

---

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

|   |           |
|---|-----------|
| <b>INTRODUCTION .....</b>   | <b>4</b>  |
| <i>Definition of Behavioural and Psychological Symptoms of Dementia (BPSD).....</i>   | 4         |
| <i>Mild or Moderate BPSD.....</i>   | 4         |
| <i>Severe BPSD.....</i>   | 4         |
| <i>Behavioural Symptoms.....</i>  | 4         |
| <i>Psychological Symptoms .....</i>   | 4         |
| <i>Duration of BPSD.....</i>  | 5         |
| <i>Factors Contributing to BPSD (Figure 1).....</i>   | 5         |
| <b>SECTION ONE- ASSESSMENT AND MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN PRIMARY AND GENERAL HOSPITAL CARE .....</b>                   | <b>6</b>  |
| <b>1.1 INITIAL ASSESSMENT IN PRIMARY AND GENERAL HOSPITAL CARE .....</b>  | <b>7</b>  |
| 1.1.1 <i>History.....</i>   | 7         |
| 1.1.2 <i>Consider: .....</i>  | 7         |
| 1.1.3 <i>Physical Examination .....</i>   | 8         |
| 1.1.4 <i>Blood Tests.....</i>   | 8         |
| 1.1.5 <i>Other investigations.....</i>  | 8         |
| 1.1.6 <i>Mental State Examination and Cognitive Assessment.....</i>   | 8         |
| 1.1.7 <i>Further Physical/Medical Assessments.....</i>  | 9         |
| <b>1.2 INITIAL MANAGEMENT IN PRIMARY AND GENERAL HOSPITAL CARE .....</b>  | <b>9</b>  |
| 1.2.1 <i>Medical/Physical Health .....</i>  | 9         |
| 1.2.2 <i>Psycho-social.....</i>   | 10        |
| 1.2.3 <i>Pharmacological Management .....</i>   | 11        |
| 1.2.3.1 <i>General Guidance .....</i>   | 11        |
| 1.2.3.2 <i>Doses of Medication for BPSD .....</i>   | 12        |
| 1.2.3.3 <i>Depression .....</i>   | 12        |
| 1.2.3.4 <i>Anxiety/Agitation.....</i>   | 12        |
| 1.2.3.5 <i>Hallucinations/Delusions .....</i>   | 13        |
| 1.2.3.6 <i>Aggression/Violence .....</i>  | 13        |
| 1.2.3.7 <i>exual Disinhibition/Hypersexuality .....</i>   | 13        |
| 1.2.3.8 <i>Sleep Disturbance .....</i>  | 14        |
| <b>SECTION TWO- ASSESSMENT AND MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN OLDER PEOPLE'S MENTAL HEALTH SECONDARY CARE SERVICES.....</b> | <b>15</b> |
| <b>2.1 ASSESSMENT IN SECONDARY CARE OR BY OPMH LIAISON SERVICE WITHIN GENERAL HOSPITAL CARE.....</b>  | <b>16</b> |
| 2.1.1 <i>History.....</i>   | 16        |
| 2.1.2 <i>Physical Examination .....</i>   | 17        |
| 2.1.3 <i>Blood Tests.....</i>   | 17        |
| 2.1.4 <i>Other Investigations .....</i>   | 17        |
| 2.1.5 <i>Mental State and Cognitive Assessment.....</i>   | 18        |
| 2.1.6 <i>Behavioural and Neuropsychological Assessments .....</i>   | 18        |
| 2.1.7 <i>Further Physical/Medical Assessment .....</i>  | 18        |
| 2.1.8 <i>Carer's Assessment .....</i>   | 19        |
| <b>2.2 MANAGEMENT IN SECONDARY CARE .....</b>   | <b>20</b> |
| 2.2.1 <i>Medical/Physical Health .....</i>  | 20        |
| 2.2.2 <i>Psycho-social.....</i>   | 21        |
| 2.2.3 <i>Pharmacological Management .....</i>   | 22        |
| 2.2.3.1 <i>Depression .....</i>   | 23        |
| 2.2.3.2 <i>Anxiety/Agitation.....</i>   | 23        |
| 2.2.3.3 <i>Hallucinations/delusions.....</i>  | 23        |
| 2.2.3.4 <i>Aggression/Violence .....</i>  | 24        |
| 2.2.3.5 <i>Sexual Disinhibition/Hyper Sexuality .....</i>   | 24        |
| 2.2.3.6 <i>Sleep Disturbance .....</i>  | 24        |

**SECTION THREE- ADDITIONAL INFORMATION FOR THE ASSESSMENT AND MANAGEMENT OF BPSD .....25**

**3.1 SYMPTOMS SUGGESTIVE OF DELIRIUM ..... 26**

**3.2 PRESCRIBING ANTIPSYCHOTICS IN PATIENTS WITH BPSD..... 26**

**APPENDIX 1: RECOMMENDED INVESTIGATIONS WHEN PRESCRIBING ANTIPSYCHOTICS.....28**

**APPENDIX 2: BPSD PATHWAY: ASSESSMENT AND MANAGEMENT IN PRIMARY AND GENERAL HOSPITAL CARE .....29**

**APPENDIX 3: BPSD PATHWAY: SPECIALIST OLDER PEOPLE’S MENTAL HEALTH SECONDARY CARE .....30**

**REFERENCES: .....31**

## Introduction

This guidance has been developed to complement the document “optimising treatment and care for people with behavioural and psychological symptoms of dementia. A best practice guide for health and social care professionals”<sup>1</sup> and aims to give greater detail to the assessment and management of people with BPSD presenting in primary care and general hospital settings.

## Definition of Behavioural and Psychological Symptoms of Dementia (BPSD)

Behavioural and Psychological Symptoms of Dementia (BPSD) are symptoms of disturbed perception, thought content, mood, or behaviour, that frequently occur in patients with dementia. More than 90% of people with dementia will experience BPSD as part of their illness, and nearly two thirds of those living with dementia in care homes will have BPSD at any one time <sup>1</sup>.

### Mild or Moderate BPSD

Symptoms are mild or moderate if they occur occasionally, are not causing serious distress or putting themselves or others at risk. For most people with mild or moderate symptoms, improvement can be achieved in 4-6 weeks without any drug treatment <sup>1</sup>.

### Severe BPSD

Symptoms are severe if they are happening very frequently and causing a great deal of distress and risk to the person and others around them <sup>1</sup>. Whilst in many cases these symptoms can be managed without resorting to drugs, medication may be appropriate for a short time in others. <sup>1,2</sup>

**Behavioural Symptoms** are usually observed by others, and include problems of physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding, cursing/swearing and ‘shadowing’.

**Psychological Symptoms** are usually ascertained on the basis of interviews with patients with dementia and carers/relatives and include anxiety, depressed mood, hallucinations and delusions.

