Antipsychotic drugs in dementia: a best practice guide
Introduction
The National Dementia Strategy launched in 2009 has set the course for a dynamic new approach to care through delivery of better experiences for people with dementia and those who care for them from diagnosis to end of life (Department of Health (DH) 2009). People with dementia should be supported to live fulfilled and positive lives and to reach their potential wherever they choose to live or during their journey through the health and social care system.

The need for excellence in care for people with dementia should be paramount for all practitioners. The changes experienced by people with dementia when entering a new environment, or the impact of ill health or a traumatic life event, can often manifest themselves in changes in behaviour or distress. Understanding and recognising the consequences of dementia are crucial to how we treat people and manage the disease.

Antipsychotic drugs have their place in treatment, although the evidence suggests an over-reliance on prescriptions. A report for the DH estimated that 180,000 people in the UK are prescribed antipsychotic drugs and that approximately 36,000 of them will gain some benefit (Banerjee 2009).

By overprescribing antipsychotic drugs, we risk masking the potential for good care, not acknowledging the educational deficit of practitioners in equipping them with skills and strategies for de-escalating behaviour through recognition and action, and not creating confident practitioners across settings to provide better care for people with dementia.

Challenging over-prescribing requires action – from clinicians, nurses, prescribers, pharmacists and everyone involved in the care of people with dementia in every setting including acute, primary care, mental health and care homes. The Call to Action (DH 2011) offers a stimulus to change practice, and supportive resources are now widely available (Alzheimer’s Society 2011).

This guide aims to summarise some of the main considerations in the prescribing of antipsychotic drugs to people with dementia. We hope that it will be of use to practitioners from a range of backgrounds who work with people with dementia and their carers.

What is dementia?
Dementia describes a clinical syndrome in which the brain fails to function (it used to be called brain failure in the same way as people talk about heart failure, liver failure or kidney failure). The signs and symptoms can be described in three groups:

- Problems in cognition (largely memory but also language).
- Problems with activities of daily living (an inability to care for oneself).
- A cluster of emotional changes (psychological and psychiatric symptoms, and behaviours that can be challenging).

Dementia is a progressive condition, and the main causes are Alzheimer’s disease (about 60 per cent) and vascular dementia (about 25 per cent), with a combination of the two being common. Other less common causes include Lewy body dementia (in which symptoms of Parkinson’s disease are present) and frontal lobe dementia.
lobe dementia (in which personality changes are marked). Other physical conditions that can give rise to the symptoms of dementia include an underactive thyroid gland, vitamin deficiency and, rarely, brain tumours. This is why blood tests and usually a brain scan are carried out when a person has an assessment for a memory problem.

Psychiatric symptoms such as depression and stress can also give rise to symptoms of dementia and are easily treatable.

**Behavioural and psychological symptoms in dementia**

Emotional changes in dementia have been described in a variety of ways (Box 1). In this guide, we will refer to them as behavioural and psychological symptoms of dementia (BPSD). They are a mixture of symptoms but broadly consist of psychological (or psychiatric) symptoms that are experienced by patients and behaviours that challenge. BPSD are common, and most people with dementia will experience at least one symptom during the course of their illness. Behaviours that challenge tend to become more common as the severity of dementia increases. BPSD cause immense distress to the person with dementia and to carers. People may be at risk – for example, when they wander. Living with a person with BPSD can put such a strain on carers that they become exhausted and find it difficult to fulfil their role. The most likely reason for a person being prescribed an antipsychotic drug is aggression, which can be verbal – including shouting – and physical, such as hitting, biting and throwing things.

**Box 1**

**Emotional changes in dementia**

Also known as neuropsychiatric features, non-cognitive symptoms or behavioural and psychological symptoms of dementia.

**Behaviours that challenge:**
- Agitation.
- Aggression.
- Wandering.
- Sleep disturbance.
- Inappropriate eating behaviour.
- Inappropriate sexual behaviour.

**Psychiatric/psychological symptoms**
- Depression.
- Apathy.
- Anxiety.
- Delusions.*
- Hallucinations.*
- Paranoic ideas.*
- Reduplications.*
- Misidentifications.*
  (*Psychosis)

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**Antipsychotic drugs**

These are powerful drugs (also known as neuroleptic drugs) that work primarily on the brain neurotransmitter dopamine to control symptoms of schizophrenia in young people. They were introduced in the 1950s and 1960s; from the 1970s they were prescribed regularly outside their licence for the management of behavioural problems in dementia.

