Factors influencing the prescribing of medications by old age psychiatrists for behavioural and psychological symptoms of dementia: a qualitative study

AMY WOOD-MITCHELL1, IAN ANDREW JAMES1,2, ANNA WATERWORTH1, ALAN SWANN1, CLIVE BALLARD3

1 Northumberland Tyne and Wear NHS Trust, Northumberland, UK
2 Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, Clinical Psychology Services for Older People, UK
3 Institute of Psychiatry, King's College, London, UK

Address correspondence to: Ian Andrew James. Fax (+44) 0191 219 5040; Tel: (+44) 0191 256 3436.
Email: ianjamesncht@yahoo.com

Abstract

Background: despite evidence of limited efficacy, psychotropic medications are widely used as a first line treatment for those with behavioural and psychological symptoms of dementia (BPSD). Clearly various factors must be influencing their continued use; these are explored here.

Aims: to examine the process by which consultant old age psychiatrists prescribe for BPSD and explore the factors that influence their decisions.

Method: a focus group generated initial questions for interviews with eight consultant old age psychiatrists, using a grounded theory methodology.

Results: differences in how assessment information was utilised resulted in inconsistencies in choice of medication between psychiatrists. Psychiatrists felt pressured to prescribe, largely due to resource issues and lack of viable alternative treatments.

Conclusion: the ways in which psychiatrists prescribe for BPSD varies amongst clinicians. Guidelines do exist, but are difficult to implement in practice. Alternative non-pharmacological strategies are required, but as yet they are difficult to access and have a questionable evidence base.

Keywords: neuroleptics, antipsychotics, challenging behaviour, care homes, qualitative

Introduction

Despite limited efficacy and problematic side effects, various medications such as neuroleptics, antidepressants, benzodiazepines, mood stabilizers are used in the treatment of behavioural and psychological symptoms of dementia (BPSD) [1, 2]. The situation is well illustrated with the use of neuroleptics, which are widely regarded as the first line pharmacological approach [1]. Eight randomised placebo-controlled trials with typical neuroleptics [3] and 18 placebo-controlled trials with atypical neuroleptics [4–6] have examined the efficacy of atypical neuroleptics over 6–12 weeks in people with Alzheimer’s disease (AD). The strongest evidence base is for risperidone, where there are five published trials indicating a modest but significant diminution in aggression compared to placebo, with a larger effect size at 2 mg/day, but limited evidence of benefit for other symptoms, such as non-aggressive agitation and psychosis [4–6]. However, the beneficial effects must be weighed against the short- and long-term adverse effects which, according to meta-analyses, include parkinsonism, sedation, oedema, chest infections, cognitive deterioration, stroke (OR 2.5–3) and mortality (OR 1.5–1.7) [2–11]. Most practice guidelines thus recommend non-pharmacological approaches as the first line treatment for BPSD [12]. Unfortunately this is far removed from the reality of clinical practice, and a better understanding of the prescribing process is needed to enable the implementation of guidance from regulatory agencies.

Participants and methods

Grounded theory [13] was used to determine why psychiatrists continue to prescribe psychotropics for BPSD. Two phases were employed:
Phase 1. A focus group was conducted in order to produce the main research question, and to discuss some of the main themes to address in the first interview. The focus group consisted of five consultant psychiatrists specialising in older adults. They were recruited opportunistically following a departmental meeting. These psychiatrists were not involved in phase two.

Phase 2. Twelve consultant psychiatrists based in north-east England (two per locality within the region) were posted information about the study and asked to participate; eight were subsequently interviewed. The participants worked in inpatient units and community-care settings; three were female and five were male. The interviews took place in four hospital settings. The interviewers were junior psychologists (AW and AWM) and provided a service different to the interviewees; thus the professional relationships between the dyads were minimal. The study was registered, and sanctioned, by Northumberland, Tyne and Wear NHS Trust Research and Development Department as a service improvement project.

The instruction given to each psychiatrist at the beginning of his/her interview was: This semi-structured interview will focus on the following question: ‘In what situations would you prescribe psychotropic medications for BPSD, and what factors would influence this decision?’

Data collection and analysis

Audio-taped interviews were conducted, which lasted between 30 and 60 min. In accordance with a Grounded Theory methodology, the interview transcripts were examined to identify concepts, which were then refined in terms of their properties and dimensions. Transcripts were scrutinised and ‘meaning units’ were identified [14]. Meaning units were made up of words, statements or sentences that described a single phenomenon. Descriptive category labels were then given, either based on the words used by the participants (in vivo codes), or from the researchers’ theoretical knowledge. These category labels are presented in the results section.