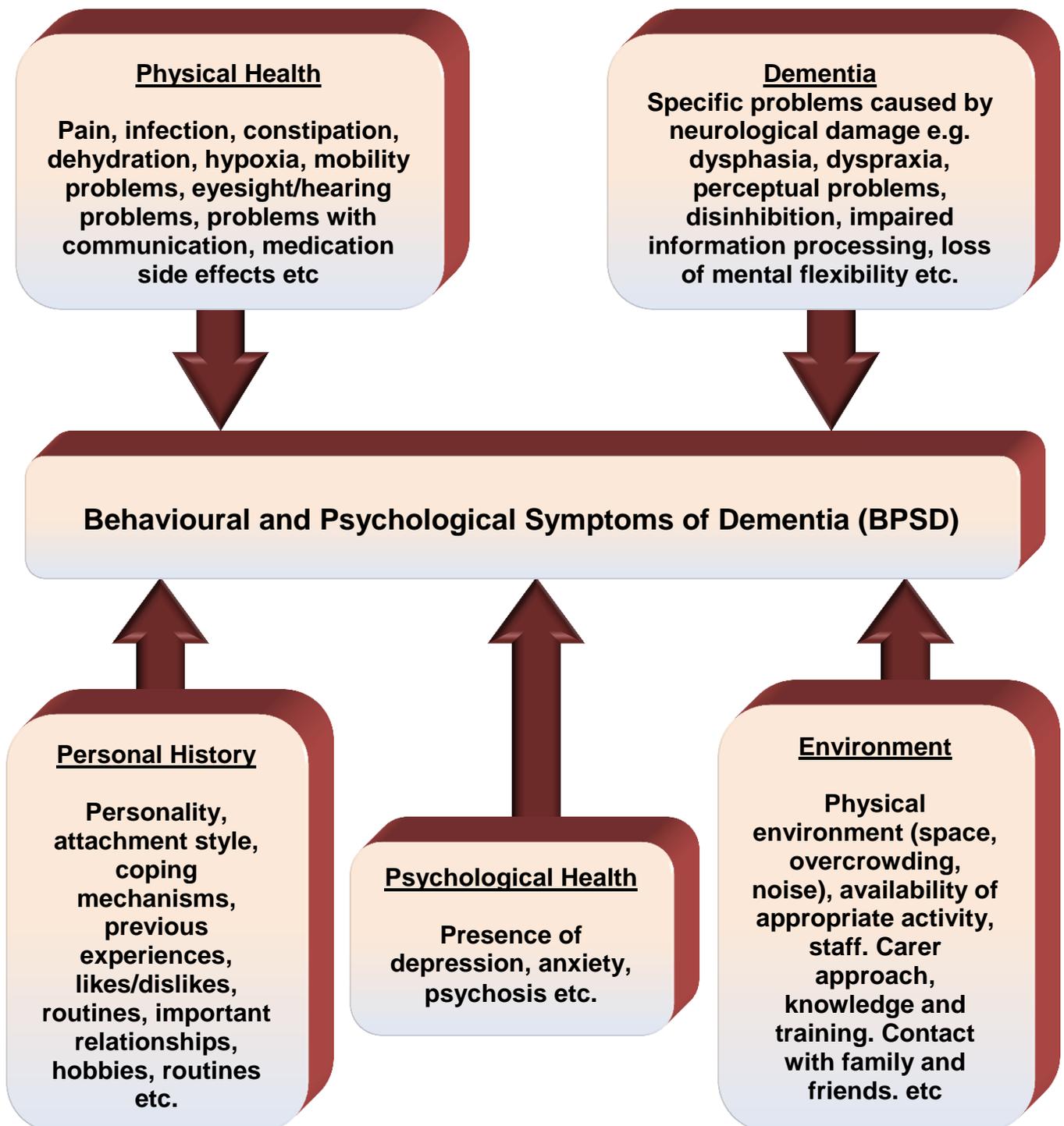
**\*Please note, whilst there may be an overlap between some of the symptoms of delirium in people with dementia, and BPSD, a diagnosis of BPSD should only be made in the absence of delirium. It is important therefore to exclude this, and manage the patient accordingly (see delirium pathway).**

Good practice guidelines, such as NICE clinical guideline 42 <sup>2</sup> emphasise that psychosocial interventions should be offered as first line interventions. It is important that each patient is assessed thoroughly and that the various contributing factors to the development of BPSD are taken into account – including the persons physical health, psychological health, personal history, environment and the neurological damage caused by the dementing process ([see figure 1](#)).

## Duration of BPSD

Many people with BPSD will experience a significant improvement or resolution of symptoms over a 4-6 week period with only simple interventions <sup>1</sup> and therefore should be managed without the use of pharmacological treatments which have been increasingly associated with major adverse outcomes and serious side effects. Current good practice guidance suggests that people with mild to moderate BPSD should be managed without the involvement of specialist mental health services. However, if symptoms persist (or get worse) after 4-6 weeks, referral to such services may be appropriate.

## Factors Contributing to BPSD (Figure 1)



## **Section One- Assessment and Management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Primary and General Hospital Care**

---

## 1.1 Initial Assessment in Primary and General Hospital Care

### 1.1.1 History

**Aims:**

- **To gather information in order to develop an initial formulation and risk assessment, and determine whether referral to Secondary Care is appropriate/indicated.**
  - **To exclude delirium as a diagnosis (please see delirium pathway).**
- Involve one or more appropriate informants.
  - Basic analysis of behaviour, e.g. onset, course and pattern of symptoms, with identified triggers, frequency, severity, risks, etc.
  - Consider use of Confusion Assessment Method (CAM) scale to identify possible delirium.
  - Risk assessment re. problematic behaviours, etc., including risk of neglect, vulnerability, falls, accidents, self-harm, suicide, risk to others, risk from others etc.
  - Consider need to inform Safeguarding team if there are issues re protection of vulnerable adults.

### 1.1.2 Consider:

- Sensory deprivation (e.g. Is the person wearing their glasses, has their eye sight been tested, are they wearing their hearing aid / is it in good working order? etc)
- Previous and current physical health, including vascular risk factors, constipation, dehydration, malnourishment, altered mobility, etc.
- Possibility of undetected or inadequately managed pain or discomfort (consider use of a pain rating scale e.g. Pain Rating Chart). Also consider possibility of hunger or low blood sugar contributing to behaviour
- Depression and previous psychiatric history (consider use of Cornell scale for depression in dementia).
- Medication – changes and side-effects, interactions, etc.
- Drug, alcohol and smoking history, including possibility of withdrawal symptoms
- Psycho-social factors.
- Caffeine intake.
- Physical environmental factors. (e.g. physical layout, poor lighting, is the environment too hot, too cold, noisy, overcrowded, lacking in appropriate activities, inadequately staffed, poor staff attention / understanding of the person's needs, poor communication between the person with dementia and staff, conflict between staff and carers or weak clinical leadership.)
- Individual biography, including religious and spiritual issues, premorbid personality, hobbies, interests, daily routines and rituals, likes and dislikes etc (– need to ensure the findings are then translated into the individual's care plan)
- Assess previous level of function and recent changes to this.
- Issues with respect to mental capacity, e.g. existence of Lasting Power of Attorney for Health and Welfare, Advanced Directives, Patient Passport, etc.

- Assess for signs suggestive of possible neglect or abuse

### **1.1.3 Physical Examination**

#### **Aims:**

- **To exclude physical health triggers to behaviour, and optimise current physical health.**
  - **To exclude delirium as a diagnosis and/or identify possible physical contributing factors to delirium.**
- Look for signs of infection, constipation, pain, distress, heart failure, side effects of medication, dehydration, malnourishment, head injury etc.
  - Neurological examination to identify any localised signs.

### **1.1.4 Blood Tests**

#### **Aim - to identify underlying cause or contributory/exacerbating physical health problems**

- **Arrange URGENTLY**
- FBC, Biochemical Profile, blood glucose (HbA1c if diabetic), Thyroid function,
- ESR/PV/CRP, B12/Folate.

### **1.1.5 Other investigations**

#### **Aim – to identify other cause or contributory/exacerbating physical health problems**

- Urine – dipstick +/- MSU.
- ECG and CXR if appropriate (e.g. if history of, or suspect chest or cardiac problems)
- Consider need for CT scan (e.g. if history of head injury, altered level of consciousness, suspect subdural, stroke, 'atypical' presentation, etc) or MRI scan.

### **1.1.6 Mental State Examination and Cognitive Assessment**

#### **Aim – to identify abnormalities of mental state which may indicate possible underlying causes and any exacerbating factors**

#### **Assess:**

- Level of arousal/attention (possibly indicative of delirium or Lewy Body Dementia).
- Evidence of fluctuation in course of the interview (e.g. impaired concentration)
- Alteration of speech (e.g. comprehension, dysphasia and word finding, loss of clarity of speech, 'muddled' thinking etc).
- Depression or anxiety.
- Psychosis (hallucinations and/or delusions)

- Abnormality of thought content (e.g. anxious cognitions, depressive thoughts, paranoid or self referent thinking, confabulation etc).
- Abnormality of thought form (e.g. concreteness of thinking and loss of mental flexibility, circumstantialities, breakdown in sentence structure etc)
- Level of confusion, understanding, judgement and insight.
- Issues regarding mental capacity/decision-making.
- Presence of specific cognitive problems e.g.
  - Praxis
  - Perceptual difficulties and recognition of environment and faces
  - Perseveration
  - Disinhibition etc.

### **1.1.7 Further Physical/Medical Assessments**

**Aim – to identify physical causes/exacerbating factors, optimize physical health and wellbeing, and avoid unnecessary transfer between care environments**

Referral to Geriatrician if:

- Complex physical health problems.
- Complex issues regarding medication.
- Complex palliative care issues.
- Advice and guidance regarding interpretation of results/ investigations.

