

Study on Drug Use Evaluation and Adherence of Antipsychotropic Drugs in Geriatric Patients and Its Impact on Their QOL

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ABSTRACT: A mental disorder, also referred to as a mental illness or psychiatric disorder, is a behavioural or mental pattern that causes significant distress or impairment of personal functioning. An antipsychotropic drug is a chemical substance that changes functions of the nervous system, and results in alterations in perception, mood, consciousness, cognition, or behaviour. The treatment of mental health conditions in the elderly population presents a range of concerns and potential complications which may cause negative effects on their medication adherence and quality of life. This research article is a short-term study on the drug use evaluation of various antipsychotropics among the geriatric population and to find a relation between adherence towards the current treatment and related quality of life.

KEYWORDS: Antipsychotropics, Adherence, Quality Of Life, MARS Questionnaire, CASP Questionnaire

Apsychoactivedrug, psychopharmaceutical, psychoactive agent or psychotropic drug is a chemical substance that changes functions of the nervous system, and results in alterations in perception, mood, consciousness, cognition, or behaviour. Psychotropic drugs are prescribed to treat a variety of mental health issues when those issues cause significant impairment to healthy functioning. Usually prescribed in psychiatric settings, these medications are typically made of synthetic chemical compounds.^[1]

II. CLASSIFICATION OF PSYCHOTROPIC DRUGS

Psychotropics are a broad category of drugs that treat many different conditions. They work by adjusting levels of brain chemicals or neurotransmitters like dopamine, norepinephrine, and serotonin.^{[2],[3]}

I. INTRODUCTION

Class	Example
Typical Antipsychotics	Chlorpromazine, fluphenazine, Haloperidol, perphenazine.
Atypical Antipsychotics	Aripiprazole, clozapine, iloperidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone.
Anti-anxiety agents	Alprazolam, clonazepam, diazepam, lorazepam.
Stimulants	amphetamine, dexamethylphenidate, dextroamphetamine, methylphenidate
Selective serotonin reuptake inhibitor (SSRI)	Citalopram, escitalopram, fluvoxamine, paroxetine, Sertraline

antidepressants	
Serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants	atomoxetine, duloxetine venlafaxine, desvenlafaxine
Monoamine oxidase inhibitor (MAOI) antidepressants	isocarboxazid, phenelzine tranylcypromine, selegiline
Tricyclic antidepressants	Amitriptyline, amoxapine, desipramine, imipramine, nortriptyline.
Mood stabilizers	carbamazepine, lamotrigine divalproex sodium, lithium

Table 1: Classes and names of psychotropic drugs^[4]

Antipsychotics

Antipsychotic medications, sometimes referred to as neuroleptics or major tranquilizers, are prescribed to treat schizophrenia and to reduce the symptoms associated with psychotic conditions such as bipolar, psychotic depression, senile psychoses, various organic psychoses, and drug-induced psychoses. People experiencing psychosis are sometimes, but not always, a danger to themselves and others. Antipsychotic medications have both a short-term sedative effect and the long-term effect of reducing the chances of psychotic episodes. Most drugs are available in oral dosage forms, while some can be given in parenteral form (intramuscular and intravenous injections).^{[5][6]}

1] Typical Antipsychotics, or First Generation Antipsychotic Drugs: The typical, or conventional, antipsychotics were first developed in the 1950s. Haldol (haloperidol) and Thorazine (chlorpromazine) are the best known typical antipsychotics. They continue to be useful in the treatment of severe psychosis and behavioural problems when newer medications are ineffective. However, these medications do have a high risk of side effects, some of which are quite severe.

2] Atypical Antipsychotics, or Second Generation Antipsychotic Drugs: These new medications were approved for use in the 1990s. Clozapine, olanzapine, quetiapine, paliperidone, risperidone, zotepine, and aripiprazole are atypical antipsychotic drugs. With the discovery of clozapine in 1959, it became evident that this drug was less likely to produce extrapyramidal effects (physical symptoms such as tremors, paranoia, anxiety, dystonia, etc. because of improper doses or adverse reactions to this class of drug) in humans at clinically effective doses than some other types of

antipsychotics. Many atypical or second generation antipsychotics block serotonin (5-HT) receptors in the brain, particularly 5-HT_{2A} receptors—the vital players in schizophrenia. In addition, atypical antipsychotics also act on adrenergic, cholinergic (muscarinic), and histamine

receptors. Side effects of atypical antipsychotic drugs include: blurred vision, nausea, vomiting, trouble sleeping, anxiety, drowsiness, weight gain, sexual problems.

