Prescriber Information Leaflet

National Clinical Guideline No. 21:
Appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia.

This National Clinical Guideline was published by the Department of Health in 2019. This guideline applies to people with dementia of any age, and of any type, and in any setting.

Recommendations (key recommendations in bold)

General Principles of care

1 Prior to considering any psychotropic medication in a person with dementia, a comprehensive assessment should be performed, by an appropriately trained healthcare professional.

2 Non-pharmacological interventions should be used initially to treat non-cognitive symptoms in a person with dementia, unless there is severe distress, or an identifiable risk of harm to the person and/or others.

Antipsychotic medication

3 Antipsychotic medication should be used with caution and only in cases where there is aggression, agitation or psychosis that either causes an identifiable risk of harm to the person with dementia and/or others or causes severe distress to the person.

4 People with Alzheimer's disease, vascular dementia or mixed dementias with **mild-to-moderate** non-cognitive symptoms should NOT be prescribed antipsychotic medication due to the increased risk of cerebrovascular adverse events and death.

5 People with dementia with Lewy bodies and Parkinson's disease dementia with **mild to moderate** non-cognitive symptoms should NOT be prescribed antipsychotic medication due to the increased risk of severe adverse reactions.

6 People with Alzheimer's disease, vascular dementia, mixed dementias, dementia with Lewy bodies, or Parkinson's disease dementia, with **severe** non-cognitive symptoms, causing severe distress, or an identifiable risk of harm to the person and/or others, may be offered antipsychotic medication, where appropriate.

7 A full discussion with the person and/or their relevant Decision Supporter about the benefits and risks, including the increased risk of stroke, transient ischemic attack and mortality, should occur before antipsychotic medication is commenced.

Recommendations (key recommendations in bold)

Antipsychotic medication

8 Atypical (second generation) antipsychotic medications are associated with fewer extrapyramidal effects and risks than typical (first generation) antipsychotics, and therefore second generation medication should be used if antipsychotic therapy is necessary for the management of non-cognitive symptoms.

9 If a risk and benefit assessment favours the use of antipsychotic medication, treatment should be initiated at the lowest possible dose and titrated slowly, as tolerated, to the minimum effective dose.

10 If there is a positive response to treatment with antipsychotic medication, decision making about possible tapering of the medication should occur within 3 months, accompanied by a discussion with the person with dementia and/or their relevant Decision Supporter.

11 If a person with dementia is taking an adequate therapeutic dose of antipsychotic medication without clear clinical benefit, the medication should be tapered and stopped; where possible after discussion with the person and/or their relevant Decision Supporter.

12 If antipsychotic treatment is being tapered, assessment of symptoms for re-emergence should occur regularly during tapering, and for a period after discontinuation of antipsychotic medication.

Acetylcholinesterase inhibitors and memantine

13 Acetylcholinesterase inhibitors are indicated for cognitive enhancement in people with mild to moderate Alzheimer's disease but are NOT recommended solely for the treatment of non-cognitive symptoms in a person with Alzheimer's disease.

Recommendations (key recommendations in bold)

Acetylcholinesterase inhibitors and memantine

14 Due to the particular risks with antipsychotics in people with Parkinson's disease dementia and dementia with Lewy bodies, rivastigmine or donepezil may be considered for non-cognitive symptoms causing severe distress when non-pharmacological interventions have proved ineffective.

15 People with vascular dementia or frontotemporal dementia who develop non-cognitive symptoms should NOT be prescribed acetylcholinesterase inhibitors.

16 Memantine is indicated as a cognitive enhancer in people with moderate to severe Alzheimer's disease, Parkinson's disease dementia, and dementia with Lewy bodies, but it is NOT recommended to be prescribed solely for the treatment of non-cognitive symptoms in a person with dementia.

Antidepressant medication

17 In people with mild to moderate dementia, and mild to moderate depression and/or anxiety, psychological treatments should be considered. Antidepressants may be considered to treat **severe** comorbid depressive episodes in people with dementia, or **moderate** depressive episodes that have not responded to psychological treatment.

Anti-convulsant medication

18 Anticonvulsant medication is indicated for the treatment of seizures, bipolar disorder, or as an adjunctive therapy for pain, but is NOT recommended as a treatment for non-cognitive symptoms in a person with dementia.

Benzodiazepines, z-drugs, and other hypnotics

19 Due to the very limited evidence to support the use of benzodiazepines in the management of non-cognitive symptoms in a person with dementia, and their significant adverse effects, they should be avoided for the treatment of non-cognitive symptoms, and usage strictly limited to the management of short-term severe anxiety episodes.

Recommendations (key recommendations in bold)

Benzodiazepines, z-drugs, and other hypnotics

20 A personalised sleep management regimen may be considered for sleep disorders in a person with dementia.

21 Melatonin should NOT be used for sleep disorders in people with dementia*.

*Melatonin is not recommended for use in the treatment of insomnia in people living with dementia. There may be some exceptions but these are very specific indications and must be commenced or discontinued under specialist supervision, such as REM behavioural disturbance or other parasomnias.