Involve other professionals:

- Physiotherapy for mobility problems, falls, pain management, etc.
- O.T. for aids/adaptations, appropriate occupation/stimulation, etc.
- Continence assessments and interventions.
- Dietician for dietary advice.
- SLT for swallowing assessments or to facilitate communication, etc.
- Long-term conditions nurse
- EoL Care Specialists
- Telehealth monitoring (via NCT / Community Matron)

## **1.2 Initial Management in Primary and General Hospital Care**

### **1.2.1 Medical/Physical Health**

**Aim – to treat any underlying physical health problems, and optimise current physical health and function, e.g. Antibiotics for infection, Laxatives for constipation, analgesics for pain, etc. This will also include management of vascular risk factors.**

- Review medication and withdraw inappropriate or unnecessary prescriptions or medications causing problematic side-effects.
- Note that opiate analgesics can exacerbate BPSD due to side effects including sedation and constipation.

- Treatment of pain should involve both pharmacological and non-pharmacological measures in severe dementia 2
- Involve other professionals, e.g.
  - Physiotherapy for mobility problems, falls, pain management, postural assessment, etc.
  - O.T. for aids/adaptations, appropriate occupation/stimulation, etc.
  - Continence assessments and interventions.
  - Dietician for dietary advice.
  - SLT for swallowing assessments or to facilitate communication, etc.
  - Advice regarding exercise, diet, fluids, caffeine reduction, etc.
  - Referral to Geriatrician, if complex physical health problems and/or complex issues regarding management of these problems.
  - Consider review and support from Long-term conditions nurse
  - Refer for Telehealth monitoring via NCT / Community Matron
  - Utilise End of Life Specialists when necessary
- Consider diagnosis of the dying phase, registration on the primary care EoL register, and the need to develop an end of life care plan with potential involvement from EoL care specialists
- Refer to GSF Prognostic Indicators to support diagnosis of the dying phase, and communicate with relevant parties
- Dementia Suite at Dove House Hospital (subject to commissioning) will be available for the treatment of low grade medical conditions in the future
- 'Just in case box' (anticipatory prescribing)
- Fast track continuing health care funding
- EoL care plan including preferred place of care shared with out of hours services
- Consider Liverpool Care Pathway

### 1.2.2 Psycho-social

**Aim – to offer first line, broad based advice/simple interventions, using a person-centred approach, to enhance self-esteem, manage risk and promote occupation and independence.**

**To be conducted by Primary Care and Care Home Providers, in conjunction with Social Services.**

- Identify and address obvious environmental triggers (e.g. overcrowding, noise, lack of activity, inadequate staff time or attention, poor communication, disorientation etc.)
- Environmental modifications to aid independence - including assistive technology (e.g. pressure alert pads, lifeline scheme, signs on doors etc).
- Consider need for staff training in person centred care for people with dementia
- Ensure that the patient's communication needs and abilities are considered by the care staff/carers
- Dementia care mapping
- Personalised activities and interventions
  - Exercise/Physical activity (e.g. walking, gentle stretching, strength training)
  - Reminiscence therapy
  - Multi Sensory stimulation
  - Therapeutic use of music
  - Life review/life story work (this may be translated into an individualised life book and / or collage and the planning of meaningful activities / occupation)
  - Soothing and creative therapies: Aromatherapy, massage, warm towels, smells of cooking, hair brushed, manicure etc
  - Animal assisted therapy
  - Memory management techniques
  - One to one interaction with 10-30 minutes of conversation and/or activity

- Family tape records etc.
- Social inclusion involving activity and recreation
  - Daily chores or tasks
  - Roles within the environment
  - Hobbies
  - Shared pastimes etc
- Sleep hygiene
  - Encouraging activity during the day
  - Reduce daytime 'napping'
  - Having a set, personalised bed time routine
  - Keeping night time noise and light to a minimum
  - Avoiding unnecessary night time interruptions
  - Avoiding caffeine after 4pm
  - Agree realistic expectations re sleep duration and quality
- Family and carer support
  - Consultation and involvement in care planning
  - Practical support for carers (e.g. respite care etc) accessed via social services
  - Psycho education
  - Peer support (carers groups) e.g. via Alzheimer's Society
  - Practical and financial support
  - Carers assessments
  - Couple reminiscence
  - Psychological therapies (e.g. CBT)

### **1.2.3 Pharmacological Management**

**Aim – to review and stop unnecessary medication, and offer evidence-based pharmacological treatment for specific target symptoms and behaviours**

#### **1.2.3.1 General Guidance**

- Consider review of medication, with withdrawal of unnecessary or inappropriate treatments (e.g. sedatives, drugs with anticholinergic side-effects, excessive use of analgesia, etc.)
- Many people with BPSD will experience significant improvement or resolution of symptoms over a 4-6 week period. 1
- Offer non-pharmacological interventions as first line treatment, unless:
  - The patient is severely distressed or
  - There is an immediate risk of harm to the patient and/or others.
- If the patient lacks capacity, discussion regarding the benefits and risks of pharmacological treatment should be undertaken with the patient's family and carers, and a decision made to prescribe drugs if it is in their best interests.
- 'Target' symptoms for pharmacological treatment should be identified, and response/side-effects of treatment closely monitored including changes in cognition.
- Treatment should be time limited with reviews undertaken at least every three months to consider whether it is clinically appropriate to continue treatment or to withdraw it slowly. Short-term prescriptions (maximum 3 months) may be used. 1

- The aim is to use a dose of medication which is as low as is necessary in order to achieve a therapeutic response, and to continue this for as short a time period as possible.
- Medication should be prescribed in conjunction with non-pharmacological approaches, not as an alternative to it.
- **Refer to Specialist (Old Age Psychiatry) Services if:**
  - o There is a significant risk of harm to others, risk of suicide, severe self-neglect, or severe distress.
  - o Lack of response to first line interventions (including drug treatments) after 4-6 weeks
  - o BPSD associated with Lewy Body Dementia, when pharmacological interventions are judged to be necessary or appropriate.
  - o When Safeguarding (protection of vulnerable adults) issues are present
  - o Further specialist assessment is necessary in view of complexity of presentation (e.g. diagnostic issues, palliative care issues etc)

### **1.2.3.2 Doses of Medication for BPSD**

- Medication should be started slowly and titrated cautiously
- Other than for antipsychotics and unless a specific dose is specified in this document the dose schedule to be used is the BNF recommended dose for the appropriate indication and age group
- Doses for antipsychotics should start at between a quarter to half usual BNF starting dose working up to a quarter to half of BNF maximum dose [1](#)
- When selecting medication consideration should be given for the potential to interact with concurrent medication

### **1.2.3.3 Depression**

Please also read [section 1.2.3.1 for general guidance on pharmacological management](#)

- If suspect depression, use an SSRI as first line (e.g. Sertraline or Citalopram<sup>2</sup>), [1](#), [2](#), [3](#) but be aware of increased risk of gastric erosion with concurrent prescription of an NSAID, and possibility of increased agitation in the first 7-10 days of treatment (consider need for concurrent use of a small dose of a benzodiazepine, e.g. Lorazepam 0.5mg-1.5mg daily).
- Consider Mirtazapine or Escitalopram as second line, (Mirtazapine if more sedative antidepressant is warranted). [3](#)
- Be aware of potential of Citalopram and Escitalopram to prolong QTc interval, and amend use in patients prescribed other drugs with prolong QTc, or with a history of cardiovascular problems.
- Consider using Cornell scale for monitoring the response of treatment

### **1.2.3.4 Anxiety/Agitation**

Please also read [section 1.2.3.1 for general guidance on pharmacological management](#)

- Consider pain management if appropriate (e.g. Paracetamol) [2](#)
- Consider possibility of depression and use antidepressant if suspected <sup>1</sup> Antidepressants may also be useful in the management of agitation. [3](#)
- Use Paroxetine (10mg-40mg) as 1st line as licensed for anxiety.
- Consider Escitalopram (5mg-20mg daily) or Venlafaxine (75mg) as 2nd line treatments which are licensed for anxiety.
- Trazodone (50mg-300mg daily) is an alternative antidepressant, licensed for anxiety, which may be considered if sedation is desirable or if patient is agitated. [3](#)
- Short-term use of benzodiazepines (between 2-4 weeks) (e.g. Lorazepam 0.5mg up to t.d.s.) can be considered in acute anxiety/agitation associated with high distress or risk. [3](#)

<sup>1</sup> Risperidone has a BNF dose for the treatment of persistent aggression in Alzheimer's dementia

