

Guidelines for antipsychotic use and withdrawal for people with dementia

The following guidelines have been written to provide information for clinicians considering the initiation and discontinuation of antipsychotic medications in patients with dementia. These guidelines are particularly aimed at GPs, secondary and primary care mental health teams, pharmacists, community healthcare staff and acute hospitals. They have been produced in line with the National Institute of Health and Clinical Excellence (NICE) Clinical Guidelines on dementia published in 2006 ⁽¹⁾.

Background

The NICE guidelines recommend that people with dementia who develop non-cognitive symptoms or behaviour that challenges, should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or others. The assessment and care-planning approach, which includes behavioural management, should be followed as soon as possible.

The *'Time for action'* report by Professor Sube Banerjee⁽²⁾ states that antipsychotics are too frequently prescribed for people with dementia. Up to two thirds of the estimated 180,000 people in the UK with dementia receiving these drugs are prescribed them unnecessarily to treat aggression and agitation.

Although it is the cognitive features of dementia which are its defining characteristics, other aspects contribute significantly to the difficulties experienced, by both the patient and the people that support them. Often these non-cognitive symptoms are described as neuropsychiatric symptoms or *'behavioural and psychological symptoms of dementia'* (BPSD). The three main types of difficult to manage behaviours are: agitation/aggression, psychosis and mood disorder ⁽³⁾.

Other BPSD include anxiety, screaming, restlessness, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding and cursing ⁽⁴⁾. It has been suggested that these behavioural changes or psychological symptoms may occur in around 80% of people with dementia ⁽⁵⁾.

In many cases, the above difficulties directly reflect the distress that the person with dementia might be experiencing. The reactions of others to such behaviour may also lead to secondary discomfort and distress.

Upon completion of his review of the evidence for antipsychotic use in people with dementia, it is noted that Professor Banerjee's conclusions were that:

- Antipsychotics seem to have a limited positive effect on treating symptoms, but can cause significant harm.
- Around 180,000 people with dementia are treated with antipsychotics per year; up to 36,000 will derive some benefit from treatment at a cost of potentially an additional 1,620 cerebrovascular adverse events, about half of which may be severe, and an additional 1,800 deaths per year.
- The use of antipsychotic medication in this group can be reduced to 1/3 of its 2009 level. This target can be achieved safely over a 36 month period.

The NHS Institute for Innovation and Improvement together with the Dementia Action Alliance (2011) has stated that that all people with dementia who are receiving antipsychotic drugs will need to have undergone a clinical review to ensure that their care is compliant with current best practice and guidelines, that alternatives to their prescription have been considered and a shared decision has been agreed regarding their future care by 31 March 2012 ⁽⁶⁾. This will address the issue of excessive antipsychotic prescribing in this vulnerable group of people. As a result there will be ongoing focus into managing the behaviour of people with dementia.

The decision to use antipsychotics in dementia

NICE guidelines advise that people with dementia who develop non-cognitive symptoms that cause them significant distress or who develop challenging behaviour, should be offered a comprehensive assessment at an early opportunity to establish the factors likely to generate, aggravate or improve the problem. For each patient an individually tailored care plan should be developed, recorded and reviewed regularly ⁽⁷⁾.

Most good practice guidelines, including the Drug and Therapeutics Bulletin (2007), recommend that non-pharmacological measures should be tried first for treating a patient with BPSD, taking into account safety considerations and the high rates of resolution of symptoms with placebo in pharmacological trials ⁽⁴⁾. Non-pharmacological measures include distraction, leave and return, activity, music and one to one care. In addition aromatherapy e.g. lavender oil/lemon balm may be effective in reducing anxiety/distress. However it should be noted that this should only be provided after taking advice from a trained aromatherapist.

Prior to pharmacological therapies being considered for the treatment of non-cognitive symptoms of depression, an early assessment of the patient should be carried out to establish the likely factors which may generate or aggravate such behaviour. The assessment should include: physical health, depression, possible undetected pain or discomfort, side effects of medication, psychosocial factors and physical environmental factors ⁽¹⁾.

However, if a patient is severely distressed and/or there is an immediate risk of harm to themselves or others, antipsychotics may need to be considered. The potential benefit of antipsychotic drug therapy must be weighed against the significant risks and side-effects that these drugs carry.

The current weight of evidence in the literature is for the use of antipsychotic drugs in patients ONLY with severe agitation/aggression and psychosis (hallucinations and delusions).