In the early 1990s, drugs were introduced that had fewer side effects, and these have gradually replaced the previous ones (Box 2). BPSD should be treated to decrease distress and harm, and increase quality of life for people with dementia and their carers. However, the assessment and management of such behaviours in dementia can be complicated. Although not licensed for the treatment of agitation in dementia, antipsychotic
Antipsychotic/neuroleptic drugs for dementia

Typical antipsychotics (first generation):
- Chlorpromazine
- Haloperidol
- Stelazine
- Promazine
- Thioridazine

Atypical antipsychotics (second generation):
- Risperidone
- Olanzapine
- Quetiapine
- Aripiprazole
- Clozapine (although very rarely used)

■ Side effects (greater in older people): cardiac, Parkinsonian side effects.
■ Not licensed for treatment of agitation (except risperidone) (Banerjee 2009).
■ 20–30 per cent of people with dementia in nursing homes are taking an antipsychotic.
■ NHS survey 2007/8 (Banerjee 2009): 5.3 per cent of people aged over 65 are prescribed an antipsychotic.

Alzheimer’s dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others’ (Banerjee 2009). The drugs can be used within their licence if symptoms of psychosis are present (Box 1), but people should still be monitored carefully for side effects.

The dangers of the antipsychotic drugs were first highlighted in 2002. Box 3 (page 6) summarises the timelines. In his report, Professor Sube Banerjee (2009) outlined the problems: ‘While the data on risks and benefits remain incomplete, there is a need to be cautious about inferences made. However, on balance, it appears that, among the 180,000 people with dementia treated with antipsychotic medication across the country each year, negative effects directly attributable to the use of antipsychotic medication at this level could equate to an additional 1,800 deaths and an additional 1,620 cerebrovascular adverse events, around half of which may be severe, per year. The high level of use of antipsychotics means that the potential benefit of their use in specific cases is likely to be outweighed by the adverse effects of their use in general.’

Research has revealed several aspects in relation to antipsychotic drugs (Banerjee 2009). The placebo response in trials is around 30 per cent – that is, 30 per cent of people taking a ‘dummy’ tablet will get better, which suggests that the process of being in a trial (people seeing you regularly, filling in forms about how you are feeling, taking a tablet) can have a positive effect. Simply reviewing the drugs (some people have been on them for more than a year without a review) and thinking about alternatives can reduce the level of prescribing by around 30 per...
cent, and support for carers can reduce the need for antipsychotics (Boxes 4 and 5, pages 7 and 8). Also, drugs to control symptoms of Alzheimer’s disease can reduce agitation.

**Good practice in preventing the need for antipsychotic drugs**

Nurses, care home staff and multiprofessional teams in care homes have a vital role in supporting people with dementia and their families to establish the likely factors that might generate, aggravate or improve BPSD (National Institute for Health and Clinical Excellence (NICE)/Social Care Institute for Excellence (SCIE) 2006). This role includes:

- Learning to understand individual clients so that their needs can be anticipated.
- Planning environments and care around individual clients.
- Viewing BPSD as an unmet need and recognising triggers.
- Taking prompt action to relieve the problem and support clients in distress.

**BOX 3**

**History of antipsychotic use in dementia**

<table>
<thead>
<tr>
<th>Period</th>
<th>Drugs Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980s/early 1990s</td>
<td>Promazine/thioridazine/ haloperidol</td>
</tr>
<tr>
<td>1990s/early 2000s</td>
<td>Switch to newer drugs – cardiac safety concerns noted (Banerjee 2009).</td>
</tr>
<tr>
<td>2003</td>
<td>US Food and Drug Administration (FDA) – risperidone.</td>
</tr>
<tr>
<td>2004</td>
<td>UK Medicines and Healthcare products Regulatory Agency (MHRA) – risperidone and olanzapine.</td>
</tr>
<tr>
<td>2005</td>
<td>FDA – aripiprazole.</td>
</tr>
<tr>
<td>2005</td>
<td>FDA – 1.7 times increase in mortality for all (special caution in Lewy body dementia).</td>
</tr>
</tbody>
</table>