<sup>2</sup> Started at standard BNF dose and titrated up to BNF maximum. Where no reduced maximum dose is specified for the elderly, the normal BNF maximum dose applies

### **1.2.3.5 Hallucinations/Delusions**

Please also read [section 1.2.3.1 for general guidance on pharmacological management](#)

- Try and establish if the patient is experiencing true psychotic symptoms or if they are describing false memories or confabulating.
- If antipsychotics are necessary/appropriate, the choice of antipsychotic should be influenced by the following considerations
  - Aripiprazole (5mg-15mg daily) is supported as a treatment in the Banerjee report.<sup>6</sup> (unlicensed indication).
  - Consider use of Risperidone only after undertaking an individual risk/benefit analysis.<sup>1, 3</sup> (unlicensed indication) taking into consideration the risks of risperidone in Lewy Body Dementia (see below), the higher propensity for Parkinson-like side-effects, including rigidity, immobility and the potential to cause hypotension.
  - Risperidone is licensed for the treatment of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others. The licence states that it should be used for no longer than 6 weeks before review or specialist referral
- Lewy Body Dementia is thought to account for 15 to 20% of all cases of dementia, and shares characteristics with both Alzheimer's and Parkinson's diseases.
- Hallucinations (particularly visual) are common in Lewy Body Dementia. However, the diagnosis is frequently missed, or it may be misdiagnosed as Alzheimer's disease, vascular dementia or delirium.
- Patients with Lewy Body Dementia who are treated with antipsychotics are at a higher risk of severe Parkinson-like side-effects( including severe rigidity, immobility), and even sudden death.
- Drugs such as aripiprazole have a lower propensity to cause extra pyramidal side effects than risperidone, and may therefore be safer in patients in whom Lewy Body Dementia is suspected as a possibility, though prescribing should only be undertaken when absolutely necessary
- When Lewy Body Dementia is suspected avoid antipsychotics if at all possible and seek specialist advice.
- Patients with Lewy Body Dementia may benefit from the prescription of an acetylcholinesterase inhibitor.<sup>2</sup>
- Consider possibility of psychotic symptoms being due to severe depression, and treat accordingly

### **1.2.3.6 Aggression/Violence**

Please also read [section 1.2.3.1 for general guidance on pharmacological management](#)

- Consider possibility of depression, anxiety or hallucinations as triggers, and treat accordingly
- Consider the use of low dose Risperidone 1 (0.25mg bd, up to a maximum of 1mg bd)), but be aware of side-effects and avoid in Lewy Body Dementia.
- Risperidone is the only antipsychotic licensed for people with dementia. The licence states that it should be used for no longer than 6 weeks before review or specialist referral. NICE guidelines suggest that treatment should be reviewed after 3 months, or according to clinical need.
- See also [advice about use of antipsychotics](#)

### **1.2.3.7 Sexual Disinhibition/Hypersexuality**

**It is important to distinguish between normal sexual behaviours performed in an abnormal context (which may be due to disinhibition due to impaired judgement) and hyper sexual behaviours that may indicate an abnormally high sexual drive.**

- The evidence base is poor for all treatments.
- Please also read section 1.2.3.1 for general guidance on pharmacological management
- Consider an SSRI as 1st line (e.g. Paroxetine or Citalopram). [3,4](#)
- Cimetidine has anti androgenic properties and may be helpful if there is evidence of hyper sexuality. [3,4](#)
- Consider antipsychotics in situations where risk of aggression is present [1, 2, 3, 4](#)
- See also advice about use of antipsychotics

### **1.2.3.8 Sleep Disturbance**

Please also read [section 1.2.3.1 for general guidance on pharmacological management](#)

- Consider whether there is a problem or risk for the patient due to sleep deprivation. If not, use non-pharmacological approaches.
- Consider possibility of depression, anxiety, or pain or other physical health problems as primary cause.
- Sleep hygiene measures (e.g. cut out caffeine etc).
- Hypnotics for short-term use (e.g. Zopiclone, Zolpidem) of up to 4 weeks. [1,2](#)
- Consider Melatonin m/r, short term use of up to 4 weeks.
- Trazodone (50mg-150mg nocte) is a sedative antidepressant which could be considered for use “off licence” if longer-term management is needed. [3](#)

## **Section Two- Assessment and Management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Older People's Mental Health Secondary Care Services**

---

## 2.1 Assessment in Secondary Care or by OPMH Liaison Service within General Hospital Care

### 2.1.1 History

**Aims – To gather information in order to develop a bio-psycho-social formulation and risk assessment. Functional analysis will form the central component of this. 5**

- Involve one or more appropriate informants.
- Behavioural and Functional analysis, e.g. onset, course and pattern of symptoms, with identified triggers, frequency, severity, risks, etc.
- Consider use of Confusion Assessment Method (CAM) to screen for possible delirium
- Risk assessment re. problematic behaviours, etc., including risk of neglect, vulnerability, falls, accidents, self-harm, suicide, risk to others, risk from others etc
- Consider referral to safeguarding team if there are issues i.e. protection of vulnerable adults.

#### Consider:

- Sensory deprivation (e.g. Is the person wearing their glasses, has their eye sight been tested, are they wearing their hearing aid / is it in good working order? etc)
- Previous and current physical health, including vascular risk factors, constipation, dehydration, malnourishment, altered mobility, etc.
- Possibility of undetected or inadequately managed pain or discomfort (consider use of a pain rating scale e.g. Pain Rating Chart). Also consider possibility of hunger or low blood sugar contributing to behaviour
- Depression and previous psychiatric history (consider use of Cornell scale for depression in dementia).
- Medication – changes and side-effects, interactions, etc.
- Drug, alcohol and smoking history, including possibility of withdrawal symptoms
- Psycho-social factors.
- Caffeine intake.
- Physical environmental factors. (e.g. physical layout, poor lighting, is the environment too hot, too cold, noisy, overcrowded, lacking in appropriate activities, inadequately staffed, poor staff attention / understanding of the person’s needs, poor communication between the person with dementia and staff, conflict between staff and carers or weak clinical leadership.)
- Individual biography, including religious and spiritual issues, premorbid personality, hobbies, interests, daily routines and rituals, likes and dislikes etc (– need to ensure the findings are then translated into the individual’s care plan)
- Assess previous level of function and recent changes to this.
- Issues with respect to mental capacity, e.g. existence of Lasting Power of Attorney for Health and Welfare, Advanced Directives, Patient Passport, etc. Assess for signs suggestive of possible neglect or abuse

- Involve family and other agencies in history taking, e.g. multi disciplinary/agency "reception meeting".
- Obtain and read medical records regarding physical health care.
- Liaison with Primary Care and appropriate Secondary Care colleagues (e.g. Neurology/Geriatric Medicine) to ensure physical health problems have been identified treated, etc., and that current physical health is optimal.
- Consider use of specialist rating scales e.g. Cornell scale for depression in dementia, Challenging Behaviour Scale, Neuro-Psychiatric Inventory (NPI), St Andrew's Sexual Behaviour Assessment Scale (SABA) etc.

### 2.1.2 Physical Examination

**Conducted by Primary Care, unless in an inpatient setting.**

**Aim - to exclude physical health triggers to behaviour, and optimise current physical health.**

- Look for signs of infection, constipation, pain, distress, heart failure, side effects of medication, dehydration, malnutrition, head injury etc.
- Neurological examination to identify any localised signs.

### 2.1.3 Blood Tests

**Conducted by Primary Care, unless in an inpatient setting.**

**Aim - to identify underlying cause or contributory/exacerbating physical health problems.**

- **Arrange URGENTLY.**
- FBC, Biochemical Profile, blood glucose (or HbA1c), Thyroid function, ESR/PV/CRP, B12/Folate.

### 2.1.4 Other Investigations

**Aim – to identify other cause or contributory/exacerbating physical health problems.**

- EEG if suspected delirium, fronto temporal dementia or CJD, or if suspect seizures.
- Urine – dipstick +/- MSU.
- ECG and CXR if clinically appropriate (e.g. history of or suspicion of cardiac or chest problems)
- Consider need for CT scan (e.g. if h/o head injury, altered level of consciousness, suspect subdural, stroke, 'atypical' presentation, etc) or MRI scan.
- Consider use of DAT scan if suspect Lewy Body Dementia.

