Market Research Report

Antipsychotics in Dementia Study

Prepared for Gerry Northam, BBC

June 2008

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Demographics

Decade qualified	N	%
1960s	11	3%
1970s	99	28%
1980s	162	46%
1990s	65	18%
2000s	18	5%
Base	**355**	

Position	N	%
Locum	15	4%
GP Assistant	14	4%
GP Registrar	7	2%
GP Partner	319	90%
Base	**355**	

NHS region	N	%
Eastern	33	9%
London	33	9%
North West	35	10%
Northern & Yorkshire	46	13%
Northern Ireland	12	3%
Other	5	1%
Scotland	30	8%
South East	52	15%
South West	34	10%
Trent	25	7%
Wales	12	3%
West Midlands	38	11%
Base	**355**	

Commitment	N	%
Full time	306	86%
Part time	49	14%
Base	**355**	

Gender	N	%
Male	280	79%
Female	75	21%
Base	**355**	

Fieldwork:

Started: 30-05-08

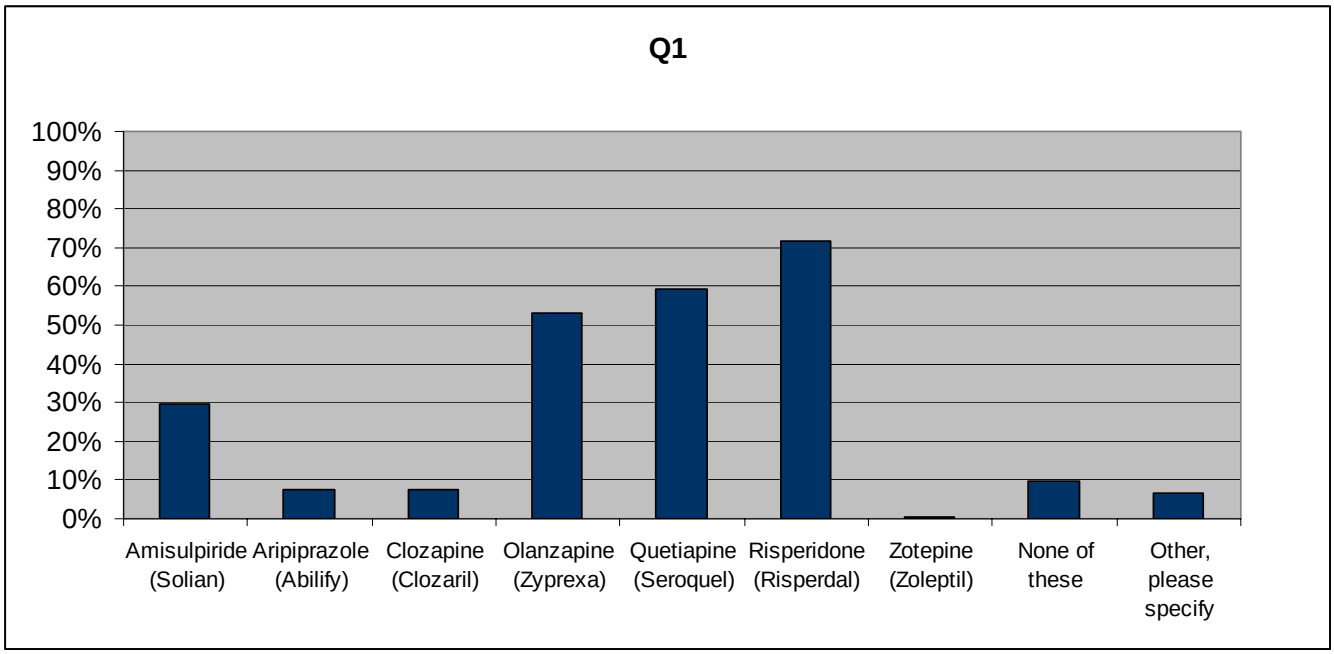
Finished: 04-06-08

Sample: 355 GPs

Q1. Which of the following antipsychotic drugs, if any, have you prescribed for elderly patients suffering from dementia in the last 4 years? (Select all that apply)

	Total	
Q1.	**N**	**%**
Amisulpiride (Solian)	105	30%
Aripiprazole (Abilify)	27	8%
Clozapine (Clozaril)	26	7%
Olanzapine (Zyprexa)	188	53%
Quetiapine (Seroquel)	210	59%
Risperidone (Risperdal)	254	72%
Zotepine (Zoleptil)	2	1%
None of these	34	10%
Other, please specify	23	6%
Base	**355**	

Q1. Other, please specify - Coded Responses	**N**	**%**
Haloperidol	13	4%
Promazine	6	2%
Chlorpromazine	5	1%
Donezepil	1	0%
Galantamine	1	0%
Pericyazine	1	0%
Rivastigmine	1	0%
Base	**355**	



(All respondents indicating other option(s) rather than “None of these” at Q1, other respondents go to Q3)

Q2. For approximately what proportion of elderly patients suffering dementia have you prescribed antipsychotic medication in the last year? (Please give a number)

