

# GUIDELINES ON THE USE OF MEDICATION FOR THE MANAGEMENT OF BEHAVIOUR THAT CHALLENGES IN DEMENTIA

<b>Document Reference No.</b>	KMPT.CliG.231.01
<b>Replacing document</b>	New document
<b>Target audience</b>	Trust wide medical and nursing staff
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<b>Group responsible for developing document</b>	Drugs and Therapeutics Committee
<b>Status</b>	Authorised
<b>Authorised/Ratified By</b>	Trust Wide Patient Safety and Mortality Review Group
<b>Authorised/Ratified On</b>	October 2022
<b>Date of Implementation</b>	October 2022
<b>Review Date</b>	October 2025
<b>Review</b>	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
<b>Distribution date</b>	March 2023
<b>Number of Pages</b>	17
<b>Contact Point for Queries</b>	<a href="mailto:kmpt.policies@nhs.net">kmpt.policies@nhs.net</a>
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## DOCUMENT TRACKING SHEET

### Guidelines on the Use of Medication for the Management of Behaviour that Challenges in Dementia

Version	Status	Date	Issued to/approved by	Comments
1.0	Final	4/10/22	Drugs and Therapeutics Committee	Formally approved
1.0	Final	27/10/22	Trust Wide Patient Safety and Mortality Review Group	Assurance given.

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**RELATED POLICIES/PROCEDURES/protocols/forms/leaflets**


**SUMMARY OF CHANGES**

Date	Author	Page	Changes (brief summary)

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## 1 INTRODUCTION

- 1.1 Dementia is a disability of mental skills brought about by changes in brain health. More than half of people living with dementia will at some point experience difficulties often referred to as Behavioural and Psychological Symptoms of Dementia (BPSD), with a cumulative risk of 80% across the course of a whole illness. BPSD is associated with poor outcomes including faster cognitive decline and greater functional impairments. The presence of BPSD is also a precipitating factor for significant carer strain and institutionalization (Royal College of Psychiatrists).
- 1.2 The term BPSD covers a diverse range of states, including:
- Aggression
  - Apathy
  - Agitation
  - Shouting
  - Hallucinations
  - Delusional thinking
  - Depression
- 1.3 Many people experience multiple and recurrent issues, so there cannot be one single approach that is effective for management. There is also a risk that referring to these changes as “symptoms” may be misleading as much of the agitation or aggression exhibited by those with dementia can be understood as a response to the environment they are in or an expression of unmet need rather than solely caused by their dementia (Alzheimer’s Society, 2017).
- 1.4 There is growing evidence that many of the medications historically used for BPSD in dementia can be harmful. This is why there is a national campaign to reduce the use of medications for the management of BPSD. People taking medication to manage behavioural difficulties are more likely to:
- die sooner
  - fall and sustain injuries
  - have other health complications
  - be sedated.
- 1.5 The purpose of this document is to focus on the non-pharmacological management of behaviour that challenges and the scientific evidence for the usefulness and risks of using medication. It also details the legal framework for offering treatment. It covers the use of antipsychotics, antidepressants, mood stabilisers, benzodiazepines, cholinesterase inhibitors and memantine, where the purpose is to reduce behaviours that challenge.

## 2 NON-PHARMACOLOGICAL MANAGEMENT OF BEHAVIOUR THAT CHALLENGES IN DEMENTIA

- 2.1 Much of the disturbed behaviour experienced by people with dementia has an underlying cause and could be an indication of distress. The focus is on improving quality of life. Often, no treatment is necessary once steps have been taken to understand the individual and their presentation. Carers can benefit from explanations behind someone’s change in behaviour.

- 2.2 As part of the initial and ongoing management of people living with dementia, offer psychosocial and environmental interventions to reduce distress. (NICE, 2018). These interventions should follow a rigorous, structured, evidence-based approach to providing care for people with dementia is fundamental. The management of behaviour that challenges has to be made with full knowledge of the person, their background, personality and any known likes or dislikes. This can be achieved by taking time to talk to members of the family and as well as the person. A tool that can be used to aid this process is Care Fit for VIPS which is based on the VIPS Framework of person-centred care developed by the Association for Dementia Studies. This can be found at [www.carefitforvips.co.uk](http://www.carefitforvips.co.uk).
- 2.3 Disturbed behaviour can be triggered by a number of clinical and environmental factors which include:
- Changes in the physical health of the person; from simple infections to pain.
  - Specific activities or a lack of meaningful activity.
  - Noise and lighting.
- 2.4 Check for and address the clinical or environmental causes of BPSD before starting any intervention. These include:
- Pain assessment - if this is confirmed or suspected, consider a trial of regular paracetamol.
  - Monitoring for signs of infection and/or delirium and treating if symptomatic.
  - Constipation
  - Medication review (see anticholinergic burden chart in appendix 4)
  - Are they comfortable? (e.g. warm/cold, hungry or thirsty)
  - Are they receiving adequate and appropriate care?
  - Addressing sensory impairments if present e.g. the use of hearing aids or glasses if appropriate.
  - Have they had a 'This is me' form filled out? If so, is there anything on there which could help identify their source of distress? ([www.alzheimers.org.uk/thisisme](http://www.alzheimers.org.uk/thisisme))
- 2.5 Strategies such as distraction, backing away, and leaving the room may be helpful for symptoms of aggression. (Kales et al, 2015)
- 2.6 Non-pharmacological care giver interventions include:
- Enhancing communication with the person with dementia
  - Reducing the complexity of the physical environment
  - Simplifying tasks for the person with dementia
  - Tailored activities for the individual e.g. music and physical activity
  - Aromatherapy
  - Hand Massage