## 2.1.5 Mental State and Cognitive Assessment

**Aim – to identify abnormalities of mental state which may indicate possible underlying cause/exacerbating factors and to assess mental capacity in terms of relevant specific decisions.**

- Assess Level of arousal/ attention (possibly indicative of delirium or Lewy Body Dementia)
- Evidence of fluctuation in course of the interview (e.g. impaired concentration)
- Alteration of speech (e.g. comprehension, dysphasia and word finding, loss of clarity of speech, ‘muddled’ thinking etc).
- Depression or anxiety.
- Psychosis (hallucinations and/or delusions)
- Abnormality of thought content (e.g. anxious cognitions, depressive thoughts, paranoid or self referent thinking, confabulation etc).
- Abnormality of thought form (e.g. concreteness of thinking and loss of mental flexibility, circumstantialities, breakdown in sentence structure etc)
- Level of confusion, understanding, judgement and insight.
- Issues regarding mental capacity/decision-making.
- Presence of specific cognitive problems e.g.
  - o Praxis
  - o Perceptual difficulties and recognition of environment and faces
  - o Perseveration
  - o Disinhibition etc.

## 2.1.6 Behavioural and Neuropsychological Assessments

**Aim – to undertake a functional analysis in order to formulate a comprehensive management plan, taking into account biological, psychological and social factors contributing to the BPSD. 5**

- Behavioural and functional analysis identifying antecedents, behaviour and consequences (ABC) using a person centred formulation based approach.
- Assessment of level of functioning (e.g. O.T.)
- Neuropsychological assessment.
- Dementia Care Mapping.
- Use of specialist rating scales (e.g. Challenging Behaviour Scale).

## 2.1.7 Further Physical/Medical Assessment

**Aim – to identify physical causes/exacerbating factors, optimize physical health and wellbeing and avoid unnecessary transfer between care environments**

- Referral to Geriatrician if:
  - o Complex physical health problems.
  - o Complex issues regarding medication.
  - o Complex palliative care issues.
  - o Advice and guidance regarding interpretation of results/ investigations.

- Involve **other professionals:**

- Physiotherapy for mobility problems, falls, pain management, etc.
- O.T. for aids/adaptations, appropriate occupation/stimulation, etc.
- Continence assessments and interventions.
- Dietician for dietary advice.
- SLT for swallowing assessments or to facilitate communication, etc.
- GP.
- If transferred to acute hospital, involve Specialist Liaison Service for older people with mental health problems and use Patient Passport Scheme.
- Long-term conditions nurse
- EoL Care Specialists
- Telehealth monitoring (via NCT / Community Matron)

### **2.1.8 Carer's Assessment**

**Aim – to assess the level of impact of the patient's problems on the carer(s) and determine the level of support needed.**

- To consider carer's physical and psychological health, as well as social, work or additional needs.
- Level of training, understanding, knowledge, stress, burden and mood.
- Level of formal and informal support available.
- Understand pre-morbid relationship between the carer and cared for person

## 2.2 Management in Secondary Care

### 2.2.1 Medical/Physical Health

**Aim – to treat any underlying physical health problems, and optimise current physical health and function, e.g. Antibiotics for infection, Laxatives for constipation, analgesics for pain, etc. This will also include management of vascular risk factors.**

- Review medication and withdraw inappropriate or unnecessary prescriptions.
- Note that opiate analgesics can cause or exacerbate BPSD due to side effects including sedation and constipation.
- Treatment of pain should involve both pharmacological and non-pharmacological measures in severe dementia (NICE CG 42, p 43)
- Involve other professionals, e.g.
  - o Physiotherapy for mobility problems, falls, pain management, postural assessment/management etc.
  - o O.T. for aids/adaptations, appropriate occupation/stimulation, etc.
  - o Continence assessments and interventions.
  - o Dietician for dietary advice.
  - o SLT for swallowing assessments or to facilitate communication, etc.
  - o Advice regarding lifestyle, diet, caffeine reduction, etc.
  - o Long Term Conditions nurse
  - o End of Life Care specialists
  - o Telehealth care monitoring via NCT/Community Matron
  - o Geriatric Medicine.
  - o GP.
  - o If transferred to acute hospital, involve Specialist Liaison Service for older people with mental health problems and use Patient Passport Scheme.
- Consider diagnosis of the dying phase, registration on the primary care EoL register, and the need to develop an end of life care plan with potential involvement from EoL care specialists
- Refer to GSF Prognostic Indicators to support diagnosis of the dying phase and communicate with relevant parties
- Dementia Suite at Dove House Hospital (subject to commissioning) will be available for the treatment of low grade medical conditions in the future
- Just in case box' (anticipatory prescribing)
- Fast track continuing health care funding
- EoL care plan including preferred place of care shared with out of hours services
- Liverpool Care Pathway

## 2.2.2 Psycho-social

**To be conducted in conjunction with Primary Care, families and carers, care home providers and Care Management.**

**Aim – to offer individually tailored interventions, using a person-centred approach, to enhance self-esteem, manage risk and promote independence.**

- Identify and address obvious environmental triggers (e.g. overcrowding, noise, lack of activity, inadequate staff time or attention, poor communication, disorientation etc).
- Consider whether an alternative environment for management is necessary.
- Environmental modification to independence – including assistive technology (e.g. pressure alert pads, life line scheme, signs on doors etc).
- Consider need for staff training in person centred care for people with dementia.
- MDT/Multi agency formulations based on comprehensive behavioural and functional analysis leading to individualised (person centred) activities and interventions including :-
  - Specific behavioural interventions including behavioural activation
  - Environmental modification and management
  - Attributional or narrative therapy based work with carers
  - Outcome monitoring (e.g. challenging behaviour scale)
  - Systematic/family therapy based work with carers and/or organisations
  - Other individualised interventions or approaches e.g.
    - Exercise/physical activity
    - Reminiscence therapy
    - Multi sensory stimulation
    - Life review/life story work (– this may be translated into an individualised life book and / or collage and the planning of meaningful activities / occupation)
    - Soothing and creative therapies: Aromatherapy, massage, warm towels, smells of cooking, hair brushed, manicure etc
    - Animal assisted therapy
    - Memory management techniques
    - One to one interaction
    - Family tape recordings etc
    - Validation therapy
    - Anxiety management
    - Anger management
- Social inclusion involving activity and recreation
  - Daily tasks and chores
  - Roles within the environment
  - Hobbies, shared pastimes etc
- Sleep hygiene
  - Encouraging activity during the day
  - Reduce daytime napping
  - Honing a set, personalised bed time routine
  - Keeping night time noise and light to a minimum

- Avoiding unnecessary night time interruptions
- Avoiding caffeine after 4pm etc
- Agree realistic expectations for sleep duration and quality
- Family and carer support and interventions
  - Consultation and involvement in care planning
  - Specific additional support (e.g. respite care etc) arranged via social services
  - Psycho education
  - Peer support (carers' groups) e.g. via Alzheimer's Society
  - Carers' assessments
  - Practical support
  - Couple reminiscence
  - Family/systematic therapy
- Individual work with carers
  - CBT
  - Adjustment/grief work
  - Interpersonal therapy
- Palliative (end of life) care
  - Advanced care planning
  - Preferred place of care
  - Decisions regarding resuscitation
  - Diagnosis of the dying phase using Gold Standards Framework, and communication to relevant parties
  - Liverpool care pathway
  - Patient passport
  - 'Just in case box'
  - EoL care plan shared with primary care including out-of-hours services
  - Involvement of EoL specialists / services
  - Fast track continuing health care funding

### 2.2.3 Pharmacological Management

**Aim – to review and stop unnecessary medication, and offer evidence-based pharmacological treatment for specific target symptoms and behaviours.**

- Many people with BPSD will experience significant improvement or resolution of symptoms over a 4-6 week period.
- Consider review of medication, with withdrawal of unnecessary or inappropriate treatments (e.g. sedatives, drugs with anticholinergic side-effects, excessive or inappropriate use of analgesia such as opiates etc.)
- Assess pain management and review use of analgesics before considering other options
- Offer non-pharmacological interventions as first line treatment, unless:
  - The patient is severely distressed or...
  - There is an immediate risk of harm to the patient and/or others.

