NHS
National Institute for
Health and Clinical Excellence

Low dose antipsychotics in people with dementia

Support for education and learning: Academic detailing aid

March 2012

This ‘Low dose antipsychotics in people with dementia’ academic detailing aid is designed to be used by experienced prescribing and medicines management personnel to support discussions with prescribers on the key prescribing and medicines optimisation messages from the ‘NPC Key Therapeutic Topics – medicines management options for local implementation’ document. This academic detailing aid is not NICE guidance.

Issue date: March 2012

Implementation of NICE guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement NICE guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in NICE guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

National Institute for Health and Clinical Excellence

MidCity Place, 71 High Holborn, London WC1V 6NA www.nice.org.uk

Supporting notes for the use of NICE academic detailing aids:

Low dose antipsychotics in people with dementia

- NICE academic detailing aids (ADAs) are designed to be used by experienced prescribing and medicines management personnel to support discussions with prescribers on the key prescribing and medicines optimisation messages from the 'NPC Key Therapeutic Topics – medicines management options for local implementation' document (available from www.npc.nhs.uk/qipp/).

- Before using any NICE ADA, users must familiarise themselves with the content of the relevant QIPP Key Slides and accompanying notes (available to download from www.npc.nhs.uk/qipp/).

- The principles that support the use of academic detailing to improve clinical decision-making have been documented widely. As far back as 1990, Soumerai and Avorn described how ADAs had been used to reduce inappropriate prescribing as well as unnecessary health care expenditure[1]. The authors highlighted the following techniques as being particularly important to successful academic detailing:
    1. *Conducting interviews to investigate baseline knowledge and motivations for current prescribing patterns.*
    2. *Focusing programmes on specific categories of physicians as well as on their opinion leaders.*
    3. *Defining clear educational and behavioural objectives.*
    4. *Establishing credibility through a respected organisational identity, referencing authoritative and unbiased sources of information, and presenting both sides of controversial issues.*
    5. *Stimulating active physician participation in educational interactions.*
    6. *Using concise graphic educational materials.*
    7. *Highlighting and repeating the essential messages.*
    8. *Providing positive reinforcement to improved practices in follow-up visits*.

- The National Audit Office's 2007 publication, '**Influencing Prescribing Cost and Quality – a suggested communication plan for prescribing advisers**'[2], suggests further ways to increase the impact of communication with clinicians. This includes sections on visiting clinicians, building a relationship, the relationship process, getting agreement, getting your plans adopted, and supporting activities, as well as follow up and monitoring.

Acronyms and symbols used in this ADA include:

BPSD: behavioural and psychological symptoms of dementia
NICE: National Institute for Health and Clinical Excellence
SCIE: Social Care Institute for Excellence

References:

1. Soumerai SB. Avorn J. Principles of educational outreach ('academic detailing') to improve clinical decision making. JAMA 1990;263:549–56

2. The National Audit Office. Influencing Prescribing Cost and Quality – a suggested communication plan for prescribing advisers. National Audit Office. 2007

Academic detailing aid

Prescribing low dose antipsychotics in people with dementia

Prescribing considerations

NHS National Institute for Health and Clinical Excellence

What are the issues here?

- More than 90% of people with dementia experience behavioural and psychological symptoms of dementia (BPSD)[1].
- Antipsychotics are overprescribed for the treatment of BPSD.
  - They are too often used as first-line treatment, ahead of non-drug therapies[3], contrary to NICE guidance[2].
  - They have limited positive benefits, and can cause significant harm to people with dementia[3].
- In 70% of people with BPSD, antipsychotics can be discontinued without worsening symptoms[1].

What would good practice look like?

