Southern Health NHS
NHS Foundation Trust

SH CP 02

Guidelines:

Managing Behaviour Problems in Patients with Dementia

Version: 3

Summary:	To manage behaviour problems in patients with dementia.	
Keywords (minimum of 5): *(To assist policy search engine)*	Behaviour problems, antipsychotics, stroke or vascular dementia, Lewy Bodies, Parkinson's Disease Dementia	
Target Audience:	Medical Staff / Medicines Management Team / Nursing Staff OPMH	
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Approved & Ratified by:	Mental Health Drugs and Therapeutics Forum Medicines Management Committee	**Date of meeting:** 21st October 2015 4th November 2015
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
Jan 2012		2	3 4	Link to Alzheimer's Society added Sertraline and Mirtazapine deleted Memantine added 2nd line for treatment of Severe Agitation/Anxiety, Psychosis and Aggression
21/10/15		3	All 6	Change of version from 1.0 Adding information about monitoring-Section 5
19/02/16		3	5	Adding cost (££) to Zopiclone

Reviewers/contributors

Name	Position	Version Reviewed & Date
Professor C Holmes		V2 January 2012
Dr V R Badrakalimuthu		V3 October 2015

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MANAGING BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA
(Does not cover rapid tranquillisation of acutely disturbed)

Patient has **B**ehavioural and **P**sychiatric **S**ymptoms in **D**ementia **(BPSD)** (delusions, hallucinations, agitation, aggression, irritability etc with steady decline in cognition over 6/12).

Yes

Does patient have a **Delirium?** (Short history < 1 week usually, confusion, hallucination, delusion with fluctuating cognition).

Yes

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

No

Apply 'PAID' approach and manage or treat:
P=Physical problems e.g. infection, pain
A=Activity-related e.g. dressing, washing
I=Intrinsic to dementia e.g. wandering
D=Depression & Delusions

Behavioural problems unresolved

If mild to moderate symptoms adopt a watchful waiting approach. Contact family for their views; consider non-pharmacological approaches e.g. creative therapies; personalised activities; social interaction. Consider specialised psychosocial support for carer and patient.

Only consider pharmacological treatment if there is psychosis, depression or behaviour where there is extreme risk or distress.

Identify the dominant target symptom group

Psychosis: Delusions/Hallucinations.

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.

Aggression

Agitation/ Anxiety

Sleep disturbance

Other symptoms: e.g. vocalisations; sexual disinhibition; stereotypical movements etc.

Could this be Dementia with Lewy Bodies or Parkinsons Disease Dementia?
Key features: long term (> 6 months) history of vivid visual hallucinations or parkinsonism or fluctuating cognition.

Yes or Unsure

Get specialist advice

No

Follow guidelines below and overleaf

In the event of continuing problems, advice can be obtained from CMHT's.

There is only one drug (Risperidone) licensed specifically for the treatment of BPSD. For other symptoms drugs are used which have either been shown to improve these symptoms in subjects without dementia or are licensed for cognitive enhancement in patients with dementia.

General guidelines if pharmacological treatment is indicated.
The use of either typical or atypical antipsychotics in patients with dementia worsens cognitive function; increases the risk of cerebrovascular events (~3x) and increases mortality rate (~2x). They should only be used after full discussion with the patient (where the patient has capacity to understand) and carer about the possible benefits and likely risks. Risk is likely to increase with increasing age and if other risk factors for cerebrovascular events are present e.g. diabetes; hypertension, cardiac arrythmias; smoking and existing evidence of **stroke or vascular dementia**. If antipsychotic treatment is considered necessary avoid typical neuroleptics and start atypical doses low (usually one half normal elderly dose) and increase every 2 -4 days if no response **(see specific doses suggestions overleaf).** Patients who respond to treatment should have the drug cautiously withdrawn after 6/12 weeks. Halve the dose for two weeks and if no re-emerging symptoms stop after a further 2 weeks. Review again after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with atypical antipsychotics may be needed in the long term but should be reviewed on a 3 monthly basis. **Patients with Dementia with Lewy Bodies or Parkinsons Disease Dementia** are particularly vulnerable to neuroleptic sensitivity reactions and also have marked extrapyramidal side effects. Advice from a specialist is advised before starting neuroleptics.
The management of antidepressants and hypnotics in patients with dementia has little evidence base and should follow existing guidelines for the management of these drugs in elderly patients without dementia. Treatment doses should follow BNF guidelines.