Antianxiety agents

Antianxiety drug, also called anxiolytic or minor tranquilizer, any drug that relieves symptoms of anxiety. Anxiety is a state of pervasive apprehension that may be triggered by specific environmental or personal factors. Anxiety states are generally combined with emotions such as fear, anger, or depression. Benzodiazepines are the most common and efficacious medications used for anxiety. Benzodiazepines in general enhance the effects of GABA. One of the most widely prescribed of these agents is alprazolam, which is used in the treatment of anxiety and panic disorder. Acute treatment with benzodiazepines generally begins with doses taken before bedtime to facilitate sleep. Tolerance may develop to the sedation. Because of the alterations in the effectiveness of inhibitory transmitter actions of GABA, which are profound in the cerebellum and cerebral cortex, the patient may also exhibit confusion and loss of motor coordination as side effects of the drug.

Zolpidem and zaleplon are antianxiety drugs that are GABA agonists, though structurally they are not benzodiazepines. The probability of developing dependence to these drugs is limited,

even with repeated or prolonged use. They are used in the short-term treatment of insomnia^[7].

Stimulants

Stimulants are the drugs that increase activity of the central nervous system and the body. Stimulants induce alertness, elevated mood, wakefulness, increased speech and motor activity and decrease appetite. Their therapeutic use is limited, but their mood-elevating effects make some of them potent drugs of abuse. The major stimulant drugs are amphetamines and related compounds, methylxanthines (methylated purines), cocaine, and nicotine. These drugs achieve their beneficial effects by increasing the levels of dopamine, serotonin, and norepinephrine in the brain. Amphetamines achieve their effect by facilitating the release of norepinephrine by nerve cells and interfere with the cells' reuptake and breakdown of the chemical, thereby increasing its availability within the brain. The most used amphetamines are methamphetamine, amphetamine sulfate. Their heavy or prolonged use causes irritability, restlessness, hyperactivity, anxiety, excessive speech, and rapid mood swings. Still higher doses or chronic use can cause agitation, tremor, confusion, and, in the most serious cases, a state resembling paranoid schizophrenia. With repeated use, tolerance develops, causes physical addiction.

Selective Serotonin Reuptake Inhibitors (SSRI)

Selective serotonin reuptake inhibitors (SSRIs) are the most prescribed antidepressants. SSRIs treat depression by increasing levels of serotonin in the brain. SSRIs block the reuptake of serotonin into neurons. This makes more serotonin available to improve transmission of messages between neurons. SSRIs are called selective because they mainly affect serotonin, not other neurotransmitters. Commonly prescribed SSRIs are citalopram, escitalopram, fluvoxamine, paroxetine, fluoxetine, sertraline. The possible side effects of these antidepressants include: insomnia, headaches, rash, blurred vision, drowsiness, dry mouth, agitation, feeling dizzy, pain in the joints or muscles, upset stomach, nausea, reduced sexual desire. Some people, especially children and young adults, may be more likely to have suicidal thoughts when they take SSRIs.

Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are a class of medications that

are effective in treating depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain. Like most antidepressants, SNRIs work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression. SNRIs block the reabsorption of the neurotransmitters serotonin and norepinephrine in the brain. Examples for SNRIs approved to treat depression include Desvenlafaxine, Duloxetine, Venlafaxine. Side effects are usually mild and go away after the first few weeks of treatment. The most common possible side effects of SNRIs include: nausea, dry mouth, dizziness, headache, excessive sweating, tiredness, constipation, insomnia etc. SNRIs are safe for most people.