Most of the evidence indicates that antipsychotics are used to treat people with Alzheimer's disease and mixed dementia. It should be noted that 60% of patients with Lewy Body dementia suffer adverse consequences with antipsychotics ⁽⁸⁾.

Assessment of the patient with dementia being considered for antipsychotic medication ⁽⁹⁾

A mapping process has been identified to assist in managing behaviour problems in patients with dementia (see appendix 1). However the patient should be:

- Assessed within the multidisciplinary team and have a care plan undertaken with a risk assessment.
- During the assessment consideration must be given to the patient's age, the type of dementia (diagnostic assessment), co-morbid psychiatric conditions, pre-existing physical health problems, current medication, non prescription drug and alcohol use, social circumstances, current physical and mental health state, including mental capacity to give consent to treatment.
- There must be discussion with the patient's family and carers and consideration of their preferences. The results of these discussions should be documented.
- Consideration should be given of the need to perform investigations (e.g. blood and urine investigations, ECG, brain scan) to exclude medical causes for the onset of BPSD.

Drugs with anti-cholinergic activity ⁽⁹⁾

There is good evidence that anti-cholinergic drugs impair cognitive function even in young healthy people. Brain acetylcholine activity is reduced in all the common types of dementia which makes people with dementia especially vulnerable to this side-effect. Drugs with anti-cholinergic activity can counteract the positive effects of anti-dementia drugs (cholinesterase inhibitors) such as donepezil, rivastigmine and galantamine which exert their therapeutic effect by enhancing cholinergic transmission.

Many drugs have a degree of anti-cholinergic activity, but there are some that have particularly high levels of anti-cholinergic actions. These are as follows:

- Tricyclic antidepressants such as amitriptyline, a selective serotonin reuptake inhibitor (SSRI) e.g. citalopram is a safer option for patients with dementia.
- Antipsychotic drugs, especially the older phenothiazine antipsychotic drugs such as chlorpromazine and levomepromazine.
- Anti-histamine drugs, especially chlorphenamine.
- Anti-Parkinsonian drugs especially orphenadrine, procyclidine, trihexyphenidyl. There are now many other safer alternatives for people with Parkinsonian symptoms. Anti-spasmodic drugs especially oxybutinin, alverine and hyoscine and similar drugs.
- Benzodiazepines especially alprazolam, although all benzodiazepines will cause sedation and put patients at risk of falls.
- Bronchodilators such as theophylline.
- Digoxin.
- Furosemide.
- Opiate analgesics especially codeine (all opiates can exacerbate cognitive function due to their opioid effect).

If at all possible, these drugs should be tailed off or substituted with a safer alternative if someone has dementia. The continued use of these drugs may preclude the use of a cholinesterase inhibitor to treat dementia.

Antihypertensive Drugs ⁽⁹⁾

Hypertension is an established risk factor for dementia, but there is also some emerging evidence that low blood pressure is associated with cognitive decline and dementia. What is definite is that blood pressure decreases as the course of dementia progresses. It is also well known that drugs causing postural hypotension can increase the risk of dizziness and falls. In summary, the risks of treating hypertension in patients with dementia may outweigh the benefits and it may be appropriate for someone with diagnosed dementia to have their blood pressure monitored more closely with cautious reduction of antihypertensive agents according to their blood pressure level.

Antipsychotic Drugs ⁽⁹⁾

The potential dangers of using antipsychotic drugs in patients with dementia are well known.

1. They can cause sedation.
2. They can increase the risk of falls.
3. They increase the risk of cerebrovascular events and sudden death.
4. They are known to exacerbate cognitive function and may accelerate cognitive decline.

However, sometimes, the use of antipsychotics in dementia for example, in people with severe psychosis or extremely severe aggressive or agitated behaviour is unavoidable.

The following should be considered in order to manage patients with dementia who are displaying these symptoms:

- All clinical decisions to prescribe antipsychotic drugs for people with dementia should be taken on the best available evidence, and with regard to the current NICE guidance. This guidance makes clear that people with dementia should only be offered antipsychotics if they are severely distressed or there is an immediate risk of harm to the person or others. The NHS locally should be following NICE guidance and PCTs have a responsibility to ensure that this happens (Government response to Sube Banerjee's report 2009).

Appendix 1 provides a flowchart for the assessment and management of behavioural problems in people with dementia.

Appendix 2 provides medication information for prescribers to ensure clinical effectiveness.

