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Editorial

Overuse of antipsychotic medication in elderly people with dementia? A view from general practice

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Antipsychotic drugs are used to treat behavioural and psychological symptoms in dementia (BPSD), which are a core part of the syndrome of dementia, or to treat – what antipsychotics are mainly licensed for – schizophrenia or bipolar disorders with psychotic symptoms. BPSD include agitation, aggression, wandering, shouting, repeated questioning, sleep disturbance, depression and psychosis. These symptoms reduce patients' quality of life, cause great distress to caregivers and are the most common reason for institutionalisation.[1]

However, results of clinical studies, which usually have short observation periods, are not all in agreement as to the effects of antipsychotics in elderly patients with dementia, for whom low dose atypical antipsychotics are now most frequently used. These drugs may or may not be effective and well tolerated (including cognitively) in the treatment of BPSD in elderly patients.[2,3] A meta-analysis of risperidone vs a placebo in psychosis of Alzheimer's disease by Katz and colleagues covered four large placebo-controlled clinical trials.[4] It showed an improvement in psychotic symptoms and general clinical improvement with risperidone when compared with a placebo, particularly for dementia patients with severe symptoms. However, it also showed significant differences in treatment emergent adverse events (see Table 2 in Katz *et al*).[4] The use of any psychotropic drug for BPSD due to dementia has a reported effect of between 0.1 and 0.2 on the continuous outcomes that assess global behavioural disturbance, which is minor.[5]

In October 2009 Sube Banerjee, Professor of Mental Health and Ageing, King's College London, published his report on the use of antipsychotic medication for people with dementia.[5] In this worrying report, Banerjee examines the use of antipsychotic medication within the NHS for people with dementia and concludes that these drugs appear to be used too often but that, at their likely level of use, potential benefits most probably outweigh their risks. This, according to Banerjee, is a problem not just restricted to the NHS but across the world, where the systems in existence for dementia treatment and care have grown by chance rather than by active planning or commissioning.

Reviewing the evidence, these drugs appear to have only a limited positive effect in treating BPSD but can cause significant harm to people with dementia. Using the best available information, Banerjee estimates, alarmingly, that 180 000 people with dementia are treated with antipsychotic medication across the UK per year. 'Of these, up to 36 000 will derive some benefit from the treatment. In terms of negative effects that are directly attributable to the use of antipsychotic medication, use at this level equates to an additional 1620 cerebrovascular adverse events, around half of which may be severe, and to an additional 1800 deaths per year on top of those that would be expected in this frail population.'

However, the evidence base for the use of antipsychotic medication for people with dementia 'includes gaps, contradictions and complexity'. We (HvM and WS) do not entirely agree with the 'emerging consensus with respect to the level of use and risk of antipsychotic drugs for people with dementia'. Banerjee points out that due to the incompleteness of the data there is a need to be cautious about inferences made. We agree that 'There is a need for more research'.

Such overuse of antipsychotic drugs in persons with dementia would be worrying, but we, as primary care physicians (PCPs), are not entirely convinced. Banerjee estimates the proportion of prescriptions which would be unnecessary if appropriate support were available to be of the order of two-thirds overall. It is not unlikely that practice may be ahead of research here. The report suggests as a possible goal to reduce the rate of use of antipsychotic medication for people with dementia to a third of its current level in the UK within three years. This would mean that in the future less than 10% of dementia patients would receive such medication. To that end and toward a general improvement in the quality of medical care for people with dementia, the report makes 11 specific recommendations.

These recommendations concern clinical governance structures in primary care trusts and mental health trusts that should 'ensure that systems and services are put in place to ensure good practice in the initiation, maintenance and cessation of these drugs for people with dementia'. Looking from the primary care and general practice perspective, we would like to emphasise that the issue of timely cessation of antipsychotic medication is not always easy for PCPs in daily practice.

The issue is not new: in 1997, Bridges-Parlet and colleagues concluded from their survey that the 'unmasking of unmanageable agitation and physical aggressiveness in a small minority must be weighed against the benefits of removing unnecessary medication in the majority of dementia patients in whom neuroleptics withdrawal is attempted'.[6] In general practice there is the additional problem that specialists, without the general practitioner (GP) being made aware, can start prescribing such drugs to a patient and an up-to-date overview of the patient's medications may be lacking.