Monoamine Oxidase Inhibitor (MAOI)

Monoamine oxidase inhibitors (MAOIs) are a class of medication used to treat depression. MAOIs work with the chemicals in your brain called neurotransmitters that allow brain cells to communicate with each other. Depression is thought to be caused by low levels of the neurotransmitters dopamine, serotonin, and norepinephrine, which collectively are called monoamines. A chemical found naturally in the body, monoamine oxidase, removes these neurotransmitters. By inhibiting monoamine oxidase, MAOIs allow more of these neurotransmitters to remain in the brain, thus elevating mood through improved brain cell communication. Besides neurotransmitters, monoamine oxidase cleans out tyramine, a chemical that helps regulate blood pressure. Because MAOIs inhibit monoamine oxidase from doing its job, they adversely affect blood pressure in addition to keeping neurotransmitters at optimal levels. People taking MAOIs have to pay special attention to their blood pressure, including avoiding certain foods. Besides blood pressure problems, people taking MAOIs should also beware of a condition called serotonin syndrome. Symptoms can include: confusion, fever, irregular or rapid heartbeat, dilated pupil etc. To avoid serotonin syndrome, people taking MAOIs shouldn't take anything for two weeks when ending MAOI treatment and starting another. MAOIs carry more side effects than other antidepressants, which is why they're often the last drug prescribed to treat depression.

Tricyclic antidepressants

Tricyclic or cyclic antidepressants (TCAs) are an early type of antidepressant. However, they are not often used as a first treatment. They are a

good choice for those whose depression is resistant to other drugs. Tricyclic antidepressants help keep more serotonin and norepinephrine available to your brain. Some tricyclic antidepressants are also used to treat other conditions, mostly in off-label uses. These conditions include obsessive compulsive disorder (OCD) and chronic bedwetting. In lower doses, cyclic antidepressants are used to prevent migraines and to treat chronic pain. They are also sometimes used to help people with panic disorder. They can also affect automatic muscle movement for certain functions of the body, including secretions and digestion. They also block the effects of histamine, a chemical found throughout your body. Blocking histamine can cause effects such as drowsiness, blurred vision, dry mouth.

Tricyclic antidepressants are more likely to cause constipation, weight gain, and sedation than other antidepressants. Possible side effects of tricyclic antidepressants include: dry mouth, dry eyes, blurred vision, dizziness, fatigue, headache, disorientation, seizure, drowsiness, constipation, urinary retention, sexual dysfunction, low blood pressure, weight gain, nausea^[8]

Mood Stabilizers

Mood stabilizers are medications used in the treatment of bipolar disorder, where a person's mood changes from a depressed feeling to a high "manic" feeling or vice versa. These drugs can help reduce mood swings and prevent manic and depressive episodes. Mood stabilizers can take up to several weeks to reach their full effect. Because of this, other psychiatric medications such as antipsychotics; are often used in the early stages of treatment to treat acute mania. Depression in bipolar disorder can be hard to distinguish from other forms of depression. Antidepressant medications can be effective; however, they must never be used alone with bipolar disorder as they can also cause a person who is depressed to switch into mania. Antidepressants may also lead to more frequent mood episodes, known as rapid cycling. This risk is lessened if the person is also taking a mood stabilizer.

Mood stabilizers can help to keep the mood of a person with bipolar disorder within this balanced range. Treatment with mood stabilizers can reduce symptoms of bipolar disorder and increase people's ability to pursue their interests and participate more fully in their relationships. Side effects of mood stabilizers include increased

sensitivity to sun, stomach upset, drowsiness, weight gain etc^[8].

III. PSYCHOTROPIC DRUGS ANDELDERLY

The treatment of mental health conditions in the elderly population presents a range of concerns and potential complications. These concerns are not limited to adverse side effects; advanced age often brings metabolic and functional changes that necessarily affect medication response. One of the most typical complications for elderly individuals is treatment-resistance depression. So called "off label" prescriptions are another serious issue for elderly people and their primary care physicians. The classic case of off-label usage is the prescription of antipsychotic drugs for the treatment of behavioural symptoms related to dementia. In elderly individuals with cognitive decline, the symptoms of depression are too easily missed. Likewise, a comorbid health conditions, such as major illness or injury, can mask underlying mood disorders^[9] Psychotropic drugs carry drug – specific warnings about potentially dangerous side effects or drug – drug interactions, and these risks are amplified in the elderly^[10] With the baby –boom population currently entering retirement, it is critical that future clinical research focus on the safe effective treatment of mental health conditions in persons over age 65^[11]

IV. DRUG UTILIZATION EVALUATION (DUE)

Drug utilization review (DUE) also referred to as drug utilization evaluation (DUE) or medication utilization evaluation (MUE), are defined as authorized, structured, ongoing review of healthcare provider prescribing, pharmacist dispensing, and patient use of medication. If therapy is deemed to be inappropriate, interventions with providers or patients will be necessary to optimize drug therapy. A DUE is drug or disease specific and can be structured so that it will assess the actual process of prescribing, dispensing, or administering a drug. DUEs involve a comprehensive review of patient's prescription and medication data before, during and after dispensing to ensure appropriate decision making and positive patient outcomes. DUE programs play a key role in helping managed health care systems understand, interpret, and improve the prescribing administration and use of medications. Employers and health planners find DUE programs valuable because the results are used to foster more efficient use of health resources. Pharmacists play a

role in this process because of their expertise in pharmaceutical care. DUEs afford the managed care pharmacist the opportunity to identify the trends in prescribing within the groups of patients.

