NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Antipsychotic Prescribing in Dementia

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Revision/Amendment Information

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	Feb 2016	First approved version	PMG (MH) SLWG
2.0	Nov18	Throughout document Terminology changed from Behavioural and Psychological Symptoms of Dementia (BPSD) to symptoms of stress and distress in dementia Hyperlinks and references updated Page 5 Hyperlinks for choice and medication website and Alzheimer's society factsheets added Section on monitoring added with hyperlinks to Physical Healthcare policy and Drug induced QT prolongation Page 6 Addition to risperidone dose advice Updated DLB Consortium reference, now 4th report. Page 7 Replaced by adapted version of updated NHS Polypharmacy guidance 2018 Hyperlink to NHS GGC Clinical Guideline Psychotropic Medicines Reviewing with Care Home Residents added Antipsychotic treatment table added Page 8 Appendix I- Antipsychotic review flowchart added Page 10-12 Leaflet updated- statistics amended in accordance with updated NICE decision aid 2018 References amended Page 13 Section for T2/T3 certificate added	PMG (MH) SLWG

Contents

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Information for the original guidance has been assimilated from areas of good practice from NHSGG&C, NHS Tayside, NHS Forth Valley and NHS Lanarkshire

This guideline was reviewed by the Prescribing Management Group (Mental Health)

2. Introduction

This guidance is intended to assist in the decision making process for the treatment of patients with symptoms of stress and distress in dementia, also referred to as Behavioural and Psychological Symptoms of Dementia (BPSD)

It is recognised that non-pharmacological interventions are first line in the management of symptoms of stress and distress in dementia, but in certain circumstances, pharmacological intervention may be required. The guidance is intended to facilitate initiation and withdrawal of antipsychotics where appropriate, giving consideration for safe and effective prescribing.

3. Scope

This guidance supports a rational approach to antipsychotic prescribing for patients with symptoms of stress and distress in dementia under the care of specialist NHSGG&C Older People's Mental Health Services, in hospitals and community settings.

4. Rationalisation of Antipsychotics for People with Dementia – Good Practice Guide for Initiation of Treatment

It is important to remember that symptoms of stress and distress in dementia are often a temporary phenomenon or a result of external influences. 'Watchful waiting' and non-pharmacological interventions should be considered and possible physical causes of deterioration should be ruled out before prescribing antipsychotics. NHSGG&C has introduced the NES training for the assessment and management (non-pharmacological) of behaviours which indicate stress or distress in patients with dementia. Contact your local Older Adult Clinical Psychologist to find out if staff in your area have been trained, or to get further information.

If required for acute distress/agitation/anxiety, consider short-term use of 'as required' benzodiazepines prescribed at the lowest effective dose e.g. lorazepam 500micrograms (maximum 2mg over 24 hours). Clearly document the reason for use and outcome. There is no evidence base supporting the long-term regular use of benzodiazepines for symptoms of stress and distress in dementia

Do Not Initiate Antipsychotics In The Following Circumstances:
Antipsychotic medication use in older people with dementia is associated with an increased risk of stroke and death. In addition, all antipsychotics have significant adverse side effects. They should only be used as a last resort for specific symptom(s) for a specified time period, with regular monitoring of effect and any adverse effects.

- It is not appropriate to initiate antipsychotic medication to manage symptoms which are unlikely to be modified by antipsychotic medication e.g. wandering, repetitive vocalisation, sleep disturbance, repetitive questioning.

- It is not appropriate to initiate antipsychotic medication when the symptoms can be managed effectively by non-pharmacological methods such as person-centred care. Ensure non-pharmacological approaches have been properly implemented, evaluated and documented before initiating antipsychotic medication.

- Other possible causes should have been investigated e.g. physical causes, psychological causes and environmental factors before initiating antipsychotic medication (Appendix II- Quick Reference Guide).

When to Initiate Antipsychotic Medication:
It may be appropriate to initiate medication where:

- The person with dementia is distressed by the target symptoms.

- The health or safety of the person with dementia is compromised by the severity of the symptoms or the safety of others is at risk.

- There has been an adequate analysis of the potential risks and benefits.