Banerjee's report focuses mainly on institutionalised patients and it must be kept in mind that, according to our information, consultant physicians do not conventionally give medical supervision to homes for the elderly in the UK. Medical care for people with dementia is also organised somewhat differently throughout Europe, which makes Banerjee's claims about a universal problem of overuse difficult to test.

In the Netherlands, for instance, there is home care, care in homes for the elderly and nursing home care. PCPs provide integrated but frequently somewhat incident-based medical care at home in a rapidly changing context. Older persons usually keep their GPs when they move to homes for the elderly. Geriatricians may provide a more structured and planned form of medical care in nursing homes in cases where they have an agreement to provide care for inpatients on a regular basis. They are also increasingly available for advice to GPs in homes for the elderly. A national Dutch general practice database shows that at any one time 32.3% of patients with an established diagnosis of dementia of the Alzheimer type are in receipt of antipsychotic drugs.[7]

There is frequently a fundamental but decreasing difference between chronic care geriatric centres for 'patients' and homes for the elderly which provide accommodation for residents. The difference has an impact on the quality of care available. In addition, even within the same country structures often are non-homogeneous. In Austria, for instance, we differentiate between elderly care homes called *Pensionistenheime*, which are mostly community run residences for elderly people, and geriatric centres – *Pflegeheime*. The latter are geriatric chronic care hospitals in some Austrian provinces, e.g. in Vienna, run medically by a consultant, who is often a GP. However, in some Austrian provinces geriatric centres are organised as care facilities where doctors are called only occasionally to make home visits by the patients or by the staff of the facility.

One retrospective analysis of data from three observational studies from the UK found no significant differences in the adjusted ratio risks for incidence of cerebrovascular accidents and transient ischaemic attacks in patients prescribed atypical antipsychotics (risperidone, quetiapine or olanzapine) in general practice, including patients with dementia, but points out that dementia appears to be an important risk factor.[8]

Reviewing the relevant literature it becomes obvious that we urgently need more data on the clinical and cost effectiveness of non-pharmacological methods of treating behavioural problems in dementia and of other pharmacological approaches as an alternative to antipsychotic medication. We also go along with Banerjee's recommendation that graduate medical education of GPs should be improved so that they can correctly diagnose BPSD – e.g. agitation, aggression, wandering, shouting, repeated questioning, sleep disturbance, depression – and improve the interface between primary care and specialised psychiatric care.

Better implementation of existing guidelines may help, as well as a more extensive and structured role for the general practice geriatric nurses that many GPs now have in the UK and in some other European countries. Antipsychotic drugs should be used as a considered second line treatment when other non-pharmacological approaches have failed, and not as a first line response to behavioural difficulty in dementia. Causal treatment for sudden unrest and agitation should be preferred. Many symptoms are due to physical illness, side effects of other drugs or drug withdrawal. Nurses could perhaps help by

soliciting a medication review by the PCP when this is overdue or when they think that 'too many cooks (doctors) spoil the broth' and the patient has lost track of his or her medication. They could also perhaps perform simple forms of medication review ('Is the patient taking what is prescribed?'), although nurses in Austria, for instance, currently have no training for such tasks.

We agree with Banerjee that a measured, planned approach would be best, but one that keeps the PCP in a central position. A collaborative care approach with a specific dementia care manager in the service of a PCP enables services to work together for the benefit of people with dementia and their carers. There may be a need for extra capacity in specialist dementia services, so that they can work with all care homes where there are people with dementia and with PCPs in these homes and in the community, but a strengthening of the role of the PCP, as in the Netherlands, may be a more integrated way forward. Collaborative care models with geriatricians, liaison psychiatrists and specially trained geriatric nurses should be explored. We should all, but policy makers in particular, ask ourselves how the trend for institutionalisation of elderly people with dementia can be stopped, as they often prefer to stay at home, and what ambulatory services are necessary to facilitate sufficient support for relatives of patients who are willing and able to keep their older family members at home.

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