

## **Guidelines for the Management of Behavioural Problems in Dementia and the use of Antipsychotic Drugs**

NHS Northamptonshire & Northamptonshire Healthcare NHS Foundation Trust  
August 2010(ammended Oct 2011)

- This is a new guideline.
- These guidelines are intended to support General Practitioners in the care of their patients with dementia both in the community and in care homes.
- It incorporates NICE clinical guideline 42 and The All-Party Parliamentary Group on Dementia: "Always a Last Resort".
- Only use antipsychotics as a last resort.
- Assess and treat any causative physical or mental health problems as a first step.
- Offer appropriate environmental, psychosocial and behavioural interventions.
- In severe distress or immediate risk of harm to others consider a time limited trial of antipsychotics.

*This guideline is adapted from: "Guidelines for the management of behavioural problems in dementia and the use of antipsychotic drugs" – Derbyshire Joint Area Prescribing Committee, April 2009, with the agreement from the author.*

# Guidelines for the Management of Behavioural Problems in Dementia and the use of Antipsychotic Drugs

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## Treatment algorithm for the management of behavioural problems in dementia

Person with Dementia presents with behavioural problems:

e.g. restlessness, wandering, agitation, aggression, sleep disturbance, sexual disinhibition, shouting

Assess risk:

- 1) None or Mild – manage in present setting
- 2) Significant – seek advice from Older People's service at NHFT

Does patient have delirium ? (short history < 1 week of confusion, hallucination, delusion with fluctuating cognition  
e.g. constipation, pain/discomfort, urinary tract infection, physical illness, other illness including delirium.

Yes

Treat underlying acute medical problem e.g. UTI, chest infection, alcohol and drug withdrawal.

No

Apply **PAIN** approach and manage or treat:  
**P**= physical problems e.g. infection, pain  
**A**=activity related e.g. dressing, washing  
**I**= Iatrogenic e.g. side-effects of drugs e.g. anti-cholinergics  
**N**=Noise and other environmental factors e.g. light

Assess for any functional mental health problems:

e.g. depression, anxiety, insomnia, psychosis

Present

Treat any associated functional mental health problems:

- 1) Depression – consider an antidepressant e.g. **Selective Serotonin Reuptake Inhibitor (SSRI)** or follow NICE guidance
- 2) Anxiety – consider a 2-3 week trial of a benzodiazepine e.g. Diazepam
- 3) Insomnia – consider a 2-3 week trial of a short-acting hypnotic of the lowest acquisition cost, currently Zopiclone
- 4) Psychosis – consider an antipsychotic drug e.g. Haloperidol, Amisulpride, Quetiapine

and, where appropriate

Not present

Non-pharmacological management – consider these approaches first for people with dementia:

- Physical presence: spending appropriate time with a person will usually help.
- Recreational and social activities and therapies. These help structure the day, provide meaning and a setting for social interaction.
- Behavioural interventions: identifying the nature, antecedents and consequences of the target behaviour, setting goals and devising a plan with ongoing review.
- Psychological and psychosocial interventions tailored to the needs of the individual patients, family, carers and care staff.
- Environmental interventions: design and layout of the physical environment, day/night routines.
- Compensating for sensory impairments, attending to diet and general health.
- Risk assessment, reduction and intervention. Appropriateness of placement.

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**If the methods described on page 2 have proved unsuccessful and patient is in severe distress or is an immediate risk of harm to themselves or others:**

As a LAST RESORT consider a 2 to 3 week trial of one of the following:

<b>Indications Behavioural problems plus:</b>	<b>Drug</b>	<b>Starting dose</b>	<b>Increase in stages to a usual maximum dose/frequency of:</b>
Possible Psychosis:	Haloperidol	500microg Twice a day	1.5mg Twice a day
or	Amisulpride	50mg Once a day	50mg Twice a day
Additional Anxiety	Diazepam	2mg Once a day	5mg Twice a day
Agitation alone	Promazine	25mg Twice a day	50mg Four times a day
Aggression + Agitation	Risperidone	500microg Once a day	1mg Twice a day
Aggression + Agitation if no response to Risperidone	Haloperidol	500microg Twice a day	1.5mg Twice a day
Possible Depression	Trazodone liquid (50mg/5ml)	25mg (2.5ml) Twice a day	50mg (5ml) Twice a day Or change to capsules

### **Treatment successful?**

#### Prescriber to:

- Monitor response.
- Attempt to withdraw after 3 months.(treatment with risperidone should be reviewed at 6 weeks in line with licence)
- Reduce **gradually** over 4 weeks, but tailor to individual response.

See NHS Northamptonshire "Algorithm for review, withdrawal and stopping of

### **Treatment unsuccessful?**

Refer to Older People's Service at NHFT.

#### Contact details for localities:

- Kettering Resource Centre,  
Kettering – 01536 494960
- Stuart Road Resource Centre,  
Corby – 01536 267262
- Orchard resource centre,  
Rushden – 01933 319601
- East & West team  
Watermill Resource Centre,  
Berrywood Hospital – 01604 596387
- Mill House,  
Towcester – 01327 351822
- Daventry Resource centre, Danetre  
Hospital Daventry – 01327 707235

### **If medication is to continue beyond 3 months:**

- Note that risperidone is the only drug licensed specifically for the treatment of BPSD and then only for 6 weeks
- It should be reviewed by the prescriber at least every 3 to 6 months during continuing treatment
- Document target symptoms and adverse effects at review.