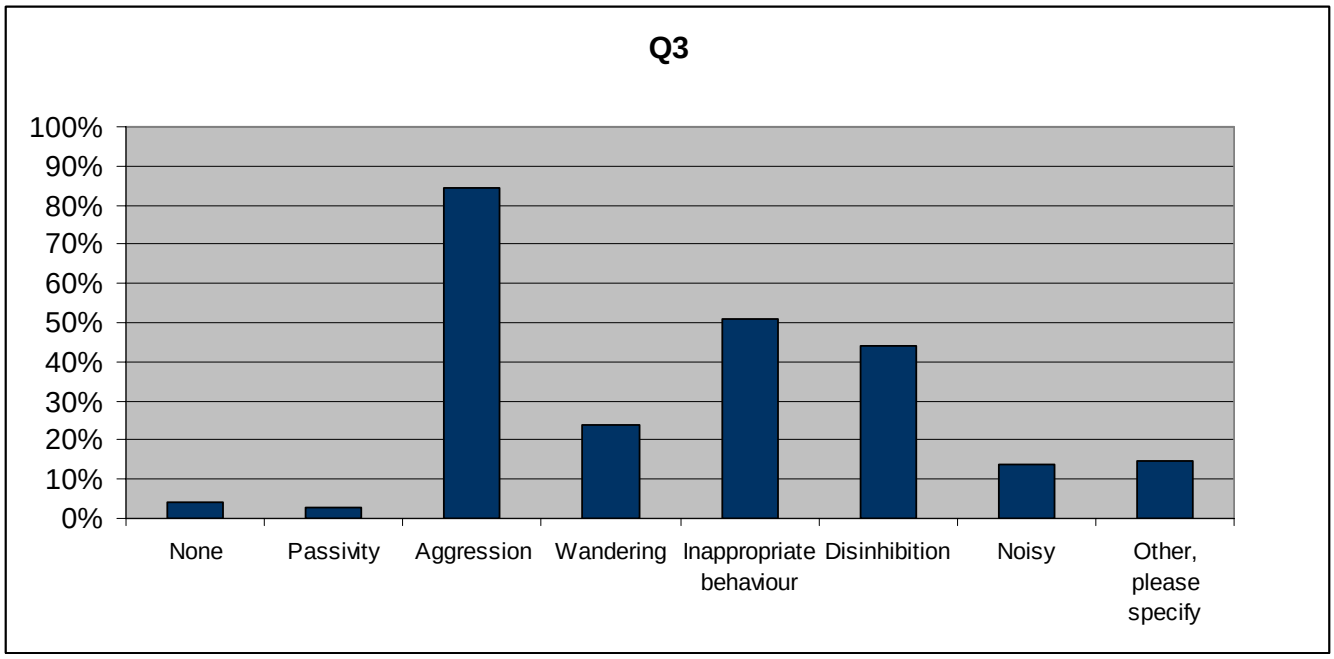
Q2.	**N**
Mean	15.7%
Range	0 – 90%
Base	**321**

Q3. What symptoms or behaviour would prompt you to prescribe antipsychotic medication for an elderly patient suffering dementia? (Select all that apply)

	Total	
Q3.	**N**	**%**
None	15	4%
Passivity	9	3%
Aggression	299	84%
Wandering	84	24%
Inappropriate behaviour	180	51%
Disinhibition	157	44%
Noisy	49	14%
Other, please specify	52	15%
Base	**355**	

Q3. Other, please specify - Coded Responses	**N**	**%**
At consultant/psychiatrist suggestion	16	5%
Distress/upsetting for family and/or staff	12	3%
Agitation	9	3%
Signs and symptoms of "psychosis"	8	2%
Hallucinations	6	2%
Anxiety	2	1%
Sleep cycle disturbance	1	0%
Delusional states	1	0%
Paraphrenia	1	0%
Insomnia	1	0%
Memory deficit interfering with independent living	1	0%
Depends on the context	1	0%
Evidence of thought disorder	1	0%
Now wouldn’t use at all - but in past have used	1	0%
Base	**355**	

Q3. What symptoms or behaviour would prompt you to prescribe antipsychotic medication for an elderly patient suffering dementia? (Select all that apply) Cont…



(All respondents indicating other option(s) rather than “None of these” at Q1, other respondents go to Q7)

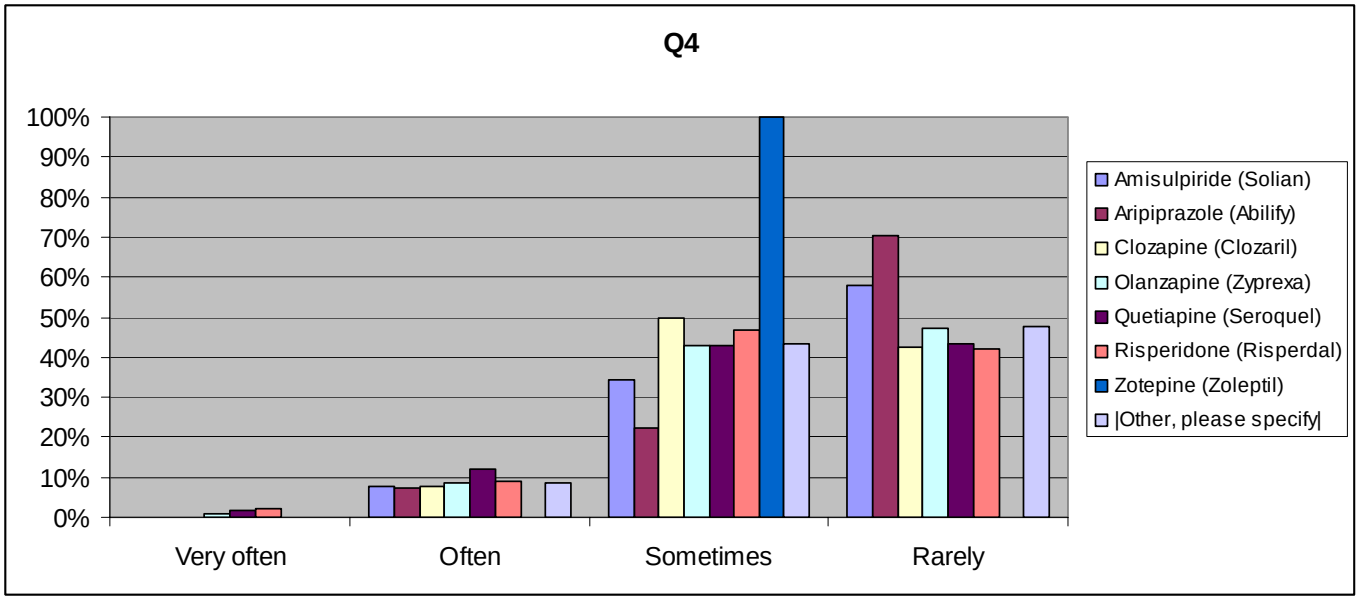
Q4. In the past 4 years, how frequently have you prescribed the following antipsychotic drugs for elderly patients suffering dementia?