Results

Data is presented in terms of the four main stages in the treatment process (referral and assessment process, decision making, choice of medication, choice of alternative to medication) and examples of the influential factors are given (see Table 1).

Referral and assessment process

Participants thought there were a number of factors influencing referral practices. The most obvious factor was the presence of a BPSD (see Table 1, section A). Of note, a number of participants had an issue with regard to the concept of BPSD, believing it to be too broad. Owing to the use of such a poorly defined term, the psychiatrists believed that many ‘unusual’ behaviours could potentially be labelled as BPSD, thus meaning people missed the real cause of the behaviour (e.g. pain). Many participants also thought that high numbers of BPSD referrals stemmed from a dearth of adequate services for older adults. Some felt this was due to an over-reliance on medication by medical professionals (general practitioners and psychiatrists) and care home staff. A number of participants thought that the development of non-pharmacological treatments was being impeded, because using the medical model was seen as potentially a ‘quick-fix’ and a cheaper option. Other participants believed that government policies, such as the National Service Framework for Older People lacked innovation due to inadequate resourcing for new services. Many participants felt that ageist attitudes were the root cause of many of these issues arising and being maintained.

The nature of care settings was viewed as important, with participants feeling that challenging behaviours were often the result of poorly designed homes, low staffing levels, under-stimulating environments, inadequate staff training and a lack of governance. In addition, the participants felt that there were also different referral thresholds across the private-care settings. For example, some participants felt that certain homes coped better than others with problematic behaviours and one thought it depended on whether ‘beds needed to be filled’.

The nature and source of the referral guided decisions about how to intervene. The participants gave particular weight to: who the referral was from and what they were requesting; what the problem was; what medication the patient was already on; and the location of the patient (i.e. home/in care/hospital—see Table 1, section A).

Participants were fairly consistent in the factors they felt should be addressed through assessment. For example, they felt that an assessment should take into account mental health issues (such as depression, psychosis), the underlying aetiology, the type and stage of dementia, as well as the level of cognitive impairment. They also thought that a description of the behavioural symptoms should be ascertained, including frequency and severity of behaviours. In addition, participants considered physical indicators ought to be examined, such as constipation or a urinary tract infection, and other sources of pain. Historical information was seen to be important, particularly information about the patient’s life history, medical and psychiatric history. Many participants also felt the emotions and thoughts of the patients should be addressed, where it was possible to do so. Within this assessment also came an acknowledgement of the patient’s environment, including staff approaches and the physical environment of the care setting. This set of features is consistent with the guidelines outlined by National Institute for Health and Clinical Excellence (NICE) [15].

Assessment involved gathering information from a variety of sources, e.g. notes (medical, psychiatric, care setting); speaking to those involved (care staff, family, other services) and speaking to the patient. However, participants varied in the amount and diversity of information they actually
Factors influencing the prescribing of medications in old age

Table 1. Quotes from interviews with psychiatrists

A. Influences on Referrals and Assessment

Concept of BPSD
P7: '... I think there’s a tendency to just to say well if someone has a dementia then the symptoms they’re presenting with are just down to BPSD, it’s a homogenous condition, where I’ve never believed that is the case. It almost seduces you to practice rather sloppy psychiatry...'

Nature of care settings
P5: '... they’re put in an environment that is crap, the patient reacts to the crap environment and society’s response is to get the psychiatrist involved—who is then told to give them an environmental intervention'.
P6: '... I think that at all levels homes are dealing with a greater level of illness and disturbance than they were designed for. ...'
P7: 'Yeah, the difficulty is, you know, there are good homes and bad homes, and often staff, both in terms of numbers of staff and their quality, are very poor...'
P2: 'I’ve got another EMI home which is absolutely useless for considering challenging behaviour... they just want medication'.

Ageism and societal influences
P5: 'So an external solution feels very wrong and it is essentially a bit ageist isn’t it? I mean kids in children’s homes don’t get medicated when they misbehave'.
P5: 'I think there’s an ageist agenda that leads to behavioural problems and then there’s almost a sense that we should be specialist in Older Age Psychiatry services to sort the current climate, but that’s very difficult'.

Government policies
P8: 'The NSF wasn’t really very innovative. I suppose this reflects that older persons services not really being at the forefront of people’s thinking'.

Money
P8: 'If you go to do some work with proper challenging behaviour then it’s a lot of man power sort of observation, managing, coming back and checking, education for the staff and in some ways when resources are limited it’s actually cheaper to just get me in, prescribe some medication for somebody'.
P5: 'These places are there to make money. If they’ve got beds they need to be filled, they’ll put up with people knocking lumps out of staff...'

