

AUDIT OF ANTIPSYCHOTIC PRESCRIBING IN DEMENTIA: CAMBRIDGESHIRE RESULTS AND LESSONS LEARNT

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SUMMARY

Background: Behavioural and psychological symptoms in dementia (BPSD) are common and distressing. Anti psychotic medication has been shown to have modest efficacy but is associated with well documented risks including excess cardiovascular events and increased mortality. The current NICE recommendations are that antipsychotics should only be prescribed to those with severe BPSD after exploring other possible interventions. There should be adequate counselling of the patient/family, an explicit risk-benefit analysis and regular review.

Methods: As part of the POMH-UK National Audit on antipsychotic prescribing in dementia we reviewed the notes of 67 patients in the Cambridgeshire area who had a diagnosis of dementia.

Results: Of the 67 patients reviewed, only 9 (13.4%) were currently being prescribed antipsychotics for BPSD. Of these patients, all were living in their own homes and were experiencing multiple distressing target symptoms. 5 had been prescribed an antipsychotic for less than 3 months and only 1 had a total duration of treatment of more than 1 year.

There was good evidence in all cases that alternative diagnoses and management strategies had been explored before prescribing an antipsychotic. However, in none was the full range of potential causes or interventions explored. In 6 cases a risk/benefit analysis for use of antipsychotic medicine was recorded and in 5 cases there was documented discussion of this with family or carers.

Of the four patients who had been prescribed an antipsychotic for more than 3 months, three had had two or more medication reviews. The fourth patient had had a trial of stopping the medication.

Prescribing of other psychotropic medication was also reviewed. Benzodiazepines were used sparingly (7.5%). Of note a significant minority of patients (10.4%) were prescribed 3 or more different psychotropic medications.

Conclusion: These results suggest that within this service antipsychotics are being used appropriately to enable patients with distressing and difficult behaviour to continue to remain at home. They were generally prescribed for a short time and reviewed.

Areas for improvement include a documented discussion of risk in all cases and ensuring that all possible causes of BPSD have been ruled out. Regular review of efficacy and tolerability is essential for all pharmacological treatments for BPSD particularly for those prescribed multiple psychotropic medications.

Key words: antipsychotics – dementia - behavioural and psychological symptoms

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BACKGROUND

Behavioural and psychological symptoms are common in dementia (50-80%) (Lyketsos 2002), with patients often having multiple symptoms. They can be distressing and difficult to cope with, as well as posing significant risks to patients and families. Antipsychotics have been prescribed with modest efficacy (Banerjee 2009) to manage these symptoms; however, concerns have arisen about the safety and ethical aspects of these drugs. Particularly in institutions, it has been suggested that antipsychotics are used as 'dementia cosh pills', possibly even as a substitute for good care (The Sun 2009). As well as a significantly increased risk of stroke and excess deaths, adverse effects of antipsychotics include sedation, falls and extra-pyramidal symptoms (Banerjee 2009). A recent Department of Health report has therefore recommended a target of a reduction in antipsychotic prescribing in dementia of 2/3 in the next year (Banerjee 2009). A national POMH-UK audit is also being conducted, to assess the appropriateness of current antipsychotic prescribing. The national results have not yet been published.

NICE recommends that antipsychotics should only be used when there is severe distress or immediate risk of harm to self or others and where other causes have been ruled out and other non-pharmacological interventions tried. Other recommendations are for adequate counselling of the patient/family, an explicit risk-benefit analysis, and regular review.

There is evidence that even those patients whose symptoms clearly improve with antipsychotics often do not deteriorate when medication is decreased or stopped at 3 month review (Ballard 2009).

METHOD

As part of the POMH-UK National Audit on antipsychotic prescribing in dementia we reviewed the notes of 67 patients in the Cambridgeshire area who had a diagnosis of dementia. A random sample of 90 patients with dementia was produced by the trust audit department. Those who were no longer open to secondary services or were inpatients at the time of the audit were excluded as were those whose notes were not available at the time of the audit. Data collected inclu-

ded basis information, place of residence, psychiatric diagnoses and information on all psychotropic medication. For those prescribed antipsychotics more detailed information was collected.

