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NHS
Sheffield
Clinical Commissioning Group

Medicines Management Team
Resources to support reducing prescribing of antipsychotics in behavioural and psychological symptoms of dementia (BPSD)

Background

- **Always a last resort 2008** [1] – inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes. In response to this MMT offered an audit as part of QoF 6 &10 - 18 practices selected this. The audit cycle demonstrated each practice either reduced prescribing and/ or developed procedures for future prescribing; from the data received, all but one practice reduced numbers of care home dementia patients on antipsychotics.
  [1] http://alzheimers.org.uk/site/scripts/download_info.php?fileID=322

- **Time for action report -The use of antipsychotic medication for people with dementia– Sube Bannerjee Oct 2009** [2]
  Key message –
  - Suggested overall a two-thirds reduction in the use of antipsychotic medication in patients with dementia over 2 years; stating these drugs appear to be used too often in dementia and, at their likely level of use, potential benefits are most probably outweighed by their risks overall.
  - Some people do benefit from these medications and there are groups (e.g. where there is severe and complex risk) where trials have not been completed but where there may be particular value in using these medications.
  - Nationally estimated 25% of dementia patients are prescribed antipsychotic for behavioral and psychological symptoms of dementia (BPSD).
  - Increased **mortality** associated with the use of atypical antipsychotic drugs
  - Increased risk of **cerebrovascular adverse events.**
  - Evidence to show minimal efficacy for antipsychotics in treating behavioural and psychological symptoms of dementia.
  - Estimated:
    180,000 people with dementia prescribed antipsychotics
    36,000 will derive some benefit
    1800 additional deaths
    1620 additional CVAs
  - Report states 11 recommendations which, if implemented, benefit will outweigh risk; auditing use of antipyschotics over 3 years being one of them.

  [2] http://psychrights.org/research/Digest/NLPs/BanerjeeReportOnGeriatricNeurolepticUse.pdf

- **NICE/SCIE CG42 – Dementia: supporting people with dementia and their carers in health and social care** [3]
  Key message re antipsychotics (1.7.2) –
  Antipsychotics should be used in the first instance only if an individual is severely distressed or if there is the immediate risk of harm to others. In less severe cases, antipsychotics should only be used after a non drug option. They should not be used for mild to moderate non cognitive symptoms.
  Consider antipsychotics for severe non-cognitive symptoms (psychosis and/or agitated behaviour causing significant distress) only if:
  - risks and benefits have been fully discussed; assess cerebrovascular risk factors and discuss possible increased risk of stroke/transient ischaemic attack and possible adverse effects on cognition
  - changes in cognition are regularly assessed and recorded; consider alternative medication if necessary

- target symptoms have been identified, quantified and documented, and changes are regularly assessed and recorded
- co-morbid conditions, such as depression, have been considered
- the drug is chosen after an individual risk–benefit analysis
- the dose is started low and titrated upwards
- treatment is time limited and regularly reviewed (every 3 months or according to clinical need).

[3] http://www.nice.org.uk/CG42

- **Extended follow-up of the DART-AD trial** [4] found patients with Alzheimer's disease who continued antipsychotic medication for behavioural or psychiatric problems were twice as likely to die as those switched to placebo. This study adds to the ever-growing evidence suggesting that all antipsychotics, regardless of their type, are associated with an increased risk of serious adverse reactions (in this case mortality) in elderly patients with dementia.

  [4] Ballard C, et al. The dementia antipsychotic withdrawal trial (DART-AD): long-term follow-up of a randomised placebo-controlled trial. Lancet Neurology 2009;8/2:151-7 doi:10.1016/S1474-4422(08)70295-3).

- **Drug Safety Update March 2009** [5] - There is a clear increased risk of stroke and a small increased risk of death when antipsychotics (typical or atypical) are used in elderly people with dementia – assessment at early opportunity to establish the likely factors that may generate / aggregate behavioural symptom. Only one antipsychotic, risperidone, is licensed for treatment of dementia-related behavioural disturbances: and then only specifically for short term (up to 6 weeks) treatment of persistent aggression in Alzheimer's dementia unresponsive to non-pharmacological approaches and where there is a risk of harm to the patient or others.

  [5] http://webarchive.nationalarchives.gov.uk/20091114175357/http://mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON041211

Audits

- National audit – the Department of Health commissioned the NHS Information Centre (now the HSCIC) to carry out an audit on the use of antipsychotic medication for people with dementia in each primary care trust in England. Non-patient identifiable data was extracted from GP clinical systems to provide information over a six year period (2006 to 2011).

  Further information:
  http://www.hscic.gov.uk/searchcatalogue?productid=7624&q=title%3a%22National+Dementia+and+Antipsychotic+Prescribing+Audits%22&sort=Relevance&size=10&page=1#top

- **MMT re- audit** – facilitated by MMT members against NICE CG42 criteria.
  - A full re-audit began in January 2015 to determine current prescribing behaviour and identify if prescribing had remained lower than the national average suggested. The information was collected from the all GP computer systems only. It is intended direction will be taken from the mental health portfolio regarding future audits
  - There was an increase in the number of patients recorded with diagnosis of dementia **without** a diagnosis of schizophrenic or bipolar disorders. The number prescribed an antipsychotic had however continued to fall from **8.4% to 4.9%** .The number of patients residing in care homes proportionately had decreased but the prescribing rate of antipsychotics was approximately the same. The audit summary is available: http://www.intranet.sheffieldccg.nhs.uk/Downloads/Medicines%20Management/Practice%20resources%20and%20PGDs/BPSD%20re-audit%20summary_2015.pdf

What support is available?

- **PRESQIPP - Reducing Antipsychotic Prescribing in Dementia Toolkit -**

  This is a comprehensive resource pack which includes guidance on reviewing and stopping antipsychotics prescribed for BPSD

https://www.prescqipp.info/resources/finish/241-reducing-antipsychotic-prescribing-in-dementia-toolkit/1353-reducing-antipsychotic-prescribing-in-dementia-toolkit

- **Non-drug treatments: systematic review**, Leeds Institute of Health Sciences
http://www.pubfacts.com/detail/19946870/Non-pharmacological-approaches-for-dementia-that-informal-carers-might-try-or-access-a-systematic-re

- **Alzheimers Co-operative Valuation in Europe (ALCOVE)**
The Toolbox has a number of resources to support limiting the use of antipsychotics.
http://www.alcove-project.eu/index.php?option=com_content&view=article&id=47&Itemid=198

- **Dementia Revealed - What Primary Care Needs to Know - A Primer for General Practice**
Page 21 - 25 covers BPSD
http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

- **Neuropsychiatric Inventory Questionnaire (NPQ-I)**
Behavioural assessment tool
http://www.medafile.com/cln/NPI-Qa.htm

- **Alzheimer's Society - Antipsychotics**
https://www.alzheimers.org.uk/antipsychotics

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