- If the patient lacks capacity, discussion regarding the benefits and risks of pharmacological treatment should be undertaken with the patient's family and carers, and a decision made to prescribe drugs if it is in their best interests.
- 'Target' symptoms for pharmacological treatment should be identified, and response/side-effects of treatment closely monitored.
- Review should be undertaken at least every three months to consider whether it is clinically appropriate to continue treatment or to withdraw it slowly. Short-term prescriptions (maximum 3 months) may be used.<sup>2</sup>
- Aim is to use a dose of medication which is as low as is necessary in order to achieve a therapeutic response and to continue this for as short a time period as is necessary.
- Medication should be prescribed in conjunction with non-pharmacological approaches, not as an alternative to it.

### 2.2.3.1 Depression

Please also read general [guidance about pharmacological management](#)

- Consider using Cornell scale for assessment and monitoring of depression in dementia
- If suspect depression, use an SSRI as first line <sup>1, 2, 3</sup> (e.g. Sertraline 50-200mg daily or Citalopram 20mg daily), but be aware of increased risk of gastric erosion with concurrent prescription of an NSAID, and possibility of increased agitation in the first 7-10 days of treatment (consider need for concurrent use of a small dose of a benzodiazepine, e.g. Lorazepam 0.5mg-1.5mg daily).
- Consider Mirtazapine or Escitalopram as second line, (Mirtazapine if more sedative antidepressant is warranted).<sup>3</sup>
- Be aware of potential of Citalopram and Escitalopram to prolong QTc interval, and avoid in patients with a history of cardiovascular problems or those prescribed other medication which may prolong QTc.

### 2.2.3.2 Anxiety/Agitation

Please also read general [guidance about pharmacological management](#)

- Consider pain management if appropriate (e.g. Paracetamol)<sup>2</sup>
- Consider possibility of depression and use antidepressant if suspected <sup>1, 2</sup> Antidepressants can be useful in the management of agitation in the absence of depression.
- Use Paroxetine (10mg-40mg) as 1st line as licensed for anxiety.
- Consider Escitalopram (5mg-20mg daily) or Venlafaxine (75mg) as 2nd line treatments.
- Trazodone (50mg-300mg daily) is an alternative antidepressant, licensed for anxiety, which may be considered if sedation is desirable, or if the patient is agitated.<sup>3</sup>
- Consider possible use of Pregabalin (300-600mg daily)
- Short-term use of benzodiazepines (between 2-4 weeks) (e.g. Lorazepam 0.5mg up to t.d.s.) can be considered in acute anxiety/agitation associated with a high level of distress or risk<sup>3</sup>

### 2.2.3.3 Hallucinations/delusions

Please also read general [guidance about pharmacological management](#)

Try and establish if patient is experiencing true psychotic symptoms or if they are describing false memories or confabulating.

- When Lewy Body Dementia is suspected avoid antipsychotics if at all possible and consider use of acetylcholinesterase inhibitor
- If antipsychotics are necessary/appropriate, consider Aripiprazole (5mg-15mg daily) as 1st line
- Consider use of Risperidone, Olanzapine or Quetiapine as 2nd line agents after undertaking an individual risk/benefit analysis.<sup>1, 3</sup>
- See also advice about use of antipsychotics

#### 2.2.3.4 Aggression/Violence

Please also read general [guidance about pharmacological management](#)

- Consider possibility of depression, anxiety or hallucinations as triggers, and treat accordingly.
- Consider the use of low dose Risperidone (0.5mg-2mg daily), but be aware of side-effects and try to avoid in Lewy Body Dementia. Olanzapine 5-10mg may be an alternative [1, 2, 3](#). See also advice about use of antipsychotics
- Consider Memantine if contraindications to antipsychotics or if risk/benefit analysis for the individual patient suggests anti psychotics would be inappropriate. [1,3](#)
- If drugs are necessary for the acute control of violence, aggression or extreme agitation, oral medication should be offered before parenteral medication.
- Refer to Trust rapid tranquillisation policy.
- BP, pulse, temperature and respiratory rate should be recorded at regular intervals agreed by the MDT until the patient with dementia becomes active again.
- If IM preparations are needed for behavioural control use: [2,3](#)
  - Or Lorazepam 0.5-1mg (repeated after 6 hours if necessary)
  - Or Haloperidol 1 – 5mg (repeated if necessary after 4-8 hours)
  - Or Olanzapine 2.5 – 5mg (followed by 2.5 – 5mg after 2 hours if necessary)

#### 2.2.3.5 Sexual Disinhibition/Hyper Sexuality

**It is important to distinguish between normal sexual behaviours performed in an abnormal contact (which may be due to disinhibition due to impaired judgement) and hyper sexual behaviours that may indicate an abnormally high sexual drive.**

The evidence base is poor for all treatments

Please also read general [guidance about pharmacological management](#)

- Consider SSRI as 1st line (e.g. Paroxetine 10mg-40mg daily or Citalopram 10-20mg daily) for disinhibited behaviour. [3,4](#)
- Cimetidine has anti androgenic properties and may be helpful if there is evidence of increased sexual drive (hyper sexuality). Cyproterone acetate is an alternative if Cimetidine is ineffective. [4](#)
- Consider antipsychotics in situations where risk of aggression is present (e.g. Risperidone 0.25mg bd up to a maximum of 1mg bd) [1,2,3,4](#) See also advice about use of antipsychotics
- Carbamazepine or Gabapentin may also be considered as an option in patients with sexual disinhibition which do not respond to other agents.

#### 2.2.3.6 Sleep Disturbance

Please also read general [guidance about pharmacological management](#)

- Consider possibility of depression, anxiety, pain or other physical health problems as primary cause
- Consider whether sleep disturbance causes distress or problems for the patient e.g. due to tiredness. If not, use non pharmacological methods only
- Sleep hygiene methods (e.g. cut out caffeine)
- Hypnotics for short term use of up to 4 weeks (e.g. Zopiclone, Zaleplon) [1,2](#)
- Consider Melatonin 2mg nocte for short term use of up to 4 weeks
- Trazodone (50-150mg nocte) can be considered for use 'off licence' for its sedative effect, if need longer term management of insomnia [3](#)

## Section Three- Additional Information for the Assessment and Management of BPSD

---

### 3.1 Symptoms suggestive of delirium

- Consider using Confusion Assessment Method to aid recognition of delirium(CAM)
- Sudden onset (over hours or days)
- Increased level of confusion, disorientation and reduced performance of ADL's
- Fluctuation in attention, concentration, distractibility, poor ability to focus etc
- Evidence of altered level of arousal (e.g. withdrawn, quiet 'subacute delirium' or over arousal, agitated etc)
- Alteration in mood (e.g. depression, anxiety, fear, irritability, euphoria, apathy, perplexity)
- Perceptual distortions, illusions, hallucinations (most often visual)
- Transient delusions, often of a paranoid nature
- Psychomotor disturbances (increased and reduced levels of activity), increased startle reaction etc
- Disturbance of sleep-wake cycle (insomnia or reversal of sleep – wake cycle, daytime drowsiness, disturbing dreams or nightmares which can continue as hallucinations after waking etc)

### 3.2 Prescribing antipsychotics in patients with BPSD

- Pharmacological interventions should only be used if the patient is severely distressed or there is an immediate risk of harm to others
- There is some evidence of a modest benefit for patients with dementia who are prescribed antipsychotics drugs associated with specific 'target' symptoms e.g. psychosis, agitated behaviour causing significant distress, hyper sexuality etc
- There should be a full discussion with the patient with dementia and/or carers about possible benefits and risks of treatment
- Possible side effects can include:
  - o Sedation
  - o Increased confusion and/or delirium
  - o Falls
  - o Increased risk of stroke/TIA (2-3 x)
  - o Increased risk of death (2-3x)
  - o Cardiotoxic effects (e.g. prolonged QTc)
  - o Extra pyramidal symptoms, such as Parkinsonism
  - o Gait disturbance
  - o Accelerated cognitive decline
  - o Increased risk of chest infections
  - o Increased risk of dehydration
- Risperidone is the only antipsychotic licensed for people with dementia. The licence states that it should only be used for no longer than 6 weeks before review or specialist referral.
- Guidance suggests weekly monitoring of sedation, fluid intake and 'early indications of a chest infection' during antipsychotic prescribing (Alzheimer's society, Dementia Action Alliance, Royal College of General Practitioners, Department of Health 2011, P. 21)
- NICE states that treatment with antipsychotic drugs should be time limited and regularly reviewed (every 3 months or according to clinical need)
- The dose should be low initially and then slowly titrated upwards

e.g. Risperidone start dose 0.25mg twice daily  
Therapeutic dose 0.5mg twice daily  
Maximum dose 1 mg twice daily

- The choice of antipsychotic drug should be made after an individual risk-benefit analysis, including assessment of cardiovascular and cerebrovascular risk.
- 'Target' symptoms should be identified, quantified and changes recorded at regular intervals
- Changes in cognition should also be assessed and recorded at regular intervals
- Once a patient has been established on an antipsychotic, withdrawal of the drug should only be done gradually (e.g. over 2-4 weeks)
- Patients with Lewy Body Dementia may be particularly sensitive to antipsychotic drugs, and their use should only be under the guidance of a specialist (e.g. old age psychiatrist, neurologist, geriatrician) and reserved for patients with significant distress.
- Alternatives to antipsychotics (e.g. antidepressants) should always be considered prior to starting an antipsychotic.

