team, as such organisations are unlikely to have sufficient familiarity with the case in order adequately to address the needs of the child or be sufficiently knowledgeable about issues of confidentiality. Patients and families may resist support from cultural organisations for fear of the local community becoming aware of their situation. Stigma and discrimination surrounding mental illness are prevalent and this may be more so among ethnic minority groups (Office of the Deputy Prime Minister, 2004).

The children of forensic in-patients are a difficult population group to access. Although we are encouraged to consider 'patients as parents', guidance given to forensic psychiatrists places an emphasis on risk assessment and working with the parent, but not the child (Royal College of Psychiatrists, 2002). Even so, although child protection procedures and the best interests of the child are central to the regulation of visits to patients in secure psychiatric units, it would seem that the responsibility of forensic mental health services towards the children may extend beyond this, and that offering support where possible is good practice. A collaborative approach involving other agencies may be the best way to undertake this.

original papers

Declaration of interest

None.

Acknowledgements

We thank the social workers for their assistance in data collection and Dr David James for his helpful comments.

References

FALLON, P., BLUGLASS, R., EDWARDS, B., *et al* (1999) *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (vol. 1) (Cm 4194, II). TSO (The Stationery Office).

OFFICE FOR NATIONAL STATISTICS (2003) *Census 2001: Key Statistics for Local Authorities in England and Wales*. TSO (The Stationery Office).

OFFICE OF THE DEPUTY PRIME MINISTER (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. Office of the Deputy Prime Minister.

ROYAL COLLEGE OF PSYCHIATRISTS (2002) *Patients as Parents. Addressing the Needs, Including the Safety, of Children whose Parents have Mental Illness* (CR105). Royal College of Psychiatrists.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *Partners in Care: Being Seen and Heard*. Royal College of Psychiatrists.

***Oriana Chao** Locum Consultant Forensic Psychiatrist, Bracton Centre, Bracton Lane, Dartford DA2 7AF, email: orianachao@doctors.org.uk, **Gori Kuti** Staff Grade in Forensic Psychiatry, Centre for Forensic Mental Health, Hackney, London

Psychiatric Bulletin (2009), **33**, 57–60. doi: 10.1192/pb.bp.107.017947

CAMILLA HAW, GRAEME YORSTON AND JEAN STUBBS

Guidelines on antipsychotics for dementia: are we losing our minds?

AIMS AND METHOD

The National Institute for Health and Clinical Excellence (NICE) and the Royal College of Psychiatrists have each issued guidance on the use of antipsychotics for behavioural and psychiatric symptoms of dementia (BPSD). We sent all old age psychiatrists an anonymous questionnaire asking for their opinions on these documents and for details of their use of antipsychotics for BPSD.

RESULTS

The response rate was 202 out of 648 (31.2%). The two documents, though similar in content provoked very different responses, with the College guidance being much more favourably received. All respondents prescribed antipsychotics for BPSD, most commonly quetiapine.

CLINICAL IMPLICATIONS

When prescribing antipsychotics for behavioural and psychiatric symptoms of dementia, psychiatrists should take both NICE and College guidelines into account and use their clinical judgement.

Individuals with dementia commonly manifest behavioural and psychiatric symptoms of dementia (BPSD) such as aggression, agitation, psychotic symptoms, sleep disturbance and wandering. The off-label use of antipsychotic drugs to treat BPSD is widespread. Studies from around the world have reported that 25–40% of elderly residents in long-term institutional care receive antipsychotics (Hagen *et al*, 2005; Snowdon *et al*, 2005; Alanen *et al*, 2006; Rochan, 2007). A UK survey found 32% of patients in care homes with dementia were prescribed antipsychotics (Alldred *et al*, 2007). In 2004, the Committee on Safety of Medicines warned of the increased risk of cerebrovascular events with risperidone and olanzapine and said these drugs should not be used to treat behavioural problems in older adults with dementia (Committee on Safety of Medicines, 2004). The Royal College of Psychiatrists' Faculty of the Psychiatry of Old Age and other stakeholders responded by issuing guidance laying down good practice guidelines for the use of antipsychotics in the treatment of BPSD (Working Group, 2004). Further guidance from the Royal College of Psychiatrists was later thought necessary due to reports of inappropriate interpretations of the earlier documents, for example patients having their antipsychotics abruptly withdrawn (Royal College of Psychiatrists, 2005). More recently, the National Institute for Health and Clinical Excellence (NICE) has issued a national clinical practice guideline on dementia with firm recommendations about the pharmacological treatment of dementia (National Collaborating Centre for Mental Health, 2007).