B. Influences on the Decision-Making Process

Pressure to prescribe
P1: '... depending on which home you go to, there’s probably a bit of pressure to do something...'
P2: 'It’s actually quite difficult sometimes to say to staff ‘well I’m not gonna give you any medication’ cos generally speaking that’s what people are expecting...'
P3: 'But I think it would also be wrong to say that you don’t have pressure from nurses, care home staff and families to prescribe as well'.

Personal influences
P1: 'But a lot of people with dementia don’t necessarily present typically and I think that’s where you need your individual clinical skills or previous experience'.
P5: 'I think its pragmatism. It’s what is possible in this situation'.

Security of placement in a care setting
P2: '... I wouldn’t be thinking about prescribing medication unless it was a situation that was imminently at risk of breakdown in which case I might consider some psychotropic medication...'
P5: '... so the pragmatic choice the patients has got is... do they move, or do you try to maintain the situation as it is.'

Risk-benefit ratio
P3: 'Not in a scientific way, we’ve looked at that as a group of consultants, and said ‘is there any way we can quantify the risk-benefit’? And the answer to that is, there isn’t, so it’s very individualised.'
P5: 'The risks are often about others getting hit. So the threshold at which you give them medication is often a point where there’s immediate real danger to other people.'

Availability of alternatives
P8: 'But if we haven’t got the alternative services to offer that team, then it tends to all slip back to prescribing. '
P2: '... I could go to a nursing home and say “I’m not going to give you a prescription today but challenging behaviour team will be in touch next week.”'

C. Influences on Choices of Medication/Dose

Familiarity of drug
P2: '... it’s a lot about previous experience in there; I mean mirtazapine is quite nice because as far as I’m aware it doesn’t kill anyone, or give them strokes or anything.'
P1: 'We all get used to a certain small group of drugs that we use and that’s probably a good thing'.

Side-effect profile and risk
P8: '... what you’re doing is making a decision based on the side-effect profile'.
P4: '... the risk of any sort of sedative medication in terms of falls'.

(continued overleaf)
collected. They also identified a number of pitfalls in the assessment process. For example, they felt that information was often inconsistent, due to the number of sources from which it was obtained. It was also very subjective and the use of rating scales was either minimal or absent.

**Decision-making process**

Participants used assessment information to inform prescribing decisions (see Table 1, section B). However, the way in which the information was utilised varied greatly across participants. For instance, all participants felt strongly that there was pressure to prescribe. They considered this pressure was evident across settings, though varied in intensity. Psychiatrists thought the pressure from staff to prescribe was greatest in private-care settings and was dependent on the behaviour being exhibited, e.g. more pressure to control aggressive behaviours with medication.

The availability of alternatives to medication influenced decisions. Those participants working in a service with a ‘quick response’ Challenging Behaviour Team said they could often delay prescribing. However, psychiatrists often felt they had little option but to prescribe if the situation was urgent, or if the placement was at risk. Accordingly, some participants said that they would weigh the risk of prescribing a medication, with the risks of moving the person to a new care environment. All participants thought...
that they were more aware of the risks of medication than previously, partly because of the introduction of the Crosswalk Student Ministry (CSM) guidelines [7]. Factors personal to the participants played a role in the decision-making process. For example, some talked of ‘intuition’ and another stated that he had become more ‘pragmatic’, meaning his prescribing had increased.

**Choice of the ‘right’ medication**

If a psychiatrist made the decision to prescribe a medication for a patient with BPSD, he had to further decide which class of medication, which medication within that class, and what dose. Although decision-making process was broadly similar, the resultant prescriptions varied greatly (see Table 1, section C). In most cases, choice of medication was based on familiarity and past experience of a drug. Participants used a small group of medications that they knew well, although there were some common ‘preferred’ medications, such as mirtazapine and citalopram as antidepressants. Often the side-effect profile was influential in choosing a medication within a particular class.

The location of the patient was also influential. For example, some participants would only prescribe ‘as required’ (prn) medications in certain settings as they were wary of how it would be used. Participants often liaised with colleagues and other professionals about which medications to use, asking for advice on drugs and dosages.

The influence of the evidence base on the choice of medication had a varying effect on participants. This was often dependent on their own exposure to, and awareness of, the evidence. However, participants also took into account whether research findings appeared to fit with their own findings from clinical practice. They usually supported their own results when there were discrepancies. In general, participants often felt powerless to implement the findings from research, particularly in circumstances where they believed there was no alternative to offer.