RESULTS

Of the 67 notes reviewed, 58 patients (86.6%) were not on an antipsychotic for BPSD, and 9 (13.4%) were. One of the 58 patients was prescribed quetiapine, but this was for bipolar affective disorder, so was not included in our consideration of patients prescribed antipsychotics for BPSD. Antipsychotics used comprised haloperidol (1/9), quetiapine (5/9) and risperidone (3/9) at modest doses.

The commonest psychiatric co morbidity overall was depression, with 10/67 (14.9%) of patients suffering from this in addition to their dementia. However, none in the antipsychotic-treated group had depression, and only one had a psychiatric co morbidity, which was an anxiety disorder. The commonest other psychotropic medications that patients were prescribed were AChE inhibitors, with 28/67 patients overall on this type of medication. Overall 17/58 patients not on an antipsychotic were prescribed an antidepressant, of whom 7 were not documented as being depressed; 4 patients in the antipsychotic group were also on an antidepressant of whom only 1 was recorded as being depressed (Table 1, Figure 1).

Table 1. Baseline Characteristics

Characteristics	% not prescribed antipsychotic population (n=58)	% Antipsychotic population (n=9)
Male	46.6% (27/58)	55.5% (5/9)
Female	53.4% (31/58)	44.4% (4/9)
Cared for at home	91.4% (53/58)	100.0% (9/9)
Institutional care	8.6% (5/58)	0.0% (0/9)
<i>Subcategory of Dementia</i>		
Alzheimer's Disease	50.0% (29/58)	33.3% (3/9)
Vascular dementia	24.1% (14/58)	44.4% (4/9)
Mixed Diagnosis	10.3% (6/58)	0.0% (0/9)
Dementia in Parkinson's disease	1.7% (1/58)	0.0% (0/9)
Other – DLB disease	0.0% (0/58)	11.1% (1/9)
Other – unspecified	6.9% (4/58)	0.0% (0/9)

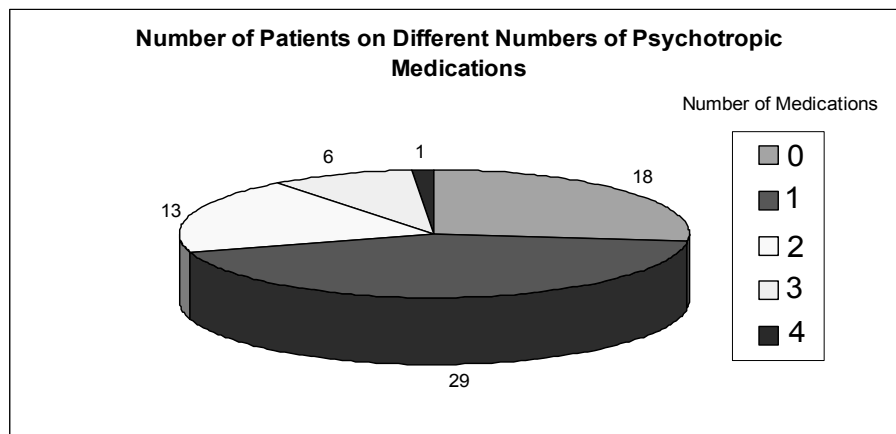


Figure 1. Number of Patients on Different Numbers of Psychotropic Medications

All patients had several specific documented target symptoms, and a wide range of target symptoms were documented, of which agitation and psychotic symptoms were the most common (Figure 2).

At least one alternative cause was considered in all patients on anti-psychotic medication. The most common alternative causes of symptoms considered were depression or a physical illness. Anxiety and pain were never considered as alternative causes of distressing symptoms (Figure 3).

Other interventions were tried in 8/9 patients before initiating anti-psychotic medication. The most common

interventions tried were social/personal activities, increased care, changes to environment, and watchful waiting. However, none of the cases explored the full range of alternative interventions (Figure 4).

There was documentation that the risks and benefits of anti-psychotics were considered in 7/9 patients. The initiation of anti-psychotic medication was documented as being discussed with the family or carers in 6/9 cases. The medication wasn't documented as having been discussed with the patients themselves, potentially because the severity of their illness at the time of initiation made this impossible.