**The following investigations are recommended when prescribing antipsychotics**

- **ECG** at baseline and with dose changes
- **U/E's and FBC** at baseline and annually
- **Blood lipids/cholesterol** at baseline, 3 months, then annually (but every 3 months for the first year for Olanzapine, Quetiapine and Clozapine)
- **Glucose/HbA1c** at baseline, after 6 months, then annually (test at 1 month for Olanzapine and Clozapine)
- **LFT's** at baseline and annually
- **BP** – baseline and frequently during dose titration/changes
- **BMI** – baseline, monthly for 3 months, then annually
- **Prolactin** – baseline, at 6 months, then annually.

*\*See table on the following page for quick reference.*

## Appendix 1: Recommended Investigations when prescribing Antipsychotics

| Parameter            | Baseline | 1 Month   | 2 Months | 3 Months | 6 Months   | 12 Months | Annually |
|----------------------|----------|---|----------|----------|--|-----------|----------|
| <b>BMI</b>           | √        | √   | √        | √        |  |           | √        |
| <b>BP</b>            | √        | <b>Monitor Frequently During Dose Titration / Changes</b> |          |          |  |           |          |
| <b>FBC</b>           | √        |   |          |          |  | √         | √        |
| <b>U/E's</b>         | √        |   |          |          |  |           | √        |
| <b>LFT's</b>         | √        |   |          |          |  |           | √        |
| <b>ECG</b>           | √        | <b>Monitor After Dose Changes</b>                         |          |          |  |           |          |
| <b>Glucose/HBAIC</b> | √        | √<br>For<br>Olanzapine<br>& Clozapine                     |          |          | √  |           | √        |
| <b>Blood Lipids</b>  | √        |   |          | √        | √<br>For<br>Olanzapine,<br>Quetiapine &<br>Clozapine | √         | √        |
| <b>Prolactin</b>     | √        |   |          |          | √  |           | √        |

**Assessment**

**Physical Examination:**

- Look for signs of infection, constipation, pain, distress, heart failure, side effects of medication, dehydration, malnourishment, head injury etc.
- Neurological examination to identify any localised signs.

**Further Physical/Medical Assessments**

- Referral to Geriatrician if:
  - Complex physical health problems.
  - Complex issues regarding medication.
  - Complex palliative care issues.
  - Advice and guidance regarding interpretation of results/ investigations.
  - Involve other professionals

**Blood tests**

- **Arrange URGENTLY.**
- FBC, Biochemical Profile, blood glucose (HbA1c if diabetic), Thyroid function,
- ESR/PV/CRP, B12/Folate.

**Other Investigations**

- Urine – dipstick +/- MSU.
- ECG and CXR if appropriate (e.g. if history of, or suspect chest or cardiac problems)
- Consider need for CT scan (e.g. if h/o head injury, altered level of consciousness, suspect subdural, stroke, 'atypical' presentation, etc) or MRI scan

**Mental State Examination and Cognitive Assessment**

To identify abnormalities of mental state which may indicate possible underlying cause/exacerbating factors. Assess arousal/attention, concentration, speech, mood, psychosis, confusion, insight, etc...

**Management**

**Medical / Physical Health / Management of vascular risk factors**

Treat any underlying physical health problems, and optimise current physical health and function (review medication, add or remove medication as necessary), e.g. Antibiotics for infection, Laxatives for constipation, analgesics for pain (opiates can exacerbate BPSD, also consider non pharmacological options in severe dementia, involve other professionals, and consider diagnosis of "dying phase", "just in case box", out of hours, Liverpool care pathway...

**Psycho-social** (To be conducted by Primary Care and Care Home Providers, in conjunction with Social Services)  
Offer first line, broad based advice / simple interventions, using a person-centred approach, to enhance self-esteem, manage risk and promote occupation and independence. Modify environment if necessary.

**Pharmacological Management**

Review and stop unnecessary medication, and offer treatment for target symptoms and behaviours

**Depression**

SSRI 1<sup>st</sup> line  
1- Sertraline:50-200 mg  
2- Citalopram: 20 mg  
Consider lorazepam 0.5-1.5 mg daily if agitation occurs

**Hallucinations / Delusions**

Refer to full Guideline (section 1.2.3.5)  
\* Consider LBD or Depression

Generally symptoms improve over a 4-6 week period. Treatment should be time limited (3 months, review: Treatment appropriate? Or Withdraw (slowly)?

**Aggression / Violence**

Risperidone  
0.25mg BD- to 1mg BD

**Sexual Disinhibition/ Hypersexuality**

SSRI 1<sup>st</sup> Line  
Paroxetine 10-40mg  
Citalopram 20mg

**Sleep Disturbance**

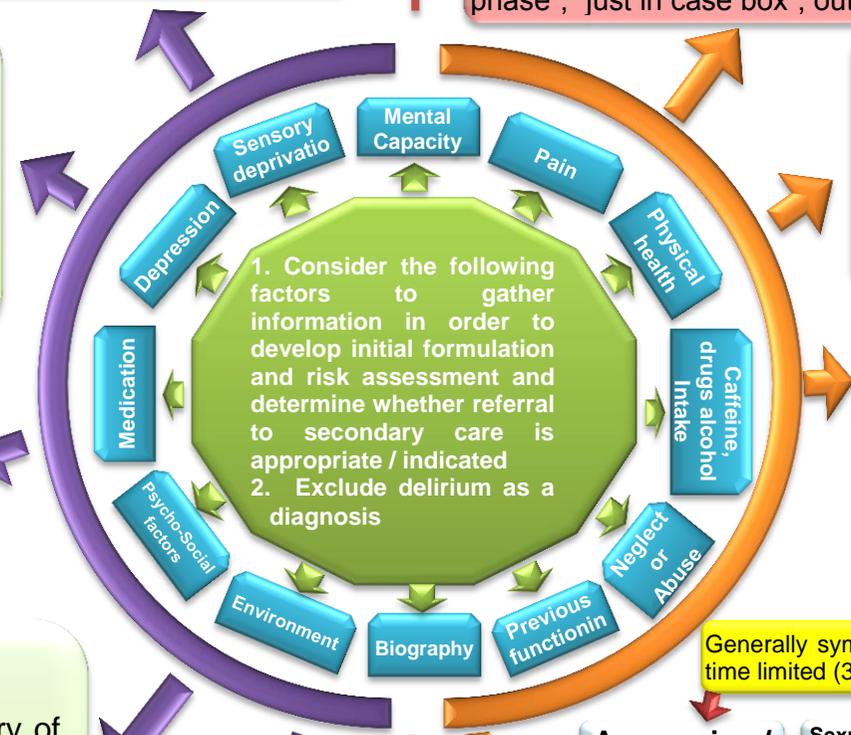
Hypnotics or melatonin  
2mg: up to 4 weeks only  
Long term: Trazodone nocte

**Anxiety & Agitation**

Paracetamol – Pain  
SSRI- Depression  
Paroxetine 10-40mg  
Licensed for anxiety

**Refer to Specialist (Old Age Psychiatry) Services if:**

1. There is a significant risk of harm to others, suicide, severe self-neglect or severe distress.
2. Problems are unresponsive to first line interventions (including medication) after 4-6 weeks
3. BPSD associated with Lewy Body Dementia, when pharmacological interventions are judged to be necessary or appropriate.
4. When Safeguarding (protection of vulnerable adults) issues are present
5. Further specialist assessment is necessary in view of complexity of presentation (e.g. diagnostic issues, palliative care issues etc)



**Assessment**

**Physical Examination** (conducted by Primary Care unless in an inpatient setting)

**Blood tests** (Conducted by Primary Care unless in an inpatient setting).

**Other Investigations (extra for Secondary Care)**

EEG if suspected delirium, fronto temporal dementia or CJD, or if suspect seizures, and DAT if suspected LBW.