Learning to understand individual clients so that their needs can be anticipated

Getting to know clients through biographical/life story approaches and person-centred assessment is fundamental to good care and can offer clues to the person’s behaviours, motivations and priorities. Key questions in assessment include:

- The person – who is this person? What is his or her life story? What has been his or her lifestyle and living environment?
- Values – what is important to this person (for example, relationships, ways of living)?
- Strengths and support – what strengths and coping strategies has he or she developed through life? Which people are his or her main supports and in what way?
- Response to current situation – how has the person been responding to changes in life, illness and his or her dementia?
- Current and future priorities – what are this person’s current priorities in life? What are his or her wishes for the future?

Behaviours that staff find challenging can often be understood through learning about individual life stories. For example:

- A woman activated the exit alarm early every morning. Staff learnt that she had grown up on a farm and went out to collect the eggs. They subsequently opened the door for her each morning, and she went out for a short time and then returned to her room.
- A man wanted to stand at the dining table and became distressed when staff encouraged him to sit. They learnt that he was religious and stood to pray before eating. Subsequently they left him to stand, which he did for a short time before sitting down for his meal.
Learning how people communicate is also vital in understanding and interpreting BPSD. When people's verbal skills deteriorate, their actions and behaviours can become their primary ways of communicating and remaining connected to the world (May et al 2009). Health assessment should be comprehensive to understand changes that might trigger BPSD. Assessing for, and measuring, depression and pain can be particularly important. Staff should also be alerted to the potential side effects of current drugs (NICE/SCIE 2006). Planning environments and care around individual clients Positive environments (physical, psychosocial, organisational, perceptual) can help

**BOX 4**

**General practice reducing antipsychotic drug use in Northumberland**

Our general practice is now working with four homes, including an elderly mentally infirm (EMI) nursing home, which was the pilot in our locally enhanced service (LES) project.

Initially reviewing all the residents in this home, I found large numbers taking antipsychotics. Of the 68 residents we have looked after, 41 had at some time been prescribed an antipsychotic and ten of the others had been on tranquillisers during the day ‘to make them manageable’.

We involve patients and relatives in discussions whenever possible. We work as a team with our care of the elderly psychiatrist, the pharmacist and our local challenging behaviour team. We started slowly but continued with medication reviews on the remainder of residents.

We rapidly discovered that taking people off antipsychotics had no detrimental effect on their behaviour. In fact, it made them better; for example, they coped with conversation more readily and their sleep was improved.

When new residents come into the home they are often on inappropriate medication, and all medication needs reviewing on a regular basis. This is done on an informal weekly basis and formally six-monthly with the medicines manager. All new residents have their initial medication reviewed at first interview with a particular emphasis on reducing polypharmacy. This improves patient care and stops drug wastage and repeat ordering of ‘as required’ medication. The home has also instituted a medicine policy whereby medication, such as paracetamol and mild antacids, is purchased and dispensed by the home without recourse to prescription.

If someone has behaviour that challenges, it is important to recognise and treat any underlying causes, such as pain. If I am concerned that someone is a danger to himself or herself or other people, we use the local challenging behaviour team; for a behavioural problem you need a behavioural approach. Currently, there is only one resident on antipsychotics for schizophrenia. We tried removing these, but his schizophrenia became worse. He is, however, on one third of his original dose.

In managing medicines effectively, a team approach is essential. Antipsychotics are remarkably ineffective in this group of patients, and stopping them is a lot easier than I would have thought. The benefits are quickly obvious, which helps to allay the concerns of nursing staff and also relatives. You will wish you had done it years ago.

The LES has now ended because of lack of funding, but the practice has come to the conclusion that the benefits to the patients and the practice mean that it would be impossible to stop easily. We are therefore continuing to offer the service free of charge.

Peter McEvedy is a general practitioner at Station Medical Group in Blyth, Northumberland, working in a locally enhanced service and prescribing lead for the area.
to promote wellbeing, orientation and control in people with dementia and help to hinder BPSD. Clear environmental signposting, cues and appropriate colour contrasting can be particularly supportive to people whose dementia compromises their vision, spatial awareness or orientation (Box 6).

