

ANTIPSYCHOTICS in DEMENTIA for BEHAVIOURAL DISTURBANCE in accordance with NICE Clinical Guideline No. 42

GUIDELINES FOR ANTIPSYCHOTICS IN DEMENTIA

Elderly people with dementia are at risk of serious and life-threatening side effects when treated with antipsychotics. There is a clear increased risk of stroke (approximately 3-fold compared with placebo) and a small increased risk of death. These risks apply to both typical and atypical antipsychotics and even short term prescribing increases the risk of serious adverse events.

Non-pharmacological interventions should always be used first-line with likely factors that may generate, aggravate or improve such behaviours considered. Antipsychotics should be reserved for patients who fail to respond to non-pharmacological approaches (see Appendix 1).

Recommendations

- All patients with dementia who are currently prescribed an antipsychotic drug should have their treatment regularly reviewed, with the outcome of the review documented in the clinical record. The medication review should take account of therapeutic response and possible adverse effects. (see Review Form- Appendix 3)
- Avoid using antipsychotics (typical or atypical) for non-cognitive symptoms or challenging behaviour of dementia unless severe psychosis/ agitation is present, an individual risk-benefit analysis has been conducted and documented, potential benefits and side effects, including effect on cognition, have been discussed with patients/carers prior to initiation, consent has been given (or it can be justified as in the patient's best interests, if capacity to consent is lacking). See Initiation Form- Appendix 3).
- In Dementia with Lewy Bodies (or where there is Parkinson's Disease), antipsychotics are only prescribed, when cholinesterase inhibitors are contraindicated/ineffective. Patients should be monitored carefully for the emergence of severe untoward reactions, particularly neuroleptic sensitivity reactions (which manifest as the development or worsening of severe extrapyramidal features after treatment in the accepted dose range or acute and severe physical deterioration following prescription of antipsychotic drugs for which there is no other apparent cause).
- Consider carefully the risk of cerebrovascular events before using antipsychotics in any patient with a previous history of stroke or transient ischaemic attack. Consideration should also be given to other risk factors for cerebrovascular disease including hypertension, diabetes, current smoking and atrial fibrillation.
- Where an **antipsychotic** is considered necessary, it should **only be initiated under specialist advice**, following a full discussion with the patient and/or carers about the possible benefits and risks of treatment and its use should be restricted to short-term. **See Guidance Implementation for the relative responsibilities of GPs and specialist services.**
- Where an antipsychotic is indicated **risperidone should be used first line**. It is the only antipsychotic licensed for treatment of dementia-related behavioural disturbances: it is licensed specifically for short term (up to 6 weeks) treatment of persistent aggression in Alzheimer's dementia unresponsive to non-pharmacological approaches and where there is risk of harm to the patient or others.
- Antipsychotics treatment in this patient group **must be reviewed at least every 6 weeks**.

Guidance Implementation

The relative responsibilities of specialist services and general practice, in implementing the guidance, are set out below:

Referral Criteria for Advice due to Behavioural Disturbance

- At the point of referral, GP will carry out physical assessment/ investigations as appropriate to eliminate possibility of delirium, and if present, treat it (Appendix 2)
- Undertake baseline tests to identify vascular risk factors and communicate to specialist services

Specialist Services* Responsibilities

- Assess the patient, establish a diagnosis and determine a management strategy with the involvement of carers (including care homes)/ relatives. Rationale for antipsychotic use must be documented. .
- Provision of explicit advice to GPs regarding the: choice of drug, duration of treatment, details of the behavioural symptoms (that the medication should be improving) including quantification, the date by which the medication should be reviewed (with the aim of withdrawal), and clarity about who is responsible for the review.
- Provision of cognition assessment
- Advice about antipsychotic dosage/ discontinuation according to clinical parameters
- Follow-up and review of medication at 6 weeks ONLY for patients discharged from in-patient-care.