Cross tabulation Q1 vs. Q4

Q4.	Very often		Often		Sometimes		Rarely		Base
	N	%	N	%	N	%	N	%	N
Amisulpiride (Solian)	0	0%	8	8%	36	34%	61	58%	**105**
Aripiprazole (Abilify)	0	0%	2	7%	6	22%	19	70%	**27**
Clozapine (Clozaril)	0	0%	2	8%	13	50%	11	42%	**26**
Olanzapine (Zyprexa)	2	1%	16	9%	81	43%	89	47%	**188**
Quetiapine (Seroquel)	4	2%	25	12%	90	43%	91	43%	**210**
Risperidone (Risperdal)	5	2%	23	9%	119	47%	107	42%	**254**
Zotepine (Zoleptil)	0	0%	0	0%	2	100%	0	0%	**2**
Other, please specify	0	0%	2	9%	10	43%	11	48%	**23**

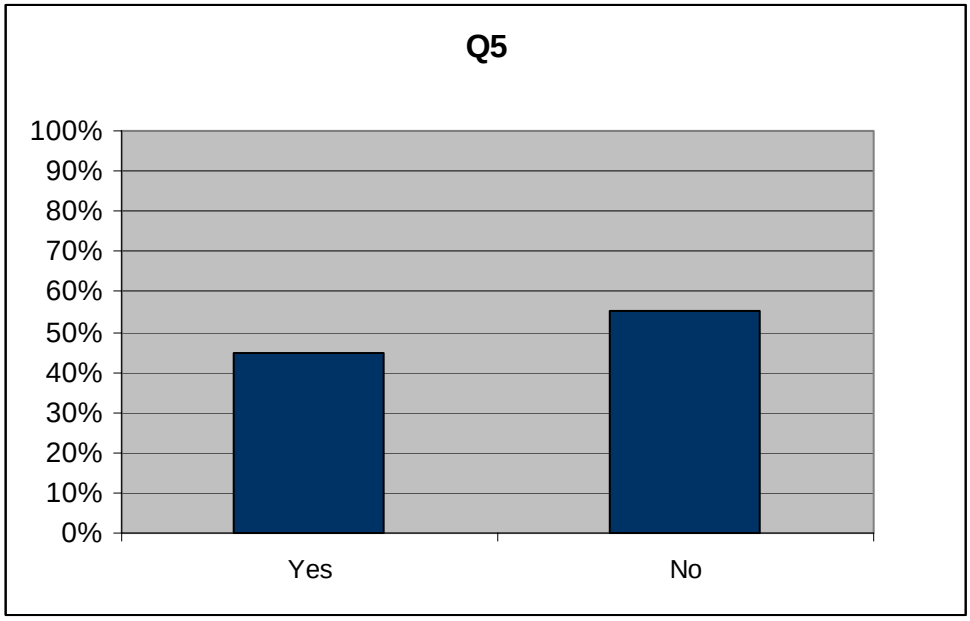
Q1. Other, please specify - Verbatim Responses	Q4.
Chlorpromazine	Rarely
Chlorpromazine	Sometimes
Chlorpromazine	Rarely
Chlorpromazine, promazine	Rarely
Chlorpromazine, promazine, haloperidol	Sometimes
Donezepil	Sometimes
Galantamine	Rarely
Haloperidol	Sometimes
Haloperidol	Often
Haloperidol	Rarely
Haloperidol	Rarely
Haloperidol	Rarely
Haloperidol	Sometimes
Haloperidol	Rarely
Haloperidol	Sometimes
Haloperidol	Rarely
Haloperidol	Sometimes
Haloperidol, promazine	Often
Pericyazine	Rarely
Promazine	Sometimes
Promazine	Rarely
Promazine, haloperidol	Sometimes
Rivastigmine	Sometimes
Base	**23**

Q4. In the past 4 years, how frequently have you prescribed the following antipsychotic drugs for elderly patients suffering dementia? Cont…



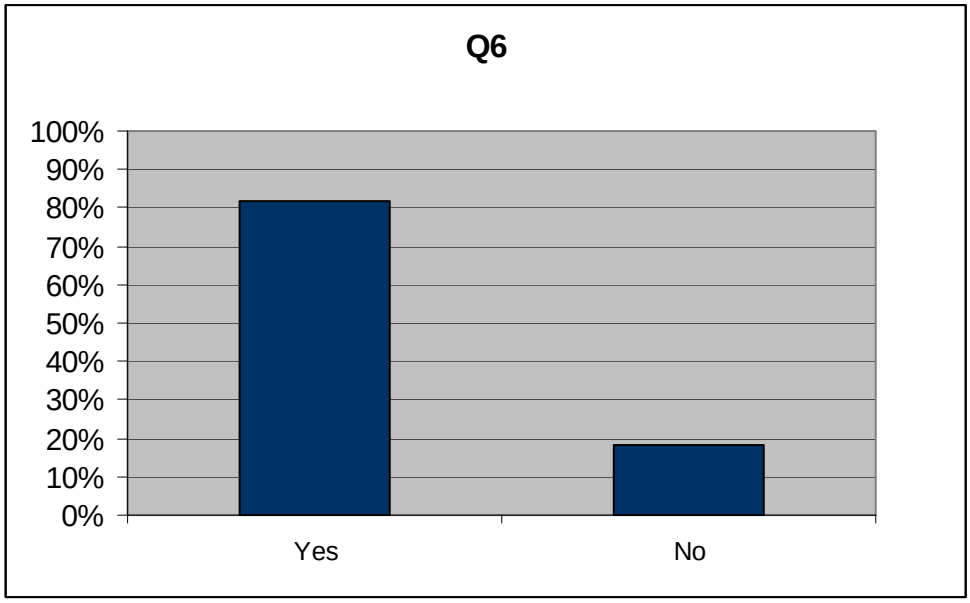
Q5. Do you ever prescribe antipsychotic medication for an elderly patient suffering dementia on a PRN basis, to be administered as needed?

	Total	
Q5.	**N**	**%**
Yes	144	45%
No	177	55%
Base	**321**	



Q6. Do you ensure that close relatives of an elderly patient suffering dementia are informed about antipsychotic medication when it is prescribed?