### 3 EVIDENCE FOR THE USE OF MEDICATION IN BEHAVIOUR THAT CHALLENGES IN DEMENTIA

- 3.1 Medication should only be considered after other approaches have been explored first. It should only be used at the lowest reasonable dose and for the shortest time possible. Long term treatment is not recommended. There should be a clear plan documented of what symptoms are being targeted with the medication, when the effect and tolerance of the medication will be reviewed, how the effect will be measured and who will conduct this review. Watchful waiting can be beneficial if risks are low.
- 3.2 There is little evidence for the effectiveness of medication to reduce behaviour that challenges. There is no evidence for any medication to reduce a tendency to shout or make loud vocalisations, wandering or sexual behaviour that others may find inappropriate (NICE, 2018). Please refer to Appendix 1 - Flow chart for management of patients with Behavioural and Psychiatric Symptoms of dementia (BPSD).

#### 3.3 ANTIPSYCHOTICS

- 3.3.1 The medication group with the largest evidence base in the management of aggression in Alzheimer's disease are antipsychotics. They should only be prescribed if the person with Alzheimer's disease is experiencing agitation, hallucinations or delusions that are causing them severe distress or if they are at risk of physical harm to themselves or others (NICE, 2018).
- 3.3.2 The two antipsychotics licensed to be used in BPSD are risperidone and haloperidol. Their licenses restrict their duration of use to a maximum of 6 weeks for persistent aggression in patients with moderate to severe Alzheimer's disease. These two antipsychotics used beyond 6 weeks and all other antipsychotics used to treat BPSD at any time will have to be used off-label. Quetiapine is the antipsychotic least likely to cause extrapyramidal side effects (EPSEs), although the evidence for its effectiveness is poor. Studies have shown that olanzapine and risperidone may reduce aggression and risperidone may reduce psychosis (Ballard et al, 2006).
- 3.3.3 **Benefit:** The size of the benefit is small, with more than five people needing to be treated before one of them experiences a worthwhile benefit.
- 3.3.4 **Harm:** Patients taking antipsychotics such as risperidone have 3 times the risk of dying than those not on treatment, Evidence indicates the risk for mortality remains elevated for at least 2 years and the actual number of deaths due to antipsychotic use increases the longer the duration of use. The main reason is the increased risk of stroke and other vascular events such as venous thromboembolisms. This risk is higher for older people, those with existing risk factors and on higher doses.

Further research has shown that patients whose symptoms did not include delusions were almost six times more likely to have a stroke with risperidone compared to those patients given a placebo. However, in patients who had delusions at the point of commencing treatment, risperidone did not significantly increase the risk of having a stroke (Howard et al, 2016).

Antipsychotics can double the risk of hospitalisations by pneumonia (Bazire, 2016), increase the likelihood of hip fractures occurring by 50% (Lee et al, 2017), cause EPSEs which can be fatal for those with Parkinson's disease (PDD) and Dementia with Lewy Bodies (DLB) and increase the risk of sedation which may worsen cognitive functioning.

Specialist advice should be sought before starting antipsychotics for patients with PDD/DLB).

### 3.3.5 When prescribing antipsychotics:

- Discuss and document the risk of harm and benefits of treatment with the person and their family and/or carer as appropriate. Assess cerebrovascular risk factors, and particular discussions should be held around increase risk of stroke (NICE, 2018)
- Target 'symptom(s)' should be identified, quantified and documented.
- Initiate antipsychotic at the lowest dose possible and titrate slowly if required.
- For risperidone, this dose will be 250 micrograms once or twice daily. The optimal dose in dementia has been shown to be 500 micrograms twice a day. There is no evidence of further benefit above 1mg a day.
- For haloperidol, 0.5 to 5 mg/day orally, as a single dose or in two divided doses. Adjustments to the dose may be made every 1 to 3 days.
- Changes in presentation should be assessed and recorded regularly.
- Review benefit of antipsychotic at 4-6 weeks. If there is an improvement in presentation and the benefit outweighs the risk for long term use then review every 3 months. The use of any antipsychotic over 6 weeks is considered off-label. An off-label form will have to be completed and this clearly documented in the patient's notes.
- Stop treatment if there is no clear benefit, after discussions with the person, their family and/or carer.
- Even when antipsychotics have been effective, dose reduction or discontinuation should be considered after 6-12 weeks as studies have shown for most people this has no detrimental effects on cognition or functional status. Withdraw with caution in patients with associated agitation and distress, severe neuropsychiatric symptoms and/or psychosis (Livingstone et al, 2017). **See guidance in Appendix E on reviewing antipsychotics prescribed for Behavioural and Psychological Symptoms of Dementia (BPSD).**
- Ensure adequate hydration and mobility to prevent cerebrovascular adverse events, particularly in the first four weeks when risk is highest (Taylor et al, 2015; Bazire, 2016).