original papers

What do old age psychiatrists feel about all this guidance, some of it highly specific and prescriptive? Is it applicable to the real world of everyday National Health Service (NHS) practice? Does it leave enough room for clinicians to exercise their clinical judgement or do psychiatrists feel they have been left without support when they prescribe antipsychotics? We surveyed the views of career old age psychiatrists to see whether or not they considered the most recent Royal College of Psychiatrists' document (forthwith referred to as the RCPsych 2005 guidance) supportive of their practice and the NICE dementia guideline too restrictive. We wanted to know whether any psychiatrists thought antipsychotics should never be used for BPSD. We sought to determine the percentage of patients with BPSD for whom old age psychiatrists prescribe antipsychotics and which drugs they prescribe most frequently.

Method

We talked to a number of old age psychiatrists to determine their views about the two sources of guidance. Although a range of opinions were expressed, the overall feeling was that the RCPsych 2005 guidance struck a better balance over the use of antipsychotics for BPSD than the NICE dementia guideline. Very few psychiatrists were of the opinion that antipsychotics should never be used. We set out to confirm or refute these views in the questionnaire, which was first piloted in our own hospital. In May 2007, after obtaining approval from the College, we sent a single mailing of an anonymous postal questionnaire to the 608 consultants and 40 associate specialists listed by the College as specialising in old age psychiatry. The questionnaire asked respondents to rate on a ten-point scale (1 – strongly agree, 10 – strongly disagree) their agreement/disagreement with the following statements.

1. The NICE guideline on dementia places clinically inappropriate restrictions on the use of antipsychotics in the treatment of BPSD.
2. The RCPsych 2005 guidance *Atypical Antipsychotics and Behavioural and Psychiatric Symptoms of Dementia: Prescribing Update for Old Age Psychiatrists* supports psychiatrists in prescribing antipsychotics for selected cases of BPSD.
3. Antipsychotics should never be prescribed for BPSD.

Respondents were invited to comment on the NICE and the RCPsych 2005 guidance on dementia and to indicate the percentage of their patients with BPSD for whom they prescribe antipsychotics. They were also asked about the clinical circumstances under which they prescribe antipsychotics for BPSD and the three antipsychotics they use most commonly (with dosage ranges). (The questionnaire is available from the corresponding author on request.)

Numerical analyses were conducted using SPSS version 14.0 for Windows. Participants' comments were subjected to qualitative analysis for commonly occurring themes. Two of the authors independently derived a list of topics from the comments and then met to reach a consensus on the major themes.

Results

Of the 648 questionnaires sent out, 207 were returned, of which 202 (31.2%) had been completed. Almost all respondents (176 of 202, 87.1%) worked in NHS community and in-patient settings, 14 (6.9%) worked in NHS community services and most of the rest (n=8, 4.0%) in specialist services.

The majority (130 of 197, 66.0%) of respondents thought the NICE guideline on dementia placed clinically inappropriate restrictions on the use of antipsychotics in the treatment of BPSD. Median score on the scale of 1–10 (1 – strongly agree, 10 – strongly disagree) was 4 (interquartile range IQR=3–7).

Most respondents (154 of 198, 77.8%) thought the RCPsych 2005 guidance supported psychiatrists in prescribing atypical antipsychotics for selected patients with BPSD. Median score on the 1–10 scale (1 – strongly agree, 10 – strongly disagree) was 3 (IQR=2–5).