- Decide and record what symptom/behaviour you are treating, set up a system for monitoring it e.g. using behavioural charts completed by nursing staff or carers and monitor and record side-effects closely (sedation, stiffness, tremor, mobility problems).

Appendix 3 provides a format for behavioural assessment. This tool will assist in ensuring that target symptoms have been identified, quantified and documented enabling clinicians to make robust decisions in relation to managing people with behavioural problems.

- Before prescribing antipsychotic medication for BPSD, likely factors that may generate, aggravate or improve such behaviours should be considered (POMH audit 2011). It should be noted that agitated behaviour can be a sign of acute physical illness, pain*, constipation, other physical discomfort or depression. These factors should be screened for, and addressed before you do anything else.
- Non-pharmacological alternatives for management (such as environmental or behavioural strategies) should always be considered/promoted first.
- **Particular care should be taken to avoid using antipsychotic drugs in people with Parkinson's Disease/Lewy Body Dementia.**
- Wherever possible, when prescribing an antipsychotic drug for someone with dementia, the risks and benefits should be discussed with the patient and/or relatives and/or care staff (there is a high level of public concern about the use of these drugs and the decision-making process must include all stakeholders). Any discussion should be documented. It is good practice to inform relatives and carers if the antipsychotic drug

being prescribed is not licensed for the treatment of behavioural and psychiatric disorders in dementia. If you do decide to prescribe 'off licence' ensure you clearly record your reasons for doing so in the clinical notes.

- Cerebrovascular risk factors must have been considered e.g. increased risk of stroke/TIA and mortality.
- Patients/carers should be asked to immediately report signs and symptoms of potential strokes/TIAs.
- Once an antipsychotic drug has been started, a review date must be set at which time the use of the drug should be reviewed. Very often behavioural disturbances in dementia are relatively short lived and a short course (e.g. one or two weeks) of an antipsychotic drug is all that is necessary.
- Do not continue the drug if it is ineffective after a week's trial.
- It should be emphasised that treatment should be time limited and regularly reviewed (every week initially and at least one review face to face in a four week period). If symptoms show improvement every effort should be made to withdraw the antipsychotic. *If there is a need to continue beyond four weeks, the patient should be referred to the specialist mental health team and a follow up should be done every month initially.*
- Another withdrawal should be attempted at three months and if this is not successful after a year.

Appendix 4 provides advice for prescribers on the withdrawal of antipsychotic medications.

- Patients should continue to be monitored if antipsychotic medication is continued beyond three months.
- Monitor for severe reactions, particularly neuroleptic malignant syndrome sensitivity reactions, development or worsening of extrapyramidal features.
- Elderly patients are particularly susceptible to postural hypotension and to hyper/hypothermia and falls.
- GPs initiating antipsychotics should limit the quantity to 21 days, and ensure arrangements are made for the patient to be reviewed or referred to a specialist (if not improving in four weeks).
- Start with extremely low doses. Low dose haloperidol i.e. no more than 2 mgs a day and low dose risperidone up to 2mg per day are both licensed for the treatment of behavioural disorders in dementia/older people (although this does not mean they are safer than any other antipsychotic).
- Avoid phenothiazine drugs such as chlorpromazine because of their sedative effect and anti-cholinergic action.

*A recent piece of research identified that a systematic approach to the management of pain significantly reduced agitation in residents of nursing homes with moderate to severe dementia. It was concluded that effective management of pain can play an important part in the treatment of agitation

and could reduce the number of unnecessary prescriptions for psychotropic drugs in this population ⁽¹⁰⁾

Drugs and falls ⁽⁹⁾

A recent systematic review of drugs associated with falls in nursing home residents showed that the use of multiple drugs, antidepressant drugs and anti-anxiety drugs were all associated with an increased risk of falls. It is important to remember that even SSRIs can be associated with a risk of falls not because they cause postural hypotension, but because they can cause postural instability in older people. It is good practice, in order to reduce the risk of falls, to reduce the overall number of drugs being prescribed for people with dementia and to review the need for antidepressant and anti-anxiety drugs.

Review all drugs that may no longer be necessary ⁽⁹⁾

Sometimes people with severe dementia, particularly those in residential or nursing home care, continue drugs long-term for no clinical reason. For example, it may no longer be appropriate for somebody with a very severe dementia and multiple physical disabilities to continue on lipid-lowering drugs. The same might also apply to anti-platelet agents, warfarin, and analgesics.