## 3.4 COGNITIVE ENHANCERS

### 3.4.1 NICE recommends considering acetylcholinesterase (AChE) inhibitors for:

- People with mild to moderate Alzheimer's disease (donepezil, galantamine and rivastigmine)
- People with mild to moderate dementia with Lewy bodies (donepezil or rivastigmine, only consider galantamine if others not tolerated)
- People with severe dementia with Lewy bodies (donepezil or rivastigmine)

### 3.4.2 NICE recommends memantine:

- As monotherapy for people with moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors
- As monotherapy for people with severe Alzheimer's disease
- In combination with an AChE inhibitor in moderate or severe Alzheimer's disease
- People with dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated

- 3.4.3 **Benefit:** Studies suggest cholinesterase inhibitors are more effective for depression, dysphoria, apathy and anxiety than for agitation, aggression and delusions (Taylor et al, 2021). It should be noted that cognitive enhancers are not licensed for BPSD. Drugs for cognition, including memantine and donepezil have not been shown to be useful for agitation in Randomised Controlled Trials (RCTs) when agitation is the target symptom (Livingston et al, 2017).
- 3.4.4 **Harm:** Agitation can itself be an adverse effect of cholinesterase inhibitors. NICE do not recommend acetylcholinesterase inhibitors or memantine to people with frontotemporal or vascular dementia (unless suspected comorbid Alzheimer's or dementia with Lewy bodies).

### 3.5 ANTIDEPRESSANTS

- 3.5.1 The prevalence of dementia and coexisting depression in Alzheimer's disease is estimated at 30-50% (Aboukhatwa et al 2010). A number of studies looking at the efficacy of antidepressant treatment in dementia found no difference between the most commonly prescribed medications and placebo when treating low mood in dementia, and there remains limited evidence to support the use of antidepressants for depression in the context of dementia.
- 3.5.2 **Benefits:** Selective Serotonin Reuptake Inhibitors (SSRIs), mirtazapine and trazadone are relatively well tolerated compared with antipsychotics (Seitz et al, 2011). Citalopram, an SSRI, may help reduce agitation (Livingston et al, 2017).
- 3.5.3 **Harm:** Older people are more likely to experience side effects such as hyponatremia, hypotension, sedation, falls and akathisia. There is insufficient evidence to support the use of trazadone in reducing agitation in dementia - any efficacy is probably due to its sedative effect. Tricyclic antidepressants (TCAs), for example amitriptyline, are best avoided in patients with dementia due to anticholinergic adverse effects.

### 3.6 MOOD STABILISERS

- 3.6.1 Do not offer mood stabilisers to manage agitation or aggression in people living with dementia, unless they are indicated for another condition (NICE, 2018).

### 3.7 MEDICATION FOR SLEEP MANAGEMENT

- 3.7.1 Difficulties with circadian rhythm and sleep are very common in dementia. For people living with dementia who have sleep problems, consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities. There is a lack of evidence to help guide pharmacotherapy of sleep problems (McCleery et al, 2014).
- 3.7.2 NICE guidelines for insomnia recommend:
- Only prescribing hypnotics when daytime impairment is severe.
  - Zopiclone or zolpidem should be used first line and temazepam second line.
  - Treatment should not continue for longer than 2 weeks.
  - Potential adverse effects include daytime sedation, poor coordination, cognitive impairment and increased risk of falls. Long term use can lead to the development of tolerance and dependence as well as increased mortality. (NICE, 2014)
  - Antidepressants, antihistamines such as promethazine, chloral hydrate, clomethiazole should not be used. Promethazine in particular has strong anticholinergic effects and has the potential to cause significant cognitive impairment.

3.7.3 Melatonin should not be offered to manage sleep problems in people living with dementia. (NICE, 2018). However, melatonin may be better tolerated or have a lower risk than other alternatives (Bazire, 2020). The prolonged release tablet is licensed for patients aged over 55 for up to 13 weeks.

#### **4 THE APPLICATION OF THE LAW IN THE TREATMENT OF THOSE WITH BEHAVIOUR THAT CHALLENGES IN DEMENTIA**

- 4.1 The majority of those with dementia and behaviour that challenges will lack capacity to consent to treatment. Treatment in the form of medication, may be given to individuals with dementia who lack capacity within the scope of the Mental Capacity Act but only if it is clearly in their best interests.
- 4.2 Medication may also be intended to help family or professional carers but to use it for this reason alone is unlawful.
- 4.3 The best interests of the patient would need to consider the small chance of medication working and the significant chance of harm. As such, medication would only be justifiable where BPSD is causing the person significant distress or placing them or others at significant risk of harm (such as from aggression) and when non-pharmacological interventions have proved insufficient.
- 4.4 For those detained under the Mental Health Act, a different legal framework exists but the same clinical balance between risk and benefit needs to be considered.