Antipsychotic treatment may be effective for psychosis, persistent physical aggression or severe agitation. It may be appropriate to consider a short course of antipsychotic in delirium. See NHS GGC Delirium Diagnosis, Risk Reduction and Management in Acute Services for further information.[1]

Consideration of antipsychotic adverse effects

The most important adverse effects associated with antipsychotic use in patients with dementia are parkinsonism, falls, postural hypotension, dehydration, constipation, chest infections, ankle oedema, deep vein thrombosis/pulmonary embolism, cardiac arrhythmia/MI and stroke (highest risk in the first four weeks of treatment). Patients should be kept well hydrated and as mobile as possible. The consideration of these potential adverse effects and decisions regarding treatment choice should be clearly documented.

Consent and statutory treatment plans

Medication initiation and changes to medication must be discussed with the patient if they have capacity. Where capacity is absent and there is an existing legal proxy i.e. welfare attorney or guardian, the decision to prescribe must be discussed with them, risks outlined and agreement sought. (See Appendix III for patient and carer information leaflet)

Patient information leaflets for the use of specific medications are available on the Choice and Medication website.[2] www.choiceandmedication.org/nhs24. An information guide for medication used for symptoms of dementia is also available from Alzheimer's Society Alzheimer's Society Factsheet Drugs used to relieve BPSD[3]

If the patient lacks capacity and if there is no formal legal welfare proxy, the principles of the Adults with Incapacity (Scotland) Act 2000 apply and treatment options should be discussed with relevant others, such as next of kin, carer or patient advocate. In either circumstance, an appropriate Section 47 certificate of incapacity is required. If a patient is subject to the Mental Health *(*Care and Treatment)(Scotland) 2003 Act, check that any psychotropic medication is included on a current T2/T3 certificate.

Commencing antipsychotic treatment

Antipsychotics should be commenced at the lowest possible dose, titrated carefully and reviewed within the first four weeks and after 6-12 weeks. At review, discontinuation of the antipsychotic should be considered unless there is ongoing significant risk and/or distress.
Appendix IV- Antipsychotic prescribing in dementia initiation and review should be used when commencing treatment and for review throughout treatment

Monitoring

The management of physical health care of older patients differs to that of a younger population for the following reasons;

- Bioavailability of medication
- An increase in the sensitivity to medication effects
- Increased frailty and multi-morbidity.

The older adult patient should receive the same standard of physical health care as that of the younger adult, paying attention to these special features. Monitor for common side effects such as extrapyramidal side effects, antimuscarinic effects (especially constipation) and effects on blood pressure and biochemistry. Please refer to NHS GGC MHS Physical Healthcare Policy[4] for further information on monitoring standards.

Where appropriate and practical, ECGs should be completed at baseline and thereafter when clinically indicated. Abnormalities should be acted on according to significance and clinical indication. Consult with cardiologist if in doubt. See NHS GGC MU Extra Drug Induced QT Prolongation for further information on QT prolongation.[5]

Licensed treatment
Risperidone is an antipsychotic licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others

The BNF dose in this case is 250micrograms twice daily increased according to response. The usual dose is 500micrograms twice daily. (Maximum 1mg twice daily)[6]
Consider a lower starting dose of 250micrograms once daily. This can be effective and may be more appropriate for those frailer patients who are at higher risk of adverse effects.

Lewy Body Disease and Parkinson's disease dementia
The use of antipsychotic medication for the treatment of symptoms of stress and distress in patients with Lewy Body disease should generally be avoided as risks are greater in this patient group. In dementia with Lewy bodies and Parkinson's disease (PD) dementia the limited evidence supports the use of cholinesterase inhibitors to target psychotic symptoms. It is acknowledged however that for more severe psychotic symptoms that have not responded to a cholinesterase inhibitor, a cautious trial with an antipsychotic may be required. First generation antipsychotics e.g. haloperidol should be avoided.
The fourth report of the Dementia with Lewy Body (DLB) Consortium[7] suggests that low dose quetiapine may be relatively safer than other antipsychotics in DLB.
Aripiprazole has theoretical advantages over conventional antipsychotics in DLB and is occasionally used in practice, however, the updated DLB Consortium did not recommend its use.
The use of antipsychotics in DLB is off-label. When commencing antipsychotic treatment for DLB or PD dementia, 'start low and go slow' e.g. 12.5mg quetiapine.

