Guidance for Review of Antipsychotic Prescribing in Patients with Dementia

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Governance or Assurance Committee	**Area Drug & Therapeutics Committee**
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Introduction

Antipsychotics have only limited benefit in treating symptoms of stress and distress (also referred to as Behavioural and Psychological Symptoms of Dementia or BPSD) in people with dementia and carry significant risk of harm, e.g. delirium, cerebrovascular events, falls and all-cause mortality. This guidance is adapted from NHS Scotland Polypharmacy Guidance 2018 and follows best practice recommendations for review of antipsychotic prescribing in dementia.

Aim

This guidance supports a rational approach for the review of antipsychotic prescribing in patients with dementia within NHS Lanarkshire hospitals, care homes and community settings.

Review of antipsychotic prescribing in patients with dementia

Medication and management of stressed and distressed behaviours:

- Medication should be used as last, not first resort, to manage stress and distress
- People with dementia on psychotropic medicines, including antipsychotics should be prioritised for multidisciplinary review
- People with dementia on antipsychotics should be reviewed every three months
- Psychotropic medicines should be withdrawn gradually

Which patients should be prioritised for review?

Patients with dementia who have been on antipsychotics for more than 3 months and have stable symptoms should be reviewed with a view to reducing or stopping antipsychotic medication. Priority groups for reducing antipsychotic medication include:

- **People in care homes**
  The prescribing of antipsychotics for symptoms of stress and distress is higher in this population.
- **People with vascular dementia**
  The risk of cerebrovascular events associated with antipsychotic medication may be higher in this population.
- **People with dementia plus history of cardiovascular disease, cerebrovascular disease or vascular risk factors**
  The risk of cerebrovascular events associated with antipsychotic medication may be higher in this population.

When should antipsychotic medication NOT be stopped?

- In patients who have a co-morbid mental illness that is treated with antipsychotic medication, such as schizophrenia, persistent delusional disorder, psychotic depression or bipolar affective disorder should not have antipsychotic medication reduced without specialist advice from Older Adult Mental Health Services.
- Patients with dementia and Learning Disabilities should not have antipsychotic medication reduced without specialist advice from Learning Disability Mental Health Services.

How to reduce antipsychotic medication? (refer to the flowchart overleaf)

- Slow reduction of antipsychotic (25% daily dose) with close monitoring.

- Suggested dose reductions (dependent on prescribed maintenance dose);
  - Quetiapine 25mg
  - Amisulpride 25mg
  - Risperidone 0.5mg
  - Olanzapine 2.5mg
  - Haloperidol 0.5mg

- If the current dose is low e.g. at the suggested starting dose, then the medication may usually be stopped without reducing further. However for patients who have a history of being sensitive to small dose adjustments consider reducing more slowly.

- Patients who have had previous dose reduction attempts with re-emergence of symptoms and/or discontinuation symptoms may benefit from smaller dose reductions.

- Review the effect after one week to assess for:
  - the re-emergence of the initial 'target' symptoms of stress and distress.
  - discontinuation symptoms can include cholinergic rebound features;
    - e.g. nausea, vomiting, anorexia, diarrhoea, rhinorrhoea, sweating, myalgia, paraesthesia, insomnia, restlessness, anxiety and agitation.
    - discontinuation symptoms generally begin within 1 to 4 days of withdrawal and subside within 7 to 14 days.

- If either target symptoms occur or there is evidence of discontinuation symptoms, make an assessment of the risks and benefits of re-instating the previous dose of antipsychotic. Further attempts to reduce the antipsychotic should be considered one month later with smaller decrements where possible (around 10% of the daily dose).

- Where severe symptoms of stress and distress recur, consider referral to Older Adult Mental or Learning Disability Mental Health Services for advice.

- Where mild to moderate target symptoms return, consider 'watchful waiting', including ongoing assessment and use of non-medication interventions.

- Following the initial reduction, if there are no particular problems after week 1 then the dose should remain the same with further review after week 2 to 4 weeks.

- If the reduction has been tolerated without any of the effects described above, then consider reducing by a further 25% after 2-4 weeks and repeat the process until the medication is stopped.

- There may be practical issues when reducing the dose, for example the availability and form of small doses of medication. It is recommended that this is discussed with a pharmacist.

References:

1. NHS Scotland Polypharmacy Guidance Realistic Prescribing 3rd edition 2018

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