Management Algorithm

Managing behavioural problems in people with dementia
(Does not cover rapid tranquillisation of acutely disturbed)

Patient has Behavioural and psychological symptoms of Dementia (BPSD) – delusions, hallucinations, agitation, aggression, irritability, etc. with steady decline in cognition over 6/12

Does patient have a Delirium?
(short history <1 week confusion, hallucination, delusion with fluctuating cognition)

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. Anticholinergics
N = Noise and other environmental factors, e.g. lighting

Behavioural problems resolved?

Consider non-pharmacological approaches such as: distraction, leave & return, activity, one-to-one care, music, aromatherapy. Carer support may improve coping ability of care(s).

Behavioural problems resolved?

Only consider pharmacological treatment if there is psychosis, depression or behaviour that is harmful or distressing to the individual or others.

First line risperidone 0.5mg-2mg per day, second line quetiapine (unlicensed) up to 100mg per day, for up to six weeks.

Use 3 ‘T’ approach – Target, Titrate, and Time

Target - Identify the dominant target symptom group
Challenging behaviour:
Psychosis: Delusions / Hallucinations - Aggression, Agitation
Other symptoms: e.g. vocalisations, sexual disinhibition, stereotypical movements, etc.

Non-challenging behaviour:
Depression, Apathy and Anxiety Depression: depressed mood and/or loss of ability to enjoy previously pleasurable activities. May or may not include apathy.
Apathy: diminished motivation, listlessness, loss of drive to engage in activities. May be perceived as laziness.
Sleep disturbance.
Titrate – start low and go slow
Time – treatments must be prescribed for a time limited period depending on the intervention.

Treat underlying acute medical problems, e.g. UTI, chest infection, constipation, side effects of drugs, alcohol and drug withdrawal, etc.

Does patient have a Delirium?

No further action

No

No further action

Yes

Yes

No further action

Yes
Guidance for GPs on the use of antipsychotics for behavioural problems in people with dementia

Some atypical antipsychotic drugs have demonstrated small positive effects, particularly over short-term use (up to 3 months), however CSM warnings, publications and independent guidance regarding the use of antipsychotic drugs in dementia indicate increased risk of stroke and sudden cardiac death.

Although there is much variation in the studies, some of the potential risks of antipsychotics in the dementia client group are:

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>Average risk untreated</th>
<th>Average risk with antipsychotics</th>
<th>Increase</th>
<th>Reference</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>1.1%</td>
<td>3.3%</td>
<td>2.2%</td>
<td>CSM 2004 Atypical antipsychotic drugs and stroke</td>
<td>Old age, obesity, DM, hypertension, smoking, cardiac arrhythmias</td>
</tr>
<tr>
<td>Sudden cardiac death</td>
<td>0.18%</td>
<td>0.27%</td>
<td>0.09%</td>
<td>N.Eng J Med 2009; 360:225-35, 294-6</td>
<td>Male, old age, high dose, smoking, CVD</td>
</tr>
</tbody>
</table>

It is also important to consider risk of other side-effects such as extra-pyramidal symptoms, hypotension, weight gain, dysregulation of blood glucose levels

People with dementia should only take these medicines when:
1. their behavioural symptoms are due to mania or psychosis and/or
2. the symptoms present a danger to themselves or others and/or
3. the person is experiencing inconsolable or persistent distress, a significant decline in function or substantial difficulty receiving needed care,

Exclude other causes of psychosis before treatment:

Efforts to exclude delirium as a cause of psychosis should take place prior to agreeing to treat with antipsychotics.

The development of non-cognitive symptoms causing significant distress, or behaviour that challenges in people with dementia should lead to physical and psychosocial assessment looking for concurrent illness, such as infection (especially UTI), undetected pain, side effects of medications (including acetylcholinesterase inhibitors), depression, anxiety, boredom, dehydration, physical environment, individual life history, psychosocial factors (against whom is the aggression directed? Is there a reason for this?), etc.

Consider whether the behaviour is primarily a problem for the person with dementia, or for their carers.

The PAIN mnemonic may be helpful:

- **P** = Physical problems, e.g. infection, pain
- **A** = Activity-related, e.g. dressing, washing
- **I** = Iatrogenic, e.g. side effects of drugs, e.g. anticholinergics
- **N** = Noise and other environmental factors, e.g. lighting
However, the risk of no treatment may be higher than the risk of treatment.

**Try non-drug therapies first if possible:**
Non-drug therapies may be helpful for people with dementia who have co-morbid emotional disorders, such as depression and anxiety. The NICE-SCIE guideline recommends that a range of psychological interventions and cognitive behavioural therapy (CBT) should be considered for depression and/or anxiety.

Care homes should develop detailed care plans, documenting life histories and interventions tailored to person’s preferences, skills and abilities. These may include aromatherapy, multisensory stimulation, therapeutic massage, animal assisted therapy, and the use of music and/or dancing. Response should be monitored and the care plan adapted / updated as needed. Only where non-drug therapies have failed and have been documented as such (which may include the use of behaviour charts – example as appendix) should prescribing be considered.

**Principles of prescribing antipsychotics in this client group:**
The Mental Capacity Act would recommend that it is good practice to involve relatives to ensure actions taken are in the patient’s best interests. The relative risks should be discussed and documented.

**Initiating antipsychotics:**
If antipsychotic treatment is considered necessary, trial an atypical antipsychotic and start treatment with the lowest possible dose (usually half of the normal maintenance dose), and increase this after 2–4 days if no response. There should be a documented assessment of risks and benefits, including the patient’s risk factors for cerebrovascular disease. Target symptoms should be identified and documented, and treatment reviewed after not more than 6 weeks to assess response (two studies have indicated the possibility of greater risk within the first four weeks of treatment, suggesting that increased vigilance and monitoring during this period is advisable). Changes in cognition should be regularly assessed and recorded; consider alternative medication if necessary.

