Antipsychotics in dementia – check list

Physical and environmental assessment

A physical and behavioural assessment has been made to establish potential underlying causes of BPSD e.g.

- the person's physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- psychosocial factors
- physical environmental factors – a change in environment, moving from home to a care home, building work can contribute to symptoms.

When to prescribe

Offer a pharmacological intervention in the first instance if severely distressed or there is an immediate risk of harm to themselves or others. People with less severe symptoms should have non-pharmacological interventions considered first.

People with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate non-cognitive symptoms should not be prescribed antipsychotic drugs because of the increased risk of cerebral vascular events and death. Non-pharmacological interventions should be used.

People with dementia with Lewy bodies (DLB) with mild-to-moderate non-cognitive symptoms should not be prescribed antipsychotic drugs because they are particularly at risk of adverse events.

Conditions which should be met for prescription of antipsychotic

Diagnosis of severe dementia (psychosis and/or agitated behaviour causing significant distress and risk of harm to self or others).

There should be a full discussion with the person with dementia and/or carers about the possible benefits and risks of treatment.

Cerebrovascular risk factors should be assessed and the possible increased risk of stroke/transient ischaemic attack and possible adverse effects on cognition discussed.

What to assess once treatment initiated

Changes in cognition should be assessed and recorded at regular intervals. Regular is not defined by NICE but regular should be defined locally, for each patient there should be an individualized plan recorded in the care record which includes planned frequency of review of the medication effects.

Target symptoms should be identified, quantified and documented in order to enable you to establish if the medication is having the desired effect.

Changes in target symptoms should be assessed and recorded at regular intervals.

The effect of co-morbid conditions, such as depression, should be considered prior to offering an antipsychotic (see physical and environmental assessment above).

Drug choice and ongoing reassessment

Only risperidone (up to 6 weeks) is licensed for persistent aggression in patients with moderate to severe Alzheimer's disease who are unresponsive to non-pharmacological interventions and when there is serious risk of harm to self or others.

The dose should be low initially and then titrated upwards if needed.

Treatment should be regularly reviewed (the time scale of the frequency of reviews should be defined locally).

For people with DLB, monitor carefully for the emergence of severe untoward reactions, particularly neuroleptic sensitivity reactions (particularly extrapyramidal side effects and unexplained deterioration in physical symptoms).

Based on: Dementia: the use of medication for non-cognitive symptoms, behaviour that challenges and behaviour control. NICE clinical guideline 42.