#### **5 EQUALITY IMPACT ASSESSMENT SUMMARY**

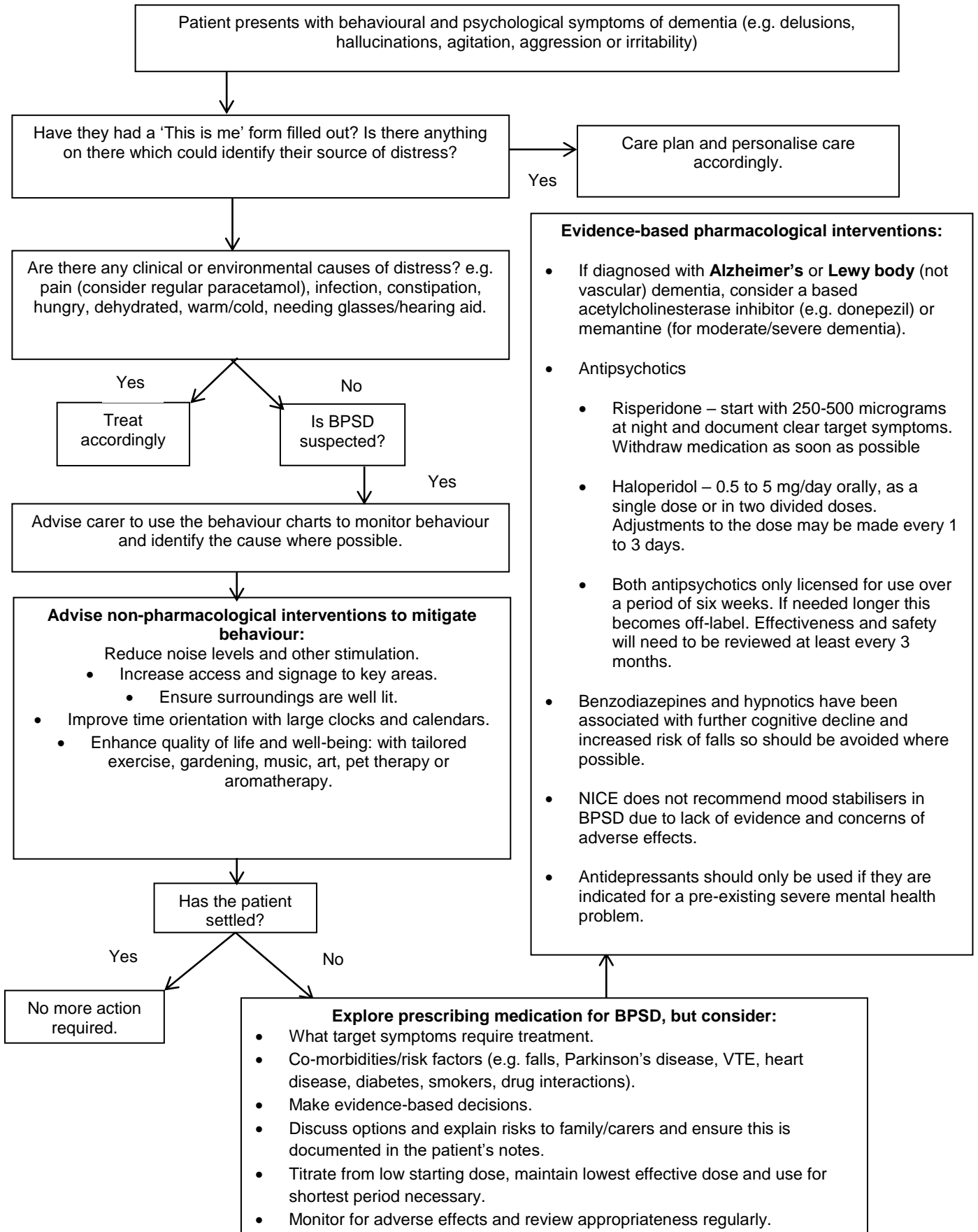
- 5.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