V. MEDICATION ADHERENCE

Medication adherence, or taking medications correctly, is generally defined as the extent to which patients take medication as prescribed by their doctors. This involves factors such as getting prescriptions filled, remembering to take medication on time, and understanding the directions.^[14] Older patients often find medication adherence difficult, as the use of multiple create challenges. Increasing medication use with age is common to address specific symptoms, improve or extend quantity of life, or heal curable conditions.^[15] Almost 20% of community-dwelling elders (65 years or older) take 10 or more medication. For some elders, underlying conditions require multiple drugs from different classes, but for others this polypharmacy is unnecessary and unfortunate. Sadly, multiple medication use creates and contributes to adherence challenges in the aging population. Reasons for non-adherence in elderly patients includes Patients assessment of risk and benefit, potential side effect, cost, regimen complexity, fear of addiction, and cognitive decline. Poor adherence can interfere with the ability to treat many diseases, leading to greater complications from the illness and a lower quality of life for patients.

MEDICATION ADHERENCE RATING SCALE (MARS)

Nonadherence to prescribed psychotropic medications is among the major behavioural risk factors among elderly patients. The Medication Adherence Report Scale is a 10- item self- report adherence scale which assesses both intentional and nonintentional nonadherence in psychosis. This scale is based on two already existing self-report measures of compliances. The first is Drug attitude inventory and second is the medication adherence questionnaire. These compliance measures have been combined to produce a compliance scale. The scale consists of 10 items that requires yes/no responses. The first 4 items are based on the MAQ and scored, no=1, yes=0. The remaining items are from DAI and coded as follows: Q5, Q6, Q9, Q10, no=1 and yes=0; Q7, Q8, no=0 and yes=1. A total score will then reflect a greater degree of compliance if it is high, and non-compliance if it is low.^[16]

VI. IMPACT ON QUALITY OF LIFE

Quality of life (QOL) is defined by the World Health Organization as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. Measuring techniques of QOL are based on questionnaire implementation. Most often they consist out of two basic principles: subjectivity and multidimensionality. The principle of subjectivity is based on individual assessment of appearances in the surrounding, while multidimensionality includes objective measuring of selected external influences on individual, who is the subject of testing.^[17]

When measuring QOL in patients taking antipsychotics, it is important to acknowledge that a variety of factors may influence QOL outcomes: these include side effects and daily dosage of the antipsychotic, depressive and negative symptoms, duration of treatment, and subjectivity tolerability. Patients’ attitudes and values, their concept of illness and health as well as their previous experiences with Medication may significantly affect the subjective response to antipsychotics. Elderly patients are at increased risk of adverse drug events because of age-related pharmacodynamic and pharmacokinetic changes. Additionally, as older adults are often prescribed multiple medications, they are at increased risk for drug–drug interactions. Common side effects in the elderly from antipsychotics include orthostatic hypotension, sedation, anticholinergic side effects, extrapyramidal symptoms (tremor and rigidity), and tardive dyskinesia (lip smacking).^[18]

CASP- 19

The Quality of Life Scale (CASP-19) uses four domains (i.e., control, autonomy, pleasure and self-realization) to assess the quality of life in individuals in early old age. CASP-19 proposes wellbeing as the satisfaction of four ‘needs’ (control, autonomy, self-realisation and pleasure). The CASP-19 may reflect the asses-based approach and has been validated in over 20 countries. It comprises of 19 items, including 4 items for control, 5 items for autonomy, 5 items for pleasure and 5 items for self-realization. Response options are “Often, Sometimes, Not often and Never”. Negative worded items are scored 0-3 and positively worded items are scored 3-0. The items are summed, and the score can range from 0 – meaning complete absence

of quality to a high score of 57. Higher scores indicate higher levels of satisfaction of quality of life. There is no “good” or “bad” scoring – because it can vary so much. But the median score is around 40. So, if someone gets a lower score than the median – it doesn’t necessarily mean they have a poor quality of life but this may present a chance to examine some opportunities to change things. CASP-19 has proved to be a quick, effective their life and see if there are, multidimensional instrument with generally good psychometric properties when compared to other existing scales.^[19]