	Total	
Q6.	**N**	**%**
Yes	263	82%
No	58	18%
Base	**321**	



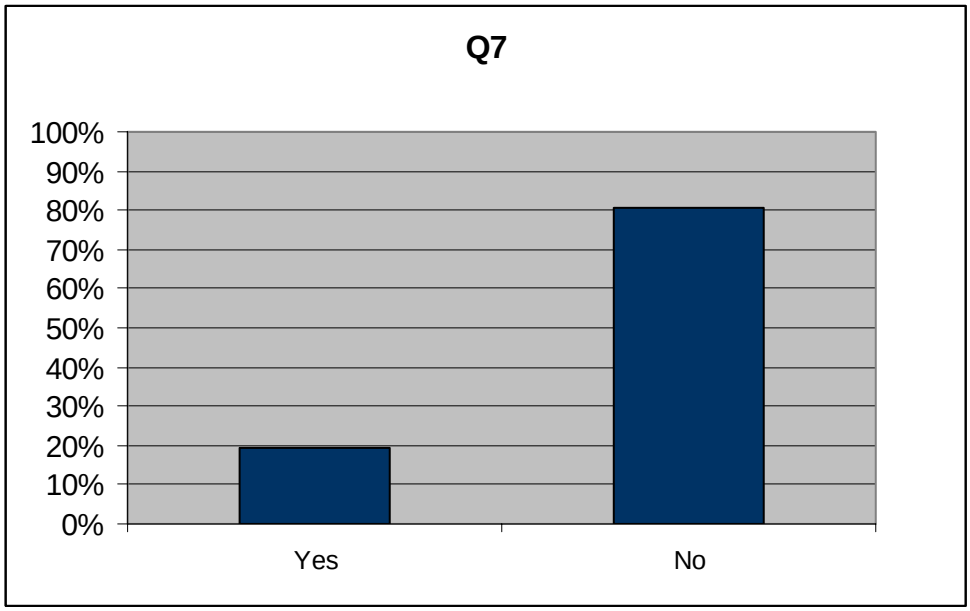
(All respondents indicating “Yes” at Q6, other respondents go to Q7)

Q6a. How do you ensure that close relatives of an elderly patient suffering from dementia are informed about antipsychotic medication when it is prescribed?

Q6a. Coded Responses	**N**	**%**
Speak to relatives directly	215	82%
Via nursing home/carers to relatives	35	13%
Speak to nursing home carers	17	6%
Via specialist who initiates it	16	6%
Discuss side effects	7	3%
Via information leaflet	6	2%
Inform by letter	2	1%
Advice from CPN	1	0%
Ask pt permission to discuss with relatives	1	0%
Base	**263**	

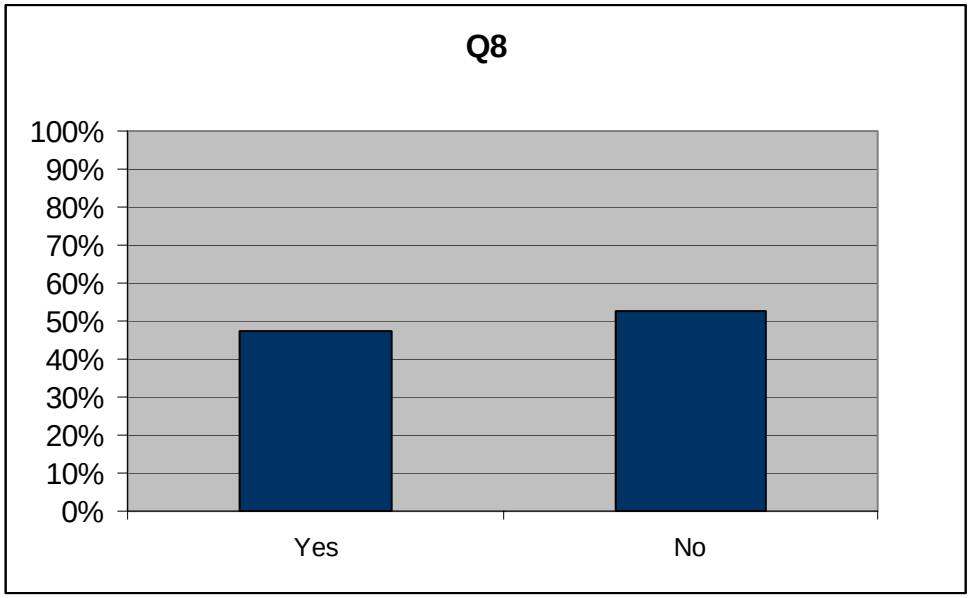
Q7. Do you know of cases where antipsychotic medication has been administered covertly after an elderly patient suffering dementia has declined to take it?

	Total	
Q7.	**N**	**%**
Yes	68	19%
No	287	81%
Base	**355**	



Q8. In your opinion, should antipsychotic medication for elderly patients suffering from dementia be discontinued after a fixed period of time?