GP Responsibilities

- Monitoring the patient's overall health and well-being
- Specific monitoring agreed with the specialist; there is no obligatory monitoring required because antipsychotic use is expected to be short-term.
- Prescribing Antipsychotic
- Reviewing continuing need of antipsychotic (always within 6 weeks, and at least every 6 weeks thereafter, if to be continued) with the aim to discontinue - using the details of the target symptoms and previous cognition assessment. The rationale for continuing use must be documented after every review, when the antipsychotic is being continued beyond 6 weeks.
- Adverse drug reaction/Interaction monitoring
- Referral into specialist services as appropriate
- Immediate referral to acute hospital is required if patients develop signs of Neuroleptic Malignant Syndrome (hyperthermia, muscle rigidity, autonomic instability, altered consciousness and elevated CPK levels)

Note: Neuroleptic Malignant Syndrome is an extremely rare adverse effect of all antipsychotics.

*** specialist services include non-medical independent prescribers**

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WHAT ARE BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS IN DEMENTIA (BPSD)?

BPSD is an umbrella term for a group of non cognitive symptoms that may include:

1. Agitation
2. Wandering
3. Sexually inappropriate behaviour
4. Depression with agitation
5. Severe anxiety
6. Delusions
7. Screaming
8. Aggression
9. Sleep disturbance
10. Persistent and distressing hallucinations
11. Restlessness
12. Throwing things
13. Hitting out at people
14. Any other distressing symptoms

WHAT TO DO IN A SUSPECTED CASE OF BPSD?

If it is behaviour, consider whether the change in behaviour is as a result of an event, for example, change of environment. A change of environment may be distressing to people with dementia and may result in change in behaviour which may resolve without any pharmacological intervention. In general, a simple process of assessing and analysing any BPSD can be by way of using the **PIECES** framework.

PIECES stands for:

- 1) **Physical** problem or discomfort
- 2) **Intellectual** / cognitive changes
- 3) **Emotional**
- 4) **Capabilities**
- 5) **Environment**
- 6) **Social / cultural**

Using the **PIECES** framework, therefore, check for:

Physical Factors

Check if there are any of the following:

Any acute medical problems, i.e. delirium?

Any recent change in drugs or use of alcohol?

Any chronic disease that may have become unstable or relapsed ?

Is the patient in pain?

Is the patient depressed and an anti-depressant needs to be considered?

Intellectual

Check the type of dementia (Alzheimer's, vascular, Lewy Body, front- temporal); the use of medications vary with different types of dementia.

Avoid anti-psychotics in Dementia with Lewy Bodies.

Emotional

Are there any symptoms of depression, anxiety, psychosis, adjustment difficulties and aggression? Treat depression with anti-depressants.

Capabilities

Is the patient bored (boredom), is the patient angry about something? Is the patient frustrated about something? Consider day centres or any group activity e.g. Art therapy.

Environment

Any change in environment? Does patient feel lost? Is there excessive noise? Is the environment unfriendly and confusing?

Social / Cultural

Are there any cultural issues in meeting the patient's needs? How is the interaction with other residents? How is the relationship with family?

A proper assessment using the above framework may highlight the problem and appropriate intervention provided without the use of antipsychotic.

NON PHARMACOLOGICAL THERAPIES

There are a range of therapies that may be considered depending on the setting. These include:

Reality orientation therapy, Reminiscence therapy, Art therapy, Music therapy, Activity therapy, Aromatherapy, Bright light therapy and Cognitive behavioural therapy.

PHARMACOLOGICAL TREATMENT

As a last resort, when other interventions have failed, the following is a guideline for use of pharmacological intervention. This should be considered as a last resort when behaviour is considered to be damaging to social relationships and resistant. The target behaviour should be documented and also there should be a documentation that a comprehensive non pharmacological treatment plan has failed.

BENZODIAZEPINES

The **CSM** advice regarding the use of benzodiazepines is "for the short-term relief of anxiety, which is severe, disabling or subjecting the individual to unacceptable distress occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness."

