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**PAN MERSEY AREA PRESCRIBING COMMITTEE
PRESCRIBING GUIDELINE**



Pan Mersey

FIRST APC BOARD DATE: 09 JAN 2012 Area Prescribing Committee
LAST APC BOARD DATE: 28 NOV 2018

**DEMENTIA - Behavioural and Psychological Symptoms (BPSD)
Use of Antipsychotics**

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The Pan Mersey Area Prescribing Committee recommends that antipsychotics prescribed for BPSD should be initiated by a dementia specialist* and reviewed in accordance with NICE/SCIE¹ guidelines

FOLLOWING SPECIALIST INITIATION *

NB: THIS DOCUMENT DOES NOT COVER THE MANAGEMENT OF DELIRIUM

Background

The core feature of dementia is cognitive decline, but BPSD is common and significant. Antipsychotics are sometimes prescribed for BPSD such as agitation, aggression, extreme anxiety, shouting, delusions and hallucinations.¹ Use of antipsychotics in people with dementia may produce only limited benefits and is associated with increased risk of stroke/TIAs, cardiac arrhythmias, chest infections, falls and mortality.^{2,3}

Managing BPSD

Involve the person/carers/care staff in developing an on-going person-centred care plan.^{1,3,4}

Identify factors that generate or aggravate BPSD. These can include physical health problems, particularly pain, but also infection, discomfort, alcohol, constipation, depression, sleep disturbance, medication side effects, psychosocial factors and environment.^{1,3,4}

Identify factors that improve BPSD e.g. music, dance, aromatherapy, cognitive stimulation, massage, multisensory stimulation, exercise, creative therapies, animal assisted therapies and well-lit environment.³

For non-severe BPSD the goal should be nil prescribing of antipsychotics⁴; use non-pharmacological interventions as listed above or watchful waiting.³ Monitor response and adapt the care plan as needed.

Managing BPSD when patient is severely distressed or there is immediate 'risk of harm'

- Reversible causes of BPSD should be ruled out before initiating antipsychotic treatment.
- Use of antipsychotics should only be considered if other interventions have been unsuccessful⁵
- Antipsychotics should only be initiated by dementia specialists*; however, in an emergency a non-specialist, e.g. a GP or general hospital doctor, may start treatment but **MUST** refer to a dementia specialist* as soon as is practical.
- Risperidone is licensed for the short-term treatment (up to 6 weeks) of persistent aggression in moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. Initially 250 micrograms twice daily is recommended; adjusted if needed by increments of 250 micrograms twice daily, not more frequently than every other day (usual effective dose 500 mcg twice daily) up to a maximum of 1 mg twice daily.
- Haloperidol is licensed for treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others. The need for continued treatment must be reassessed after no more than 6 weeks. Initially 0.5 to 5 mg/day orally, as a single dose or in 2 divided doses. Adjustments to the dose may be made every 1 to 3 days.
- In Lewy Body Dementia or Parkinson's disease dementia, extreme care is required. Low dose quetiapine appears to be better tolerated if considering an antipsychotic.⁶ In practice, doses from 12.5mg to 150mg/d are used in BPSD.
- If an antipsychotic is prescribed, prescriptions should be time limited and reviewed every 6 weeks or according to clinical need, for benefits and side effects.¹

All involved in the patient's care should always question continued use in a settled patient.

- Antipsychotics must be gradually discontinued, in discussion with relevant colleagues and ideally, the initial prescriber, unless benefits of continued treatment outweigh the known risks.

***Dementia Specialists: Consultant Psychiatrists, Neurologists, Psycho-geriatricians, Geriatricians and their Specialist Registrars, Specialist Non-Medical Prescribers and GPs with extended role.**

Note: Patients who are not eligible for treatment under this statement may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. In this situation, follow locally defined processes.

DEMENTIA - Behavioural and Psychological Symptoms (BPSD) Use of Antipsychotics

<p>EFFECTIVENESS⁷ Antipsychotic drugs show minimal efficacy for BPSD.^{1, 2} Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in clinical improvement in 91 to 200 of these people (in addition to those who improve without antipsychotics).²</p>	<p>SAFETY⁷ Antipsychotics are associated with a number of major adverse outcomes and side effects including sedation, extrapyramidal side effects, dehydration, falls, chest infection, accelerated cognitive decline, stroke and death.^{5, 9, 10} One meta-analysis reported mortality with antipsychotic drugs of 3.5% versus 2.3% for placebo.¹¹ Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in:² - 10 deaths - 18 cerebrovascular events - 58 to 94 people with gait disturbances (in addition to those who experience these without antipsychotics) Extreme care is needed if prescribing antipsychotics in patients with Lewy Body or Parkinson's disease dementia.</p>
<p>COST⁷ The greater cost of using behavioural interventions, rather than antipsychotics, is more than compensated by health care savings due to the reduced incidence of stroke and falls.⁸ Taking into account quality of life improvements, the net benefit of using behavioural interventions rather than antipsychotics in England has been estimated as £54.9 million per year.⁸</p>	<p>PATIENT FACTORS⁷ Patient specific factors may generate, aggravate or improve BPSD, e.g. environment, physical health, pain, depression.^{1,4} Challenging behaviours in dementia may be a way of communicating an unmet need.¹ The decision to prescribe antipsychotics should be taken on an individual basis after full consideration and discussion with the patient and/or carer about the risks and benefits.¹ The use of patient decision aids can be helpful.</p>

PRESCRIBING INFORMATION - involve carers

Define and document target symptoms and severity.

If an antipsychotic is necessary, use low initial dose and titrate gradually; monitor for side-effects. Treatment should be time limited and regularly reviewed.

Carefully review and if appropriate, consider discontinuing antipsychotic unless the person is severely distressed or there is an immediate risk of harm to the person or others

Settled patients prescribed antipsychotics for BPSD should have the dose of antipsychotics slowly reduced over a period of at least 1-2 weeks. Gradual withdrawal of antipsychotics is advised to reduce the incidence of withdrawal symptoms eg nausea, vomiting, headache, irritability, diarrhoea, sweating and insomnia. See below suggested regimen for reduction/discontinuation and seek specialist advice if required:

- Haloperidol – Reduce daily dose by 0.25-0.5mg every week
- Quetiapine – Reduce daily dose by 12.5-25mg every week
- Risperidone – Reduce daily dose by 0.25-0.5mg every week

Patients should be monitored for recurrence of symptoms following reduction or discontinuation.

Previous doses should only be reinstated if the patient severely deteriorates resulting in extreme anxiety or risk of harm to self or others.

Document all discussions and decisions.

IMPLEMENTATION NOTES

Do not prescribe antipsychotics for BPSD unless initiated by a dementia specialist or in an emergency (see previous page)*.

Regularly review use of antipsychotics in BPSD and question need for continued use in 'settled' patients.

REFERENCES

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