in the absence of a coded diagnostic indication for HIV and diabetes medications as an attempt to provide a comparison for poor documentation of diagnoses on encounter forms. We hypothesize that prescribing psychotropics in the absence of a psychiatric diagnosis increases with age, is attenuated by potential medical indications for use and medical comorbditiy, and is substantially more common than prescribing HIV or diabetes medications without an indicated diagnosis.

METHODS

Sample and Data Sources

The sample includes all outpatients who received at least one prescription for a psychotropic medication (defined below) in VHA nationally during fiscal year (FY) 2010 (October 1, 2009 to September 30, 2010). Sociodemographic and diagnostic data were obtained from the outpatient encounter files and data on filled prescriptions from the Decision Support System pharmacy file.

Measures

Psychotropic medication prescriptions were classified into six groups as follows and measures were constructed to represent any use of each class and the number of prescriptions from within each class:

1. *Antidepressants* included amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine, isocarboxazid, phenelzine, selegeline, tranylcypromine, bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, maprotiline, mirtazapine, nefazodone, paroxetine, sertraline, trazodone, and venlafaxine.
2. *Antipsychotics i*ncluded chlorpromazine, fluphenazine, perphenazine, thioridazine, thiothixene, trifluoperazine, aripiprazole, clozapine, haloperidol, loxapine, molindone, olanzapine, paliperidone, quetiapine, risperidone, and ziprasidone.
3. *Benzodiazepine/sedatives/hypnotics* included alprazolam, chlordiazepoxide, chlorazepate, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, temazepam, triazolam,