Based on 1.CSM CEM/CMO/2012/1(MHRA); 2.BNF (2015); 3.Faculty of Old Age Psychiatry (2008); 4. Maudsley Guidelines; 5.NICE-SCIE guidelines; 6. SIGN 2006;7. NICE TA217; NICE Updates March 2015; 8. A best practice guide for health and social care professionals. Alz Soc.
Authors: Prof C Holmes/ Dr V R Badrakalimuthu – September 2015

1 Guidance on non-pharmacological measures to reduce BPSD

1.1 Interventions that aim to communicate with people with dementia, helping staff to understand and fulfil wishes, reduce symptomatic and severe agitation during the intervention and for 3–6 months afterwards. This suggests that training caregivers in communication, person-centred care skills or dementia care mapping are clinically important interventions, as shown by a 30% decrease in agitation.

1.2 Sensory interventions significantly improved agitation of all severities while in place. Activities and music therapy by protocol reduce overall and symptomatic agitation in care homes while in place (Livingston et al, 2014).

1.3 Providing care giver with education and support, training in stress reduction or cognitive reframing techniques (or both), and specific skills in problem solving to manage behavioural symptoms, such as increasing activity of the person with dementia; enhancing communication with the person with dementia; reducing the complexity of the physical environment; and simplifying tasks for the person with dementia (Kales et al, 2015).

2 Guidance on pharmacological measures to manage BPSD

2.1 Of all agents currently used for behavioural and psychological symptoms of dementia, atypical antipsychotics have the strongest evidence base, although their benefits are moderate. Any such benefits must be balanced against the risk of adverse events, including mortality. The mortality findings among individual antipsychotic agents seem to be consistent with the tolerability profile of individual atypical antipsychotics in the CATIE-AD trial, where olanzapine and risperidone were more efficacious than either quetiapine or placebo, but quetiapine and placebo were better tolerated (Kales et al, 2015)

2.2 Antidepressants have shown limited benefit for depression in dementia. Recent evidence indicates that citalopram may hold promise for the treatment of agitation in dementia, but more research is needed to determine the optimal dose given concerns about possible QT prolongation at 30 mg (Kales et al, 2015).

2.3 Although a meta-analysis shows a small but significant improvement in behavioural and psychological symptoms of dementia with cholinesterase inhibitors over placebo during six months of treatment, the improvement may not be clinically significant (summary estimate 1.72 point improvement *v* placebo on the 120-point neuropsychiatric inventory (NPI) scale (Kales et al, 2015).

2.4 Valproate preparations (including sodium valproate and valproate semisodium) are no more effective than placebo for treating agitation or behavioural disturbances in people with dementia. Adverse effects such as falls, sedation, gait disturbances, tremor, muscular weakness, thrombocytopenia, gastrointestinal disorders and urinary tract infections were more common in people taking valproate preparations than placebo (NICE, March 2015). There are conflicting results about the efficacy of carbamazepine for managing aggression, agitation and behavioural disturbances in people with dementia. Adverse effects are statistically significantly more common with carbamazepine compared with placebo. hyponatraemia, leukopenia, thrombocytopenia, eosinophilia, central nervous system (CNS) adverse reactions gastrointestinal disturbances, fluid retention and allergic skin reactions occur commonly or very commonly with carbamazepine (NICE, March 2015). Antiepileptics are not recommended for managing BPSD.