	Total	
Q8.	**N**	**%**
Yes	168	47%
No	187	53%
Base	**355**	

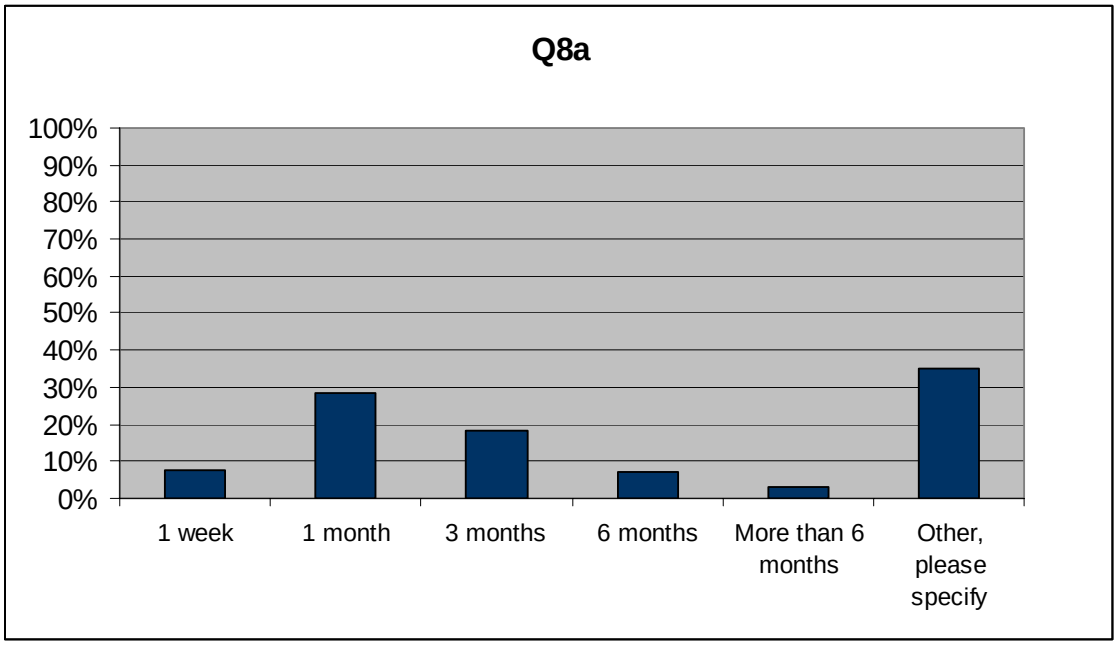


(All respondents indicating “Yes” at Q8, other respondents go to Q9)

Q8a. For how long should antipsychotic medication be used in elderly patients suffering from dementia?

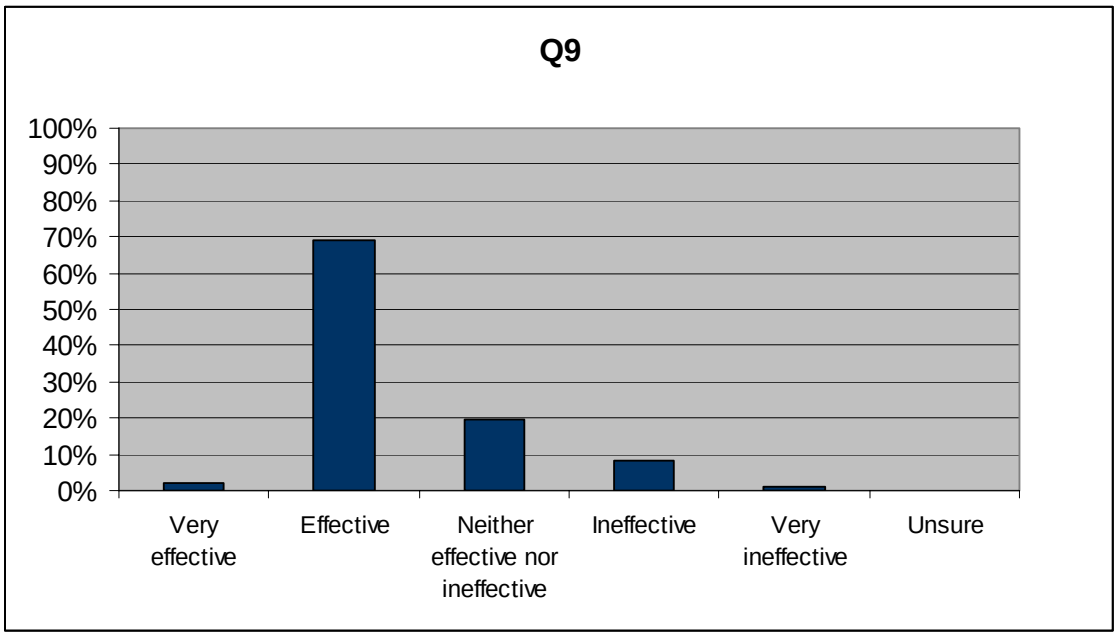
	Total	
Q8a.	**N**	**%**
1 week	13	8%
1 month	48	29%
3 months	31	18%
6 months	12	7%
More than 6 months	5	3%
Other, please specify	59	35%
Base	**168**	

Q8a. Other, please specify - Coded Responses	**N**	**%**
Depends on circumstances	41	24%
As short as possible	6	4%
Never	3	2%
As long as necessary	2	1%
Less than 2 weeks	1	1%
3 weeks	1	1%
1-6 weeks	1	1%
Base	**168**	



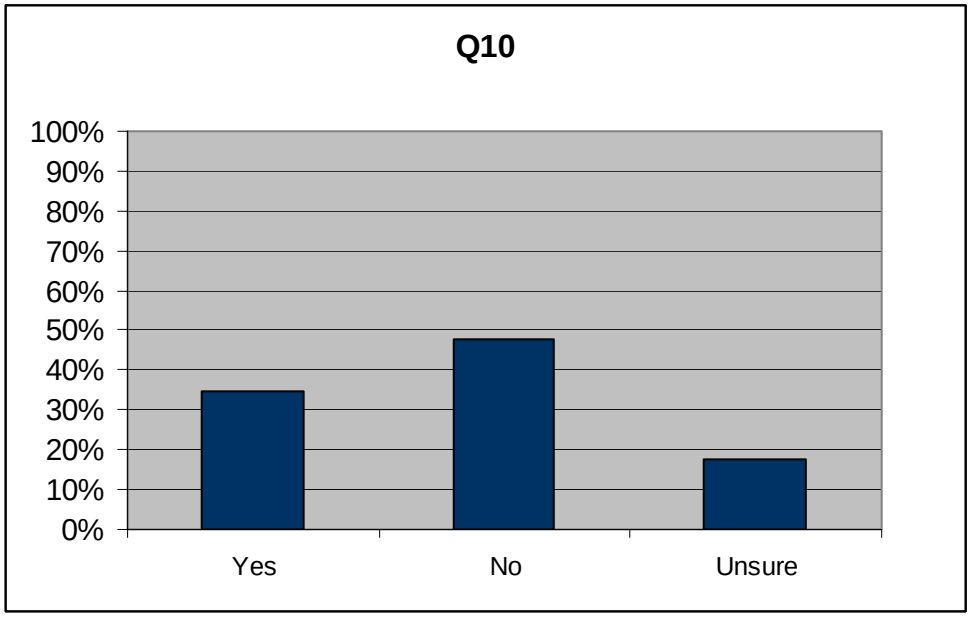
Q9. How do you rate the clinical effectiveness of antipsychotic medications for elderly patients suffering dementia?