Inappropriate use of antipsychotic medicines in care homes

Excessive prescribing of antipsychotic medications or their use when unnecessary is considered to be inappropriate and has been described as '*chemical restraint*'. A lack of training in dementia care for care home staff means that professionals are often not aware that symptoms such as restlessness and shouting can be due to an expression of unmet needs. As stated previously this could be because of unidentified pain or boredom due to a lack of social activity being available. It is reiterated that antipsychotic medications should never be prescribed as a first resort and a quick and accessible way of managing behaviour. An individual's care should be personalised and aimed at meeting their particular needs.

Examples of where the prescribing of antipsychotic medicines may be inappropriate are:

- The use of antipsychotic medicines as an easier alternative to non-pharmacological interventions. For example, medication given to people at times that are convenient to the care home and their staffing levels rather than at times that would optimise their therapeutic effect.
- PRN medicines administered routinely and not only on an occasional basis as prescribed. PRN medicines administered from monitored dosage system (MDS) containers and given at scheduled times as a matter of routine rather than as occasional use.
- Care homes giving exaggerated details of people's mental state to prescribers leading to new prescriptions or increased doses. This includes failure to have supporting documentary evidence in care notes

or the use of behavioural charts demonstrating that there is sufficient need to request prescriber intervention.

- PRN medicines being administered to people without supporting recorded evidence from care notes or in behavioural charts to support that their use was clinically justified.
- Medicines given covertly where people are able to consent. Medicines given covertly where people are assessed as not having capacity to consent but there has been no or inadequate assessment of capacity as per the Mental Capacity Act (2005). Failure to consult with a multi-disciplinary team about the covert administration of medicines and document this. Failure to provide full and accurate individualised care planning relating to this need.
- Giving doses of antipsychotic medicines to people when their use is worsening their psychological presentation or when the development of side-effects places the health and welfare of people at an increased risk.
- The administration of medicines by staff who have not been trained or have regularly been deemed competent in relation to the use of antipsychotic medicines.

The above list is not exhaustive but aims to present some of the concerns raised regarding the use of antipsychotic medicines.

Finally, it is emphasised that care homes should understand the benefits and have the skills and expertise to provide non-pharmacological measures such as distraction, leave and return, activity, music, aromatherapy (under guidance) and one to one care for their residents.

Summary of Key Points and Conclusion

This summary can be printed out with appendices 1 - 4. It can then easily be used by clinicians to support robust assessment/review of patients with dementia.

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop challenging behaviour, should be offered a comprehensive assessment at an early opportunity to establish the factors likely to generate, aggravate or improve the problem.

Appendix 1 (page 12) outlines the process to be undertaken when considering how to manage behaviour problems in people with dementia.

Where behaviour is severe and complicated and medication is indicated, then an atypical antipsychotic should be preferred over a typical one. In this event the '3T' (target, titration, time) approach should be used:

- Drug treatment should have a specific target symptom
- Starting dose should initially be low and then titrated upwards
- Drug treatment should be time limited

Maintenance should be at the lowest possible effective dose, for the shortest possible time.

Appendix 2 (pages 13-14) outlines best practice guidelines where a decision has been taken to prescribe antipsychotic medication for a person with dementia.

Appendix 3 (pages 15-16) is a behaviour chart which can be handed to family members/carers/care home staff for completion. This will provide valuable information to the clinician and help in the decision making process around managing an individual's dementia and whether to prescribe antipsychotic medication.

In incidences where the patient has been reviewed by the specialist and a decision is made to continue the antipsychotic medication the patient should be reviewed regularly (at least monthly); at review, reduction or cessation of the medication should be actively considered.

Appendix 4 (page 17) gives best practice guidelines where a decision has been taken to withdraw antipsychotic medication in a person with dementia. Page 18 outlines citalopram maximum dose reductions (new guidance from MHRA, November 2011)

In conclusion, it should be stated that while the efficacy of antipsychotics is lower than previously supposed and adverse effects more frequent, there is evidence to support their careful use. This may be justified after assessment

of the risks and benefits involving, where possible, the patient, carers and family.

