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Hertfordshire Partnership NHS
University NHS Foundation Trust

Hertfordshire Care Pathway

for the Management of Behavioural and Psychological Symptoms of Dementia (BPSD)

Version 1 January 2012

Hertfordshire Community NHS
NHS Trust

East and North Hertfordshire NHS
NHS Trust

West Hertfordshire Hospitals NHS
NHS Trust

NHS
Hertfordshire

Hertfordshire

The National Dementia Strategy Group for Hertfordshire recommended that a subgroup, including partner organisations, develop a care pathway to provide guidance on the management of symptoms of acute behavioural and psychological disturbance in people with dementia.

Background

The rationale for the development of this care pathway were the recommendations made by Professor Sube Banerjee in his report "Time for Action" to the Minister of State in October 2009. The development of behavioural and psychological difficulties (eg agitation, aggression, wandering, shouting, repeated questioning and sleep disturbance) is common in dementia. These cause problems in themselves, which complicate care, and they can occur at any stage of the illness. They are a legitimate object for intervention to decrease distress and harm, and increase quality of life for the person with dementia and their carers.

The systems that we have in place to manage behavioural problems in dementia have grown by chance rather than by specific planning or commissioning and there are important gaps in services and skills. "Time for Action" concluded that current systems appear to deliver a largely antipsychotic-based response. It is clear that these medications are being prescribed to deal with behavioural and psychological symptoms in dementia rather than just for psychosis. The evidence includes gaps, contradictions and complexity but there is emerging consensus with respect to the level of use and risk of antipsychotic drugs for people with dementia. Reviewing the evidence, these drugs appear to have only a limited positive effect in treating these symptoms but can cause significant harm to people with dementia.

However, some people do benefit from the use of antipsychotic medication and there are groups (eg where there is severe and complex risk) where trials have not been completed but where there may be particular value in using these medications. However, it appears that they are too often used as a first-line response to behavioural difficulty in dementia rather than as a considered second-line treatment when other non-pharmacological approaches have failed.

It is recommended that the care pathway will be promoted across organisations in Hertfordshire including specialist services, General Practice and Care Homes.

The following partner organisations were involved in the development of this Care Pathway:

Hertfordshire Partnership NHS Foundation Trust

NHS Hertfordshire

West Hertfordshire Hospitals NHS Trust

East and North Hertfordshire NHS Trust

Hertfordshire Community NHS Trust

Mental Health GP Leads

Quantum Care

Hertfordshire National Dementia Strategy Group

Hertfordshire Joint Commissioning Teams

Hertfordshire Care Pathway for Managing Behavioural Symptoms in Dementia (BPSD) - November 2011

Patient has Behavioural and Psychological Symptoms of Dementia (BPSD) e.g delusions, hallucinations, agitation, aggression, irritability, etc.

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Does the patient have Delirium? - short history of confusion, hallucination, delusion with fluctuating cognition.

Yes →

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

No ↓

Apply P.A.I.N approach and manage and treat:

P = Physical care e.g. pain

A = Activity related e.g. care tasks

I = Intrinsic to dementia e.g wandering
= Iatrogenic e.g. drug induced

N = Noise and other environmental causes

Complete Alzheimer's Society 'This is Me' or equivalent

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See NICE Guideline for Non-Pharmacological Management of BPSD

Have you considered non-pharmacological methods of managing behaviour e.g. day care, aromatherapy, activity programmes, distraction, one-to-one care, animal assisted therapy, massage, music therapy, improved lighting, carer support.

Review after 4 weeks

Yes ↓

Risk Assessment

Is there an imminent risk to self or others ?

No →

Yes ↓

See NICE Guideline for Pharmacological Management of BPSD

Consider medication (see options overleaf)

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Consider risk factors for cerebrovascular disease e.g. previous history of stroke, transient ischaemic episodes, hypertension, diabetes, smoker atrial fibrillation.

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Principles of pharmacological management:

- Preferably short term with regular review
- Aim to review treatment after 4 weeks and if appropriate consider stopping treatment
- Start doses low and increase slowly
- Obtain consent if patient has capacity to consent
- Discuss with relatives if does not
- Antipsychotic medication should only be used where there is a risk to patient and others
- Check for polypharmacy, drug interactions and additive side effects.

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Behavioural problems remain severe – Refer to Specialist Mental Health Team for Older People (SMHTOP)

For enhanced risk assessment, documentation of behaviour (CMA12) and capacity.