	Total	
Q9.	**N**	**%**
Very effective	8	2%
Effective	246	69%
Neither effective nor ineffective	69	19%
Ineffective	29	8%
Very ineffective	3	1%
Unsure	0	0%
Base	**355**	



Q10. Have you ever known an elderly patient with dementia suffer serious side-effects following the use of an antipsychotic drug for dementia?

	Total	
Q10.	**N**	**%**
Yes	123	35%
No	170	48%
Unsure	62	17%
Base	**355**	



(All respondents indicating “Yes” at Q10, other respondents go to Q11)

Q10a. What side effects are you aware of that occurred following the use of an antipsychotic drug for dementia?

Q10a. Coded Responses	**N**	**%**
Drowsiness/excessive sedation	50	41%
Extrapyramidal/ parkinsonian symptoms	45	37%
Falls	30	24%
Increase in confusion	22	18%
Stroke	9	7%
Delusions/hallucinations	7	6%
Postural hypotension	6	5%
Insomnia	4	3%
Vomiting	3	2%
Mood disturbance	3	2%
Agitation	3	2%
Cardiac arrhythmia	3	2%
Diabetes	3	2%
Rash	3	2%
Withdrawn	2	2%
Weight gain	2	2%
Personality change	2	2%
Anticholinergic effects	2	2%
Constipation	2	2%
Coma	1	1%
Aggression	1	1%
Disinhibition	1	1%
Fatigue	1	1%
Fractures	1	1%
Respiratory infection	1	1%
Fit	1	1%
Neutropenia	1	1%
Urinary problems	1	1%
Reduced mobility	1	1%
Masking another medical condition	1	1%
Base	**123**	

Q11. Comments about the subject or questionnaire.

Q11. Comments - Verbatim Responses
1. Psychiatrists (often counterintuitively) sometimes use these drugs. Other psychiatrists don't. 2. Sometimes people with schizophrenia become demented and carry forward their treatment. 3. There is a real problem in the acute management of disturbed behaviour for which some medication may be appropriate, at least in the short term. This needs to be monitored carefully. Most often a benzodiazepine is most appropriate, though sometimes a neuroleptic is needed. It is inappropriate to be totally rigid about banning antipsychotics. They are certainly valuable in psychosis. Balancing risk and benefit should always be part of therapeutic intervention. We often use drugs with a long list of potential side effects because they also have a long list of potential benefits. 4. I am very doubtful as to whether the newer antipsychotics are any safer than the older ones.
A complex area. Hysteria by the media should be avoided as it helps no one and generally staff are trying to act in the patient's best interests. Sometimes some sort of sedating medication is needed for a while for everyone's safety, but there is a danger that no one feels it is safe to stop it in case the behaviour returns and the patient and carers are badly affected. More training and awareness must help all concerned.
A difficult management problem and potential ethical dilemma. My feeling is that an agitated and disinhibited patient is hardly likely to be happy and is a potential danger to themselves and others so treatment is appropriate.
A lot of theses questions seems loaded - does the Raida programme have an agenda about inappropriate doping of demented patients. Most of my demented patients are cared for in a highly specialised Nursing Home where antipsychotics are used as a last resort and wherever possible patient's challenging behaviour is dealt with through behavioural management techniques. There is no doubt that there are cases where even with 1 to 1 care the safety of a patient or fellow residents can only be ensured using these agents. Benzodiapines being an even blunter cosh. Interestingly it is distressed relatives who often ask for sedation.
A very important issue - many factors involved here - increased longevity, new regulations, new legislation such as the Mental Capacity Act, increased awareness of human rights, and also of the notification of abuses of the elderly
All patients who are prescribed any regular medication should be reviewed regularly and the need and effectiveness of that medication assessed. This is a safer and more humane approach than a planned 'must stop medication and see' approach (see previous approach).
Always through close co-operation with the mental health for the elderly team
Antipsychotic drugs in the elderly are always commenced by the psychiatrist for the elderly.
Antipsychotics should be withdrawn, but not after a fixed period of time, when it seems appropriate. Nursing these patients can be very difficult when they are aggressive, violent, hurting other residents and staff, I think there needs to be some medication that we can use, otherwise physical restraint may be the only measure and that seems inappropriate
Any prescriber of antipsychotics to elderly patient with dementia should be aware and vigilant to potentially serious side effects. Despite potential serious risks, it's still not uncommon practice even in psychiatric OPD.

Q11. Comments - Verbatim Responses
As GP I would never initiate these medications without going through a specialist psychogeriatric assessment.
As usual this is not a black and white area; I hate prescribing sedatives to demented patients - sometimes they are so disturbed there seems no other option; sometimes sedatives are recommended by consultants - I usually prescribe less than the recommended dose or none at all.
As with all medicines, benefits and side effects must be carefully weighed up. medication should be regularly reviewed, not repeated ad infinitum
Atypical antipsychotic agents are not licensed for use in dementia, unless the patient is also suffering from a psychotic process too which occasionally happens. In these cases prescribing is generally undertaken by the secondary care psychiatric services.
Benzodiazepines are also used to control behaviour and benzos are more likely to be used on a prn basis
Bring back thioridazine. If we can not use these drugs, and usually they are initiated by a consultant psychogeriatrician, then what are we supposed to do? Use high dose benzodiazepines which will also get criticised in the media? It is often unfair for these type of patients to be cared for in a home looked after by teenagers and or foreign staff who have little experience or qualifications to understand the needs of these type of patients. My mother suffered and I mean *SUFFERED* 7 years of *SEVERE DISTRESS* with vascular dementia. Why did she have to suffer so? What other options are the critics going to offer? Perhaps euthinasia would be indicated for some patients?
Can be a very difficult position to maintain people in community, often prescribing done on specialist advice
Can be very difficult to manage sometimes. Government provides very little in way of specialist dementia care and often trying to manage best we can in inappropriate/ difficult setting
Clearly, the dose needs to be as small as possible.
Covert administration known years ago but not recently. Use should be monitored and reviewed rather than discontinued after fixed period of time.
Covert medication is wrong; it should only take place if a patient is sectioned. But sectioning in dementia is rare. See Mental Health Act Manual by Richard Jones 1-720 (page 324 10th Edition, publisher Sweet & Maxwell)) or www.nmc-uk.org "Position Statement on the Covert Administration of Medicines - Disguising medicine in food or drink"
Dementia in the elderly is difficult to treat. I refer them to Psychiatrist with interest in elderly before commencing treatment unless they are danger to themselves or others.
Depends on who is keeping a close eye on the patient if I decide to prescribe.
Difficult area - case by case & assess how things go. Great caution is needed
Drug treatment is essential for SOME patients
Drugs are always initiated after consultant opinion
Good content
I always refer to a psychogeriatrician for an opinion before prescribing an antipsychotic to demented patients as this is only an option after increased care and behaviour support have been tried.
I believe antipsychotics do have a role in selected patients with dementia
I get the feeling that the questionnaire is designed to show that antipsychotics are being used inappropriately in people with dementia. I can assure you that in our