**Further Physical/Medical Assessments**

- Referral to Geriatrician if:
  - Complex physical health problems.
  - Complex issues regarding medication.
  - Complex palliative care issues.
  - Advice and guidance regarding interpretation of results/ investigations.
  - Involve other professionals: Physiotherapy, OT, Dietician, or if transferred to acute hospital Specialist Liaison Service for older people...

**Carer's Assessment**

Assess the level of impact of the patient's problems on the carer(s) and determine the level of support needed.

**Behavioural and Neuropsychological Assessments**

Undertake a functional analysis in order to formulate a comprehensive management plan, taking into account biological, psychological and social factors contributing to the BPSD. Dementia Care Mapping, CBH Scale, OT, etc...

**Management**

**Medical / Physical Health / Management of vascular risk factors**

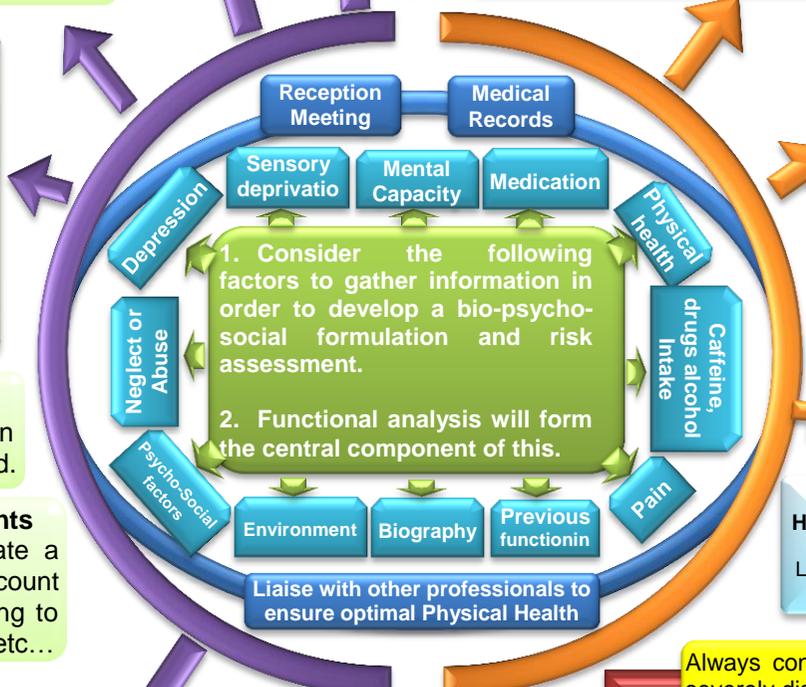
Treat any underlying physical health problems, and optimise current physical health and function (review medication, add or remove medication as necessary), e.g. Antibiotics for infection, Laxatives for constipation, analgesics for pain (opiates can exacerbate BPSD, also consider non pharmacological options in severe dementia, involve other professionals, and consider diagnosis of "dying phase", "just in case box", out of hours, Liverpool care pathway...

**Psycho-social**

(To be conducted in conjunction with Primary Care and Care Home Providers, families and carers, and Care Management) Offer individually tailored interventions, using a person-centred approach, to enhance self-esteem, manage risk and promote occupation and independence. Consider alternative environment if necessary. MDT / Multi Agency assessment and leading to individual interventions.

**Pharmacological Management**

Review and stop unnecessary medication, and offer treatment for target symptoms and behaviours



**Sleep Disturbance**

Hypnotics or melatonin 2mg: up to 4 weeks only  
Long term: (off-License)  
Trazodone 50-150mg nocte

**Hallucinations / Delusions**

1<sup>st</sup> Line: Aripiprazole 5- 15mg  
2<sup>nd</sup> Line: Risperidone, Olanzapine, Quetiapine \* If LBD suspected Consider AChE-Inh instead. Consider Depression

Always consider non-pharmacological actions first and only use if patient is severely distressed or at risk of harming himself or others. Generally symptoms improve over a 4-6 week period. Treatment should be time limited (3 months, review: Treatment appropriate? Or Withdraw (slowly)?

**Sexual Disinhibition**

SSRI 1<sup>st</sup> Line  
Paroxetine 10-40mg  
Citalopram 10-20mg

**Hypersexuality**

- 1- Cimetidine
- 2- Cyproterone
- 3- Antipsychotic when risk of aggression
- 4- Carbamazepine or gabapentin are alternatives if others don't work..

**Anxiety & Agitation**

- 1- Paracetamol – Pain
- 2- SSRI- Depression
- 1<sup>st</sup> line Paroxetine 10-40mg
- Also Licensed for anxiety
- 3- Trazodone/Benzodiazepine

**Depression SSRI 1<sup>st</sup> line**

- 3- Sertraline: 50-200 mg
- 4- Citalopram: 20 mg
- Consider lorazepam 0.5-1.5 mg daily if agitation occurs
- 3-Mirtazapine/escitalopram 2<sup>nd</sup> Line

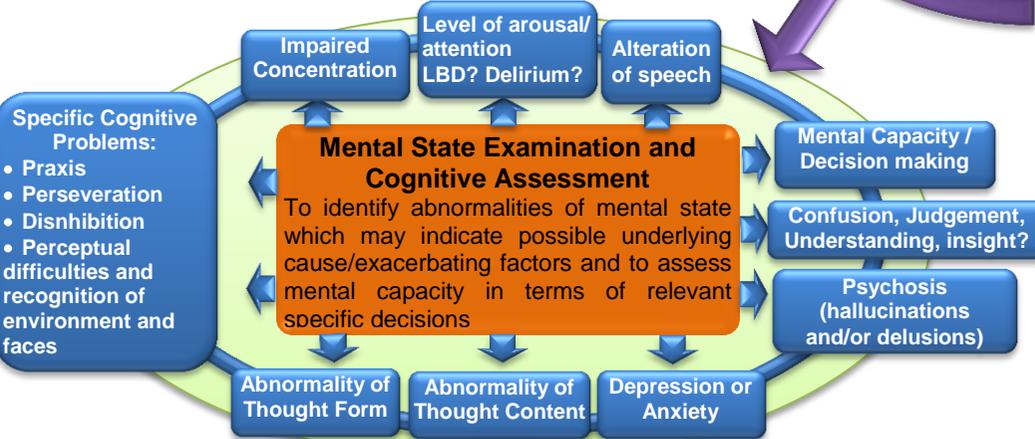
**Aggression / Violence**

**ORAL MEDICATION**

Risperidone 0.25mg BD- to 1mg BD  
Olanzapine: 5-10mg daily

**IM**

Lorazepam 0.5-1mg (repeat 6h)  
Haloperidol 1mg-5mg (repeat 4-8h)  
Olanzapine: 5-10mg daily



Primary Author:

Dr David Lawley  
Consultant Psychiatrist  
Older Peoples' Mental Health Services  
Humber NHS Foundation Trust  
Email: [David.Lawley@humber.nhs.uk](mailto:David.Lawley@humber.nhs.uk)

Production Date: 14/03/12

Drug and Therapeutics Committee approval obtained on:

Older Peoples' Mental Health Clinical Network approval obtained on:

Review Date: By July 2013 or sooner if there are national, local or best practice updates

*The reviewed guidance will need to be signed off by Humber NHS Foundation Trust's Drug and Therapeutics Committee by 29<sup>th</sup> September 2012 followed by approval from the Older Peoples' Mental Health Clinical Network.*

### **References:**

1. 'Optimising treatment and care for people with behavioural and psychological symptoms of dementia: A best practice guide for health and social care professionals' (Alzheimer's society, Dementia Action Alliance, Royal College of General Practitioners, Department of Health 2011).
2. 'Dementia. Supporting people with dementia and their carers in health and social care' (National Institute of Health and Clinical Excellence November 2006) Clinical Guideline 42
3. Complete guide to Behavioural and Psychological Symptoms of Dementia (BPSD) International Psychogeriatric Association (2010)
4. 'Hypersexuality in dementia' (Series H., and Degano P., – Advances in Psychiatric Treatment (2005) Volume 11 (424-43))
5. 'Functional analysis based interventions for challenging behaviour in dementia'- (Cook, ED et al The Cochrane Library -February 2012).