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*“Consider medication for non-cognitive symptoms or behaviour that challenges in the first instance only if there is severe distress or an immediate risk of harm to the person with dementia or others” NICE CG42*

### **Factors to consider before prescribing antipsychotic drugs in older adults with dementia:**

- There is a lack of good information/evidence on the pharmacological treatment of behavioural symptoms of dementia.
- Consider alternatives to antipsychotic drugs. The Royal College of General Practitioners (RCGP) suggests that behavioural symptoms may be the result of depression which should be treated appropriately. For others, a trial of short-term benzodiazepines may be appropriate.
- The Committee on Safety of Medicines (CSM) previously advised that the Risperidone and Olanzapine should not be used for treating behavioural symptoms of dementia, due to the increased risk of stroke in this population. The CSM continue to advise that a risk of stroke with other atypical antipsychotics cannot be ruled out. However, the Medicines and Healthcare products Regulatory Agency (MHRA) have since reviewed new evidence and updated the license for the efficacy of Risperidone for the short-term management (up to 6 weeks) of aggression in patients with moderate to severe Alzheimer’s dementia.
- Current evidence from recently published studies, seems to suggest that all antipsychotic drugs (both conventional and atypical) appear to increase the risk of mortality in elderly patients treated for behavioural and psychological symptoms of dementia (BPSD).
- The perceived benefits of using an antipsychotic drug to treat behavioural symptoms of dementia must be weighed against associated risks:
  - a) The possibility of cerebrovascular events should be considered carefully before treating any patient with a history of stroke or transient ischaemic attack
  - b) Risk factors for cerebrovascular disease and cardiovascular disease (e.g. previous history of stroke, hypertension, diabetes, smoking, obesity and atrial fibrillation) should also be considered.
  - c) Increased risk of falls due to postural hypotension and/or sedation occurring as a side effect of antipsychotic drugs, as well as the possibility of extra-pyramidal side effects (EPSE) that may affect mobility and quality of life.
- Typical antipsychotic drugs must be avoided in patients with Lewy body dementia or Parkinson’s Disease as this group of people are more prone to EPSE. In this patient group low dose atypical antipsychotic drugs may be trialled and titrated according to response.

In the management of behavioural and psychological symptoms of dementia, where pharmacological treatment is deemed necessary, the prescriber should use the most appropriate treatment, taking into consideration the cautions/risks mentioned above and selecting medication according to the needs of each individual patient.

Behavioural symptoms of dementia may occur due to underlying conditions that may have gone unnoticed and/or untreated. Therefore it is important to assess each individual patient for signs and symptoms of physical illness, infection, pain or other underlying mental health issues.

### **If an antipsychotic drug is considered necessary, the following suggested standards for monitoring and review should be adopted:**

- Target symptoms should be clearly defined and documented.

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- Ensure that consideration is given to the balance of risks and benefits of prescribing the drugs.
- Baseline investigations should be considered before initiating treatment (e.g. U&Es, LFTs, TFTs, Random Blood Glucose, ECG).
- Considerations should be made as to whether the patient has mental capacity to consent to medication – seek further advice if uncertain. A useful reference is BMA Assessment of Mental Capacity: Guidance for Doctors and Lawyers. 2nd Edition. London BMJ Books 2004.
- If a decision is made to use an antipsychotic drug, start with the lowest possible dose and titrate slowly according to patient response (consult BNF/SPC for doses in elderly patients).
- Patient and/or carers should be provided with information i.e. the need for treatment and possible effects.
- Medication should be reviewed regularly during the titration period.
- Adverse effects must be considered at each review.
- Medication should be reviewed at least monthly during the first 3 months of stability.
- Recent evidence from the All-Party Parliamentary Group on Dementia state that “a prescription should be time-limited because of lack of evidence of sustained benefit with antipsychotic therapy beyond 12 weeks”.
- **If medication is to continue beyond 3 months, then it should be reviewed by the prescriber at least every 3 to 6 months during continuing treatment. Document target symptoms and adverse effects at reviews.**

### **References:**

- Guidelines for the management of behavioural problems in dementia and the use of antipsychotic drugs. Derbyshire Joint Area Prescribing Committee, April 2009.
- Atypical antipsychotics and behavioural and psychiatric symptoms of dementia: Prescribing update for Old Age Psychiatrists. The Royal College of Psychiatrists Faculty for the Psychiatry of Old Age, 2004.
- All-Party Parliamentary Group on Dementia: “Always a Last Resort”. April 2008.
- Atypical antipsychotics and behavioural and psychiatric symptoms of dementia (BPSD): Summary of evidence and standards for prescribing antipsychotic drugs in older adults with dementia. Derbyshire Mental Health Services NHS Trust, April 2007.
- The use of antipsychotic medication for people with dementia: time for action. A report for the minister of state for care services. Professor Sube Banerjee. November 2009.
- NICE Clinical Guideline no.42 – “Dementia: Supporting people with dementia and their carers in health and social care”. November 2006.
- NICE Clinical Guideline no. 42 Audit Support Tool 2009 – “Dementia: the use of medication for non-cognitive symptoms, behaviour that challenges and behaviour control”.