Antipsychotic	**Indication**	**Dose range**
Risperidone	Persistent aggression in moderate to severe Alzheimer's dementia *	250 micrograms daily to 1mg bd
Quetiapine	DLB or PD dementia	Start at 12.5mg daily and increase cautiously as tolerated
Aripiprazole	DLB or PD dementia**	Start at 1mg aripiprazole daily and increase cautiously as tolerated eg in 1mg increments

*risperidone licensed for short term management of Alzheimer's dementia
** anecdotal evidence for use of aripiprazole in DLB and PD dementia

5. **Rationalisation of Antipsychotics in Patients with Dementia -Good Practice Guide for Reduction/Cessation of Treatment**
Adapted from NHS Scotland Polypharmacy Guidance 2018[8]

Antipsychotics have only limited benefit in treating symptoms of stress and distress in older people with dementia and carry significant risk of harm e.g. delirium, cerebrovascular events, falls and all-cause mortality.

Medication and management of stressed and distressed behaviours:

- Medication should be used as last, not first resort, to manage stress and distress
- People with dementia on psychotropic medicines should be prioritised for multidisciplinary review
- People with dementia on psychotropic medicines should be reviewed every three months
- Psychotropic medicines should be withdrawn gradually

Which patients should be prioritised for review?

Patients who have dementia and who have been on antipsychotics for more than 3 months and have stable symptoms should be reviewed by initiating team or in consultation with mental health services with a view to reducing or stopping antipsychotic medication. Priority groups for reducing antipsychotic medication include:

- People in care homes (see NHS GGC Clinical Guideline Psychotropic Medicines Reviewing with Care Home Residents for support in reviewing psychotropic medications other than antipsychotics[9])
- People with vascular dementia
- People with dementia plus history of cardiovascular disease

When should antipsychotic medication NOT be stopped?

Patients who have a co-morbid mental illness that is treated with antipsychotic medication, such as schizophrenia, persistent delusional disorder, psychotic depression or bipolar affective disorder should not have antipsychotic medication reduced without specialist advice.

How to reduce antipsychotic medication? (Appendix I: Antipsychotic Review Flowchart)

