NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Psychotropic Medicines Reviewing with Care Home Residents

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Lead Author:	Chris Johnson
Approval Group:	Prescribing Management Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

This guidance contains information related to reviewing: **Page**

Introduction

As is well known psychotropic medicines are effective for treating and managing a variety of diseases and conditions. However, they are also associated with a variety of avoidable drug related harms: cognitive impairment; increased falls risks with associated hip fracture; stroke and death.

Therefore this guidance is intended as a resource to assist medical and non-medical healthcare professionals' decision making process when reviewing psychotropic medicines with Care Home residents, and where appropriate carers and welfare proxies e.g. those with power of attorney regarding health related issues.

As with other areas of healthcare, effective medication review relies on the collaborative efforts of the broader healthcare team, residents, carers and welfare proxies. It does not rely on, or expect one healthcare discipline to undertake and implement medication reviews and changes without the collaborative support of the broader healthcare team, residents, carers and welfare proxies. As an inclusive collaborative approach to medication review is more effective at minimising the use of inappropriate psychotropic medicines.

References:

- SIGN Guidelines www.sign.ac.uk
- NICE Guidelines www.nice.org.uk
- Scottish Government Model of Care Polypharmacy Working Group. Polypharmacy Guidance (2nd edition). March 2015. Scottish Government.
- Banerjee S. The use of antipsychotic medication for people with dementia: Time for action. 2009:1-65.
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- Billioti de Gage S, Moride Y, Ducruet T, et al. Benzodiazepine use and risk of Alzheimer's disease: case-control study. BMJ 2014;349:g5205.

Managing Symptoms of Stress and Distress in Dementia (BPSD): Issues to Consider. Quick Reference Guide.

Useful references and resources

- Diagnosis, Prevention and Management of Delirium. Acute Service Division NHSGGC July 2012. http://www.staffnet.ggc.scot.nhs.uk/Acute/Emergency%20Care%20Med%20Specialities/Emergency%20Medicine%20and%20Emergency%20Services/SGHED/Documents/Delerium.pdf

- Scottish Government Model of Care Polypharmacy Working Group. Polypharmacy Guidance (2nd edition). March 2015. Scottish Government. http://www.sehd.scot.nhs.uk/publications/DC20150415polypharmacy.pdf

- The Abbey Pain Scale: For measurement of pain in patients who cannot verbalise http://www.wales.nhs.uk/sitesplus/documents/862/FOI-286f-13.pdf

- Meeting needs and reducing stress. Guidance on the prevention and management of clinically related challenging behaviour in NHS settings. http://www.reducingdistress.co.uk/reducingdistress/

- Managing Behaviour and Psychological Problems in Patients with Diagnosed or Suspected Dementia, NHS Nottinghamshire Area Prescribing Committee. Jan 2012 http://reducingdistress.co.uk/reducingdistress/wp-content/uploads/2013/11/Managing-Behaviour-and-Psychological-Problems-in-Patients-with-Diagnosed-or-Suspected-Dementia.pdf

Acknowledgements
With thanks to Shona Mackie and Ann Haugh, NHS Forth Valley, who developed the flowchart, and NHS Lanarkshire for allowing the use of an amended version of Managing Symptoms of Stress and Distress in Dementia guidance, Oct 2014.

Psychotropic medicines: NHSGGC Guidance for reviewing psychotropic medicines with Care Home residents

This guide has been designed to be used by care staff and GPs to assist in the management of symptoms of stress and distress in dementia and to eliminate possible causes for changes in emotions, behaviour and functioning. It should be referred to in the first instance, and appropriate assessments/interventions should be carried out prior to utilising sedating medicines or referring to Older People's Mental Health Services.