A total of 162 comments on the NICE guideline on dementia were received: 40 positive (24.7%), 111 negative (68.5%) and 11 in which the respondent had not read or could not recall the guidance (6.8%). Comments fell into several broadly defined themes (Table 1). Of the 135 comments on the RCPsych 2005 guidance, 105 were positive (77.8%), 20 were negative (14.8%) and 10 had not read or could not remember the document (7.4%). Overall, the NICE guideline on dementia was perceived as too restrictive for secondary care, as placing too great an emphasis on the risks of antipsychotics in BPSD and unrealistic given current resources. The RCPsych 2005 guidance was seen as more balanced, practical and useful to justify prescribing decisions.

Almost all respondents (190 of 199, 95.5%) disagreed with the statement that antipsychotics should never be prescribed for patients with any type of dementia. Median score on the 1–10 scale (1 – strongly agree, 10 – strongly disagree) was 10 (IQR=9–10). All respondents reported that they prescribed antipsychotics for BPSD. The median percentage of their patients with BPSD for whom they prescribed antipsychotics was 40% (range 5–90). The most common indications for antipsychotics were: psychosis (93.3%), aggression (89.1%), agitation (72.0%) and sexual disinhibition (50.3%). Other indications included: when other measures (including non-pharmacological ones) had failed, risk of harm to self or others, severe intractable distress and where a patient's placement was at risk. Some emphasised the importance of first trying other measures before antipsychotics, for example antidepressants and non-pharmacological interventions, and the need to balance risks against benefits. Quality of life was also important: 'the angry, distressed, deluded, unhappy patient would not willingly choose to be like that', 'in dementia it is quality of life that is important, not quantity'.

The three most commonly prescribed antipsychotics for BPSD are given in Table 2, together with the median usual dosage ranges. Quetiapine was by far the most

https://doi.org/10.1192/pb.bp.107.017947 Published online by Cambridge University Press

Table 1. NICE and RCPsych guidelines: psychiatrists' comments by the most common themes

	Comments, *n*	Examples of comments
NICE guideline on dementia: positive themes		
Balances the risk and benefits of using antipsychotics	10	'Quite balanced. Does not exclude the use of anti-psychotics in BPSD.'
Antipsychotics only for short-term use in severe BPSD and need to review	7	'Advises caution and regular review. Important to emphasise short-term treatment and regular review.'
Appropriately cautious guidance	7	'They have tried their best. It's right to be careful where potentially serious side-effects are concerned.'
Emphasis on non-pharmacological treatment is good	6	'I agree – other options should be considered before resorting to antipsychotics.'
NICE guideline on dementia: negative themes		
Too restrictive for secondary care	32	'I think we are being asked to treat very difficult patients with an arm tied behind our back.'
Over-emphasises the risks of antipsychotics	19	'Too anti-antipsychotic.'
Unrealistic in very disturbed patients and with lack of resources	17	'Assumes an ideal world of psychological treatment in what is the most under-resourced area of psychiatry.'
Encourages use of typicals that have more side-effects and carry the same or greater risks	14	'The use of older generation drugs has gone up which are no better and in fact are worse.'
Suggests treatments that are not generally available and are not evidence-based	9	'It recommends aromatherapy before antipsychotics! Animal-assisted dance therapy is just laughable.'
RCPsych guidance: positive themes		
Pragmatic, reflects everyday practice	26	'Useful for psychiatrists in their routine clinical practice.'
Balances the risks and benefits of using antipsychotics	19	'Beginning to bring balance into the argument.'
Useful to justify clinical decisions	12	'Supports clinicians in using personal clinical judgement.'
RCPsych guidance: negative themes		
Non-committal and unhelpful	9	'It sits on the fence a bit! Non-committal and not very helpful.'
Needs updating on the risks of antipsychotics	6	'Needs more comprehensive analysis of relevant publications.'
Not realistic	4	'Aromatherapy of little use in the acute situation!'

BPSD, behavioural and psychiatric symptoms of dementia; NICE, National Institute for Health and Clinical Excellence; RCPsych, Royal College of Psychiatrists.

commonly prescribed antipsychotic. Although atypicals were used more often than typicals, haloperidol was the second most popular antipsychotic and several other typicals were also prescribed, albeit less frequently.