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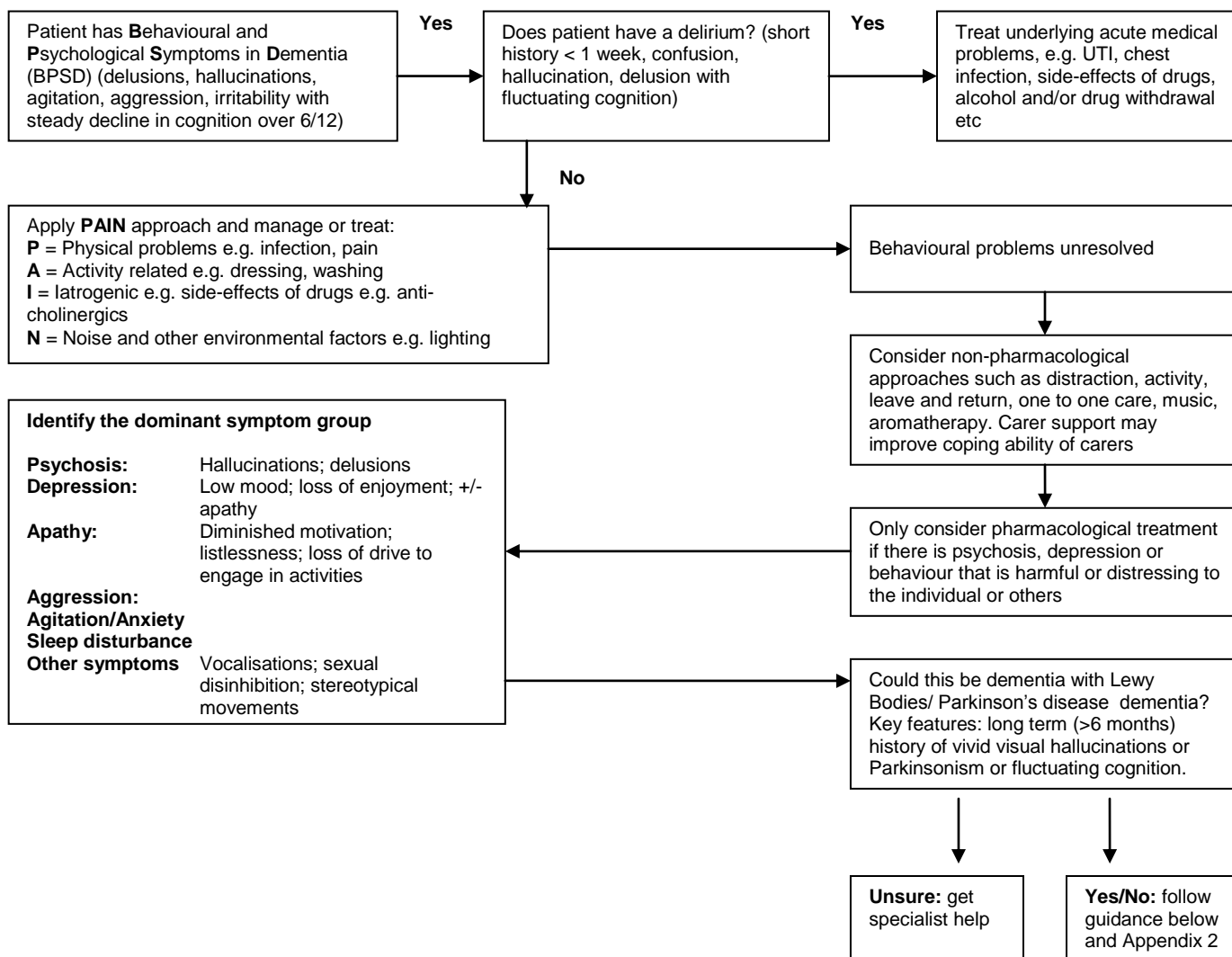
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APPENDIX 1 - MANAGING BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA (10/11) – FLOW CHART



General guidelines for the prescription of antipsychotic drugs in dementia (for specific guidance see overleaf)

These guidelines aim to reduce antipsychotic prescribing in line with recommendation one in the Department of Health Time for Action report.

If the patient you are seeing is not known to the Dementia Service consider a referral. This will enable prompt assessment for appropriate non-pharmacological treatment and for cholinesterase inhibitor therapy.

Remember that depression and anxiety are common in dementia and it is often safer to use an antidepressant as a first line treatment before considering antipsychotic medication.

Care should be taken to avoid using antipsychotic drugs in people with Parkinson's Disease/ Lewy Body dementia.

When possible, before prescribing an antipsychotic drug for someone with dementia, the risks and benefits should be discussed with relatives and/or care staff. It is important to inform relatives and carers if the antipsychotic drug being prescribed is not licensed for the treatment of behavioural problems in dementia. If you do decide to prescribe 'off licence' ensure you clearly record your reasons for doing so in the clinical notes.

