Psychotropic drug prescribing in residential aged care homes

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Individualised psychosocial interventions are needed as alternatives to pharmacological sedation

Sedating psychotropic drugs, including antipsychotics and benzodiazepines, are commonly prescribed in residential aged care facilities (RACFs), despite extensive evidence of their limited efficacy for treating behavioural and psychological symptoms in older people and of their potential for eliciting serious adverse effects, including death.[1] As a consequence, efforts are afoot in many countries to minimise the use of these medications in RACFs. In this issue of the *MJA*, Westbury and colleagues[2] report findings from the RedUSe study of a multi-component intervention designed to reduce the prescribing of sedative medications in Australian RACFs. This uncontrolled investigation employed four complementary interventions in 150 nursing homes: psychotropic medication audits by a local champion nurse; RACF staff education sessions conducted by a pharmacist using benchmarked local data and incorporating training in non-pharmacological interventions; interdisciplinary prescribing reviews for each RACF resident; and academic detailing for prescribers. This intervention sequence was repeated twice, 3 months apart. Data for 12 157 RACF residents collected at baseline, 3 months and 6 months indicated that prescribing of antipsychotics and benzodiazepine had decreased significantly following the intervention: the prevalence of antipsychotic use dropped from 21.6% of residents at baseline to 18.9% at 6 months, and that of benzodiazepines from 22.2% to 17.6%. For 39% of RACF residents taking antipsychotics or benzodiazepines at baseline, medication was ceased or the dosage reduced at 6 months.

The importance of the RedUSe study is that it demonstrates the feasibility of the large scale implementation of a relatively straightforward intervention for reducing potentially inappropriate prescribing of sedatives in RACFs. It improves on previous work by not excluding residents in generic nursing homes prescribed psychotropic medication for psychiatric indications, and by examining benzodiazepines as well as antipsychotics. The investigators included RACF residents with and without dementia. The RedUSe study nevertheless has some limitations. The contribution of each of the four components of the intervention to reducing psychotropic use was not examined, so it is unclear whether all are needed. The proportions of RACF staff who participated in the educational sessions and of prescribers who took up the offer of academic detailing were not reported, nor the extent to which non-pharmacological interventions were implemented. Further, we await with interest the clinical findings and economic analyses of the RedUSe study, as these could be critical to its national implementation.

As previous research has found mixed clinical outcomes following antipsychotic cessation in people with dementia,[3,4] the results from a recent cluster randomised, factorial controlled trial conducted in people with dementia are instructive.[5] This study applied four interventions in 16 United Kingdom nursing homes (277 participating residents): person-centred care, antipsychotic review, social interaction with pleasant activities, and exercise. There was a 50% reduction in antipsychotic use following antipsychotic review; this was, however, associated with an increase in neuropsychiatric symptoms, which were mitigated by exercise and social interaction with pleasant activities. These findings suggest that there are prudent limits to reducing antipsychotic prescribing, at least for RACF residents with dementia, and that substitution of non-pharmacological interventions is important. Less is known about benzodiazepine cessation in this setting.

Prescribing practices are just one of several factors relevant to managing problematic behaviour in RACFs. In the current model of residential aged care, care is often highly task-focused rather than individualised and flexible. Floor space in some facilities is insufficient to allow the free circulation of residents or to minimise the risk of inadvertent close physical encounters that can lead to aggressive behaviour and falls. Some facilities do not provide residents with ready access to outdoor areas for expressing motor overactivity, or to sunlight that would help maintain normal sleep–wake cycles. Personal care staff often receive scant training in non-pharmacological management techniques and only limited supervision by registered nurses.

As a consequence, a major challenge in Australia is providing access to individually tailored, non-pharmacological interventions for RACF residents with problematic behaviour. Resources need to be redirected and the greater cost of high quality individualised care acknowledged. Psychosocial interventions should be provided in a prosthetic environment that recognises the functional losses experienced by RACF residents, particularly those with dementia. There is increasing evidence for the efficacy of

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non-pharmacological interventions, including a range of low cost sensory and psychosocial practices and structured care protocols, for managing behavioural and psychological symptoms in people with dementia.[6]

For the small number of RACF residents with dementia complicated by severe agitation, aggression, or psychosis who cannot be humanely managed in conventional RACF environments, providing purpose-built sub-acute care facilities would be optimal. Despite their limitations, the alternative is worse: keeping severely agitated people with dementia in acute hospital settings that are quite inappropriate for their needs.

While waiting for sorely needed improvements to the Australian model of RACF care and the provision of appropriate sub-acute care facilities, some help is available. It varies in quality and accessibility, but includes local public sector mental health services for older people, the Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Teams (SBRT). For people with dementia and their families, Dementia Australia (previously Alzheimer's Australia; www.dementia.com.au) provides additional services, including telephone counselling, support groups and educational sessions.

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