

Antipsychotic drugs

Summary

90% of people with dementia experience [behavioural and psychological symptoms](#), such as restlessness and shouting, at some point. These distressing symptoms can often be [prevented or managed without medication](#). However, people with dementia have frequently been prescribed [antipsychotic drugs](#) as a first resort and it has been estimated that around two thirds of these prescriptions are inappropriate. Reducing the use of [antipsychotic drugs](#) for people with dementia is a national priority in England (DH, 2009a) and is a key element identified in the [Dementia Plans for Wales](#) (Welsh Assembly Government, 2010).

An [audit of antipsychotic prescriptions for people with dementia](#) (NHS Information Centre, 2012) has revealed that antipsychotic prescriptions for people with dementia have reduced by 52 per cent between 2008 and 2011. However, it also revealed strong regional variations in the number of prescriptions. There must now be continuing action at a local level in England, and urgent action in Wales and Northern Ireland to improve [treatment](#) and care in order to reduce the use of the drugs. The point must be reached where [antipsychotic drugs](#) are only prescribed to people with dementia when necessary and appropriate.

It must be ensured that antipsychotic prescriptions for people with dementia are reviewed regularly, to ensure that they are appropriate, and stopped as soon as possible. Better [training for health and social care professionals](#) working with people with dementia would reduce the number of prescriptions of [antipsychotics](#) and support the use of [alternative methods for managing behaviour](#). Alzheimer's Society is working in partnership with key organisations to support health and social care professionals to provide better dementia treatment and care.

Background

People with dementia often experience [behavioural and psychological symptoms of dementia](#) (BPSD) such as aggression, [agitation](#), loss of inhibitions and psychosis ([delusions and hallucinations](#)). 90% of people with dementia will experience these symptoms at some point, and they are particularly common in people in the later stages of the condition and in care home settings. [These symptoms](#) can be distressing for the person and their carers, as well as putting the person at risk.

There are [treatment](#) and care approaches that can prevent [BPSD](#) from occurring, or help to manage them without needing to resort to medication. Yet people are frequently prescribed [antipsychotic drugs](#) as a first resort. Antipsychotic drugs were developed to treat people with schizophrenia. They eliminate or reduce the intensity of psychotic experiences such as delusions and hallucinations, and

can also have a calming or sedative effect. In some cases [antipsychotics](#) can be the right treatment option. However, they are linked to serious side effects, particularly when used for longer than 12 weeks.

The majority of [antipsychotic drugs](#) are not licensed to treat dementia. One antipsychotic drug - [risperidone](#) - is licensed to treat dementia in very specific circumstances for up to six weeks. However, doctors can prescribe a product off-label following protocol set out by the General Medical Council (GMC) in 2008, and other antipsychotics are widely used for people with dementia.

A [review to Department of Health by Professor Sube Banerjee](#) (DH; 2009a) states that around 180,000 people with dementia in the UK are being prescribed [antipsychotic drugs](#). Increasing concerns by carers, patient organisations and academics about the appropriateness and safety of prescribing antipsychotic drugs to people with dementia has led to several reviews of the evidence and it is clear from these that the majority of prescriptions were inappropriate.

[Professor Banerjee's review](#) found that of the 180,000 prescriptions for people with dementia overall, 140,000 are inappropriate; this is around two thirds of overall use of the drugs for people with dementia. [Antipsychotic drugs](#) have been used inappropriately in all care settings. For example:

- [The All Party Parliamentary Group on Dementia](#) (2008) found that over-prescribing is a [significant problem in care homes](#) and estimated that up to 105,000 people are prescribed [antipsychotic drugs](#) inappropriately.
- An Alzheimer's Society report on dementia care in general hospitals ([Counting the cost, 2009](#)) found that [antipsychotic drugs](#) are widely used to treat people with dementia in a hospital environment and a quarter of nurses surveyed felt that this use is inappropriate.

In 2012 the NHS Information Centre published the results of an [audit of prescriptions of antipsychotic drugs](#) by GP practices in England. Their report found that antipsychotic prescriptions for people with dementia reduced by 52 per cent between 2008 and 2011. However, there was strong regional variation, with rates of prescribing of antipsychotic drugs up to six times higher in some areas than in others. This indicating the need for ongoing local action to ensure that everyone's prescription for [antipsychotic drugs](#) is reviewed so that only those people with dementia who benefit are kept on antipsychotics.

Reasons for inappropriateness include:

People with dementia are at a high risk of dangerous side effects

The side-effects of [antipsychotics](#) can be very harmful and can rob individuals of their [quality of life](#). Side effects include excessive sedation, dizziness and unsteadiness, which can lead to increased falls and injuries, as well as parkinsonism (tremors and rigidity), body restlessness, reduced well-being, social withdrawal and accelerated cognitive decline.

Recent research has shown that there is up to a 9-fold risk of stroke in the first four weeks (Klijer, 2009) and that there is almost a doubling in the risk of mortality (Food and Drug Administration, 2005). The DH review found that the [antipsychotic drugs](#) are contributing to 1,800 deaths a year, for example, death by pneumonia (DH, 2009a).