Why is a comprehensive assessment important?
A comprehensive assessment helps to understand the symptom a person has and how that's manifesting in a behaviour and what are the things that might be driving that symptom and behaviour.

What should a comprehensive assessment include?
A review of medical, mental health history (including depression) and medication history; physical examination, including consideration of possible delirium, or undetected pain or discomfort (with an appropriate assessment of same); assessment of the severity, type, frequency, pattern and timing of symptoms, and other potentially contributory or comorbid factors.

What tools can help me collect information as part of a comprehensive assessment?

RAGSTER

R = Rule out delirium, pain and depression
A = Agree and decide on which behaviours to target
G = Gather information
S = Select interventions/solutions
T = Trial of interventions or solutions
E = Evaluate
R = Review

The PIECES Tool

Physical
Intellectual
Emotional
Capabilities
Environment
Social

Alzheimer's Society UK Traffic Light System

Green: No symptoms
Amber: Mild or moderate symptoms
Red: Severe symptoms

The ABC tool

Antecedent
Behaviour
Consequence

Where should the comprehensive assessment be performed?

This assessment should be performed in an appropriate environment that optimises the person's comfort and ability and includes any support that the person may require.

Who should perform the comprehensive assessment?

The assessment needs to be performed by a nurse or doctor who is competent in assessing a person with dementia who may be distressed, but all members of the team caring for the person can give really useful information to support this.

Where can I find more information?

https://www.hse.ie/eng/dementia-pathways/resources-for-practice/implementation-of-national-clinical-guideline-no-21/

Good Practice Points

1 At all times, and throughout the dementia trajectory, an individualised and person-centred approach should be promoted and practiced by all doctors, nurses, pharmacists, and health and social care professionals.

2 The risk and benefits of pharmacological intervention using psychotropic medication should be discussed with the person, and/or their relevant Decision Supporter, in all cases where possible.

3 Psychotropic medication that is commenced for non-cognitive symptoms in a person with dementia should be reviewed regularly to assess efficacy, adverse effects and continued need.

4 If psychotropic medication is necessary for the management of non-cognitive symptoms, oral medication should be used initially. In the exceptional case where parenteral treatment is necessary, the intramuscular route is preferred to intravenous administration, and single agents are preferred to combination therapy.

5 If rapid tranquilisation is needed, attending doctors and nurses should be adequately trained and have access to adequate monitoring and resuscitation facilities, and should consult their local institutional policy.

6 There is little evidence that antipsychotics are effective in the treatment of certain non-cognitive symptoms such as walking about, hoarding, fidgeting, inappropriate voiding, verbal aggression, screaming, sexual disinhibition and repetitive actions. Therefore, any use in the management of these symptoms needs to be particularly justified.

7 Doctors, nurses, pharmacists and health and social care professionals are strongly advised to contact a specialist team with experience in treating people with Lewy body dementias for direct advice on a person with Parkinson's disease dementia or dementia with Lewy bodies who has distressing psychosis.

Good Practice Points

8 Doctors and nurses who prescribe antipsychotics should have written information available for the person with dementia and their family about possible side effects (e.g. falls, confusion, drowsiness), as well as easy to understand information about the risk of serious adverse events (stroke, death).

9 In rare cases where a person with dementia has had two or more failed attempts of antipsychotic withdrawal and requires ongoing maintenance therapy with an antipsychotic, the person should be reviewed at the point of re-prescribing and at least 6 monthly thereafter.

10 Apart from their role in the treatment of depression, antidepressants may have a role in the treatment of other **severe** non-cognitive symptoms in a person with dementia (such as agitation), where pharmacological treatment has been deemed necessary. If trialled for other non-cognitive symptoms, antidepressants should be used with caution, with close monitoring for side effects.

11 There are no studies of z-drugs for sleep disorders in people with dementia. Due to their significant side effects, if z-drugs are considered, it should be for the shortest period possible (or as specified by medication license).

Resources

Scan code to access National Clinical Guideline No. 21 which provides detailed information on the appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia.

Scan code to access an algorithm to guide appropriate prescribing of psychotropic medication for non-cognitive symptoms in a person with dementia.

Scan code to access more detailed information on comprehensive assessment.

Scan code to access 'Non-cognitive symptoms of dementia: Guidance on non-pharmacological interventions for healthcare and social care practitioners' which provides detailed information and guidance on the use of non-pharmacological interventions in supporting people with non-cognitive symptoms of dementia.

Resources

Scan code to access a Plain English guide for people with dementia and their family carers and supporters in relation to prescribing psychotropic medication for non-cognitive symptoms of dementia.

Scan code to access an Easy Read guide for people with dementia and their family carers and supporters in relation to prescribing psychotropic medication for non-cognitive symptoms of dementia.

DementiaPathways.ie includes resources and guidance to support good practice in dementia care. Dementia Pathways complements **www.understandtogether.ie** which is an online resource for the general public, offering information, service sign-posting, and advice on dementia.

www.hse.ie