There are several risks associated with the use of antipsychotic drugs in dementia. They can cause sedation, increase the risk of falls; increase the risk of cerebrovascular events and sudden death. The long term use of such drugs can accelerate cognitive decline.

The only product licensed for the treatment of behavioural problems in dementia is risperidone. Both risperidone and olanzapine have been linked to an increased risk of cerebrovascular events. It is likely that all antipsychotic drugs are associated with an increased risk of stroke.

It is important to record a 'target symptom' which is to be monitored. The duration of prescription and review date should be set and agreed with carers. Behavioural symptoms in dementia are often short lived and only a short course of a drug may be needed. If a patient needs regular antipsychotic medication for more than a week a referral to the Dementia Service is recommended.

APPENDIX 2 - MANAGING BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA (10/11) – PRESCRIBING GUIDELINES:

Alzheimer's disease

Key Symptom	First Line	Length of treatment/review frequency	Evidence Type	Second Line	Evidence Type	Length of treatment/review frequency
Depression	Citalopram#, Sertraline Fluoxetine	12 -24 weeks/4weeks	2-3	Mirtazapine Other SSRI	3	12-24 weeks/initially fortnightly and then 4 weekly
Apathy	Citalopram#, Sertraline Fluoxetine	12-24 weeks/initially fortnightly and then 4 weeks	2-3	Donepezil, Rivastigmine, Galantamine	2	4 week –until MMSE <8/ initially monthly
Psychosis	Risperidone, Haloperidol*	3-12 months/ 4 weeks review and then 3 monthly	1, 5	Quetiapine, Olanzapine, Aripiprazole	2	3- 12 months/4weeks initially and then 3 monthly
Aggression	Risperidone, Haloperidol*	2 -12 weeks/weekly review	1, 5	Quetiapine, Olanzapine, Aripiprazole	2	2-12 weeks
Moderate agitation/ anxiety	Citalopram#	12 -24 weeks, If beneficial can continue up to 2 years for anxiety/initially fortnightly and then monthly	3	Trazodone, Mirtazapine, Memantine	4	12 -24, if beneficial can continue up to two years
Severe agitation/ anxiety (after antidepressant trial)	Risperidone, Haloperidol*	2-12 weeks/weekly review	1, 5	Aripiprazole, Memantine Quetiapine, Olanzapine,	2-4	2-12 weeks
Poor sleep	Zopiclone	2 -4 weeks/weekly	3	Temazepam	3	2- 4 weeks
Initiated by primary or secondary care.	Antipsychotic - risperidone, haloperidol, quetiapine & olanzapine Antidepressant - citalopram, fluoxetine*, sertraline, mirtazapine & trazodone Hypnotic – zopiclone & temazepam,					
Initiated by secondary care- Amber shared care	Donepezil, rivastigmine, galantamine, memantine					

* ECG required

see page 18 re MHRA guidance on dosing

Vascular dementia and stroke related dementia

The cholinesterase inhibitors and memantine are not licensed for treatment of vascular dementia and should not be used. Prescribers are advised to follow prescribing guidelines for Alzheimer's disease, however prescribing of drugs with established increased risk of cerebrovascular events, such as antipsychotics, should be carried out with extreme caution.

Dementia with Lewy bodies or Parkinson's disease dementia

Key Symptom	First Line	Length of treatment/review frequency	Evidence Type	Second Line	Evidence Type	Length of treatment/review frequency
Depression	Citalopram#	20-40mg 12-24 weeks/4 weeks	4	Sertraline	4	12-24 weeks/initially fortnightly and then 4 weeks