Medication	Dose	Frequency	Duration
Lorazepam	0.5 mg	Start with a single dose and increase, depending on severity, up to a maximum of 4 x per day	Review after 1 week and discontinue after 2 weeks
Diazepam	Start with a low dose of between 2-5 mg	Start with a single dose up to a maximum of 4 x daily	Discontinue after 2 weeks

Dementia patients on Benzodiazepine are at risk of falls, and caution should be taken for those with breathing difficulties.

ANTIPSYCHOTICS

GPs should only prescribe under consultant guidance, in line with the Trust's Guidance on Antipsychotics in Dementia for Behavioural Disturbance

For delirium screen, refer to the Oxford Handbook of General Practice Page 976-977 which details a summary of presentation, examination, likely causes, differential diagnosis, investigations and management.

Tests to screen for delirium:

- Adequate history including 3rd person informant, to exclude delirium. (Considering differential diagnosis of delirium or delirium superimposed on dementia.)
- Suitable Physical examination
- Tests (urine dipstick, glucose, ketones, blood, protein, nitrates, white cells) and send for MSU as necessary
- Check BM to exclude hypo/hyperglycaemia
- Blood FBC, U&E, TSH, LFT, ESR
- 'Bone' and vitamin B12 and Folate
- Consider an ECG and Chest X-ray if appropriate to clinical picture

**Appendix 3 South Staffordshire & Shropshire Healthcare NHS Foundation Trust
 ANTIPSYCHOTICS IN DEMENTIA: INITIATION
 To be filed in patients notes once completed**

Name:	NHS No.:
Address:	DoB:
.....	
Date of Assessment:	
Diagnosis:	
Current Medication:	
.....	
Physical Health:	
.....	
Target Symptoms:	
Psychosis:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Physical Aggression:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Severe Agitation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (pls specify below):	Yes <input type="checkbox"/> No <input type="checkbox"/>
.....	
Benefits explained:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Non-pharmacological methods already tried or being tried concurrently:	
	Yes <input type="checkbox"/> No <input type="checkbox"/>
Risk of ADR discussed with Patient/Carer:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient been detained under the MHA:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient has Capacity:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Treatment in Patient's Best Interest:	Yes <input type="checkbox"/> No <input type="checkbox"/> (at least one must be present)
Necessary to Reduce Risk of to Others:	Yes <input type="checkbox"/> No <input type="checkbox"/> " "
Drug Recommended & Suggested Regimen:	
.....	
Review Date (within 6 weeks):	
Review to be done by:	
Specialist Services: <input type="checkbox"/>	GP Surgery: <input type="checkbox"/>
Other Provider: <input type="checkbox"/> Please specify:	
Name of Clinician:	Signature:
NB: DO NOT USE THIS FORM IF ANTIPSYCHOTICS ARE USED TO TREAT SYMPTOMS NOT RELATED TO DEMENTIA (e.g. pre-existing schizophrenia)	

South Staffordshire & Shropshire Healthcare NHS Foundation Trust
ANTIPSYCHOTICS IN DEMENTIA: REVIEW
To be filed in patients notes once completed

Name:	NHS No.:
Address:	DoB:
.....	
Date of Review:	
Diagnosis:	
Current Medication:	
.....	
Significant Changes Since Last Review:	
.....	
Have any ADRs occurred Yes <input type="checkbox"/> No <input type="checkbox"/>	
Improvement in Target Symptoms:	
Psychosis:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Physical Aggression:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Severe Agitation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (pls specify below):	Yes <input type="checkbox"/> No <input type="checkbox"/>
.....	
Appropriate to Continue Medication: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes pls state why:	
.....	
Drug Recommended & Suggested Regimen:	
.....	
Next Date of Review:	
Review to be done by: Specialist Services: <input type="checkbox"/> GP Surgery: <input type="checkbox"/>	
Other Provider: <input type="checkbox"/> Please specify:	
Name of Clinician:	Signature: