

# Antipsychotics in dementia: a team approach from pharmacy is needed

By Ian Maidment, Stephen Guy and Dave Branford, members of the College of Mental Health Pharmacists

The recent inquiry of the All-Party Parliamentary Group on Dementia into the prescribing of antipsychotic drugs to people with dementia living in care homes ("Always a last resort") makes uncomfortable reading. It found that over-prescribing of antipsychotics continues to remain a problem in many care homes.

Dementia affects about a third of people aged 65 years or over. The most common reason for using antipsychotics in this population is to treat the behavioural and psychological symptoms of dementia (BPSD), such as agitation, aggression, wandering and disinhibition. Approximately half of people with dementia will exhibit some of these symptoms. However, BPSD are usually transient and frequently respond to behavioural interventions or changes in the environment. Moreover, there is increasing evidence that antipsychotics have only limited, if any, efficacy with regard to BPSD.

The problems associated with antipsychotic drugs in people over 65 and with dementia are increasingly well-understood; common side effects include sedation, dizziness, falls, stroke and Parkinson-like problems, such as tremor. More seriously, the anticholinergic activity of antipsychotics worsens cognition and these drugs double mortality rates.

The parliamentary group's report highlights possible reasons for the high use of antipsychotic drugs and other medicines to manage BPSD, including:

- A lack of training of staff working in care homes (resulting in a failure to provide patient-focused care)
- A lack of leadership within homes
- Limited external support
- Failure to use behavioural techniques as a management option

There are also failures to recognise that the prescribing of antipsychotics should be a short-term response, and that inadequate review of the prescription can lead to continued antipsychotic use even after BPSD have receded.

A large section of the report describes the potential role of regular medication review

(not to be confused with medicines use review) to improve care and to ensure appropriate use of antipsychotics.

The US is cited as an example of good practice; its Nursing Home Reform Amendment, which became effective in October 1990, limited the use of antipsychotics. Care homes in the US are required by law to employ an accredited pharmacist to review prescribed medicines, including antipsychotics.

The report also discusses the suggestion by dementia charities for an extension of the role of the dispensing pharmacist to perform medication reviews.

Although the report does not advocate any specific approach it states "a single, named individual should have the responsibility for undertaking the review and clarity is needed about who this should be". Any pharmacist delivering such a service would need the necessary skills and knowledge and may need to be accredited. Details of any mechanism for accreditation of the responsible person were not covered in the report and require further elucidation.

The accessibility and capacity of community pharmacists lend themselves to

this role but there are a number of barriers that need to be overcome. The first is the role of secondary care prescribers in initiating the antipsychotic drug and the extent to which they continue to be involved. The report highlighted that pharmacists with a lack of experience in the field may be reluctant to challenge secondary-care-led prescribing.

Homes will need to develop alternatives to medicines use rather than switching from antipsychotics to alternative types of sedative. Reducing the reliance of a care home on medication requires, not only for the pharmacist to have an understanding of mental health medication and alternative treatment pathways, but also to have the ability to influence the original prescriber.

A further possible barrier is evidence that suggests community pharmacists are less comfortable with dealing with mental health issues than with physical health problems (*Psychiatric Services* 2004;55:1434-6).

Any accreditation system would, therefore, need to ensure consistency of service and to

give pharmacists competence and confidence and, perhaps, have a method of robust supervision.

A second option would be to use specialist mental health pharmacists working in both primary and secondary care. They are more likely to have the necessary skills, knowledge and experience and some are accredited via the College of Mental Health Pharmacists.

This second option would use accreditation mechanisms that are already in place. However, most of the trained mental health clinical workforce is based within secondary care, whereas patients are within primary care. Moreover, within secondary mental health care there is already high demand for specialist mental health pharmacists and many mental health trusts are experiencing difficulty with recruitment.

A possible solution to this conundrum, would be for pharmacists in the various sectors to work together as a team. Community pharmacists will continue to have limited impact if they work in isolation and pharmacy as a profession has been slow to recognise the potential of teams working across organisational boundaries. This approach would involve specialist pharmacists providing liaison with secondary care prescribers and community teams, and, in addition, training and providing supervision to community based pharmacists, who would deliver regular clinical pharmacy and medication review in this population. Such potential for outreach work for specialist clinical pharmacists was identified in the recent pharmacy White Paper for England.

One of the most successful schemes of this type to date was the Department of Health-funded Derbyshire pharmaceutical care scheme for older people with mental health problems, in 2001. This scheme involved the training of a number of community pharmacists, who made joint visits with a key worker and undertook medication reviews and medicine adherence reviews in the homes of older people with mental health problems, including dementia. The programme was managed and co-ordinated by a pharmacist who worked closely with the community mental health teams and secondary care mental health pharmacists.

Whatever final system is developed, the need for team working that involves the specialist workforce is clear. Without such collaboration it is likely that one of the most vulnerable populations in society will continue to be put at significant risk from inappropriate medicines management.

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