Positive environments support individual lifestyles: familiarity (with items of personal significance); predictability (avoiding unnecessary disruption); personal space and privacy; social engagement when desired; safety and security; independence; orientation; choice; control; freedom of movement; restfulness and relaxation; interesting activities; success in achievement; and optimal physical, sensory and psychosocial functioning.

Viewing BPSD as an unmet need and recognising triggers Behaviour that might become challenging for staff can alternatively be understood as an expression of physical or emotional discomfort. Staff should try to value all behaviour as meaningful and to find reasons why the person is behaving in that way (May et al 2009).

**Box 5**

**Care homes liaison team reducing antipsychotics in Kirklees, Yorkshire and Humber**

The team members were becomingly increasingly concerned about the high levels of psychotropic medication being prescribed (particularly to manage symptoms of dementia) on an ongoing basis in care homes without frequent reviews. In particular, they listed unnecessary prescribing, unwanted side effects and potential risks to the clients (such as oversedation, raised risks of strokes/falls and mortality). The team initially developed a caseload of all clients that were prescribed antipsychotics in particular care homes. Clients were initially reviewed through telephone contact with the home every six months.

The team found that, after it had reduced the dose and finally stopped the antipsychotic medication, staff in some care homes were contacting GPs and the medications were restarted. This problem was resolved by changing from six-monthly telephone reviews to visits by a doctor and member of the liaison team every three to four months. This enables a thorough review of care plans, client contact and discussions with staff. The reviews can be time-consuming for the team, which can affect the limited medical staff time.

Findings from the team’s audit of the medication reviews were:

- In EMI nursing homes – in June 2008, 112 people were prescribed antipsychotic medication at a cost of £2,592.26 per month; in December 2008, this had decreased to 37 people at a cost of £1,189.95 per month.
- In other nursing homes – in June 2008, 80 people were prescribed antipsychotic medication at a cost of £1,849.92 per month; in December 2008, this had reduced to 27 people at a cost of £619.73 per month.

An overall initial cost of £4,441.68 per month was reduced to £1,609.68, with an annual saving to the primary care trust of £31,584 in one year. These figures are in addition to a presumed reduction in side effects. There were no subsequent admissions to inpatient services as a result of medication reviews.

The team has also developed a pre-referral pack for all care homes in Kirklees. This provides care staff with advice on dementia, medications, nutrition, managing aggression, settling into care and other topics.

Further information: Care Homes Liaison Team, Kirklees, Yorkshire and Humber
Through getting to know residents and good record-keeping (Box 7, page 10), staff can recognise when a change occurs – for example, in memory, demeanour or behaviour.

Staff should always investigate the reasons for changes, through observing and communicating with the person. For example, is the person hot, thirsty, tired or distressed about something? Is there an underlying health change such as a delirium, an early chest infection, constipation? If so, signs of health change should be investigated, for example by checking urine, bowel function, breathing/coughing, pulse and blood pressure.

Important actions for staff:

1. Do not assume that changes are because of dementia.
2. Look for other causes and investigate these.
3. Take action to remedy the problem.
4. Keep accurate records of any changes and ensure that these are dated.

Screening and assessment tools are helpful. For example, the ABC approach (Stokes 2000) examines behaviours in terms of the:

- Antecedents, triggers and causes.
- Behaviour.
- Consequences of that behaviour.

Other useful screening tools have been developed – for example, for risk of wandering (Dewing 2005). Dementia care mapping is now widely used to assess well-being and ill-being in people with dementia (Bradford Dementia Group 2005).

**Taking prompt action to relieve the problem and support the client in distress.** Through the above actions, staff can anticipate problems and unmet needs that a person with dementia might experience and plan effective interventions to prevent these escalating. Staff should strive to

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**BOX 6**

**Reducing antipsychotics for individual clients: example 1**

A man receiving high-dosage antipsychotic medication transferred from hospital into an Anchor Housing care home. Risperidone had been prescribed because of high levels of anxiety and distress presenting in the late evening and night, which affected others in the hospital ward. The home immediately requested a review of medication with the allocated psychiatrist.

**Effects on the client and others** During the interim period before review, the situation escalated. The man became incontinent, withdrawn from social activity in the home, sleeping during the day and consequently missing visits from family and friends.

