NHS
Nottinghamshire Area Prescribing Committee

Managing Behaviour and Psychological Problems in Patients with Diagnosed or Suspected Dementia in Primary and Secondary Care

Guidelines for use with people who have diagnosed or suspected dementia in Nottingham and Nottinghamshire

MANAGING BEHAVIOUR AND PSYCHOLOGICAL PROBLEMS IN PATIENTS WITH DIAGNOSED OR SUSPECTED DEMENTIA

(Does not cover rapid tranquillisation of acutely disturbed patients)

Quick points

1. Patient with dementia with Behavioural and Psychological Symptoms of Dementia (BPSD)
- consider delirium
- review all medication (consider side effects of anticholinergics, Parkinson's disease medications, opiates)
- identify and address provoking/exacerbating factors and physical health problems
- consider the patient's personal history, consult carers for extra information
- if unresolved develop a person-centre care plan with family/carers
- try watchful waiting, symptoms may resolve without intervention over a few months
- if considering drug treatment, first identify dominant target symptom
- initiate drug therapy appropriate to target symptoms
- review at 6 weeks then every 3 months
- actively try withdrawing/stopping the drug
- some symptoms do not respond to drug treatment e.g. wandering or shouting

2. **Key messages for secondary care**
- always communicate drug changes appropriately (this applies to transfer of care from community mental health services)
- provide a reason for each prescription for BPSD
- request a review of drugs prescribed for BPSD every 3 months and try withdrawing/stopping the drug
- complete care plan if prescribing an antipsychotic and send a copy to the GP (appendix one)

3. **Key message for GPs and primary care**
- on-going antipsychotic prescriptions require a prescribing care plan (appendix one)
- for patients in care homes, consider referral to the Dementia Outreach Teams if simple measures ineffective
- antipsychotic medication is for specialist initiation or recommendation only
- review all drugs prescribed for BPSD every 3 months and try withdrawing/stopping the drug
- pharmacists are in an ideal position to support GPs and request prescription review

4. This is a complex and contentious area. These are guidelines. They may not always apply in each individual clinical situation. Please use your professional judgement.

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V4.1	Last reviewed: July 2023	Review date: July 2025

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(Does not cover rapid tranquillisation of acutely disturbed patients)

Patient has a Behavioural and Psychological Symptom in Dementia (BPSD): delusions, hallucinations, agitation, aggression, irritability, etc.

Yes

Does patient have delirium? (<1 week history increased confusion, fluctuation, inattention or drowsiness)

Yes

Seek and treat underlying medical problems (infections, brain, metabolic, or hypoxic disorders), & review medication.

Follow guidelines for delirium e.g. NICE

No

Identify, document and address provoking or exacerbating factors:
- Physical problems: pain, constipation, urinary symptoms, thirst or hunger
- Activity-related: boredom, misinterpretation of care tasks
- Treatment related: catheters, monitors, infusions, effects of medication
- Environment: noise, temperature, lighting, change of room, ward or bed space

Write a care plan. Consider person centred approaches. Involve family carers for information and help with care. Collect information on biography, preferences and routines. Understand what the person with dementia experiences. Develop a relationship to relieve anxiety. Repeat explanation and reassurance frequently (up to every 30 mins). Don't confront, punish or humiliate. If agitated try 'leave & return', distraction activity (matched to level of ability), or one-to-one care. Consider watchful waiting for 2 or 3 days. Patients may settle.

Behavioural problems unresolved

Identify the dominant target symptom group

- Psychosis: delusions or hallucinations (but care over 'delusions' due to forgetfulness)
- Depression
- Emotional liability; distress (e.g. crying, anger) disproportionate to emotional stimulus
- Apathy
- Aggression, agitation, anxiety
- Sleep disturbance
- Wandering
- Vocalisations, shouting, calling out

Consider pharmacological treatment if there is distressing psychosis, or behaviour that is harmful or severely distressing to the individual or puts others at risk. Continue person-centred approaches.

Could this be Dementia with Lewy Bodies or Parkinson's Disease Dementia? Key features: Parkinsonism, visual hallucinations, delusions, fluctuation. If unsure get specialist advice.

Follow treatment guidelines overleaf

General guidelines if antipsychotic treatment is indicated

Both typical and atypical antipsychotics worsen cognitive function, increase risk of stroke (3x) and death (2x), and can significantly reduce quality of life. They should only be used after discussion with the patient (if s/he has capacity to understand) or family carer about possible benefits and risks. Risk increases with age and vascular risk factors, and in established cerebrovascular disease. If antipsychotic treatment is necessary, **start at low dose and increase slowly every 2-4 days if no response**.

Always review for effects and side-effects. Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia are particularly vulnerable to antipsychotic sensitivity reactions and extrapyramidal side effects. Extreme caution is required.

Patients who respond to treatment should be reviewed after 6 weeks. Consider withdrawal: halve the dose for one week and if no worse stop the drug. Review after 1 week. If the symptoms re-emerge reintroduce the drug at starting dose. Over half of BPSD resolve within 6 months. However, BPSD can persist and treatment with antipsychotics may be needed in the long term, but **should be reviewed 3 monthly**. At each review ask about sedation, falls, anticholinergic side effects and extrapyramidal side effects. Monitoring of blood pressure, pulse, weight, HbA1C, lipid profile, renal and liver function, FBC, prolactin and ECG should be done at baseline, after 3 months and then annually (physically frail patients may need more frequent physical health monitoring).

Secondary care prescribers: Communicate drug changes to the GP. Provide a reason for each prescription and complete an antipsychotic care plan (appendix one). Request a review every 3 months.

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Primary care prescribers: Antipsychotic prescriptions require a prescribing care plan (appendix one). Try withdrawing/stopping the drug after 3 months. For patients who have been taking antipsychotics long-term a more cautious reduction over 4-6 weeks or longer, depending on the individual, is recommended. If problems are ongoing, refer to Community Mental Health, or the care home Dementia Outreach Teams (via Single Point of Access).

Alzheimer's Disease

Key Symptom	First Line	Second Line
Depression (1)	Watchful waiting, refer CMHT	Citalopram(2), Mirtazapine (1)
Emotional lability	Citalopram (2)	Mirtazapine (1)
Psychosis (3)	Risperidone (6)	Amisulpride, Aripiprazole
Aggression	Risperidone (6)	Haloperidol, Memantine
Severe Anxiety	Mirtazapine	Trazodone (7)
Severe Agitation	Risperidone (6)	Amisulpride, Aripiprazole, or Memantine ± short term lorazepam
Poor Sleep (4)	Sleep Hygiene & CBT	Zopiclone
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

*Please note the medicines are listed in alphabetical order and are not necessarily in order of clinical recommendation

Dementia with Lewy Bodies (LBD) or Parkinson's Disease Dementia (PDD)

Key Symptom	First Line	Second line
Depression (1,5)	Citalopram (2)	Mirtazapine
Psychosis (3)	Stop dopamine agonists, consider reducing L-DOPA	Quetiapine (5), Rivastigmine
Aggression (1,5)	Quetiapine (5)	Memantine, Rivastigmine
Severe Anxiety (5)	Citalopram (2)	Donepezil , Mirtazapine, Rivastigmine
Severe Agitation (5)	Citalopram(2)	Quetiapine (5), Rivastigmine or Memantine ± short term lorazepam
Poor Sleep (4)	Sleep Hygiene & CBT	Zopiclone
REM sleep behaviour (nightmares, hyperactivity)	Clonazepam (8)	Melatonin (8)
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

*Please note the medicines are listed in alphabetical order and are not necessarily in order of clinical recommendation

NOTES

(1) The largest trial to date showed sertraline and mirtazapine to be ineffective for treating depression in Alzheimer's disease. Use with caution in patients with pre-existing severe mental health problems.
(2) The dose of citalopram should start at 10mg/day and not exceed 20mg/day due to dose-related prolongation of QTc interval.
(3) The evidence base for treating psychosis is poor. Antipsychotics will not work for 'understandable delusions' caused by forgetfulness, such as 'living in the past'.
(4) Sleep disturbance or sleep reversal is very common. Maximise daytime activity. A trial of hypnotics may be justified but may need longer than recommended treatment duration if problems persist.
(5) Quetiapine and SSRIs may worsen motor symptoms of PDD.
(6). Risperidone is the only oral atypical antipsychotic licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate-to-severe Alzheimer's Dementia.
(7) Trazodone – start at 25mg/day and increase cautiously at weekly intervals up to 50-100mg/day. Trazodone and SSRIs can increase falls risk.
(8) Specialist initiation for treatment of REM sleep disorders in Parkinson's disease line with NG 71

For further information on specific medicines, refer to the Nottinghamshire Area Prescribing Committee Prescribing Information Sheets – available here

Vascular dementia or stroke-related dementia and other dementias

There is little evidence base for the treatment of BPSD in vascular and other dementias and prescribers are advised to follow the guidance for Alzheimer's Disease. Specialist advice may be required, especially for rare dementias such as fronto-temporal dementias.

Dose guidelines for use of psychotropic medicines in dementia

This needs to be judged according to the situation, including severity of symptoms, previous responses to drugs, age and weight, and general physical fitness or frailty. Small doses for small people.

Psychotropic	Starting dose	Usual dose
Risperidone	250microgram twice daily	500microgram-1mg twice daily
Quetiapine	25mg once daily	25-150mg once daily or in divided doses
Haloperidol	500microgram twice daily	500microgram-1mg twice daily
Amisulpride	25mg once daily	25-50mg once daily or in divided doses
Aripiprazole	2.5mg once daily	2.5-10mg once daily
Lorazepam	0.5mg once daily	0.5mg-1mg per day
Trazodone	25mg once daily	50-100mg in divided doses

A reference list is available on request.

Version Control - Managing Behaviour and Psychological Problem in Patients with Diagnosed or Suspected Dementia in Primary and Secondary Care

Version	Author(s)	Date	Changes
1.0	Based on original work done by Hampshire Partnership NHS Foundation Trust, and NHS East Midlands. Rowan Harwood (Professor of Geriatric Medication, NUH) , John Lawton (Senior Pharmacist, NHCT), Esther Gladman (GP, Prescribing Lead, Nottingham City), Jonathan Waite (Consultant in Old Age Psychiatry)	Jan 2012	New guideline
2.0	Rowan Harwood (Professor of Geriatric Medication, NUH) , John Lawton (Senior Pharmacist, NHCT), Esther Gladman (GP, Prescribing Lead, Nottingham City), Jonathan Waite (Consultant in Old Age Psychiatry)	Dec 2014	
3.0	Rowan Harwood (Professor of Geriatric Medication, NUH) , John Lawton (Senior Pharmacist, NHCT), Esther Gladman (GP, Prescribing Lead, Nottingham City), Bala Ganesan (Consultant in Old Age Psychiatry, NHCT), Krish Anandamandiram (Consultant in Old Age Psychiatry, NHCT), Patricia Mabeza (Lead Pharmacist MHSOP, NHCT) and Nick Sherwood (MH Efficiencies Pharmacist, Rushcliffe CCG/NHCT).	Nov 2018	-Added guidance on referral to DOT for care homes -Specified medicines to review as a general point – opiates, anticholinergic, PD drugs -Promote sleep hygiene and CBT under poor sleep -Reduce recommended lorazepam dose to 0.5-1mg -Added trazodone recommended dose -Added melatonin for REM sleep behaviour in LBD/PDD
4.0	Rowan Harwood (Professor of Geriatric Medication, NUH) , John Lawton (Senior Pharmacist, NHCT), Esther Gladman (GP, Prescribing Lead, Nottingham City), Bala Ganesan (Consultant in Old Age Psychiatry, NHCT), Patricia Mabeza (Lead Pharmacist MHSOP, NHCT), Hannah Godden (MH Interface Pharmacist, N&N CCG/NHCT)	Oct 2021	-Additional guidance on physical health monitoring -Amisulpride and aripiprazole added 2nd line for psychosis in Alzheimer's Disease -Haloperidol and olanzapine removed for psychosis in Alzheimer's Disease -Temazepam removed from both tables -Quetiapine added 2nd line for psychosis and severe agitation in LBD and PDD -Mirtazapine added 2nd line for severe anxiety in LBD and PDD
4.1	Patricia Mabeza (Lead Pharmacist MHSOP, NHCT), Zoe Hobbs (Senior Clinical Pharmacist, NHCT)	July 2023	-Added appendix one (antipsychotics in dementia assessment and monitoring form)

Appendix One: Antipsychotics in Dementia Assessment and Monitoring Form/Tool

Patient Details

Patient Name		Ward / Address	
Date of Birth		Hospital Number/NHS Number	
Name of Main Carer			

Dementia Subtype (tick which applies)

Alzheimer's		Dementia with Lewy Bodies		Vascular		Unspecified		
Fronto-temporal		Parkinson's		Mixed				

Symptoms secondary to dementia (tick which applies)

Psychosis - delusions		Physical aggression		Sleep disturbance	
Psychosis - hallucinations		Verbal aggression		Disinhibited behaviour	
Depression / low mood		Agitation		Wandering / restlessness	
Distress		Anxiety		Vocalisation	
Other (please state)					

Pre-treatment Assessment (tick which applies)

Have the following causes of BPSD been considered?

Depression		Side effects of medication e.g. anticholinergic burden		Treatment related: catheters, monitors	
Anxiety		Environment: noise, temp., lighting, ward, bed space			
Delirium				Other (please comment):	
Activity: boredom, misinterpretation of care tasks		Physical: pain, constipation, urinary tract infection, chest infection, thirst, hunger			

Which non-pharmacological interventions were tried before an antipsychotic? (tick which applies)

Review of social and personal activities with family/carer involvement	
Changes in staff approach e.g. distraction	
Changes to environment e.g. lighting, TV, quiet areas, orientation aid	
Watchful waiting and monitoring	
Other (please comment):	

Baseline Physical Monitoring (repeat monitoring after 3 months, then annually if antipsychotic continues)

Within the last 3 months has the patient had the following tests:

Blood pressure		Yes	FBC		Yes
		No			No
Heart rate		Yes	U&Es		Yes
		No			No
Weight		Yes	LFTs		Yes
		No			No
ECG		Yes	TFTs		Yes
		No			No
Fasting blood glucose OR HbA1c		Yes	Prolactin		Yes
		No			No
Lipid profile		Yes	The patient is too distressed. Therefore, monitoring has not been successful (please tick)		
		No			

Antipsychotic				
Full discussion with patient (or if lacks capacity the carers) about the risks and benefits of antipsychotic treatment				Yes
				No
Has the patient (or if lacks capacity the carers) been given a patient information leaflet about the chosen antipsychotic e.g., Choice and Medication				Yes
				No
Start date of drug*:		Antipsychotic name:		
Total daily **regular** dose (mg):		Total daily **PRN** dose (mg):		
Clinician initiating/reviewing drug:				

*If an antipsychotic was started by another team and there is not an antipsychotic care plan in place, please state the start date if known. Please then state the current antipsychotic and current dose that will be reviewed under your care.

Signature: ……. Date: ……

Review of Antipsychotics in Dementia

Patients who respond well to new antipsychotic treatment should be **reviewed after 6 weeks**. Afterwards, withdrawal of the antipsychotic must be considered. If BPSD persists and treatment with antipsychotics is needed long term, they should be reviewed **every 3 months**.
Please review antipsychotic therapy **weekly during in-patient multi-disciplinary team meetings**.
Please document any reviews in the table below.

Review	Date	Comments e.g., dose or drug change	Clinician Reviewing (Print and sign)
1			
2			
3			
4			
5			
6			
7			
8			

Antipsychotic on Discharge tick which applies	
The antipsychotic was stopped before discharge	
The antipsychotic will be continued by secondary care prescribers	
Communication has been made to the GP regarding the antipsychotic name and dose, the reason for prescribing and who and when it should be reviewed.	
Review date after discharge please state and add to patient discharge summary	