Q11. Comments - Verbatim Responses
local area there is close liaison between GPs and the older adults community mental health team and that antipsychotics are only introduced after thorough assessment by members of this team. The use of the drugs is regularly reviewed, and they are withdrawn as soon as is feasible.
I have just as much aversion to the use of chemical coshes as anyone else. However, sometimes life is imperfect and one is left trying to choose the lesser of two evils, and sometimes part of the overall picture being assessed includes the well being of other people, including relatives and nursing staff, as well as, sometimes, the competence of staff in particular institutions and the suitability of accommodation.
I have never initiated an antipsychotic in a patient with dementia - but have continued prescribing once prescribed by the patient's psychiatrist.
I have only come across covert medication use in hospital practice where it has been done according to appropriate procedures. The use of anti psychotic medication is enabling two of my patients to continue to be cared for at home. Without it they would need to be institutionalised
I hope it is not another doctor/ nursing home bashing report which takes no account of the practicalities of looking after a severe demented individuals by some tiny minded self important out of the real world reporter
I know that there is a need for antipsychotics to be occasionally used in dementia after the patient has been assessed physically and psychologically
I only prescribe ant-psychotics to dementia patients when advised by a psychiatrist or CPN
I only prescribe on the advice of a psychogeriatrician.
I rarely initiate these medications - nearly always started by consultant specialising in old age psychiatry; must be absolute last resort; well aware of the serious risks of using medication and feel very uncomfortable using them, try to stop them quickly if patient settles
I recommend that anti psychotic therapy should not be initiated in primary care but can be prescribed under shared care protocol after initiated by specialist.
I think it is well established that Conventional Antipsychotics are not beneficial but that Atypical Antipsychotics have a place in controlling Psychosis and Aggression in patients with Dementia but only under specialist supervision and with regular review. I would not initiate these drugs but refer for specialist assessment if I thought they might be indicated.
I think these drugs need specialist assessment before use so I have never initiated them. Nice has had something to day recently about them
I think this is a subject where there isn't a wrong or right answer. I wouldn't prescribe for the sake of prescribing - nor would I prescribe purely for someone else's comfort. However relatives are often incredibly distressed by a demented patient's agitation and I do think it's worth trying various drugs to see whether that agitation can be lessened. Also it's worth remembering that medicine is practised by people who are seeing the reality of patients' lives and not living in ivory towers... I have lots of patients with dementia who are cared for solely by their spouse, 24 hours a day, 7 days a week with no respite. They cannot cope without sleep and rest. If my prescribing an anti-psychotic to the demented patient enables the spouse to sleep for a few hours a night without worrying about them then I consider that worth doing. The cost to society and the patient him/herself is potentially a good deal less than not doing so.
I would only prescribe antipsychotics for an elderly patient if they psychotic
I wouldn't prescribe for any length of time without the second opinion of a consultant psychogeriatrician

Q11. Comments - Verbatim Responses
If there was appropriate accommodation for dementia patients with adequate staff the need for antipsychotics would be much reduced. They are only given as a last resort
Initial prescribing usually from specialists in secondary care. I would ct drugs if appropriate
It is a very vexed area - with significant risk of harm [e.g. CVA] to be balanced against carers ability to continue-this is so even in large professional nursing homes run to high standards-it is sometimes necessary to provide a degree of anti-psychotic control to allow staff to safely care for an old person-old lady's can be surprisingly violent and dangerous without warning and I have known cases of significant injury to nursing home staff.
It is easy for journalists to be critical about the use of antipsychotics in the elderly demented, but this ignores the real and major problems these people are both having and causing to those around them, for which antipsychotics do provide a workable solution.
It is important to consider carers' views when treating the patient
Like all other medications there are circumstances where these drugs are useful and help a patient to have a better existence than they would without them. There are cases of misuse and excessive use and these tend to make it harder to convince carers and patients that the drug may be appropriate for their relative or themselves. Withdrawal from time to time to assess the continued need is sensible but fixed time periods for this may not be clinically appropriate
Like most things in medicine, clinician has to decide risk/ benefit ratio
Mostly treatment given when in residential institution. I suspect that lack of money (nb profit motive) means that patients have to be given medication when staff time not available. This is a deplorable situation resulting from Conservative and New Labour privatisation. These places should be run on a not for profit scheme. Profit seems to be more important than appropriate care.
No comments × 267
Not very well researched subject. Increasing elderly population will make this a much more pressing clinical need given the current increasing prevalence of dementia in the elderly. This is either they don't die of physical causes before their mental abilities declines measurably or the condition has become more common when it was because it was underdiagnosed in the past or it was thought to be "just old age" or the condition has become more common because of other co-morbidity (obesity/hypertension) pre-disposes to it.
Prescribed very rarely and in extreme circumstances
Questions far too closed to allow fair responses - programme obviously fishing for huge 'expose' of 'widespread bad practice' - perhaps programme should spend a lot of time with very disturbed demented patients in the real world
Some of these Q are more suited to discursive rather than to limited choice tick box answers and so the answers you get are less to be relied upon. Do I use antipsychotics Y/N? True answer - in general NO, but on rare occasions when other measures have been tried & failed and where severely disturbed behaviours such as aggression are threatening other patients or staff, then YES. Given this, would aggression therefore prompt me to use an antipsychotic? Well NO, this would not be the first thing I'd be prompted to think of or do. But YES, I have on occasions used an antipsychotic when the prompt for intervention was originally aggression. So are antipsychotics effective or ineffective? Well NO, they usually don't have a sustained useful effect, but YES, a small number of patients do seem to respond well.