**Care and support** The care team investigated to identify why the man was so agitated at night. A record of his behaviours was maintained and carefully monitored to establish if a pattern or triggers for this behaviour existed. His family was involved in piecing together a life story. Building on this information, the team identified that, when getting up during the night at home, he turned right to his bathroom. In the care home he had been unable to find the bathroom door. With the client, the care team re-arranged the room to reflect the layout of his home. As a consequence, his agitation and distress lessened and no further incidents of incontinence occurred.

**Case review** At the time of the review, the man, although heavily medicated, was now starting to make friends with others and take part in everyday activities.

**Conclusion** As the man’s initial anxiety and distress had reduced, all involved agreed to reduce the antipsychotic with a view to stopping the medication in the following weeks.

Further information from Victoria A Metcalfe, dementia specialist and lifestyle manager at Anchor. www.anchor.org.uk
respond immediately to expressions of need, such as to go to the toilet or to walk around, and to take measures to relieve discomfort, pain or distress. The person’s response should be monitored, the change and response documented, the care plan updated/modified and the advice of professionals sought whenever appropriate.

Techniques that do not use drugs

A wide range of interventions can be used to control symptoms such as agitation and aggression (Box 8). Others include reminiscence therapy, validation therapy, reality orientation, exercise, transcutaneous electrical nerve stimulation (TENS), environmental manipulation and structured activity (Boxes 9 and 10, pages 12 and 13). Recent reviews of the research evidence for these interventions have shown some interesting findings. Generally, the research evidence to support most interventions is modest and the design of trials to test their effects is often poor. The results do not easily suggest that the interventions could be implemented broadly across nursing and residential homes (they are often studied in specialist settings), and whether or not the improvement would outlast the duration of the intervention itself is unclear.

However, good evidence shows that social interaction can have positive effects on people with dementia and their carers (Cohen-Mansfield et al 2007, Ballard et al 2009) – this accords with what most people see in clinical practice. Care planning and education in care homes for people with dementia can have significant benefits in helping the management of agitation and aggression and thus reducing the need for medication.

If a person carries out a specific intervention for someone with dementia in the short term, the fact

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BOX 7

Reducing antipsychotics for individual clients: example 2

Following a diagnosis of dementia, and increasing anxiety and care needs, a woman moved from her own home to an Anchor Housing care home.

Effects on the client and others

Over the next weeks, she became more anxious, dizzy and nauseated. She became verbally and, on occasions, physically aggressive towards employees trying to support her and other clients. The family and care team questioned her placement and requested additional support from the dementia specialist.

Care and support

An immediate GP visit was requested, the outcome being to monitor the client’s behaviour and review it weekly. The care team, with specialist support, studied the ‘transitional shock’ that may affect a person moving to a new environment. The woman’s weight was monitored and a significant loss was seen. The care team and family developed a life story for the client, and the activities co-ordinator supported her on a one-to-one basis, finding suitable creative pursuits and tapping into reminiscence-based activities to add to the life story work. The care team use life-story work to support clients through this transition and to build relationships. The catering manager asked the client about her food preferences to boost her nutritional status.

Case review

As the weeks passed and relationships improved, the woman’s behaviours changed. Her medication was reduced and stopped.

Conclusion

The life-story work gave an insight into the person. Employees said they could connect with the woman through conversation, photographs and activities that they now knew she enjoyed. The care team reported a close relationship with the family who was astonished at the change in the woman’s behaviour. The family said this was the happiest they had seen their relative for years.

Further information: Victoria A Metcalfe, dementia specialist and lifestyle manager at Anchor. www.anchor.org.uk
that symptoms of anxiety and agitation may
decrease significantly is not surprising. That could
simply be a result of the presence of the person
who is carrying out the trial (the therapist). It
would be significant if the effect of the treatment
lasted longer than the actual intervention. Also, it
is important that interventions can be implemented
by people who are not necessarily specialist
therapists. A review (Neal and Briggs 2003)
suggested that some evidence exists for
improvement with validation therapy (in which the
therapist enters the world of the person with
dementia and uses empathy as the main
therapeutic tool). This type of treatment can be
carried out in a group, which has the advantage of
enabling several people to be treated at once. This
approach makes the therapy potentially more
applicable to a large number of people and less
dependent on the individual relationship between a
therapist and the person with dementia.