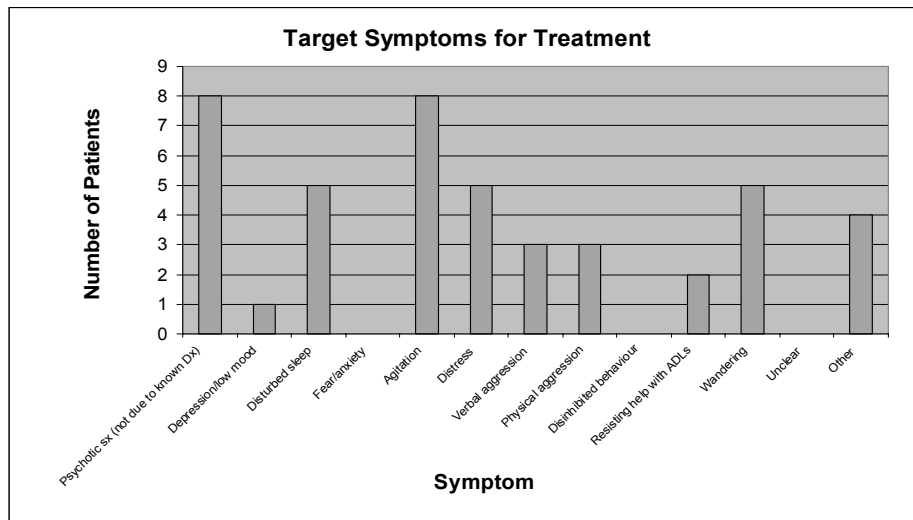


Figure 2. Target Symptoms for Treatment

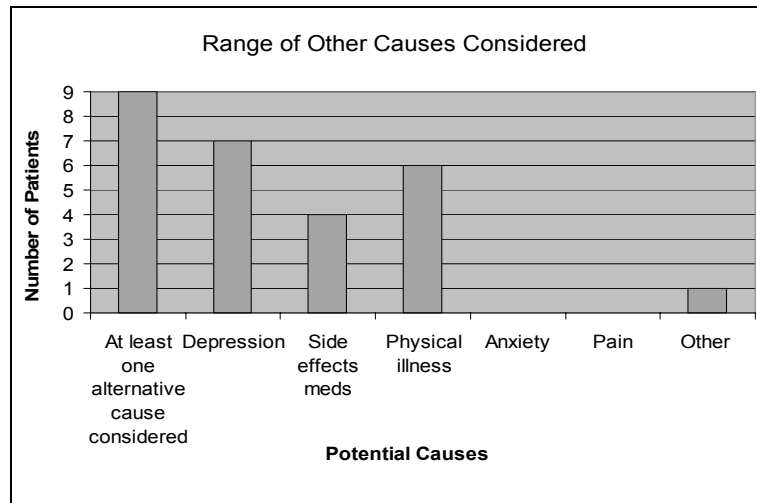


Figure 3. Range of Other Causes Considered

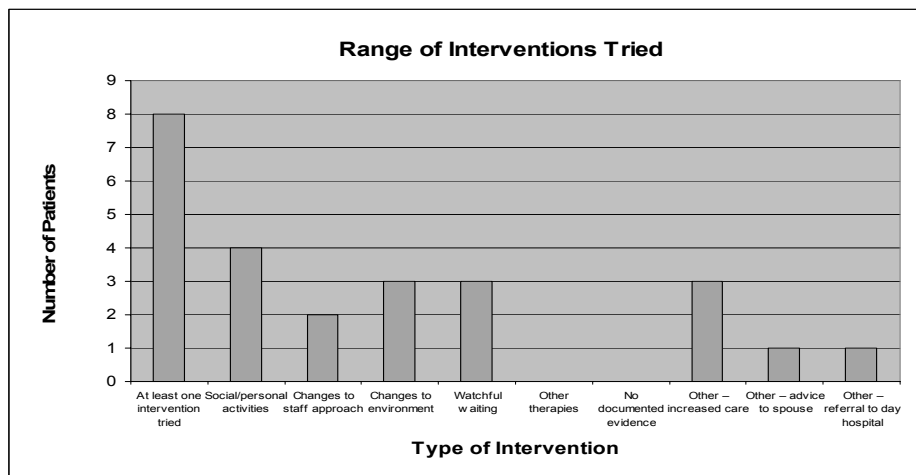


Figure 4. Range of Interventions Tried

5/9 patients had had their antipsychotic medication prescribed for more than 3 months. However, 6/9 had never previously been prescribed an antipsychotic. Only 1 patient had had an antipsychotic prescribed for a total of more than a year.