VII. METHODS

STUDY DESIGN AND SETTINGS

A prospective prescription monitoring study carried out for a period of six months in General medicine, Cardiology, Psychiatry, Orthopaedic and Surgery departments of a 450 bedded tertiary care hospital. Elderly patients with age greater than 60 years and patients who are willing to participate in the study were only included and Informed Consent Form were obtained from the patients. Patients admitted in ICU, CCU and outpatients were excluded from the study.

DATA COLLECTION

A total number of 132 patients were included in the study and demographic data, social history, past medical history, past medication history, dosage forms, category of drugs, concurrent medications prescribed, severity and risk category of drug interactions and individual medication adherence and quality of life were analyzed. The demographic analysis suggested that males (57%) were represented with more antipsychotic drugs compared to females (43%). The age group of 60-70 years among elderly was found to be represented with maximum antipsychotropic prescription (57%),

and minimum antipsychotropic prescription for patients above 80 year old (14%). Here, most of the patients prescribed with antipsychotropics were admitted in Psychiatry department (39%). 13% patients account with a social history of alcoholism whereas the proportion of smokers and none of any habits were 2% and 70 % respectively. 15% of patients accounts with both alcoholism and smoking. In this study, 47.72% patients were previously prescribed with single antipsychotropics whereas, 52.27% of patients with multiple antipsychotropics. Analysis of diagnostic pattern suggested that (27.35%) cardiovascular diseases was the most common illness encountered, followed with respiratory disorder (11.21%), depressive disorder (9.42%), diabetes mellitus (9.42%), Alcoholic Depressive Disorder (7.62%), Psychosis (7.17%) etc. This analysis is useful to find the precipitating cause for the prescribing medication, and also to judge the rationality for such prescribing pattern.

VIII. RESULTS

From this study it is evident, the most commonly prescribed antipsychotropic drug were Lorazepam (17.80%), Clonazepam (16.10%), Olanzapine (13.69%) and the least prescribed antipsychotropics include Levetiracetam, Clozapine, Rasagiline, Brivaracetam, Zolpidem and others (Table 2). Here, we found that Atypical Antipsychotics (28.72%) is the most commonly prescribed category of antipsychotropic medication, followed by Antianxiety agents (25.81%), Typical antipsychotics (11.63%) etc. (Table 3). Among the different brands of antipsychotropic prescribed in various departments, the most used brands were T. Loricon (13.5%), T. Oleanz (12.5%), T. Clonotril (12%), etc. (Table 4).

Table 2: Distribution based on antipsychotropic drugs (N=292, n=132)

Antipsychotropics	Frequency	Percentage
Lorazepam	52	17.80
Clonazepam	47	16.10
Olanzapine	40	13.69
Risperidone	26	8.90
Trihexylphenidyl	23	7.88
Escitalopram	20	6.84
Alprazolam	13	4.45
Quetiapine	8	2.74
Haloperidol	5	1.71
Desvenlafaxine	5	1.71
Divalproex	4	1.38
Amisulpride	4	1.38

Venlafaxine	4	1.38
Duloxetine	4	1.38
Lithium carbonate	3	1.03
Clobazam	3	1.03
Fluoxetine	3	1.03
Amitriptylline	3	1.03
Levetiracetam	2	0.68
Clozapine	2	0.68
Rasagiline	2	0.68
Brivaracetam	2	0.68
Levodopa	2	0.68
Carbidopa	2	0.68
Zolpidem	2	0.68
Donepezil	2	0.68
Trifluoperazine	2	0.68
Others	7	2.39

Table 3: Distribution based on category of antipsychotropic drugs (N=275, n=132)

Category	Frequency	Percentage
Atypical antipsychotics	79	28.72
Antianxiety agents(BZD)	71	25.81
Typical antipsychotics	32	11.63
Anticholinergics	23	8.36
SSRI	23	8.36
SNRI	14	5.09
Anticonvulsants	14	5.09
Tricyclic antidepressants	11	4
MAOI	4	1.45
Mood stabilizers	3	1.09
Sedativesand Hypnotics	1	0.36