Symptoms of aggression and agitation can be of
different severities, and their effect can also differ.
For example, a person with dementia can be upset,
distressed and cause a great deal of distress to
others around him or her. Other people can have
mild symptoms of anxiety that do not cause them
much upset and that may be barely noticeable to
others. So support should be tailored to the
symptoms. For example, if a person is acutely
distressed and is potentially a danger to himself or
herself or others, some more urgent intervention
than talking may be needed. Some form of sedative
medication might be required, and, in exceptional
circumstances, an assessment under mental health
legislation needed.

With many interventions, the technique is often
an amalgamation of several approaches, such as
trying to improve communication skills and
sometimes involving music and movement.

Aromatherapy can be calming; essential oils can
be delivered through massage, in the air or even
added to a bath. Lavender and lemon balm
(Melissa officinalis) are the two most commonly
used and for which the most evidence exists
(Burns et al 2002). Massage can be effective in its
own right, but is best applied by experienced and
trained practitioners. The evidence for
aromatherapy suggests that it can have a
beneficial effect on agitation, although the results
of several trials indicate that this effect may be
modest (Burns et al 2011).

Bright-light therapy seems to have a beneficial
effect on agitation, although the results
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Work with people with delirium has shown
that good light can reduce symptoms – people

BOX 8

Managing behavioural and psychological
symptoms of dementia

Assessment

- ABC assessment (antecedents, behaviours,
  consequences).
- Physical assessment, particularly pain.
- Mental state assessment, particularly depression.

Alternatives to drugs

- Aromatherapy/ massage.
- Bright light therapy.
- Recreational activity.
- Simulated presence.
- Multi-sensory stimulation.
- Music therapy.
- Other therapies, such as doll therapy, pets.
with dementia who experience ‘sundowning’ (where a person becomes more agitated when the daylight begins to fade) do so, at least in part because they are cut off from the normal cues that lighting provides. This may be improved by increasing the amount of natural light and by using glass in the design of homes, bearing in mind that glass houses can become unbearably hot.

Maintaining physical mobility, including recreational activities, is important for a host of reasons – physical and mental wellbeing; preventing pressure ulcers; preventing illness related to immobility, such as pneumonia; and maintaining balance and thus preventing falls. Evidence suggests that physical mobility can improve sleep. Physical mobility can also improve symptoms of depression (Teri et al. 2003) and have benefits for carers.

Music therapy uses music and sound in a range of ways and should be tailored to the person’s previous likes and dislikes. Simulated-presence therapy is an approach in which the immediate surroundings of the person with dementia are kept as familiar as possible, with reminders of things that have happened in his or her life – making a video of life events or audio recordings can be helpful. Sometimes, the therapeutic use of dolls can be beneficial.

One of the important messages from the studies on alternative therapies is that these interventions do not harm people – no evidence suggests a deterioration in memory, cognitive function or an increase in anxiety. Therefore, these interventions are safe and trying them empirically does no harm. Of course, this depends on local custom and practice, and in some homes, showed an average 44 per cent reduction. As the project progressed, and information was disseminated across the group, the baseline percentages of antipsychotic drug use became lower.

Critical to the success of the reduction of antipsychotic medication in the group has been the use of specialist observational tools such as dementia care mapping (Bradford Dementia Group 2005), the Abbey Pain Scale (Abbey et al. 2004) and the Cornell Scale for Depression (Alexopoulos et al. 1988). All the tools have helped staff to work proactively, rather than reactively, and to provide evidence to work in collaboration with the resident’s GP or consultant.

Further information: Jason Corrigan, Four Seasons Health Care, www.fshc.co.uk
The Stop, Think, Assess, Review (STAR) campaign in Cornwall

**Box 10**

The Stop, Think, Assess, Review (STAR) initiative is a county-wide, multi-agency educational toolkit aimed at reducing the use of inappropriate medication in people with dementia. Developed by Cornwall and Isles of Scilly Primary Care Trust, Royal Cornwall Hospitals Trust and Cornwall Care, it provides information on behavioural and psychological symptoms of dementia (BPSD), explanations of factors contributing to BPSD, alternative strategies to medication and information about prescribing to assist health workers.

The initiative also promotes a three-monthly checklist to review, monitor and reduce the prescribing of medication, and an ‘at a glance’ summary and pathway, plus a laminated information booklet with practical observational tools to monitor behaviour.