#### **6 HUMAN RIGHTS**

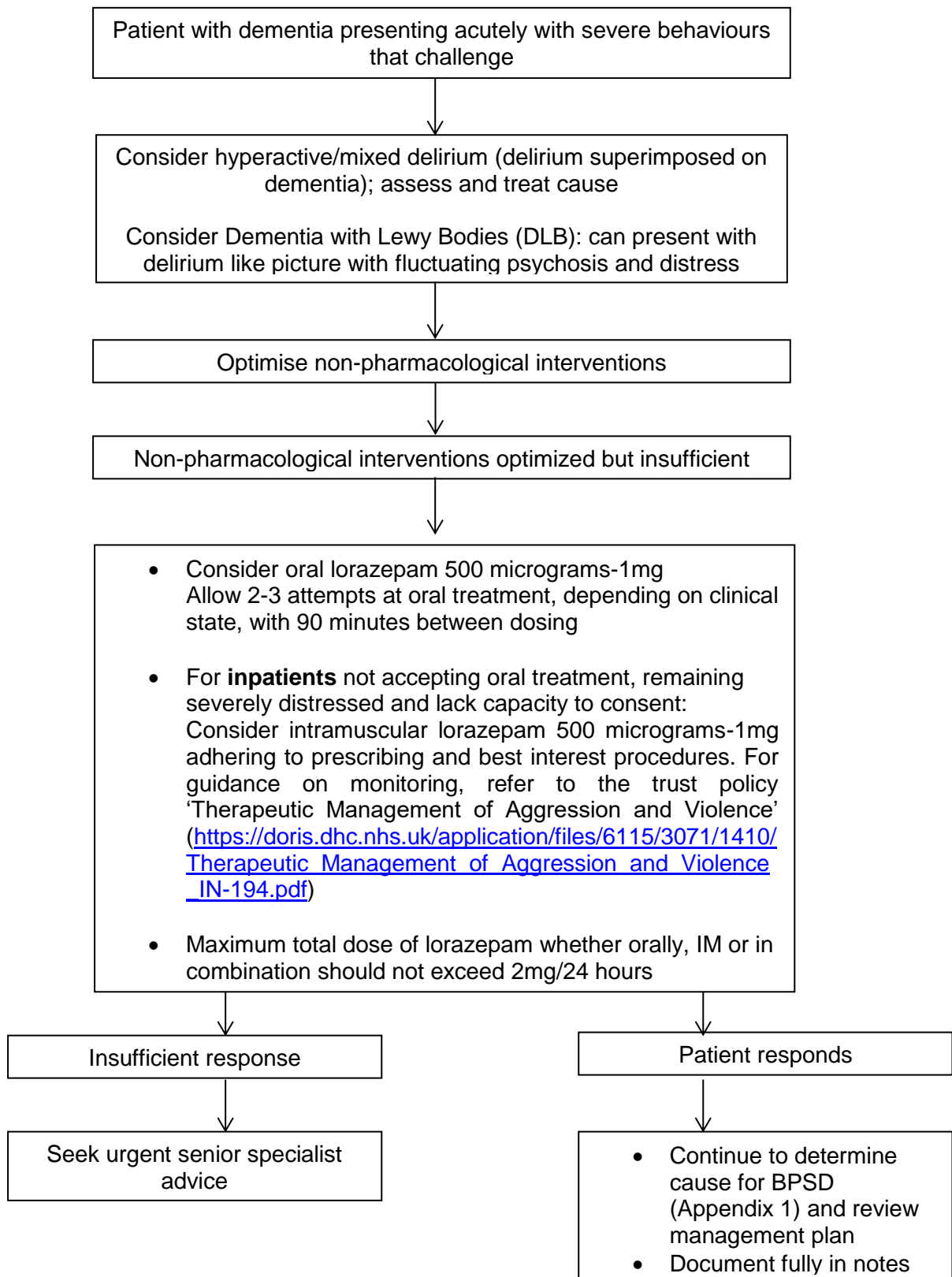
- 6.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

# APPENDIX A: FLOW CHART FOR MANAGEMENT OF PATIENTS WITH BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS OF DEMENTIA

(ADAPTED FROM NHS WORCESTERSHIRE-GUIDELINES FOR THE MANAGEMENT OF BPSD)



**APPENDIX B PHYSICAL HEALTH MONITORING OF ANTIPSYCHOTICS**  
**APPENDIX C MANAGEMENT OF ACUTE AND SEVERE BPSD FLOW CHART**





## APPENDIX D ANTICHOLINERGIC EFFECT ON COGNITION (AEC) SCALE

### Commonly prescribed drugs and anticholinergic burden

Medications with anticholinergic activity have been shown to increase the risk of cognitive decline and increase the risk of mortality over 2 years, especially in the older adult population. They also reduce the efficacy of acetylcholinesterase inhibitors and can cause sedation, delirium, falls and constipation.

The table below is a useful guide to the anticholinergic effect on cognition (AEC) scores (Taylor et al, 2021) for a range of medications, and should be considered when prescribing, particularly for those with dementia. It is good practice to keep the anticholinergic burden to a minimum (preferably 0) in older people.

### Drugs on the Anticholinergic effect on Cognition (AEC) scale

#### AEC Score 1 (mild)

Amiodarone  
Aripiprazole  
Atropine eye drops  
Bromocriptine  
Buspirone  
Carbamazepine  
Cinnarizine  
Citalopram  
Cyclizine  
Diazepam  
Domperidone  
Fentanyl  
Fluoxetine  
Flupentixol  
Hydroxyzine  
Hyoscine Butylbromide  
Isocarboxazid  
Lithium  
Midazolam  
Mirtazapine  
Phenelzine  
Pirenzepine  
Prednisolone  
Quinidine  
Quinine  
Sertraline  
Solifenacin  
Temazepam  
Zuclopentixol

#### AEC Score 2 (moderate)

Amantadine  
Chlorphenamine  
Desipramine  
Dicycloverine  
Diphenhydramine  
Disopyramide  
Levomopromazine  
Olanzapine  
Paroxetine  
Pethidine  
Pimozide  
Prochlorperazine  
Promazine  
Quetiapine  
Tolterodine  
Trifluoperazine