Medication will be considered following principles listed above.

Hertfordshire Care Pathway for the Management of Behavioural and Psychological Symptoms of Dementia (BPSD) (NB - "start low, go slow")

It is a general principle that where a behavioural or psychological problem is identified that would be treatable without dementia, for example, with depression or psychosis, this should be treated in the normal way. This applies in particular to depression where an SSRI anti-depressant in standard dose would be appropriate. ***Mirtazapine*** and ***trazodone*** have hypnotic effects and may be particularly useful if there is depression with insomnia.

Few drugs are licensed for BPSD. All drugs in BPSD either have unproven efficacy or significant side effects. Therefore drug treatment for BPDSD should only be started when the problem and associated risks are severe and other options have been exhausted. Beware of polypharmacy and additive side effects.

Atypical anti-psychotics

Have been associated with CVA, worse cognitive outcome and reduced life expectancy in people with dementia. These risks need to be balanced against the risks of the behaviour, benefits to a patient distressed by BPSD and the understanding that we are treating a progressive terminal condition.

Risperidone - starting dose 0.25 mg bd - do not prescribe more than 1mg bd without referring. ***Risperdal*** has a licence for short term (up to 6 weeks) treatment of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and where there is a risk of harm to self or others.

Quetiapine - starting dose 12.5 mg od – do not prescribe more than 100mg per day without referring.

Amisulpride - starting dose 50 mg bd.

Typical anti-psychotic drugs

These often have worse Parkinsonian side effects than atypical drugs. Though there is less evidence about safety than atypical drugs, there is no evidence they are safer.

Promazine at a starting dose of 25 mg od is a frequent choice of some specialists in Old Age Psychiatry and is licensed for "agitation and restlessness in the elderly".

Anticonvulsants

Carbamazepine and **valproate** are a frequent choice of some specialists since the risks of antipsychotics have been highlighted. There is limited evidence of efficacy and although there is no clear evidence of risk, as there is for antipsychotics, they have associated with their own side effects.

Other Drugs

Trazodone at a starting dose of 50 mg nocte is also used. This is particularly appropriate where there is depression, but is often used without specific evidence of depression.

Mirtazapine 15 mg nocte for depression.

Citalopram compared well with risperidone in a trial (Pollock et al 2007 using 10 - 40 mg/day) both for agitation and psychosis, though there was no placebo group. Max dose in older people 20 mg daily.

Lorazepam (0.5 - 1 mg) is often used where behaviour is a time limited problem, on a prn basis. In general, there is little evidence of benefit of benzodiazepines and it is important to make sure that a prn dose does not become regular. Diazepam 2 mg may be an alternative but is longer acting.

Dementia Drugs

While there is some evidence that the AChEI drugs for Alzheimer's disease (***donepezil***, ***rivastigmine*** and ***galantamine***) reduce subsequent BPSD compared to placebo in a milder "memory clinic" population, this is less clear for moderate to severe dementia or for the specific outcomes of agitation and aggression. NICE endorses these drugs where anti-psychotic drugs are inappropriate or have been ineffective.

Memantine is associated with less BPSD than placebo after 6 months of treatment (though there is little improvement from the baseline state, just less worsening). It is not clear that this translates to efficacy for established BPSD, especially the more severe forms. It is generally a well-tolerated drug.

Lewy Body Dementia

In Lewy Body Dementia, anti-psychotic drugs have particularly severe side effects and should be avoided if at all possible. A non-pharmacological approach is preferable. In most cases a different class of drug should be used first line and an anti-psychotic drug should be reserved for second line. In this condition, there is often felt to be a stronger case to consider AChEI drugs (***donepezil***, ***rivastigmine*** and ***galantamine***), though NICE guidance for Alzheimer's Disease does not apply to Lewy Body Disease.

Dementia in Parkinson's Disease

This is closely related to Lewy Body dementia. ***Rivastigmine*** is licensed. Starting dose 1.5 mg bd oral or 4.6 mg patch. Increase to up to maximum tolerated dose up to 6mg bd or 9.5 mg patch. There is currently no arrangement in Hertfordshire to fund treatment of Parkinson's disease dementia with rivastigmine. If an anti-psychotic is used, ***Clozapine*** is licensed for the treatment of psychosis in Parkinson's disease, though this must be prescribed in secondary care. ***Quetiapine*** is used as an alternative.