Behavioural and psychological symptoms can be the result of unmet need that require different solutions

The APPG report (2008) found that the prescription of [antipsychotic drugs](#) to people with dementia

was often the result of factors other than the symptoms of dementia. In particular, a lack of [training in dementia care](#) for staff means that professionals are often not aware that symptoms such as [restlessness and shouting](#) out can be the expression of unmet needs. This could be because of unidentified pain or boredom due to a lack of social activity being available in the care home. The report found that [antipsychotic drugs](#) are often prescribed as a first resort, as a quick and accessible way of [managing behaviour](#), when people with dementia often require different solutions such as person centred care that meets an [individual's particular needs](#).

The APPG report highlighted a lack of training for staff, and a lack of specialist advice and support as key issues. One third of care home managers surveyed for an Alzheimer's Society report [Home from home](#) (2008) reported no support or very limited support from the local older people's mental health service.

Antipsychotic drugs only have modest benefits for specific symptoms and for a short time period

Evidence from placebo controlled trials show that the drugs have some modest beneficial treatment effects for aggression and to a lesser extent psychosis over a period of 6-12 weeks for people with Alzheimer's Disease (eg Ballard and Howard, 2006; Schneider et al., 2006). In line with this evidence, the [drug risperidone](#) is only licensed for up to 6 weeks treatment of persistent aggression in those with moderate to severe Alzheimer's disease. In addition, alternatives to the drug must have been tried and there must be a risk of harm to the patient or others. This has many commonalities with the NICE-SCIE guidance (2006) on prescribing antipsychotics to people with dementia (although it states 12 weeks treatment duration).

Yet a third of Community Mental Health Teams in a survey said that [antipsychotics](#) were used regularly in their area for patients with mild psychotic symptoms (National Audit Office, 2007) and the APPG report (2008) also found that the drugs were being prescribed for [mild symptoms such as restlessness](#). In addition, research has found that people with dementia are often prescribed an antipsychotic drug for a period of 1-2 years or longer (eg Margallo-Lana et al. 2001), which suggests that people are not receiving a regular review.

Reducing the use of antipsychotic drugs to treat people with dementia

In response to mounting evidence, the inappropriate prescription of [antipsychotic drugs](#) to people with dementia was highlighted in the [National Dementia Strategy for England](#) (DH, 2009b), in the National Dementia Action Plan for Wales (2010) and in Professor Sube Banerjee [review for the Department of Health](#) of the use of antipsychotic drugs for people with dementia in all care settings in 2009 (DH, 2009a). Professor Banerjee's review suggested that [antipsychotic](#) use should be reduced by two thirds and made recommendations for how this can be achieved. In response, the Government committed to reduce the use by two thirds by November 2011.

>Alzheimer's Society welcomed the initiatives being delivered by the Department of Health to support this reduction. The Society also supported the [Dementia Action Alliance](#) call to action on antipsychotics, launched in June 2011.

>The key aim of this work was to ensure that people with dementia being prescribed [antipsychotics](#) have the use of the drugs reviewed, to ensure that they are appropriate. This work also involved working with organisations including Department of Health and the Royal College of GPs to provide support and [tools](#) for health and social care professionals to ensure that people with dementia receive treatment and care that is designed to reduce the need for [antipsychotics](#).

>Alzheimer's Society welcomed the news that [antipsychotic prescriptions for people with dementia have been reduced by 52 per cent](#) between 2008 and 2011 (NHS Information Centre, 2012). However the audit also found that there were strong regional variations, with rates of prescribing

of antipsychotic drugs up to sixtimes higher in some areas than others. This means that tens of thousands of people with dementia are still having their lives put at risk by these drugs, and there is a need to continue to focus on reducing the number of prescriptions, so that antipsychotic drugs are only used as a last resort.

The point must be reached where [antipsychotic drugs](#) are only prescribed to people with dementia when necessary and appropriate. This means that the [drug risperidone](#) must be used within the specific terms of its license as a last resort for aggression, when all other methods have failed to alleviate the most [distressing symptoms](#) of dementia, and only when it is in the best interests of the person. Other prescribing of antipsychotics to people with dementia must take place within the remit of specific guidance by the GMC (2008) and the NICE-SCIE dementia guideline (2006), and only when alternative approaches have been tried.

Priorities for action

The Society believes the following actions should take priority to reduce the use of [antipsychotics](#). This work needs to happen across England, Wales and Northern Ireland.

Improve treatment and care to prevent and manage BPSD

[Health and social care professionals](#), from GPs to care staff, need to feel confident and empowered to support people with dementia through person-centred care. Tools and guidance for achieving this are available in best practice guides, available from 9 June 2011 (Alzheimer's Society; 2011a, 2011b). Person-centred care involves fully assessing the person's behaviour, health and current treatments, as well as understanding their history, interests, personality and culture to develop an [individual care plan](#). The care plan should be designed to provide access to interventions tailored to the person's preferences, skills and abilities.