#### AEC Score 3 (severe)

Alimemazine  
Amitriptyline  
Atropine  
Benztropine  
Chlorpromazine  
Clemastine  
Clomipramine  
Clozapine  
Cyproheptadine  
Dothiepin  
Doxepin  
Hyoscine Hydrobromide  
Imipramine  
Lofepamine  
Nortriptyline  
Orphenadrine  
Oxybutynin  
Procyclidine  
Promethazine  
Trihexyphenidyl  
Trimipramine

The AEC scale is available as a regularly updated web-based app ([www.medicheck.com](http://www.medicheck.com))

Where medications are already prescribed, consider alternative medication which do not affect the cholinergic system or that do not easily cross the blood-brain barrier (and hence affect cognition). Please see table on the next page for a summary of medicines to avoid in dementia and suggested alternatives. For further information, look at 'Safer prescribing for physical conditions in dementia' in chapter 6 of the Maudsley Guidelines.

<b>Condition</b>	<b>Medicines to avoid</b>	<b>Recommended alternatives</b>
Allergic conditions	Chlorphenamine Promethazine Hydroxyzine	Cetirizine Loratidine Fexofenadine
Hypersalivation	Hyoscine hydrobromide	Atropine (sublingual, off-license)
Nausea/vomiting	Cyclizine Metoclopramide Prochlorperazine	Domperidone Ondansetron (red on formulary)
Pain	Codeine Tramadol Fentanyl	Paracetamol Oxycodone Buprenorphine Topical NSAIDs
Urinary frequency	Oxybutynin Tolterodine Fesoterodine? (lack of data)	Darifenacin Trospium (2nd choice) Solifenacin (if above not available)

# KENT AND MEDWAY GUIDANCE ON REVIEWING ANTIPSYCHOTICS PRESCRIBED FOR BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN PRIMARY CARE<sup>1</sup>

## 1. INTRODUCTION

NICE recommends that antipsychotic medication should only be used in people with dementia if they are:

- At risk of harming themselves or others.
- Experiencing agitation, hallucinations or delusions that are causing them severe distress.

If antipsychotics are used, they should be tried alongside other activities to try to help their distress.

NICE also suggests that, before starting treatment with antipsychotic medicines, the benefits and harms should be discussed with the person and their family members or carers.

Further information can be found via the link below.

<https://www.nice.org.uk/guidance/ng97/resources/antipsychotic-medicines-for-treating-agitation-aggression-and-distress-in-people-living-with-dementia-patient-decision-aid-pdf-4852697005>

A range of information can also be found via the following link, which is designed to support people with dementia in care homes.

<https://www.southeastclinicalnetworks.nhs.uk/wp-content/uploads/2021/03/Dementia-OPMH-Guidance-forPCNs-and-Care-Homes.pdf>

## 2. GUIDANCE ON REVIEWING ANTIPSYCHOTICS FOR BPSD IN PRIMARY CARE

- All patients with dementia currently on antipsychotics for BPSD should have the antipsychotic reviewed at least every 3 months or more frequently if necessary as recommended by NICE to assess the risks and benefits of continued treatment and to consider its discontinuation unless:
  - the antipsychotic was prescribed for a pre-existing condition prior to a diagnosis of dementia e.g. schizophrenia, bipolar affective disorder, psychotic depression.
  - the patient is still under regular review by KMPT.
  - there is a detailed care plan in place for ongoing antipsychotic use recommending a different time frame. This could be the case in patients where repeated trials of discontinuing antipsychotics have been unsuccessful.

- Ideally, patients that have taken these medicines for more than 3 months should be reviewed in accordance with NICE guidance by the initiating prescriber but on occasion, this is missed and patients end up on the medication indefinitely.
- This guidance has been developed as a tool to assist prescribers in primary care in reviewing these patients in their own home and in care homes (both residential and nursing).
- The review can be carried out by a Non-Medical Prescriber or PCN pharmacist where appropriate, and if the individual has the competency to prescribe antipsychotics in BPSD. This will need to be in agreement with the patient's GP with all review information fed back to the GP.

### **What should the review include?**

- Therapeutic response to the antipsychotic.
- Adverse events: include falls, sedation, low blood pressure, chest infection (use of antipsychotics in elderly increases risk of pneumonia by 60%), anticholinergic effects (dry mouth, constipation, blurred vision, urinary retention) and extrapyramidal side effects (EPSEs).
- Decision to continue or trial of reduction/discontinuation.
- Monitoring: yearly blood test and ECG (as per Physical Health Monitoring Requirements for Commonly Prescribed Psychotropic Medications). This is necessary if the antipsychotic is continued.
- Date of next review **(see Appendix A for a template form for review)**.
- Family/carer(s) inclusion and support in decisions made to reduce or stop the antipsychotic **(see Appendix B for an example of carer information leaflet)**.