Discussion

In this survey of old age psychiatrists, two-thirds of respondents thought the NICE guideline on dementia was too restrictive, whereas over three-quarters felt the RCPsych 2005 guidance supported psychiatrists in prescribing these drugs to individuals with dementia. The NICE guideline provoked a larger number of comments (mostly negative) compared with the RCPsych 2005 guidance which received mostly positive comments. All respondents reported that they prescribed antipsychotics for at least some of their patients with BPSD (on average 40%) and the overwhelming majority disagreed with the

Table 2. Antipsychotics for BPSD: psychiatrists' reports of their three most commonly prescribed antipsychotics and usual dosage range

Antipsychotic	Psychiatrists prescribing the antipsychotic,[1] *n*	Usual daily dosage range (median values), mg
Quetiapine	165	25–150
Haloperidol	89	0.5–2
Risperidone	85	0.5–2
Amisulpride	85	50–150
Olanzapine	64	2.5–10
Sulpiride	23	100–200
Promazine	14	25–150
Trifluoperazine	13	1–4
Aripiprazole	9	5–17.5
Other typical antipsychotics	10	–

BPSD, behavioural and psychiatric symptoms of dementia.

1. Three most commonly prescribed drugs.

https://doi.org/10.1192/pb.bp.107.017947 Published online by Cambridge University Press

original papers

statement that antipsychotics should never be prescribed for BPSD. Quetiapine and haloperidol were the most frequently prescribed antipsychotics.

Limitations

The study has a number of limitations. The response rate to the questionnaire was 31%, which was low (although not unusual for a single mailing of an anonymous questionnaire) and could reflect sample bias. It may be that those psychiatrists who responded were more negative in their attitudes towards the NICE guideline on dementia and/or more frequently prescribed antipsychotics for BPSD. The questions we asked were designed to be provocative but are likely to have introduced bias. Another possible source of bias was the categorisation of comments as either positive or negative and by theme, even though ratings were made independently by two authors.

The fact that quetiapine was the most commonly prescribed antipsychotic is likely to relate to the Committee on Safety of Medicines (2004) alert about risperidone and olanzapine. There is now evidence that the increased risk of death applies to all atypicals (Schneider *et al*, 2005). Several respondents thought the NICE guideline on dementia encourages the prescribing of the older typical drugs. In our survey, haloperidol was very commonly prescribed and some respondents reported using other typicals. Several studies have reported the risk of cerebrovascular events and increased mortality to be similar for typicals and atypicals (e.g. Gill *et al*, 2005; Trifirò *et al*, 2007), with two recent studies reporting a higher risk of death in patients receiving typicals than atypicals (Wang *et al*, 2005; Gill *et al*, 2007). Some respondents pointed out that the increased risk of cerebrovascular events and death with antipsychotics is likely to be a class effect. Evidence of efficacy in BPSD, though limited, is greatest for risperidone and olanzapine, the antipsychotics featured in the Committee of Safety of Medicines alert (Lee *et al*, 2004).

Both the NICE guideline and the RCPsych guidance discuss the use of antipsychotics in BPSD and appear to come to similar conclusions about the use of these drugs in dementia, yet the psychiatrists in our survey perceived the NICE guideline in a much more negative light. This may be due to the following features of the NICE document: its tone ('people with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate non-cognitive symptoms should not be prescribed antipsychotic drugs'), source (large organisation set up by the Government) and content (inclusion of non-pharmacological measures lacking an evidence base, for example animal-assisted therapy and massage). However, NICE has pointed out their guidance is not binding on clinicians, although it should be taken into account when making clinical decisions (Anonymous, 2007). Many old age psychiatrists appear to be troubled by the NICE guideline on dementia, although they feel the RCPsych 2005 guidance goes some way to redressing the imbalance. Of course, there are other treatments for BPSD which should be considered, such as cholinesterase inhibitors for Lewy body dementia, as well as non-pharmacological interventions.

Declaration of interest

None.

References

ALANEN, H.-M., FINNE-SOVERI, H., NORO, A., *et al* (2006) Use of antipsychotic medications among elderly residents in long-term institutional care: a three-year follow-up. *International Journal of Geriatric Psychiatry*, **21**, 288–295.