**The patient must have an elective planned review within 6 weeks.** Patients who show symptomatic improvement to treatment over 6 to 12 weeks should then have their antipsychotic withdrawn cautiously, in regular step wise intervals. If treatment continues beyond the short term then it should be regularly reviewed – at least every three months, and treatment stopped every few weeks to check that it is not causing adverse effects. Consider the risk-benefit ratio of continuing or changing/switching medicines. If the person is well settled, there may be a higher risk of switching but side effects should be monitored. Consider also whether there is a continuing need for the medication or whether a gradual withdrawal may be appropriate.

In Lewy Body Dementia extreme caution is necessary for the use of antipsychotics.

Risperidone (0.5 to 2mg per day) is now the only antipsychotic licensed for “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.” Adverse effects, especially a decline in functioning require careful monitoring. Remember that the SPC for risperidone warns of a higher incidence of mortality in patients treated concurrently with furosemide and risperidone.
Quetiapine (up to about 100mg per day) is commonly used and remains an option (but is unlicensed for this use and has very limited evidence of effectiveness); the same principles apply regarding dosage and review. Other unlicensed medications are sometimes prescribed by local consultant psychiatrists where other options have failed.

**Conventional antipsychotics:**
These should be avoided but may be necessary - e.g. for rapid tranquillisation (see below); or if atypical have been ineffective and an antipsychotic agent is still indicated.

**Alternative medications:**
There is some evidence that anticholinesterases and memantine, regardless of whether the patient has been prescribed them previously, may decrease agitation and aggression, though the evidence is not fully established in this group. Prescribing of these drugs should only be initiated by specialists in the care of people with dementia. Bear depression in mind if there are behaviour changes, such as irritability, in which case SSRIs may be effective. If disturbances of the sleep-wake cycle are distressing, a short term trial with small doses of a hypnotic may be helpful.

**Rapid tranquillization:**
In occasional circumstances, rapid tranquillization may be necessary to prevent serious harm to self and others. A combination of haloperidol and lorazepam would be appropriate, paying close attention to dose considering the age and build of the individual concerned.

**Further references:**
1. Banerjee S. The use of antipsychotic medication for people with dementia : Time for action. A report for the Minister of State for Care Services, October 2009
3. NWMHP, Information on Dementia, Medication Choice,
Appendix:

Behaviour Record Chart

Name of Resident:……………………………………

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Observations of what happened prior to the incident</th>
<th>Type of Behaviour Observed</th>
<th>What happened immediately after the incident and how was the incident handled</th>
<th>Signature</th>
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Notes on how to fill in behaviour chart.

**Observations Prior to Incident**
1. Where was the person, and exactly what were they doing?
2. Was anyone else around, or had anyone just left?
3. Had a request been made of the person?
4. Had the person asked for, or did they want something to eat or drink?
5. Had the person asked for, or did they want a specific object or activity?
6. Had an activity just ended, or been cancelled?
7. Where were you and what were you doing?
8. How did the person’s mood appear, e.g. happy, sad, angry, withdrawn or distressed?
9. Did the person seem to be communicating anything through their behaviour, e.g. I don’t want….; I want….?

**Behaviour**
Include a full description of what the person did.

**How was the incident handled?**
2. How did the person respond to your reaction to the behaviour?
3. Was there anyone else around who responded to, or showed a reaction to the behaviour?
4. Did the person’s behaviour result in them gaining anything they did not have before the behaviour was exhibited, e.g. attention from somebody (positive or negative); an object, food or drink; or escape from an activity or situation?
| Title | Prescribing Guidance  
The use of antipsychotics for behavioural problems in people with dementia (version 2) |
<table>
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<tr>
<td>Description of policy</td>
<td>To support prescribers in making prescribing decisions on the use of antipsychotic medication in managing behavioural symptoms of dementia, to reduce inappropriate use, and minimise adverse effects of the medications.</td>
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<td>Scope</td>
<td>Prescribing in primary care for behavioural problems in people with dementia</td>
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<tr>
<td>Prepared by</td>
<td>Sue Woodruff, Senior Clinical Pharmacist Co-ordinator</td>
</tr>
<tr>
<td>Impact Assessment (Equalities and Environmental)</td>
<td>Completed – no impact</td>
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| Other relevant approved documents | 6. Banerjee S. The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services, October 2009  
3. NWMHP, Information on Dementia, Medication Choice, |
| Evidence base / Legislation | Level of Evidence: B  
A. based on national research-based evidence and is considered best evidence  
B. mix of national and local consensus  
C. based on local good practice and consensus in the absence of national research based information. |
| NHSLA Risk Manag. Standards / Standards for Better Health | Supports national guidance |
| Consultation on document | Dr Jonathan Hillam, Consultant Psychiatrist, Norfolk & Waveney Mental Health Partnership; NHS Norfolk Pharmacists Network Group; NHS Norfolk Drug & Therapeutics Commissioning Group |
| Training implications | n/a – update to existing policy |
| Monitoring and audit | Prescribing audits within GP practices – antipsychotic use in people on dementia registers |
| Dissemination | Is there any reason why any part of this document should not be available on the public website? ☐ Yes / ☑ No |
| Approved by | Drugs & Therapeutics Commissioning Group |
| Authorised by | Drugs & Therapeutics Commissioning Group |
| Review date and by whom | March 2017 |
| Date of issue | March 2015 |
### Version Control
(To be completed by policy owner)

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<td>S Woodruff</td>
<td></td>
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<td>S. Woodruff</td>
<td>Approved</td>
<td>Approved by D&amp;T Commissioning Group 15 March 2012</td>
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