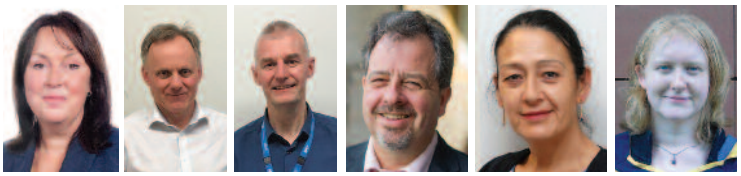
JDC asks...

Many care homes still rely on antipsychotic medication for some people with dementia. But do they have any alternative?



From left: Sarah Rochira, Chris Rusius, Anthony Bainbridge, Clive Ballard, Claire Royston and Isabelle Latham

In considering how the inappropriate use of antipsychotic medication for people with dementia living in care homes could be addressed, it is important to look beyond the medical model of care that often prevails.

This model seeks only to manage the so called "challenging behaviour" of people with dementia, rather than looking at what unmet need may be causing this behaviour.

It is essential to remember that people living with dementia are often experiencing significant changes to their physical and psychological functioning. They are often trying to make sense of a new environment and coming to terms with the loss of things that are familiar, which provide reassurance, comfort and wellbeing.

Furthermore, in many cases, individuals who are being prescribed antipsychotic medication inappropriately may have lost their ability to communicate or understand what people are saying to them, or may find themselves in pain and be unable to describe it. They may be experiencing significant fear and anxiety, so "challenging behaviour" is in fact a distressed response to their circumstances.

With a growing awareness of the benefits of person-centred care, there are now real opportunities for care providers and commissioners of care to ensure that their staff have the right knowledge and skills to support people with dementia more effectively, and work with family members and carers so they understand the things that matter most to an individual, the things that provide vital comfort and reassurance.

Adopting this approach and seeking to prevent distressed responses is the starting point for reducing the inappropriate use of antipsychotic medication and, more importantly, improving the quality of life of people with dementia living in care homes.

Sarah Rochira is older people's commissioner for Wales

There have been several recent pendulum swings against the prescribing of antipsychotics for people with dementia, due in part to increasingly publicised concerns about risks. Antipsychotic use for people with dementia has become considered "poor practice".

But one in four people with dementia experience some psychotic symptoms, which may be highly distressing. It's important to consider if the pendulum has swung too far, meaning some people with dementia are being denied beneficial treatment.

Antipsychotic prescribing has been described in highly emotive ways, but this can result in potentially depriving some people of appropriate treatment because its use has become frowned upon. If people have distressing psychotic symptoms, objective evaluation of the pros and cons of prescribing antipsychotic medication must be conducted.

Psychotic symptoms as part of dementia can cause great suffering and distress in a small minority. To not consider antipsychotic medication for such people is potentially doing them a disservice. As a corollary, prescribing anti-psychotics when not indicated is doing people an even greater disservice. Getting the balance right involves a highly detailed process.

A small study at our NHS trust has shown that certain people with dementia have substantial reductions in symptom severity and substantial improvements in quality of life when they are prescribed antipsychotics. The results also show minimal adverse effects when intensive systematic monitoring is in place.

Whenever antipsychotic medication is being considered, however, we strongly advocate the involvement of specialist older adult mental health services.

Dr Chris Rusius is old age psychiatrist and Anthony Bainbridge is consultant nurse, both at Sheffield Health and Social Care NHS Trust

Current antipsychotic treatments can cause serious adverse events: they almost double the risk of death and triple the risk of stroke. They are even more harmful in dementia subtypes including dementia with Lewy bodies and Parkinson's disease dementia.

When I started my work focusing on antipsychotic medication, in the late 1990s, about half of people with dementia in care homes were prescribed these drugs. I'm pleased to say that research, including my own work, has played a key role in showing the harms and limited benefits of these medications, leading to more than a 50% reduction in their use. We are working to improve understanding in health care professionals to reduce this still further.

Some of my own work has shown that better training of care staff can halve the use of anti-psychotic medication, improve quality of life, and reduce mortality. Our effective interventions involved the incorporation of person-centred care planning and person-centred activities around social interaction. Although this is an intensive process, it worked.

Another avenue we need to explore is alternative pharmacological interventions. A really exciting recent breakthrough is our successful phase 3 trial of the novel anti-psychotic Pimavanserin, which is now licensed in the US for treating neuropsychiatric symptoms in people with Parkinson's disease dementia. The drug has also shown promise with Alzheimer's disease.

This needs further exploration but could be a significant step towards providing relief from terrifying and disturbing symptoms without the adverse effects of previous therapies.

Professor Clive Ballard is pro-vice-chancellor and executive dean at University of Exeter Medical School.

Around one in five elderly people in care homes are prescribed antipsychotic medications, often in response to the experience of distress, agitation or other behavioural and psychological symptoms

arising as part of the experience of dementia. There is a consensus that they have been widely over-prescribed, but a simplistic approach of withdrawal of medication alone is likely to result in more distress for the individual.

What is needed is a rigorous protocol for their use, including standards and monitoring to ensure appropriate prescription and review. This should be complemented by training to help care teams to understand that when a person with dementia develops behavioural symptoms, such as agitation, this will commonly be a reaction to distress.

An approach to management which emphasises empathy and an understanding of the person behind the dementia is often an effective way of managing the situation without resorting to antipsychotic drugs.

One element of our Dementia Care Framework is the development of a medication "app" which includes detailed information regarding the dose limits of each type of antipsychotic medication and best practice standards. It requires that antipsychotic medication is prescribed within therapeutic limits, and that each resident has an annual review of medication by their GP and a personalised care plan with a rationale for prescribing it.

The framework also includes specific learning to enable care staff to develop appropriate non-drug approaches to address the behavioural symptoms, utilising a focus on empathy and understanding the meaning of behaviour. Our use of antipsychotic medication has now dropped from an overall prevalence of 22.7% to 18.6% of residents, and we expect continued reductions.

Dr Claire Royston is group medical director, Four Seasons Health Care.

The answer to the question is yes. Evidence shows that many of the behavioural challenges and psychological symptoms experienced by people living with dementia that can prompt antipsychotic prescribing are manageable with good quality person-centred care and personalised psychosocial interventions instead of medication.

But care staff need support to do this. Good quality person-centred care and interpreting the need behind a person's behaviour is complex, emotionally sophisticated work and does not happen unless the culture inside and outside of an organisation supports it. It takes resources, skill and will on behalf of all involved in the life of a person living with dementia, from their daily care assistant to the occasionally-visiting GP.

Acute care, primary care, social care and community support are all part of the bigger picture that impacts on a person living with dementia in a care home. Until all parts of that system recognise the importance of psychosocial care and work to support staff and informal carers to develop and apply such approaches, then care homes will be left dealing with prescriptions that are not of their initiation, and unpicking behaviours and circumstances that are not entirely of their own making.

How much different would the situation be if a person living with dementia moved into residential care as part of a planned, supported, and optimistic process rather than in response to crisis, ill-coordinated care, and inadequate support for the person and those who care for them?

For more information about the evidence base mentioned above, go to www.worc.ac.uk/discover/dementia-fits-programme.html

Isabelle Latham is senior lecturer at the Association for Dementia Studies, University of Worcester

PERSPECTIVES

A 'ticking time bomb': the vicious circle of homelessness and ill-health

By Mark Ivory

Mark Ivory is Editor of *JDC*

Walking around the shopping districts of London in the December cold was to witness the stark contradiction between the twinkling Christmas lights inviting us to spend our money and the homeless people huddled under sleeping bags with no money to spend. For those of us of a certain age, it was like stepping back into 1980s Britain when homelessness was an epidemic spread by the harsh welfare policies of the time.

Now it's back and for much the same reasons. Numbers of homeless people have soared to more than 300,000 since housing benefit cuts began in 2011 and widespread dependency on insecure private tenancies isn't helping. But this isn't the only explanation, particularly where older people are concerned. The rapid increase in homelessness among this age group, which the Local Government Association (LGA) describes as a "ticking time bomb," is linked with ill-health including conditions like dementia and depression (see *News* p5).

In a new report, *The Impact of Homelessness on Health*, the LGA says there has been a 111% increase in statutory homeless applicants over 60 since 2009/10 and a 155% increase in applicants aged 75 or over. It forecasts that councils will accept something like 20 people over 60 as homeless every day by 2025, up from nearly 10 a day now. Once homeless, adequate health and social care can be hard to access, reinforcing the vicious circle in which ill-health leads to homelessness and homelessness exacerbates ill-health.

Dementia is part of the mix of implicated health conditions, along with physical and mental health problems, alcohol abuse and gambling addiction. Nobody knows what the homelessness figures are for people with dementia as such, but it stands to reason that, like the figures for dementia itself, they are going up. It is not yet a massive issue, although there is a danger that it will become one unless it catches the attention of housing, health and social care professionals putting their heads together to solve the problem as best they can.

Local authorities and the NHS have the powers to act, if not the resources. The Homelessness Reduction Act 2017 gives more people the right to local authority assistance to relieve or prevent homelessness, including those who leave or are forced out of their homes because illness has led to relationship breakdown, rent arrears or the sale of their house or flat. Clearly, there is a role here for health and social care professionals to work with housing colleagues on ensuring that nobody with dementia or any other condition ends up in unsuitable temporary accommodation or even on the streets.

Resources are, as ever, the elephant in the room, and higher benefits, more social housing and stronger legal protections for householders with private tenancies would make a huge difference. But the LGA is surely also correct to point out that doing nothing comes at great cost. Responding quickly to any deterioration in someone's living circumstances is the economical way to improve health outcomes and reduce inequalities.