Table 4: Distribution based on commonly prescribed brands of antipsychotropics (N=200, n=132)

Brand Name	Frequency	Percentage
T.Loricon	27	13.5
T.Oleanz	25	12.5
T.Clonotril	24	12
T.Riswel LS	19	9.5
T.Ativan	16	8
T. Alprax	12	6
T.Olagress	12	6
T.Naza	9	4.5
Inj.Serenace	9	4.5
T. Nexito plus	8	4
T. Parkin	8	4
T.Resque	8	4
T.Petril MD	5	2.5

T.Desveren	5	2.5
T.Risp plus	5	2.5
T.Qutan	4	2
Inj.Lora	4	2

Polypharmacy can lead to poor compliance, drug interaction and adverse drug reactions, underuse of effective treatment, healthcare cost, and medication error. It is preferable to keep the mean number of drugs per prescription as low as possible because multiple drugs lead to increased risk of drug interaction. The number of potential DDIs with antipsychotropics were identified using Micromedex Online Database. Among this there were a total of major (45.74%), moderate (46.80%) and minor(7.44%) interactions found between different antipsychotropics. The common drug that is involved in major interactions was Clarithromycin. The other classes of drug that interacts include Antibiotics (25%), Antihypertensive, Antiemetics and Opioid Analgesics (10.4%) etc. Most common side effects with antipsychotropics were dizziness and weakness with the percentage of (29.7% and 21.6%) followed by agitation, diarrhoea, constipation and confusion. Using MARS questionnaire medication adherence of 132 patients were studied and among them 54.54% of patients were adherent to the treatment.

Using CASP -19 questionnaire, quality of life of 132 patients were studied and among them 29.54% have low, 66.67% moderate and 3.80% high rate of quality of life.

From this study, patients more at the age between 60-70 shows increased adherence to antipsychotropics with a slight improvement on their quality of life.

XI. DISCUSSION

The study entitled was conducted to evaluate the drug utilization pattern and medication adherence of antipsychotropics that causes an impact on quality of life of geriatric patients. It was designed to study the prescribing pattern of antipsychotropic medications for various indications with evidence for its benefit in each prescribed condition. For conducting the study, 132 patient data from were collected and entered in the Data Entry Form. This study was carried out for a period of 6 months. The patient data were statistically analysed and found that: 57 % were aged between 60- 70 and 14% of age group above 80. Males (57%) were the most effected population than females (43%). Cardiovascular diseases were the most common illness encountered (27.35%). Lorazepam was the most prescribed ones and most of the drugs

were prescribed as tablets (17.80%). Mostly prescribed brands were T.Loricon (13.5%), T. Oleanz (12.5%) and T. Clonotril (12%). The drugs that involved in major drug interaction among antipsychotropics were Lorazepam and Olanzapine and with other drugs was Clarithromycin. The drug groups frequently involved in drug interactions were Antibiotics, Antihypertensives, Antiemetics and Opioid Analgesics. Most common side effects were dizziness and weakness. Among 132 patients 54.54% were found to be adherent with psychotropics treatment. The quality of life of 3.80% were found to be high and 66.67% were found to be moderate with antipsychotropic treatment.

X. CONCLUSION

In the senior population, physical changes brought on by concomitant illnesses and ageing may cause psychological disorders to present differently and progress more slowly. From the Drug Utilisation Evaluation, it was found that elderly population is prescribed with antipsychotropic along with other medication. Antipsychotropics of tablet dosage forms are used more than any other dosage form. Atypical antipsychotropics and Benzodiazepines were the mostly prescribed category of psychotropics. Lorazepam and Clonazepam were commonly used psychotropic drugs. Generally, it is considered that nonadherence to prescribed antipsychotropic medications is among the major behavioural risk factors for elderly patients. However, from this study, we found that more of the elderly population shows increased adherence to antipsychotropics and have achieved a slight improvement in their QOL. This study provides evidence on the association between treatment adherence and QOL in elderly population. Therefore, improving adherence to antipsychotropic medication would seem to be essential to improve the quality of life of patients. These findings should be an input for designing interventions to promote adherence to antipsychotropic medication in mental health services life of geriatric patients.

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