Apathy	Citalopram#, Sertraline	12-24 weeks/initially fortnightly and then 4 weeks	4	Donepezil, Rivastigmine, Galantamine	2	If beneficial can be continued/ Initially monthly and then 3 monthly review
Psychosis ***	Quetiapine	12.5 -100 mg for 12- 60 months Monitor weekly initially and 10 monthly	3	Rivastigmine, Donepezil, Galantamine	2 – 3	If beneficial can be continued/ Initially monthly and then 3 monthly review
Aggression	Quetiapine	12.5 – 100 mg for 2-12 weeks/ review weekly	3	Donepezil, Galantamine, Rivastigmine	3	If beneficial can be continued/ Initially monthly and then 3 monthly review
Moderate agitation/ anxiety	Citalopram #	20-40mg 12-24 weeks/initially fortnightly and then 4 weeks	3	Rivastigmine, Donepezil, Galantamine	2 – 3	If beneficial can be continued/ Initially monthly and then 3 monthly review
Severe agitation/ anxiety (after antidepressant trial)	Quetiapine	12.5-100mg 2 - 12 weeks/weekly review	3	Rivastigmine, Donepezil, Galantamine	3	If beneficial can be continued/ Initially monthly and then 3 monthly review
Poor sleep	Zopiclone	2 -4 weeks/weekly	3	Temazepam,	3	2-4 weeks/weekly
REM sleep behaviour (nightmares, hyperactivity)	Clonazepam**	4- 24 weeks	3			4 -24 weeks
Initiated by primary or secondary care.	Antipsychotic - risperidone haloperidol quetiapine, & olanzapine Antidepressant - citalopram#, fluoxetine, , sertraline, mirtazapine & trazodone Hypnotic – zopiclone & temazepam,					
Initiated by secondary care- Amber shared care	Donepezil, rivastigmine, galantamine, memantine					

** 500 – 1000 microgram nocte *** consider reducing antiparkinsonian medication first
see page 18 re MHRA guidance on dosing

Evidence levels: 1 = Metanalysis; 2 = RPCT's; 3 = Other studies; 4 = Expert Opinion; 5 Local Practice

Dosage Guidelines for antipsychotics in Dementia

Antipsychotic	Starting Dose	Optimal Dose	Length of treatment/review
Risperidone	250 microgram bd	500 microgram bd	2 weeks -12 months/weekly initially and then monthly
Haloperidol	500 microgram bd	1mg bd	2 weeks -12 months/weekly initially and then monthly
Quetiapine	25mg od	25 - 150mg daily	2 weeks -12 months/weekly initially and then monthly
Olanzapine	2.5mg -5mg od	10mg od	2 weeks -12 months/weekly initially and then monthly

NOTE: Anti-cholinergic drugs impair cognitive function, if possible STOP or REDUCE. The Anti-cholinergic Burden (ACB) scale is a useful clinical assessment tool to identify risk (see link below).

<http://www.uea.ac.uk/mac/com/media/press/2011/june/anticholinergics+study+drug+list>

Antidepressants – SSRI (e.g. citalopram) is a safer choice
Antipsychotics – especially chlorpromazine
Antihistamines – especially chlorphenamine
Antiparkinsonian drugs – especially orphenadrine, procyclidine and trihexyphenidyl
Antispasmodics – oxybutinin, hyoscine
Benzodiazepines
Bronchodilators – theophylline
Digoxin
Furosemide
Opiate analgesics – especially codeine

Key:

Active involvement in tasks/interests E

Restlessness, agitated A

Resting, settled R

Sleeping S

It is good practice that behaviour charts be completed for each patient by family members/carers/care home staff.

Completed behaviour charts will provide valuable information to the clinician and help in the decision making process around an individual's health care needs.

APPENDIX 4 - MANAGING BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA (10/11) –GUIDELINES FOR WITHDRAWING ANTIPSYCHOTICS IN DEMENTIA

If antipsychotic medication has been used for only 2-3 weeks it can be stopped without tapering off.

If a patient appears to be benefiting from antipsychotic medication the maximum period of time to give this should be limited to 3 months. These should then be withdrawn over a period of 4 weeks (Alzheimer's Society Guideline 2011:864). However smaller doses can be tapered off quickly e.g. Risperidone 500 micrograms, Olanzapine 2.5mg, Quetiapine 50mg, Aripiprazole 5mg (Alzheimer's Society Guideline 2011:865)

Note: Sudden withdrawal can cause decrease in sleep efficiency and increase in behavioural problems (Ruth et al 2004).

If a patient needs further continuation of antipsychotic medication and this exceeds over 1 year, withdrawal should be slower e.g. over a period of 2 months. However smaller doses can be tapered off quickly.

Note: A small fraction of patients may need to continue with medication due to persisting behavioural symptoms or psychotic symptoms and deterioration of behaviour when attempted to stop at three weeks and three months.