- Following the best practice guide: 'Optimising treatment and care for people with behavioural and psychological symptoms of dementia'[1]. Key practice points from this are:
- Consider specialist referral in cases of extreme risk or distress[1].
- Begin management with watchful waiting for 4 weeks (including assessment of medical conditions and pain) and simple non-drug treatment[1].
- Use specific interventions if symptoms are severe or persist after watchful waiting and simple non-drug treatments:
  - psychosocial interventions
  - drug treatment of underlying health disorders (e.g. pain relief) as appropriate[1].
- Consider a trial of antipsychotics if specific interventions have been unsuccessful and symptoms are causing extreme distress or risk of harm[1].

Why is this important?

- Overprescribing of antipsychotics for BPSD results in unnecessary side effects and increases the risk of stroke and premature death[1,3].
- In 2009, it was estimated that antipsychotic prescribing for BPSD could be reduced safely to about a third of the current levels[3].
- Behavioural interventions are a more efficient use of public money than antipsychotic drugs[4].
- Reducing the prescribing of antipsychotics in dementia is a priority of the National Dementia Strategy[5].

What can we do?

- Review, and where appropriate, revise prescribing of low dose antipsychotics in people with dementia, in accordance with NICE/SCIE guidance[2] and the NICE Quality Standard on dementia[6].
- Where antipsychotics are necessary, or are already being prescribed, monitor for side effects and progression of symptoms:
  - review at 6 and/or at 12 weeks[1].
  - Discontinue treatment at review, unless patient still has severe symptoms, or previous discontinuation caused symptoms to return[1].

Prescribing low dose antipsychotics in people with dementia
A framework for decision-making

NHS National Institute for Health and Clinical Excellence

Efficacy

- Antipsychotic drugs show **minimal efficacy** for BPSD[3].
- Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in clinical improvement in 91 to 200 of these people (in addition to those who improve without antipsychotics)[3].

Safety

- Antipsychotics are associated with **a number of major adverse outcomes and side effects,** including sedation, parkinsonism, gait disturbances, dehydration, falls, chest infection, accelerated cognitive decline, stroke and death[1].
- Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in:
  - 10 deaths
  - 18 cerebrovascular events (~ half of which are severe)
  - 58 to 94 people with gait disturbances

(in addition to those who experience these without antipsychotics)[3].

Cost

- The greater cost of using behavioural interventions for BPSD, rather than antipsychotics, is more than compensated by health care savings due to the reduced incidence of stroke and falls[4].
- Taking into account quality of life improvements, the net benefit of using behavioural interventions rather than antipsychotics in England has been estimated as £54.9 million per year[4].

Patient factors

- Patient-specific factors may generate, aggravate or improve BPSD, e.g. environment, physical health, pain, depression[2].
- Challenging behaviours in dementia may be a way of communicating an unmet need[2].
- The decision to prescribe antipsychotics should be taken on an individual basis after full consideration and discussion with the patient and/or carer about the risks and benefits[2].

References:

1. Dementia Action Alliance, Royal College of General Practitioners and Department of Health. Optimising treatment and care for people with behavioural and psychological symptoms of dementia. A best practice guide for health and social care professionals. Alzheimer's Society. 2011
2. NICE/SCIE. NICE clinical guideline 42. November 2006 (amended March 2011)
3. Banerjee S. The use of antipsychotic medication for people with dementia: Time for action. Department of Health report. November 2009
4. Matrix Evidence. An economic evaluation of alternatives to antipsychotic drugs for individuals living with dementia. NHS Institute for Innovation and Improvement. 2011
5. Department of Health. Quality outcomes for people with dementia: building on the work of the National Dementia Strategy. September 2010.
6. NICE. Dementia Quality Standard. June 2010

Related NICE guidance:

- Dementia: Supporting people with dementia and their carers in health and social care. NICE clinical guideline 42 (2006) accessible at http://guidance.nice.org.uk/CG42.
- Mental wellbeing and older people. NICE public health guideline 16 (2008) accessible at http://guidance.nice.org.uk/PH16.
- Service user experience in adult mental health. NICE clinical guideline 136 (2011) accessible at http://guidance.nice.org.uk/CG136.