STAR enables health and social care staff to take positive action to resolve the challenges of prescribing with practical and safe alternatives.

Further information: STAR, Cornwall and Isles of Scilly Primary Care Trust

**Alternative medications**

Drugs other than antipsychotics can be effective. Drugs used to treat Alzheimer’s disease (the cholinesterase inhibitors, such as donepezil, galantamine and rivastigmine, and memantine) may have some benefit in reducing the symptoms of BPSD and delaying their emergence. Carbamazepine (which is used to treat epilepsy) can improve symptoms of agitation – this may be related to the fact that spikes of brain activity are associated with agitation and, although these do not amount to a diagnosis of epilepsy, drugs that calm the brain in this way can help. Sleep can be helped by standard sleeping draughts such as zopiclone, but benzodiazepines are best avoided as they can cause confusion. Pain is an obvious symptom that often cannot be detected or expressed, particularly by a person with advanced dementia, and if any evidence of pain is present a trial of a simple analgesic, such as paracetamol, might be useful. If any evidence exists of rapid eye movement sleep disorder, in which a person becomes disturbed, then clonazepam can be used to good effect.

**Conclusion**

Reducing the distress experienced by people with dementia and their carers remains a priority. Reaching for a drug to suppress symptoms may seem like an easy fix, and medication has its place in treatment, but the dangers associated with antipsychotics are clear (Boxes 11 and 12, page 14). Good
**Box 11**

`Person first – dementia second': addressing unmet need

Bupa care homes carry out action audits of prescribed antipsychotic use every six months. The audits enable us to detect trends and to concentrate interventions on areas where use remains high or, positively, to show where use is low or a home has achieved marked reductions.

From these high performing homes, we have learnt lessons that have been communicated to all Bupa’s care homes – namely, that low antipsychotic use is associated with close liaison and good relations with GPs who carry out regular medication reviews, in particular within one month of admission. Low use also occurs in homes where nurses and carers are advised that antipsychotics are to be a last resort after reasons for distress and behaviours that challenge have been sought, and alternative solutions considered. Alternative solutions include the need to improve residents’ quality of life through occupation and companionship.

To support our antipsychotic reduction programme, in partnership with Bradford University’s Dementia Group, Bupa has designed, and is delivering to our 234 specialist dementia care units, the Person First – Dementia Second training programme, which promotes the message that behaviour in dementia can be a communication of people’s ways of living and coping.

To enable best practice, Bupa is introducing an antipsychotic medication screen that records when and why these drugs are prescribed. The screen also schedules multiprofessional reviews including, whenever possible, residents and their families. In turn, this supports a non-pharmacological care pathway for challenging behaviour, which interprets distressed and invasive behaviour as unmet need and, through psychosocial assessment methods, provides staff with person-centred solutions as alternatives to prescribed antipsychotics.

Further information: Graham Stokes, head of dementia care, Bupa Care Homes, www.bupa.co.uk

**Box 12**

Pharmaceutical company support services

HC-One Care Homes has developed an internal audit system to review antipsychotic medication use. Working with local pharmacists, all homes have completed audits throughout the UK since May 2010. The care home manager communicates with the pharmacist to complete some pre-work before the medication audit. This includes gaining consent from the resident or guardian. The pharmacist will visit the home and review each service user who has been diagnosed with dementia and is taking antipsychotic medication. This is done in collaboration with the home care team and GP.

The pharmacist follows up the audit with an electronic copy, including any actions on each service user’s audit for homes to act on, and, if necessary, carries out any immediate interventions. After about 28 days, the pharmacist will call the home to review the progress of these actions. A further review takes place 84 days after the initial audit. At this stage, the home will be signed off as complete or will be re-audited by the pharmacist on an agreed date.

Our results show that antipsychotic medication was reduced, titrated or discontinued by around 12 per cent after one month and about 31 per cent after three months following the medication audit.

Further information: Paul Smith, head of dementia, HC-One Care Homes
fundamental care can prevent the need for medication, and a broad range of interventions that do not use drugs has now been identified. This guide is aimed at enhancing the understanding of emotional and behavioural problems associated with dementia and the measures that can be taken to support people, relieve distress, and ultimately improve the health quality of life of those who live with dementia.

REFERENCES