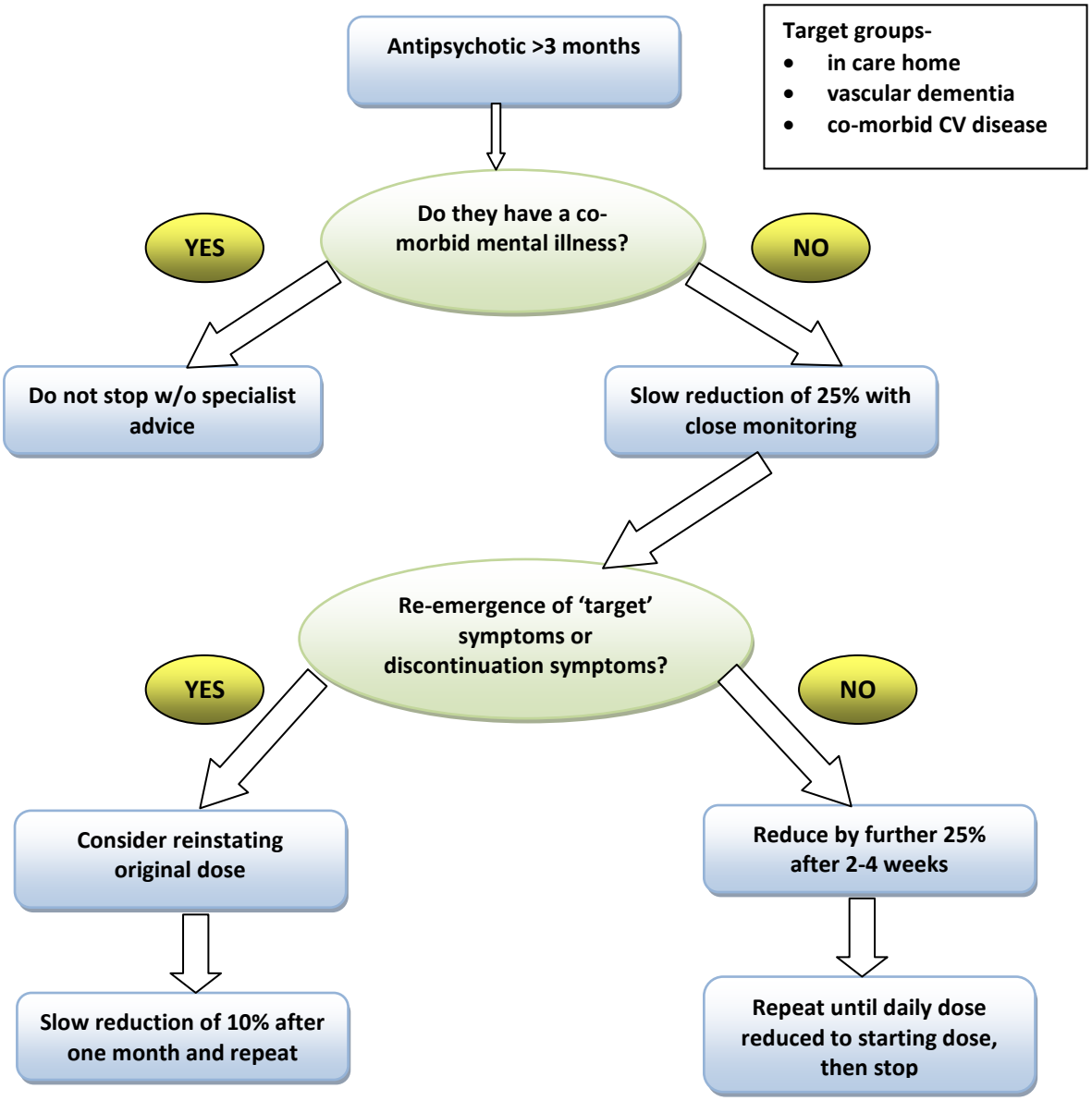
- Slow reduction (25% daily dose) with close monitoring
- Review the effect after one week to assess for: the re-emergence of the initial 'target' symptoms of stress and distress
- Discontinuation symptoms include nausea, vomiting, anorexia, diarrhoea, rhinorrhoea, sweating, myalgia, paraesthesia, insomnia, restlessness, anxiety and agitation. Generally begin within 1 to 4 days of withdrawal and abate within 7 to 14 days
- If either of the above occurs the clinician should make an assessment of the risks and benefits of re-instating the previous dose of antipsychotic. Further attempts to reduce the antipsychotic should be made one month later with smaller decrements (10% daily dose)
- If there are no particular problems after week 1 then the dose should remain the same with further review after week 2 to 4 weeks.
- If the reduction has been tolerated without any of the effects described above then reduce by a further 25% and repeat the process
- There may be practical issues when reducing the dose, for example the availability and form of small doses of medication. It is recommended that this is discussed with a pharmacist.
- It is suggested that once the total daily dose is reduced to the recommended starting dose for the individual antipsychotic, it may be stopped
- In addition to reviewing antipsychotic prescriptions, review any other medication prescribed for antipsychotic side effects as they may no longer be required once the antipsychotic has been stopped.

6. References

1. NHS GGC Clinical Guideline Delirium Diagnosis, Risk Reduction and Management in Acute Services. March 2018
2. Choice and medication www.choiceandmedication.org/nhs24
3. Alzheimer's Society Publications and factsheets https://www.alzheimers.org.uk
4. NHS GGC Mental Health Service Physical Healthcare Policy April 2018
5. NHS GGC Medicines Update Extra Drug Induced QT prolongation. Issue8. Jul 2018