2.5 RCTs comparing benzodiazepines with placebo for behavioural and psychological symptoms of dementia are lacking. Given serious concerns about adverse events, such agents are not recommended except for management of an acute crisis.

3 Summary recommendations specific to type of dementia

3.1 Alzheimer's Disease

Key symptom	First line	Evidence type	Second line	Evidence type
Depression	Citalopram	3		
Apathy	Citalopram	3	Donepezil [S]; Rivastigmine [S]; Galantamine [S]	2
Psychosis	Risperidone	1	Olanzapine; Memantine [S]	2 - 3
Aggression	Risperidone [L]	1	Olanzapine, Memantine [S]	2 - 3
Moderate Agitation/ Anxiety	Citalopram.	3	Trazodone; Mirtazapine; Memantine [S]	4
Severe Agitation/ Anxiety	Risperidone, Olanzapine	1	Memantine [S].	2 - 4
Poor sleep	Temazepam; Zopiclone (££)	3	Zolpidem	3

3.2 Dementia with Lewy Bodies or Parkinsons disease dementia

Key symptom	First line	Evidence type	Second line	Evidence type
Depression	Citalopram	4	Sertraline Mirtazapine	4
Apathy	Citalopram	4	Donepezil [S]; Rivastigmine [S]; Galantamine [S]	2
Psychosis*	Rivastigmine [S]. Donepezil [S]; Galantamine [S].	2 - 3	Quetiapine	3
Aggression	Quetiapine.	3	Donepezil [S]; Galantamine [S]. Rivastigmine [S].	3
Moderate Agitation/ Anxiety	Citalopram.	3	Rivastigmine [S]. Donepezil [S] Galantamine [S]	2 - 3
Severe Agitation/ Anxiety	Quetiapine.	3	Rivastigmine [S] Donepezil [S]; Galantamine [S].	3
Poor sleep	Temazepam; Zopiclone (££)	3	Zolpidem	3
REM sleep behaviour (nightmares; hyperactivity)	Clonazepam**	3		

* consider reducing antiparkinsonian medication first: ** 500-1000 microgram nocte: [L] = Licensed indication [S] = Secondary care initiation

Evidence levels: 1 = Metanalysis; 2 = RPCT's; 3 = Other studies; 4 = Expert opinion; £ = cost

3.3 Vascular dementia or stroke related dementia.

There is little evidence base for the treatment of BPSD in Vascular dementia or stroke related dementia. The cholinesterase inhibitors (Donepezil; Rivastigmine; Galantamine) and memantine are not licensed for the treatment of pure vascular dementia and should not be used. Prescribers are advised to follow the guidance for Alzheimer's Disease but to use with extreme caution drugs with an established increased cerebrovascular risk (i.e. antipsychotics)

3.4 Other BPSD and other dementias (e.g. Fronto-temporal lobe dementia)

There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Specialist advice should be sought.

4 Drug dose guidelines for use of neuroleptics in dementia

Neuroleptic drug	Starting dose	Optimum dose
Risperidone	250 microgram b.d.	500 microgram b.d.
Olanzapine	2.5mg o.d.	5-10mg o.d.
Quetiapine	25mg o.d.	25-150mg daily
Aripiprazole	5mg o.d.	10mg o.d.

5 Monitoring

Psychotropic medications such as neuroleptics and benzodiazepines should be started at the lowest possible dose and should be used for shortest duration. Where the target symptoms undergo remission, then there has to be a review of need for medication. Trial without medication may be offered where appropriate to avoid adverse effects from long-term use of medications. CMHTs can be contacted for specialist advice about changing doses or discontinuing medications used for managing BPSD**.**

6 References

Kales H, Gitlin L & Lyketsos C (2015) Assessment and management of behavioural symptoms of dementia, *BMJ*, **350**; h369

Livingston G, Kelly L, Lewis-Holmes E, et al. (2014) Non-pharmacological interventions for agitation in dementia: systematic review of randomised controlled trials. *British Journal of Psychiatry* **205**, 436–442.