ALLDRED, D. P., PETTY, D. R., BOWIE, P., *et al* (2007) Antipsychotic prescribing patterns in care homes and relationship with dementia. *Psychiatric Bulletin*, **31**, 329–332.

ANONYMOUS (2007) Lawyers claim 'concession' over prescribing for Alzheimer's. *BMJ*, **335**, 11.

COMMITTEE ON SAFETY OF MEDICINES (2004) *Atypical Anti-psychotic Drugs and Stroke: Message from Gordon Duff, Chairman, Committee on Safety of Medicines (CEM/CMO/ 2004/1).* Medicines and Healthcare Products Regulatory Agency.

GILL, S. S., ROCHON, P. A., HERRMANN, N., *et al* (2005) Atypical antipsychotic drugs and risk of ischaemic stroke: population based retrospective cohort study. *BMJ*, **330**, 445–450.

GILL S. S., BRONSKILL, S. E., NORMAND, S. L. T., *et al* (2007) Antipsychotic drug use and mortality in older adults with dementia. *Annals of Internal Medicine*, **146**, 775–786.

HAGEN, B., ESTHER, C. A., IKUTA, R., *et al* (2005) Antipsychotics drug use in Canadian long-term care facilities: prevalence and patterns following resident relocation. *International Psychogeriatrics*, **17**, 179–193.

LEE, P. E., GILL, S. S., FREEDMAN, M., *et al* (2004) Atypical antipsychotic drugs in the treatment of behvioural and psychological symptoms of dementia: systematic review. *BMJ*, **329**, 75–79.

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH (2006) *Dementia. Supporting People with Dementia and their Carers in Health and Social Care.* NICE (http://www.nice.org.uk/Guidance/CG42).

ROCHAN, P. A., STUKEL, T. A., BRONSKILL, S. E., *et al* (2007) Variations in nursing home antipsychotic prescribing rates. *Archives of Internal Medicine*, **167**, 676–683.

ROYAL COLLEGE OF PSYCHIATRISTS (2005) *Atypical Antipsychotics and Behavioural and Psychiatric Symptoms of Dementia.* Royal College of Psychiatrists (http://www.rcpsych.ac.uk/PDF/BPSD.pdf).

SCHNEIDER, L. S., DAGERMAN, K. S. & INSEL, P. (2005) Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. *JAMA*, **294**, 1934–1943.

SNOWDON, J., DAY, S. & BAKER, W. (2005) Why and how antipsychotic drugs are used in 40 Sydney nursing homes. *International Journal of Geriatric Psychiatry*, **20**, 1146–1152.

TRIFIRÒ, G., VERHAMME, K. M. C., ZIERE, G., *et al* (2007) All-cause mortality associated with atypical and typical antipsychotics in demented outpatients. *Pharmacoepidemiology and Drug Safety*, **16**, 538–544.

WANG, P. S., SCHNEEWEISS, S., AVORN, J., *et al* (2005) Risk of death in elderly users of conventional vs. atypical antipsychotic medications. *New England Journal of Medicine*, **353**, 2335–2341.

WORKING GROUP FOR THE FACULTY OF THE PSYCHIATRY OF OLD AGE OF THE ROYAL COLLEGE OF PSYCHIATRISTS, ROYAL COLLEGE OF GENERAL PRACTITIONERS, BRITISH GERIATRICS SOCIETY & ALZHEIMER'S SOCIETY (2004) Guidance for the management of behavioural and psychiatric symptoms in dementia and the treatment of psychosis in people with history of stroke/TIA. Royal College of Psychiatrists.

***Camilla Haw** Consultant Psychiatrist, St Andrew's Healthcare, Billing Road, Northampton NN1 5DG, email: chaw@standrew.co.uk, **Graeme Yorston** Consultant Old Age Psychiatrist, **Jean Stubbs** Head Pharmacist (retired), St Andrew's Healthcare, Northampton

https://doi.org/10.1192/pb.bp.107.017947 Published online by Cambridge University Press