Therefore, the choice of medication varied greatly, and many psychiatrists were aware that their prescribing was ‘off-license’. However, participants also varied in terms of monitoring the effects of their prescribing. Thus they varied in the use of home visits, telephone calls, ward rounds or referrals to a community psychiatric nurse. However, all felt they had limited resources to help them monitor. Participants were also aware that placebo effects played a role in the use of medication and some felt they would try a medication even if they were unsure of the cause of the behaviour.

Therefore, the evidence base had a limited effect on the choice of medication. What was more influential was past experience of a drug, although guidelines such as CSM [7] were taken into account.

**Choice of an alternative to medication**

If psychiatrists made the decision not to prescribe, this would often be in order to ‘buy time’ to allow for the possibility of spontaneous recovery (see Table 1, section D). During such a period many would simply engage in a period of watchful waiting, i.e. schedule a future appointment. However, some psychiatrists referred to other services (e.g. community psychiatric nurses, psychology, occupational therapists, challenging behaviour teams) with the intention of conducting more detailed assessments and/or intervening non-pharmacologically.

There was also variability in the non-pharmacological approaches that the psychiatrists themselves would engage. Frequently, they took the form of discussions with staff in order to ‘normalise’ behaviours. They would also make suggestions to carers, and educate them about the nature of dementia. Some psychiatrists would offer recommendations for environmental change, such as moving a resident’s room. All participants felt that non-pharmacological interventions could reduce ‘challenging behaviours’. Nevertheless, they felt these approaches were often time consuming and there was a lack of resources to conduct the interventions. Some participants also felt that the suitability of psychosocial interventions depended on the location of the patient, with some homes likely to be resistant.

There was a general sense that participants were unsure as to the nature and range of non-pharmacological approaches. One participant questioned the evidence base of non-pharmacological approaches, believing that placebo effects often played a role in any change made. There seemed to be a number of factors that limited the use of non-pharmacological approaches, largely a lack of resources and difficulties in implementation. Psychiatrists thus often felt powerless to address BPSD non-pharmacologically.

**Discussion**

Despite guidelines promoting the use of non-pharmacological approaches, the prescribing of psychotropic medications is high for BPSD in dementia. The results suggest there are a number of reasons for this deviation from clinical guidance, external to the patients and their behaviours. The most striking finding of the study is the lack of consistency in prescribing amongst psychiatrists. This appeared to be due to the sheer number of factors influencing a psychiatrist’s decision to prescribe and the consequent choice of medication. However, the main influential factor appeared to be a lack of viable alternatives. Psychiatrists often felt pressured to ‘do something’ and believed that in many cases non-pharmacological approaches were not feasible due to a lack of resources, time constraints and difficulties in implementation. More generally, the participants thought there was a poor value base with respect to this clinical area and this was probably due to society’s negative attitude towards age and ageing. Consequently, participants felt they had little option but to prescribe. They believed that in order to reduce prescribing for this group, issues had to be addressed, particularly the nature and culture of care settings and the availability and feasibility of non-pharmacological interventions [16].
A. Wood-Mitchell et al.

Limitations and future research

It was felt that a qualitative approach was required, due to the exploratory nature of the research. However, the specific approach has limited the generalizability of the findings due to both the small sample size and the fact that the participants were recruited exclusively from northeast England. It is relevant to note, however, that the eight psychiatrists recruited exceeded the minimum criterion for the methodology and generated data that achieved saturation, with no new themes emerging after the seventh interview. Despite limitations, the study will assist in the future development of a model or algorithm to aid prescribing [2]. This is particularly relevant following the recent calls made for more efficient prescribing of drugs within the NHS [1]. An algorithm of this kind would also help to iron out inconsistencies in prescribing and further guide psychiatrists and GPs to make better use of suitable non-pharmacological alternatives.

Key points

What is already known on this topic
• The use of psychotropic medications for BPSD in the United Kingdom is high, and prescribing of these medications is increasing.
• Recent guidelines suggest that in most cases neuroleptics should be used secondary to non-pharmacological strategies.

What this study adds
• Psychiatrists think that there are pressures on them to prescribe, although where alternatives are available this alleviates pressure.
• Psychiatrists believe there is a lack of feasible alternatives to prescribing.
• Psychiatrists feel that societal and systemic influences maintain high prescribing rates.
• There are inconsistencies in the process by which psychiatrists prescribe. Whilst guidelines exist, psychiatrists feel in many cases they are unable to be implemented.
• The care homes are not designed, nor their staff trained, to deal adequately with residents’ problematic behaviours.

Conflict of interest

None

References


Received 8 November 2007; accepted in revised form 26 February 2008