cannot be maintained. For example, in the study quoted by the authors,⁴ neuroleptics were restarted or increased in 27-36% of cases because of a deterioration in the patient's mental state. In the same study, participating physicians were also encouraged to refer all patients taking neuroleptics for psychiatric review, which clearly has major resource implications. "Educational packages" have also been highly effective in reducing inappropriate neuroleptic use. They may be more effective than legislation.⁵

In the United Kingdom the provision of care for elderly mentally ill people is changing rapidly. Many NHS continuing care beds for them have closed, and the imposition of "eligibility criteria" from 1 April 1996 may further restrict access to long term hospital care. Consequently, increasingly dependent and behaviourally disturbed elderly patients are entering nursing homes, placing an added strain on general practitioners who may have little experience or training in their management.

Instead of considering legislation to restrict neuroleptic use, it would be better to increase levels of awareness and education in general practitioners and nursing home staff concerning the diagnosis and management of mental illness and behavioural disturbance in the elderly. Adequate staffing levels within nursing homes are vital in reducing inappropriate drug use, as is ready access to a multidisciplinary old age psychiatry service. Unfortunately, these can only be provided if sufficient resources are made available.

The media have leapt on McGrath and Jackson's study with great enthusiasm, reporting stories of elderly people being "drugged up" inappropriately. Although misuse of neuroleptics is associated with adverse effects, when used correctly neuroleptics can be highly effective in reducing distressing symptoms and behaviours. It would be unfortunate if the perceived message from this research were that "neuroleptics are bad," as this might adversely affect the rights of elderly severely mentally ill patients within nursing homes to receive adequate and appropriate treatment.

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Substantial study is imminent

EDITOR,—Alice McGrath and Graham Jackson's survey of neuroleptic prescribing in nursing homes is a timely addition to the scant British literature on this important subject.¹ They report a high prevalence of "inappropriate" neuroleptic prescribing according to American guidelines. However, judging appropriateness by guidelines fails to recognise the potential complexity of the decision to prescribe neuroleptics for patients with dementia.² For example, the term wandering subsumes a variety of behaviours, including leaving exits, trailing of carers, and persistent, purposeless pacing. The latter is often not

amenable to environmental manipulation and may be construed as organically driven and therefore more suitable for pharmacological intervention than other types of wandering.³ Similarly, the term agitation describes so many behaviours that it is almost meaningless. What is required is a thorough effort to understand the patient's predicament, from which flows proper management of needs and any behaviour problems, including the judicious use of psychotropic drugs, bearing in mind that, in dementia, psychotic features and depression may be short lived phenomena (C Ballard, Royal College of Psychiatrists winter meeting 1996).

Now, with most long stay care outside hospital settings, close liaison between primary care and specialist services is crucial. We are about to embark, over the next year, on a substantial study and audit of neuroleptic use at the interface of the primary care specialist and old age psychiatric team; we hope to report constructive results.

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Behaviour problems are underdocumented

EDITOR,—By applying American guidelines on neuroleptic use within nursing home facilities, Alice McGrath and Graham Jackson have deemed the prescription of these drugs for Glasgow nursing home residents to be potentially inappropriate in most cases.¹ Their interpretation of the findings may be incorrect.

No data are provided on the extent of behaviour problems among the patients studied. Previous research in similar settings suggests that a high prevalence of behaviour problems can be anticipated.^{2,3} Neuroleptic use may seem inappropriate in many cases because the behaviour had already been modified by treatment, but the nature of the study does not permit elucidation of this point.

The American legislation allows for deviation from the guidelines on antipsychotics if the prescriber can present a rationale for their use.⁴ This requires that the nature and severity of behaviour problems and response to drug treatment are carefully recorded. Although the management of disturbed behaviour is a routine part of the care process in most long term care settings, documentation of this important area is often poor.

Using a rating scale⁵ which is quick and simple to perform we assessed the prevalence and severity of behaviour disturbance in 104 patients aged 65-98 (mean 82) years in long term geriatric medical care and recorded the use of psychotropics in this group. In 52 of 76 patients tested the abbreviated mental test score was less than 6 out of 10, consistent with moderate to severe cognitive impairment. Twenty eight patients could not be scored because of severe deafness or dysphasia. Only 10 patients had no behaviour disturbance. The commonest problems identified were agitation (57 (55%) patients), nocturnal restlessness (51 (49%)), irritability (50 (48%)), and noisiness or verbal aggression (49 (47%)). Physical aggression occurred in 29 (28%) patients. In all, 46 patients (44%) were receiving one or more psychotropic medications

(31 neuroleptics, 9 temazepam, 4 diazepam, 2 chlormethiazole). Of 64 patients whose behaviour disturbance was considered severe enough to cause appreciable distress to themselves, other patients, or staff, only 31 (48%) were receiving psychotropics. The use of neuroleptics was therefore higher than that found by McGrath and Jackson, but given the extent of behaviour problems identified this was not felt to be inappropriate. Indeed, some clinicians suggested that given the high prevalence of untreated behaviour disturbance there may have been underuse of psychotropics.

Documentation of behaviour problems and response to treatment in long term care settings should be routine. Without this information it is impossible to assess whether the prescription of psychotropic drugs in the nursing homes documented by McGrath and Jackson is appropriate or inappropriate.

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Use may be justified if other factors have been considered

EDITOR,—The report by Alice McGrath and Graham Jackson¹ warrants further comment. They report that 88% of nursing home residents received neuroleptics inappropriately. They did not report psychiatric diagnoses nor reasons for the prescription. Mann *et al* found that nearly half the residents of local authority homes were receiving psychotropic medication, but also reported on the high levels of psychiatric morbidity among this group.²

Delusions and hallucinations are not limited to severe functional disorders but are common in dementia. They increase distress in the sufferer and the burden on carers and may be associated with aggression.³

Agitation, violence, wandering, restlessness, and sleep disturbance may occur in 30-50% of patients with Alzheimer's disease⁴ and often lead to admission to an institution. These behaviours are common reasons for referral to old age psychiatry services.

The management of troublesome behaviours in dementia includes a search for physical, environmental, and psychological precipitants. The management should include psychosocial interventions, attention to the environment, and the use of interpersonal skills by trained staff. Although there is evidence that non-pharmacological interventions may be effective, these approaches are labour intensive and may be underutilised in many nursing and residential homes. The extent of psychotropic medication use is likely to be influenced by the ability of staff to tolerate behaviour disturbance, which in turn may be influenced by staffing levels and training. Training for care staff is distinctly lacking and requires urgent attention. Even in the best staffed homes the use of psychotropic medication may still have an important role in management.

Although there is substantial clinical experience on the use of psychotropic medica-