### **HOW TO DISCONTINUE/DE-PRESCRIBE ANTIPSYCHOTICS**

- Reduce the dose of the antipsychotic as detailed in table 2 or discontinue immediately if the patient is on a low dose. Low doses are detailed in table 1. Review every stage of dose reduction to evaluate patient response.
- If the antipsychotic is given in split doses across the day, decrease only one dose to start with, choosing the dose likely to have the least impact on the patient.
- In some cases, it may be necessary to implement small decreases in dose particularly if symptoms reappear. In these patients when the lowest dose has been achieved on a daily basis, administering on alternative days is also an option before stopping completely. If behavioural problems continue, other strategies should be considered instead of or

alongside the antipsychotics such as regular pain relief or behavioural strategies, based on individual assessment.

- Appendix C details the suggested pathway for reviewing and stopping prescribed antipsychotics for BPSD.
- Seek advice from KMPT if needed or consider re-referral if indicated.

**TABLE 1: ANTIPSYCHOTICS COMMONLY USED TO TREAT BPSD AND SUGGESTED DAILY LOW DOSES**

ANTIPSYCHOTIC	SUGGESTED DAILY LOW DOSE (ALSO CONSULT BNF)
Olanzapine	Less than 2.5mg
Quetiapine	Less than 50mg
Risperidone	Less than 0.5mg (500 microgram)
Haloperidol	Less than 0.5mg (500 microgram)

**TABLE 2: REDUCING AND STOPPING ANTIPSYCHOTIC**

Drug	Total daily dose	Step 1 (Review day)	Step 2 (Two weeks after step 1)	Step 3 (Two weeks after step 2)
Risperidone	Up to 500 micrograms	<b>Stop</b>		
	Up to 1mg	Halve dose	<b>Stop</b>	
	Over 1mg	Halve dose	Halve dose	<b>Stop</b>
Quetiapine	25mg	<b>Stop</b>		
	Up to 50mg	Halve dose	<b>Stop</b>	
	Over 50mg	Halve dose	Halve dose	<b>Stop</b>
Olanzapine	2.5mg	<b>Stop</b>		
	Up to 5mg	Halve dose	<b>Stop</b>	
	Over 5mg	Halve dose	Halve dose	<b>Stop</b>
Haloperidol	Up to 500 micrograms	<b>Stop</b>		
	Up to 1mg	Halve dose	<b>Stop</b>	
	Over 1mg	Halve dose	Halve dose	<b>Stop</b>

1. This document is based on the Reducing Antipsychotic Prescribing in Dementia Toolkit developed by PrescQIPP.

## BPSD REVIEW GUIDANCE APPENDIX A: BPSD ANTIPSYCHOTIC MEDICATION REVIEW TOOL

Patient name			
Patient date of birth		Date of assessment	
Practice			
GP			

Date antipsychotic initially commenced		Antipsychotic prescribed	
Dose of antipsychotic currently prescribed		Date of last antipsychotic review(s) – if applicable	

Therapeutic response?	Yes		No	
Please specify improvements noted				

Adverse events	Yes - please detail	No
Falls		
Sedation		
Low blood pressure		
Chest infection		
Anticholinergic side effects (e.g. constipation, blurred vision, urine retention, dry mouth)		
Extra-pyramidal side-effects/mobility		
Other cause(s) * Please specify		

	Yes	No
On balance, the decision to continue with antipsychotic prescription was made in light of the patient's presentation, symptomatology and risk to self or others?		
Any dose or drug changes? Please specify		
Non-drug intervention(s). Please specify		

This prescription should be reviewed within a maximum of 6 weeks from initial prescription and then as a minimum 3 monthly.

Date of next scheduled review	
Review completed by (name of prescribing doctor)	
Signature	
Date	

## BPSD REVIEW GUIDANCE APPENDIX B - CARER INFORMATION LEAFLET

*This may be adapted and customised, particularly the text highlighted in yellow, so that the information is appropriate.*

[Date]

### **CARER INFORMATION LEAFLET: REDUCING OR STOPPING ANTIPSYCHOTICS MEDICATION IN PEOPLE LIVING WITH DEMENTIA**

There is evidence that suggests some medicines used to treat behavioural problems in people with dementia can have some serious side-effects. These include increasing the risk of the person having a stroke or falling. These medicines are called antipsychotics. There is also evidence that many behavioural problems disappear or become less troublesome over time, even without medication.

Taking into account the current national guidelines, it has been decided by [insert name of practice] that most patients being prescribed an antipsychotic for behavioural problems should have this medicine reduced or stopped to see if it is still needed. It is our intention to try and stop prescribing the antipsychotic in approximately [add time scale, e.g. 'one week's time']. If you have any concerns, please do not hesitate to contact the practice for advice.

Practice details [Add number]

Clinical trials have shown that when stopping medication, even if the person was taking an inactive tablet (placebo), some carers think they see a worsening of behaviour. This may be due to the behavioural problems returning or a heightened sensitivity to any unwanted behaviour.

To help properly assess whether behaviour has significantly changed after the medicine is reduced or stopped we would like you to complete a diary, starting one week before the medication is reduced or stopped. A diary sheet has been designed for you to record on it the types of behavioural problems you are concerned about and how troublesome they are each day.