The tailored [care plan](#) will help staff to implement alternatives which can include small-scale changes to everyday practice, for example, providing a rich care home environment and activities that are based on an individual's hobbies and interests. The NICE-SCIE guidance (2006) also recommends a range of interventions such as [aromatherapy and massage](#). There is a need for further research to be completed on the clinical and cost-effectiveness of such interventions; Professor Banerjee's review (2009a) recommends that this be completed by the National Institute for Health Research and the Medical Research Council.

Commission multi-disciplinary local specialist older people's mental health services to provide in-reach service to care homes

Commissioners must also commission services with the multidisciplinary expertise to offer alternatives to [antipsychotic drugs](#) and to support care staff to implement these alternatives. Currently, access to specialist support is patchy. Yet, Ballard et al (2002) found that a psychiatric liaison service significantly reduced the use of antipsychotic drugs. Each primary care trust should commission an in-reach service to improve the quality of care provided and reduce the use of antipsychotic drugs.

Train health and social care professionals in dementia

Working in the care of people with dementia can be [immensely challenging](#) and there are currently inadequate numbers of staff that are well trained in supporting people with dementia. Research has shown that training and support for care home staff reduces the need to use [antipsychotics](#) in residents with dementia and can be a viable alternative for managing [challenging behaviour](#) (Fossey et al., 2006; the FITS programme).

Alzheimer's Society is campaigning for [training](#) and support for all health and social care staff to enable them to support people with dementia and their carers. Training must be evidence-based and delivered by experts in the field. It must include understanding and implementing [person-centred care](#), [communication skills](#), the [behavioural and psychological symptoms](#) of dementia, the risks and benefits of [antipsychotic drugs](#), and available alternatives. Involving carers and people with dementia in [decision-making](#), including the core principles of the [Mental Capacity Act](#), must also be included.

Introduce systems to monitor and review prescriptions

Careful monitoring and review is necessary whenever [antipsychotics](#) are prescribed, however, this is often not carried out. The Society recommends that there should be a formal review by an appropriate professional before prescribing and then once every three months, to ensure that they are appropriately used for a limited time-period and in the best interests of the individual.

To enable this process, professionals must be supported to understand what defines [behaviour](#) as mild or severe, and how to assess the balance for a particular individual between the risks associated with the use of [antipsychotic drugs](#), the distress the individual and others may be experiencing and the benefits of the drug. Guidelines on the assessment process, including monitoring and discontinuation, should be available and used. Alzheimer's Society, with the Royal College of General Practice and the DH, have published [a flow chart for GPs on the appropriate use of antipsychotics](#) (Alzheimer's Society; 2011b). This should be widely used.

Involve people with dementia, family and friends in decision-making

People with dementia and carers must be consulted to ensure that they are fully involved in [decision-making](#), and that they have information on why the drug is being prescribed, and the risks, to enable them to make an informed decision. People can refuse any drug treatment as long as they have the [capacity](#) to understand the impact of that decision. If someone lacks the capacity to make decisions, then a friend, carer or relative (or advocate) should always be involved as much as possible. Professionals must have reference to the [Mental Capacity Act \(2005\)](#). Alzheimer's Society's [tool for people with dementia and carers](#) seeks to empower carers to request a review and ask questions about the use of [antipsychotics](#) for a loved one (Alzheimer's Society; 2011a).

Ensure prescribing is within the GMC and NICE-SCIE protocols

Specific work should continue to take place, locally and led at a national level by the DH, to ensure that in the long term people with dementia are prescribed [risperidone](#) within the specific terms of its licence, or that other [antipsychotic drugs](#) are prescribed within the remit of the GMC (2008) and the NICE-SCIE dementia guidelines (2006).

This would involve working with all professional bodies, including the Royal Colleges and the GMC, to raise awareness amongst professionals of the licence and its implications; of the GMC guidance on off-label prescriptions and the implications that this has for the prescriber in terms of responsibilities and accountability; and the NICE-SCIE guidelines.

Now that this drug is licensed, a NICE appraisal on the cost-effectiveness of prescribing the [antipsychotic drug risperidone](#) for people with dementia is within their remit. This must happen urgently.

The Society campaigns for:

- Alternatives to [antipsychotic drugs](#) to be available and used, including person-centred care,

with support from multi-disciplinary specialist teams.

- [Training](#) and support for health and social care staff in dementia, as this has been shown to be a [viable alternative](#) to using [antipsychotic drugs](#).
- Formal procedures for the prescribing of [antipsychotics](#) and formal requirements for a review on a regular basis (once every three months).
- People with dementia and carers to be consulted over the use of medication, with appropriate information and support to allow them to be involved in informed decision-making.
- Raising awareness of the license for [risperidone](#), and of the GMC and NICE-SCIE protocols.
- A NICE appraisal of the cost-effectiveness of [risperidone](#)

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Alzheimer's Society National Dementia Helpline

England, Wales and Northern Ireland: 0300 222 11 22

9.00am-5.00pm Monday-Friday

10.00am-4.00pm Saturday-Sunday

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