6. British National Formulary BNF76. Sep18-Mar19
7. McKeith IG, Boeve BF, Dickson DW, Halliday G, Taylor JP et al. Diagnosis and management of dementia with Lewy bodies: Fourth consensus report of the DLB Consortium. Neurology. 2017 Jul 4;89(1):88-100.
8. NHS Scotland Polypharmacy Guidance Realistic Medicine 3rd Edition 2018
9. NHS GGC Clinical Guideline. Psychotropic Medicines Reviewing with Care Home Residents. May2017
10. National Institute for Health and Care Excellence. NICE Decision aid for Dementia: assessment, management and support for people living with dementia and their carers. June 2018

Appendix I: Antipsychotic review flowchart



Appendix II - Quick Reference Guide

The following is a guide to causation and management of symptoms of stress and distress in dementia. At any stage of dementia the person may display symptoms of stress and distress including; psychotic symptoms, aggression, agitation, wandering, anxiety, irritability, loud and/or repetitive vocalisation, apathy, repetitiveness, uncooperativeness, sexual disinhibition, inappropriate urination/defecation, disturbed sleep, sundowning etc.

This guide has been designed to be used by all staff to assist in the management of symptoms of stress and distress and to eliminate possible causes for changes in emotions, behaviour and functioning. It should be referred to in the first instance, prior to utilising psychotropic medication.

There has been a ***rapid*** change in the patient's behaviour

There has been a ***gradual*** change in the patient's behaviour

Exclude Physical Causes

- **Delirium –** Urine dipstick/MSSU, check temperature, bloods e.g. FBC, U&E, LFT, TFT, ESR, CRP, Glucose, Vitamin B12, folate & ferritin levels & 4AT assessment
- **Dehydration** – check above blood levels; especially U&E. Commence on fluid balance chart
- **Pain** – complete appropriate pain assessment tool e.g. Abbey Scale
- **Hunger** – monitor and complete fluid and diet charts
- **Constipation** –monitor bowel habits
- **Tiredness** – chart sleep pattern
- **Medication** – side effects
- **Medication withdrawals –** e.g. benzodiazepines, opiates
- **Sensory Impairment** – sight &/or hearing deficit - refer to sensory impairment service for assessment and advice (where applicable)
- **Hypoxia** – cyanosis, laboured breathing pre-existing conditions e.g. COPD

Consider Psychological Causes

- **Depression** – observe for any mood or behavioural changes. Complete appropriate assessment tool
- **Hallucinations** – more commonly seeing&/or hearing things. NB exclude delirium
- **Delusions –** more commonly paranoia &/or suspiciousness. NB exclude delirium
- **Sundowning -** increased agitation and activity occurring in the late afternoon/early evening

Consider Environmental Causes

- **Noise levels** – over stimulation/elevated noise levels can be antagonistic
- **Lack of social stimulation**
- **Inappropriate music** – ensure age related and appropriate to thepatient group
- **Environment/layout**
  - Is it conducive to the specific patient group?
  - Could it potentially increase confusion and disorientation in people suffering from cognitive impairment?

Consider Other Causes

- **Staff** – tone of voice, approach, body language, poor verbal and/or non-verbal communication
- **Inflexible routines** – e.g. toileting, bathing, bedtimes
- **Task orientated care**
  - lack of person-centred care
  - not knowing the person
- **Patient group**
  - Do other individuals trigger behaviours
- **Continuity of staff**
  - Therapeutic relationships
  - Team continuity

Exclude other causes if there has been no improvement or further deterioration in the patient's behaviour

Adapted from Quick Reference Guide NHS Forth Valley

Appendix III - Patient and Carer Information Leaflet.

Information for carers and patients about

Antipsychotic Medication in Dementia

What is dementia?

Dementia is an illness that causes a progressive worsening of brain function. Dementia affects people in different ways and common symptoms are memory loss, difficulties with communication and personality change. There are many causes of dementia but the common types are Alzheimer's and Vascular.

What are symptoms of stress and distress in dementia? (also referred to as behavioural and psychological symptoms of dementia)

People with dementia can develop symptoms of stress and distress which become more common as the illness develops. These symptoms can be distressing for the person and for those who care for them.

Sometimes a person may develop delusions (believing things that aren't true, like people stealing from them) or hallucinations (seeing or hearing things that aren't there).

Other times a person's character may change, making them more easily upset, angry or even aggressive.

