GUIDELINES FOR THE MANAGEMENT OF BEHAVIOURAL PROBLEMS IN DEMENTIA & THE USE OF ANTIPSYCHOTIC DRUGS

- This is a new guideline
- It incorporates NICE clinical guideline 42 & The All-Party Parliamentary Group on Dementia: “Always a Last Resort”.
- Only use antipsychotic drugs as a last resort.
- Assess & 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.
Treatment algorithm for the management of behavioural problems in dementia

Dementia sufferer 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 Old Age Psychiatry Department at DMHST

Examine for & treat any causative physical disorder
e.g. constipation, pain/discomfort, urinary tract infection, physical illness, other illness

Treat any associated functional mental health problems:
(a) Depression – consider an antidepressant e.g. Selective Serotonin Reuptake Inhibitor (SSRI), Mirtazapine or Trazodone
(b) Anxiety or Insomnia – consider a short-term trial of a benzodiazepine e.g. Diazepam, Temazepam
(c) Psychosis – consider an antipsychotic drug e.g. Amisulpride, Quetiapine, Haloperidol

Non-pharmacological management1 - 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 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

If the above methods have proved unsuccessful & 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 medication:

<table>
<thead>
<tr>
<th>Indications Behavioural problems plus:</th>
<th>Drug</th>
<th>Starting dose</th>
<th>Increase in stages to a Maximum dose/frequency of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible Psychosis</td>
<td>Amisulpride</td>
<td>50mg Once a day</td>
<td>50mg Twice a day</td>
</tr>
<tr>
<td>Additional Anxiety</td>
<td>Diazepam</td>
<td>2mg Once a day</td>
<td>5mg Twice a day</td>
</tr>
<tr>
<td>Possible Psychosis</td>
<td>Haloperidol</td>
<td>500microg Twice a day</td>
<td>1.5mg Twice a day</td>
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<tr>
<td>Agitation alone</td>
<td>Promazine</td>
<td>25mg Twice a day</td>
<td>50mg Four times a day</td>
</tr>
<tr>
<td>Psychosis + Parkinson's Disease or Lewy Body Dementia</td>
<td>Quetiapine (unlicensed)</td>
<td>25mg Once a day</td>
<td>50mg Twice a day</td>
</tr>
<tr>
<td>Aggression + Agitation</td>
<td>Risperidone</td>
<td>0.5mg Once a day</td>
<td>1mg Twice a day</td>
</tr>
<tr>
<td>Possible Depression</td>
<td>Trazodone Liquid.</td>
<td>25mg (2.5ml) Twice a day</td>
<td>50mg (5ml) Twice a day</td>
</tr>
</tbody>
</table>

If Treatment Successful? Monitor response & attempt to withdraw after 3 months
If Treatment Unsuccessful? Refer to Old Age Psychiatry Department at DMHST
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 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 advice that a risk of stroke with other atypical antipsychotics cannot be ruled out. However, the Medicines & Healthcare products Regulatory Agency (MHRA) have since reviewed new evidence & updated the license for the efficacy of risperidone for the short-term management (up to 6 wks) of aggression in patients with moderate to severe Alzheimer’s dementia.
- Current evidence from recently published studies, appear 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 the 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 effect mobility and quality of life
- Typical antipsychotic drugs must be avoided in patients with Lewy body dementia or Parkinson’s Disease.

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 &/or untreated. Therefore, it is important to assess each individual patient for signs & 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
- Ensure that consideration is given to the balance of risks and benefits of using an antipsychotic drug
- Baseline investigations should be considered before initiating treatment (e.g. U&Es, LFTs, TFTs, Random Blood Glucose, ECG)
- Consideration should be made as to whether the patient has the mental capacity to consent to medication – seek further advice if uncertain
- If a decision is made to use an antipsychotic drug, start with the lowest possible dose & 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. need for treatment & 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 advice 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 at least every 3 to 6 months during continuing treatment. Document target symptoms & adverse effects at reviews.

References:
1. Working group for the faculty of Old Age Psychiatry RCPsych, RCGP, BGS and
Alzheimer’s society, following CSM restriction on risperidone and olanzapine.


8. Adapted version of DMHT ‘Standards for Prescribing Antipsychotic Drugs in Older Adults with Dementia’ from guideline; “Atypical antipsychotics and behavioural and psychiatric symptoms of dementia (BPSD) – summary of evidence and standards for prescribing antipsychotic drugs in older adults with dementia”.


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