NHS

Nottinghamshire Area Prescribing Committee

Managing Behavioural and Psychological symptoms in People with Diagnosed or suspected Dementia in Primary Care

Guidelines for use in people with dementia in Nottingham and Nottinghamshire

Ratified by: Trust Medicines Optimisation Group March 2025. Review date: March 2028
Antipsychotic Assessment and Monitoring in Dementia V5.0
Accessibility checked. Contains tables and flow charts which may not be accessible to screen readers

Managing Behavioural and Psychological symptoms in People with Dementia in Primary Care

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-centred 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 symptoms.
- 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)
- Document reasons for each prescription for BPSD.
- Document when the medication can be reduced or stopped.
- request a review of drugs prescribed for BPSD every 3 months and try withdrawing/stopping the drug.
- complete an antipsychotic in Dementia assessment and monitoring tool if prescribing an antipsychotic and send a copy to the GP (appendix one)

3. **Key message for GPs and primary care**
- antipsychotic medication is for specialist initiation or recommendation only
- for patients in care homes, consider referral to the Dementia Outreach Teams if non-pharmacological interventions are ineffective
- on-going antipsychotic prescriptions require a prescribing Antipsychotics in Dementia Assessment and Monitoring Form/Tool (appendix one)
- 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. These are guidelines developed to best support the management of people living with dementia. It is a complex and contentious area and may not apply in every clinical situation. We would encourage you to use your professional judgement to ensure the most appropriate care for each individual and refer to the NICE guidelines available on: https://www.nice.org.uk/guidance/ng97

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

Patient has a Behavioural and Psychological Symptom associated with Dementia (BPSD): delusions, hallucinations, agitation, aggression,

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 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

-Formulate a care plan. Consider person centred approaches.

-Involve family and carers. Collect information on biography, preferences and routines.

-Understand what the person with dementia experiences.

–Develop a relationship to relieve anxiety. -Don't confront, punish or humiliate

-Consider watchful waiting for 2 or 3 days.

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, fluctuations in consciousness, REM sleep behaviour disorder (acting out dreams without waking up)

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 she/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. If dementia with Lewy bodies is suspected, do not start antipsychotics in primary care.

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 Antipsychotics in Dementia Assessment and Monitoring Form/Tool (appendix one). Request a review every 3 months.

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Primary care prescribers: Antipsychotic prescriptions require an Antipsychotics in Dementia Assessment and Monitoring Form/Tool (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

All patients with Alzheimer's, Dementia with Lewy Bodies, Parkinson's disease dementia, and Mixed Dementia should be considered for Acetyl Cholinesterase Inhibitors and/or memantine unless specifically contraindicated, tried and no benefit, or stopped because of adverse effects.

Key Symptom	First Line	Second Line
Depression	Watchful waiting, Consult Specialist services, CMHT	Sertraline
Psychosis (2)	Watchful waiting, Consult Specialist services, CMHT	Aripiprazole, Risperidone (5),
Aggression	Watchful waiting, Consult Specialist services, CMHT	PRN lorazepam (1), Risperidone (5),
Severe Anxiety	Watchful waiting, Consult Specialist services, CMHT	Sertraline, Trazodone (6)
Severe Agitation	Watchful waiting, Consult Specialist services, CMHT	PRN lorazepam, Risperidone (5),
Poor Sleep (3)	Sleep Hygiene & CBT	PRN Zopiclone,
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

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

Key Symptom	First Line	Second line
Depression	Watchful waiting, Consult Specialist services, CMHT	Sertraline (4),
Psychosis (2)	Stop dopamine agonists, consider reducing L-DOPA,	Quetiapine (4), Aripiprazole
Aggression	Watchful waiting, Consult Specialist services, CMHT	PRN Lorazepam, Trazodone (6)
Severe Anxiety	Watchful waiting, Consult Specialist services, CMHT	Trazodone (6), Sertraline
Severe Agitation	Watchful waiting, Consult Specialist services, CMHT	PRN Lorazepam, Trazodone (6)
Poor Sleep (3)	Sleep Hygiene & CBT	PRN Zopiclone,
REM sleep behaviour (nightmares, hyperactivity)	Memantine	Clonazepam, Melatonin (7)
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

NOTES

(1) Benzodiazepines can increase risk of falls and should be used as PRN only.

(2) The evidence base for treating psychosis is poor. Antipsychotics will not work for 'understandable delusions' caused by forgetfulness, such as 'living in the past'.

(3) 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.

(4) Quetiapine and SSRIs may worsen motor symptoms of PDD. Antipsychotics should not be initiated in DLB or suspected DLB without specialist advice.

(5). 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.

(6) Trazodone – Trazodone is not licensed to treat aggression or agitation associated with dementia. However, it is used for this clinical purpose widely. Please view the following citations supporting its use for this purpose,
https://pubmed.ncbi.nlm.nih.gov/9169246/ https://pubmed.ncbi.nlm.nih.gov/21629010/
https://journals.sagepub.com/doi/10.1177/0269881117744996
https://www.alzdiscovery.org/uploads/cognitive_vitality_media/Trazodone-Cognitive-Vitality-For-Researchers.pdf Start at 25mg/day and increase cautiously at weekly intervals up to 50-100mg/day. Trazodone and SSRIs can increase falls risk.

(7) Specialist initiation for treatment of REM sleep disorders in Parkinson's disease in 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	Maximum dose
Risperidone	250microgram twice daily	500microgram once daily	1mg twice daily
Quetiapine	25mg once daily	25-100mg once daily or in divided doses	200 mg once daily or in divided doses
Aripiprazole	2.5mg once daily	2.5-10mg once daily	15 mg once daily
Lorazepam (9)	0.5mg once daily PRN	0.5mg-1mg per day PRN	0.5mg-2mg per day PRN
Trazodone	25mg once daily	50 mg BD	100 mg BD

A reference list is available on request.

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	