Once the medication is reduced or stopped, please keep recording any behavioural problems for the next 7 days. If there is a sudden worsening of behaviour that you feel is unmanageable then please call the practice to discuss your concerns.

We may agree to restart medication so you need to have a supply of a suitable medicine, just in case. Even if a medicine is restarted for behavioural problems, the intention is to regularly stop the medicine to assess its ongoing benefit.

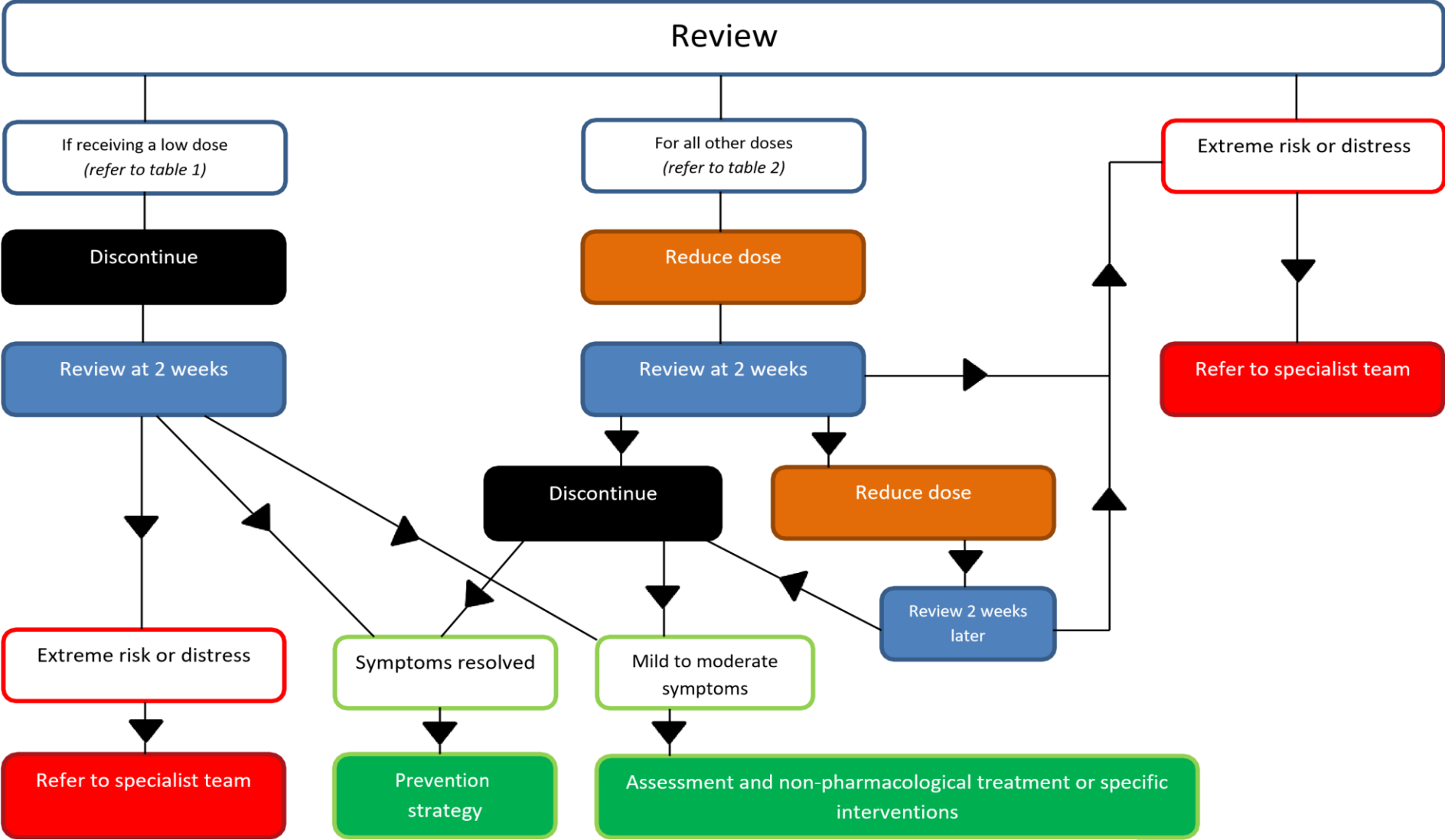
If you feel that once stopped the antipsychotic is no longer needed then there is no need to let the practice know. A review can always be arranged if any difficult behavioural problems return.

Please take any unwanted medicines back to your community pharmacy or dispensing doctor for safe disposal.

Yours sincerely

Dr [Name] and partners

**BPSD REVIEW GUIDANCE APPENDIX C: SUGGESTED PATHWAY FOR REVIEWING AND STOPPING PRESCRIBED ANTIPSYCHOTICS FOR THE MANAGEMENT OF BPSD**



Approved by: KMMOC, Clinical Cabinet  
 Approval Date: Ratified By Clinical Cabinet March 2022 Review Date: March 2024