Medication reviews were audited in the 5 patients who had been prescribed an antipsychotic for more than 3 months. 4/5 patients had had one or more medication reviews since starting the medication; the fifth patient had had a trial of stopping the medication. All patients

had had a review addressing the therapeutic response to the medication, whilst 3/5 had reviews which addressed the possibility of side effects. Side effects considered included mobility problems, sedation, low blood pressure, and chest infection. Anticholinergic side effects and falls were never considered, and no patient had had the full range of potential adverse events reviewed. The patient and/or carers were involved in the medication review in all five cases, and in 4/5 cases the outcome of the medication review was clearly documented.

DISCUSSION

Despite the concern about the harm caused by antipsychotics in dementia there is a body of opinion that the use of antipsychotics for BPSD may be justified using a palliative model: to reduce severe distress in those whose life expectancy is short (Treloar 2010). The patients who were prescribed antipsychotics within this audit appeared to fit this description. All had multiple well documented target symptoms which were causing distress both to the patient and their carer. Carers (often elderly themselves) may struggle to manage symptoms such as sleep disturbance or aggression; ameliorating these symptoms can be the crucial factor in enabling patients to remain cared for at home with their families. Indeed, all of the patients prescribed antipsychotics in this audit were cared for at home.

POMH emphasises the need to consider a full range of alternative causes of BPSD prior to prescribing. Although we found that frequently a few other causes had been investigated, in none had a full range of causes been explored and in none had there been documented consideration of pain as a possible aetiology. This may be related to the lack of record of negative findings. However many patients with severe dementia cannot articulate feelings of pain, hunger or thirst and these can imitate psychological distress and must be considered and ruled out. In fact, a recent study does indeed suggest that simple painkillers can improve BPSD in patients with dementia in nursing homes (Husebo 2011). Many of the studies looking at alternative strategies for managing BPSD have been carried out in an institutional setting; however, for those cared for within a home environment a different range of strategies may be needed, including education and support to modify

the environment or carers' approach, and a variety of respite packages to relieve the strain of managing these difficult behaviours around the clock.

The rate of prescribing of other psychotropic medication in this study is high. The results suggest that antidepressants are often prescribed within this service for patients who are not depressed for management of BPSDs. Prescription of benzodiazepines is modest. It is important to bear in mind that none of these medications are without risk and that polypharmacy in particular is associated with increased risks.

CONCLUSION

These results suggest that within this service antipsychotics are being used appropriately to enable patients with distressing and difficult behaviour to continue to remain at home. They were generally prescribed for a short time and reviewed.

Areas for improvement include a documented discussion of risk in all cases and ensuring that all possible causes of BPSD have been ruled out. Regular review of efficacy and tolerability is essential for all pharmacological treatments for BPSD particularly for those prescribed multiple psychotropic medications.

REFERENCES

1. Ballard et al., *A Randomised, Blinded Placebo-Controlled Trial in Dementia Patients Continuing or Stopping Neuroleptics (The DART-AD Trial)*, *Lancet Neurology*, 2009; 8: 151-157.
2. Banerjee, S., *The Use of Antipsychotic Medication for People with Dementia: Time for Action*. 2009, Department of Health.
3. Husebo, B.S., et al., *Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial*. *BMJ* 2011; 343:d4065.
4. Lyketsos, C.G., et al., *Prevalence of neuropsychiatric symptoms in dementia and mild cognitive impairment: results from the cardiovascular health study*. *JAMA*, 2002. 288(12): p. 1475-83.
5. *The Sun*, Nov 2009.
Treloar, A. et al., *Ethical dilemmas: should antipsychotics ever be prescribed for people with dementia*. *BJPsych*, 2010; 197: .88-90.

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