Q11. Comments - Verbatim Responses
Given this is what I think, now have a look at my answers to your questions and see if you could draw this out from them. These black and white questions may be good journalism and good for rabble-rousing, but the impoverished picture they paint is not good science, or ultimately good for patients.
Some people have dementia AND psychosis - it is these that I use antipsychotics for. I am not using them for aggressive behaviour etc
The antipsychotics might not be ideal for these patients but they are very difficult cases to deal with day in day out. The carers-being family or professionals in care homes can be driven to destruction .It is easy for the media to criticise this kind of prescribing but they do not have to look after such patients.
The large majority of anti psychotics prescribed by me have their prescriptions initiated by psychiatrist for ongoing use!
The last question re effectiveness of drug in dementia - my answer only refers to the symptoms the dementia gives rise to i.e. behavioural issues making patient unmanageable as well as the patient being distressed by the symptoms. An important issue is that because of the fear of doing harm with antipsychotic medication commonly I would now prescribe a less effective and possibly sedative drug e.g. promethazine
The prescribing culture is changing - we are now much more aware of the need for appropriate behavioural management rather than relying on sedative-type medication.
The question about discontinuation of medication did not give the option of using a flexible approach
The questionnaire is too black or white e.g. ever known side effects not how often rarely or often
The questions are too simplistic as the answers depend heavily on the context of the situation
The use of antipsychotics in dementia has always involved balancing the pros and the cons.
There has been a complete change in this area in the past 7 years and use is now a lot more targeted, restricted and appropriate. Staff are more aware of alternatives, but often have not had sufficient training to put them into place. this medications do have adverse effects for the patients, but equally staff and the patients are at risk from some of the behaviour these patients suffer from, there has to be some balance involved
There is a careful balance needed with antipsychotic use in dementia - they are over used in my opinion but this needs to be weighed against the needs of relatives and carers who in all fairness they are given to patients to help the relatives and carers more than the patients - but are helping the patients by allowing the relatives and carers to cope with them avoiding institutional care which is often the only alternative when care in patients own home breaks down
These medications can be very useful used with discrimination, and nearly always they are used in conjunction with consultants in psychiatry within our GP practice. They are not a panacea and are not used as such
These patients are a diverse group in terms of need/situation/severity/co-morbidity etc. A questionnaire that asks about 'typical' patients ignores the wide variety of scenarios and replies will be crude
These questions are quite leading by design and do not lend well to the exploration of the complexity of managing elderly patients with dementia. Generalisations are only too often the territory of the media and become a baton for inappropriately zealous political backlash, unnecessary anxiety for relatives and fear for professionals trying to provide some comfort to very distressed patients.
This debate can be quite unbalanced.

Q11. Comments - Verbatim Responses
Aggression and noisy behaviour in nursing and residential home patients can make the live of other residents a misery. It's their home too. Sometimes judicious use of antipsychotics can avoid the need for an individual to move to a specialist facility for the elderly mentally infirm. Such facilities are often much less pleasant than standard nursing homes and the enforced move can cause distress to patient and relatives alike.
This in an ideal world would be all specialist led treatment but the services are not often available at short notice.
This is a contentious area. Beyond the headlines are thousands of agitated demented patients in nursing homes with staff under resourced to manage them. I am sure many GPs loathe these drugs but we are being asked to care for a population whose government has turned their back on them but love to blame GPs for all the ills in modern society.
This is an interesting area. As a GP with some psychogeriatric experience, I was asked to write an article on the subject of 'The Chemical Cosh' a few years ago (it was in Update, I think, but I could find it if you're interested).
This is not a very detailed or specific questionnaire. I wonder whether this will be misused during the programme or used for some (political or personal agenda) benefits
This is political bluff and bluster, care of some needy elderly will be compromised by political bandwaggoning here.
Those who criticise should spend a month working in a care home
Too simplistic to be helpful. I don't personally think these Rx's are that useful, but are often used as staff levels are not able to cope with a more patient-orientated approach to behaviour issues. Many are started by psychiatric services. It's often a case of making do...
Usually antipsychotic medication is recommended by secondary care especially by psychogeriatricians. In our practice we ensure patients are regularly reviewed either by secondary care or primary care usually with multidisciplinary team involvement. Patients with dementia can have poor capacity and not be able to make an informed decision regarding what may be in their best interests. They can be a danger to themselves and sometimes to others.
Usually in my experience these are drugs that are initiated by 2ndry care and we as GPs are then asked to continue prescribing them.
Very easy to criticise medics re the use of antipsychotics but patients with dementia are difficult to handle - that's why relatives put them into homes!!!!. Some patients can be distressed or harm themselves because they are unaware of danger. Staffing levels are not always ideal but patients with no memory may ideally need 1-2- 1 attention for every waking hour which is just not feasible. I have know patients who scream constantly if they are left alone for more than 30 seconds which is distressing for everyone including staff, other residents, visitors and the patients themselves
We have a very good relationship with our homes and our local CMHT and are very happy with our policies
We still try to avoid this difficult subject
When it describes prescribing - this is usually on advise of psychogeriatricain
Would be more likely to refer to elderly mental health services for outreach if at home or seek transfer to specialised EMI home.
Yes I am experienced in this area and am aware of the value of antipsychotic drugs and the dangers of inappropriate use - I hope my views are aired, as so often with media programmes only "sensational and headline grabbing" comments are picked up and broadcast, and as usual negative reporting. This causes

Q11. Comments - Verbatim Responses	
unnecessary anxiety to patients and relatives. I hope you will report to them in a balanced way and the final result is equally balanced.	
you tailor treatment to need and try to minimise use coping with aggressive confused elderly is difficult and you have to consider the carer as well as they bear the brunt of the aggression its not a simple scenario if the carer ceases to care or becomes physically abusive if they are end of tether you have to look at the whole scenario	
You try looking after a demented patient and you'll probably occasionally want to give them something! I don't trust BBC health correspondents who are institutionally biased against doctors.	
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