What is antipsychotic medication?

Risperidone, an antipsychotic, is licensed for use in severe distress or aggression in Alzheimer's dementia.

There are other antipsychotics which are sometimes used including;

- haloperidol which may be used if a person has delirium as well as dementia;
- quetiapine which is used in Parkinson's or Lewy body dementia.

When do we use antipsychotics?

In some cases a person may become very severely distressed by their symptoms or the level of physical aggression becomes hard to manage safely.

We always aim to manage these symptoms using non-drug methods, such as distraction and taking part in other activities. Occasionally however this does not work and the doctor or nurse may suggest using an antipsychotic drug.

We only use these drugs when other alternatives do not work and the person is very distressed or aggressive.

What are the benefits of using antipsychotics?

These medications have been shown to be helpful for reducing levels of physical aggression and reducing psychotic symptoms (such as delusions and hallucinations).

For some people with dementia this can make a big difference to them, their family and carers.

Are there any risks of using antipsychotics?

No medication is free from side effects. This group of medications has been shown to cause some important side effects.

These include:

- Sedation (drowsiness)
- Muscle stiffness, slowing of movements or shakiness
- Ankle swelling
- Increased risk of falls
- Increased risk of infections
- Increased risk of blood clots
- Increased risk of stroke
- Increased risk of death

Risk of stroke[10]

- Taking antipsychotic medication increases the risk of stroke from 0.8% to 2%
- That means for every 1000 people living with dementia who have hallucinations, delusions or agitation and who take an antipsychotic for 6-12 weeks, while they are taking it, on average;
  - 980 people will not have a stroke whether they take an antipsychotic or not
  - 8 people will have a stroke whether they take it or not
  - a further 12 people will have a stroke because they take an antipsychotic

Risk of death[10]

- Taking antipsychotic medication increases the risk of death from 2.2% to 3.3%
- That means for every 1000 patients living with dementia who have hallucinations, delusions or agitation and who take an antipsychotic for 6-12 weeks, while they are taking it, on average;
  - 967 people do not die whether they take an antipsychotic or not
  - 22 people die whether they take the antipsychotic or not
  - a further 11 people die because they take the antipsychotic

This is the average. Some people will be at greater or lower risk of dying. It is not possible to know in advance what will happen to an individual person.

The doctor or nurse will discuss with the patient (where possible) and a family member or carer when considering these medications. There is often a balance between quality of life and risk of side effects.

How long are antipsychotics given?

In most cases we give people a short course of medication (up to 6-12 weeks). We know that usually a person's symptoms get better in time (often just a few weeks) and we aim to stop the medication as early as possible. A small number of people may need to be on medication longer term. This group of people often have the most severe and distressing symptoms.

The following websites contain useful information and links to resources:

NICE Decision Aid Antipsychotic Medicines for treating agitation aggression and distress in people living with dementia[11]

https://www.choiceandmedication.org/nhs24/

Alzheimer Scotland 0808 808 3000 www.alzscot.org

Alzheimer Society www.alzheimers.org.uk

Appendix IV - <u>ANTIPSYCHOTIC PRESCRIBING IN DEMENTIA INITIATION AND REVIEW</u>

Name: (addressograph)		Consultant Psychiatrist:	
CHI:		Location:	
Diagnosis:			
Indication for antipsychotic medication			

PRE-TREATMENT tick as appropriate

Management plan for symptoms of stress and distress in place	
Non-pharmacological methods and alternative treatments tried	
Physical co-morbidities considered	
Capacity considered and AWI Section 47 form /treatment plan completed as req^{d}	
T2/T3 certificate completed as appropriate	
Written Information provided e.g. Information for carers and patients about antipsychotic medication in dementia	
Discussion with patient/relative/carer/ welfare guardian/welfare attorney Name: Date:	

INITIATION OF TREATMENT

Antipsychotic	
Initiation dose/ titration schedule	
Date commenced	

REVIEW OF TREATMENT

Review period from initiation	Date	Response None/mild/moderate/good	Side effects	Still indicated? Consider withdrawal if stable Action
4 weeks				
Between 6 – 12weeks				
Every 3 months				