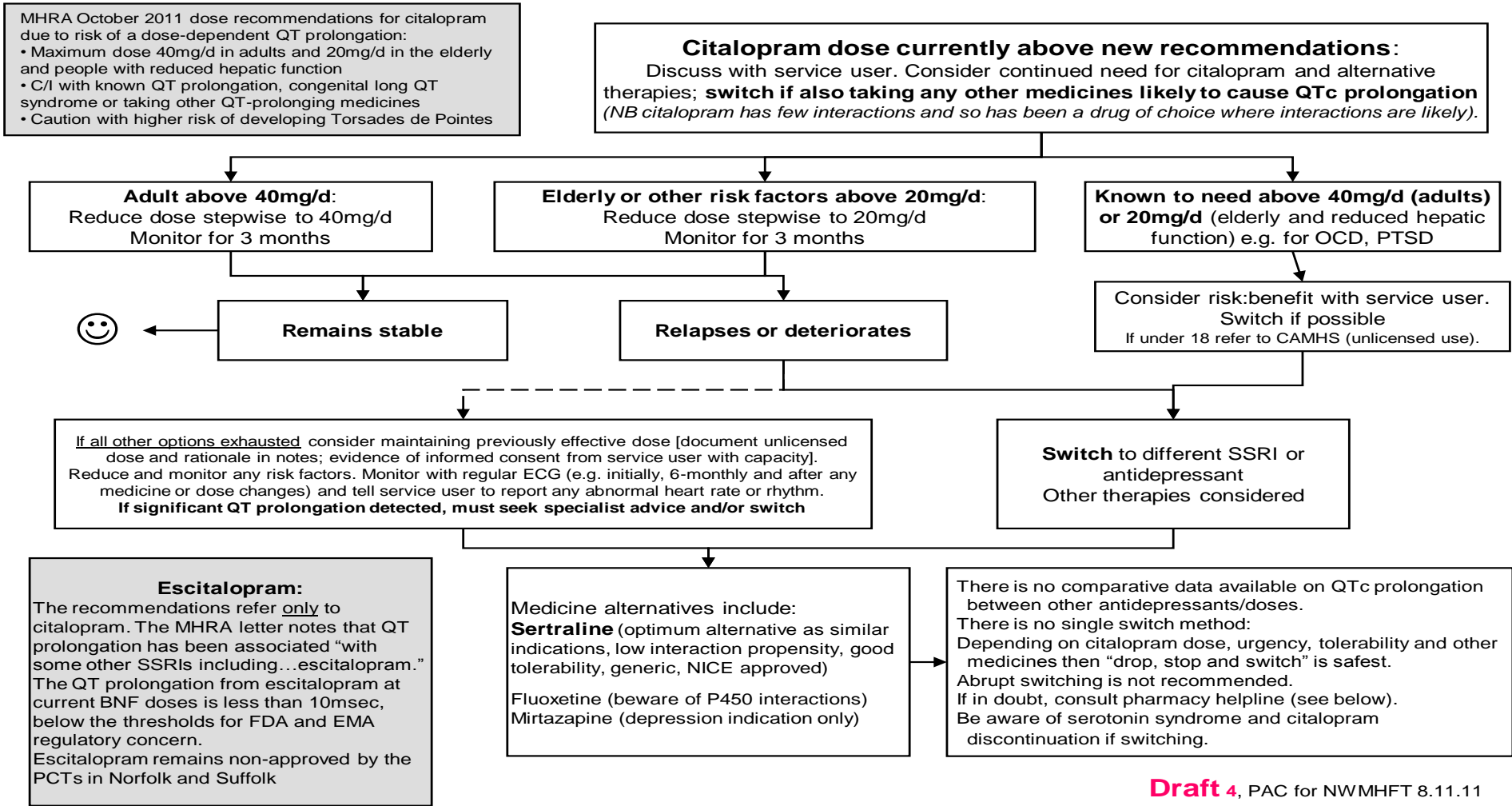
When withdrawing antipsychotic medication, the patient should be regularly monitored for signs and symptoms that might suggest a relapse****.

It will be helpful to have reminders on the GPs' electronic systems to review antipsychotic prescribing after 3 weeks and withdraw them unless they are providing a clear and ongoing benefit.

Electronic flagging for pharmacists at three weeks will also help to remind the GP about reviewing or withdrawing antipsychotic medication.

**** Acute withdrawal symptoms such as nausea, vomiting, sweating, and insomnia have very rarely been described after abrupt cessation of high doses of antipsychotic medicines ⁽⁵⁾.

Citalopram maximum dose reductions (new guidance from MHRA November 2011)



Draft 4, PAC for NWMHFT 8.11.11

Helpline 01603-421212 or www.nwmhft.nhs.uk and click Learn more about medicines