There has been a ***rapid*** change in the patient's behaviour

Exclude Physical Causes

- **Delirium –** check temperature, bloods, (e.g. FBC, U&E, LFT, TFT, ESR, CRP, Glucose, Vitamin B12, folate and ferritin levels, MSSU) and 4AT (rapid Assessment Test link)
- **Dehydration** – check above blood levels; especially U&E. Commence on fluid balance chart
- **Pain** – complete appropriate pain assessment tool e.g. Abbey Scale
- **Hunger** – monitor and complete fluid and diet charts
- **Constipation** – monitor bowel habits
- **Tiredness** – chart sleep pattern
- **Medication** – side effects
- **Medication withdrawals –** e.g. benzodiazepines, opiates
- **Sensory Impairment** – sight &/or hearing deficit - refer to sensory impairment service for assessment and advice (where applicable)
- **Hypoxia** – cyanosis, laboured breathing, pre-existing conditions e.g. COPD
- **Change of environment**

There has been a ***gradual*** change in the patient's behaviour

Exclude Psychological Causes

- **Depression** – observe for any mood or behavioural changes. Complete appropriate assessment tool
- **Anxiety** – as per depression above
- **Hallucinations** – more commonly seeing and/or hearing things. NB exclude delirium
- **Delusions –** more commonly paranoia and/or suspiciousness. NB exclude delirium
- **Sundowning -** increased agitation and activity occurring in the late afternoon/early evening

Exclude Environmental Causes

- **Noise levels** – over stimulation/elevated noise levels can be antagonistic
- **Lack of social stimulation**
- **Inappropriate music** – ensure age related and appropriate to the client group
- **Environment/layout**
  - Is it conducive to the specific client group?
  - Could it potentially increase confusion and disorientation in people with cognitive impairment?

Exclude Other Causes

- **Staff/carers** – tone of voice, approach, body language, poor verbal and/or non-verbal communication
- **Inflexible routines** – e.g. toileting, bathing, bedtimes
- **Task orientated care**
  - lack of person-centred care
  - not knowing the person
- **Client group**
  - Triggered by the behaviour or others: staff and/or fellow
- **Continuity of staff**
  - Therapeutic relationships
  - Team continuity
  - Staff interaction

Exclude other causes if there has been no improvement or further deterioration in the patient's behaviour

Antidepressants

All patients prescribed antidepressants should be reviewed at regular intervals in line with current National and local guidance (1,2). Antidepressants demonstrate limited to marginal benefits in treating depression in people with dementia (3-6), however for some they may reduce depressive symptoms and improve general functioning (7). Although there are relatively few studies of antidepressants for the treatment of agitation and psychosis in dementia sertraline, citalopram and trazodone use has been associated with modest reductions in symptoms of agitation and psychosis (8-9).

Consider

- Review ongoing antidepressant need and where possible consider stopping:
  - **Priority for review:**
  - First episode: review 6 months after remission achieved.
  - Recurrent episodes: review at 6 monthly intervals or annually considering illness chronicity and severity, to tailor continued treatment to patients needs.
  - **Caution:** Past involvement with psychiatry team(s) and/or history of recurrent depression
  - **Exclude:** Palliative care patients, patients with current psychiatry team involvement.
- Other drugs causing depression or anxiety symptoms: benzodiazepines, z-hypnotics, beta-blockers, etc.
- Selective serotonin re-uptake inhibitors demonstrate a flat dose response for the treatment of depression, therefore for routine care **50's enough and 20's plenty** to assess efficacy for sertraline 50mg daily and citalopram/fluoxetine/paroxetine 20mg daily respectively.
- Mirtazapine is more sedating at 15mg than at higher doses.
- Older people are more susceptible to antidepressant associated adverse effects such as falls, hyponatreamia, anxiety, agitation, confusion, gastro-intestinal bleeds (with SSRIs and venlafaxine), postural hypotension, tachycardia (with tricyclics), etc.

How to withdraw antidepressants

- Do not stop suddenly.
- Gain agreement with the patients, carers, and/or welfare guardians.
- Patients with current or past psychiatry involvement consider asking psychiatry to review ongoing use and reduction.
- Antidepressants can usually be stopped by reducing the dose or frequency over a 4 week period or longer. Slow reduction over a period of months may be required for some patients; especially for those receiving longer courses of antidepressants and older patients.
- Discontinuation or withdrawal like symptoms may occur on stopping or reducing doses. These are usually mild and self limiting and resolve over about 1-2 weeks but can be severe, particularly if the drug is stopped abruptly, and may be mistaken for relapse symptoms.
- Paroxetine and venlafaxine are associated with discontinuation symptoms due to their short half life.
- Fluoxetine can be stopped at 20mg daily due to its long half-life. However, slower reductions may be appropriate for some patients taking alternate days for 4 weeks then every third day for 4 weeks then stop. Higher doses should be tapered to 20mg daily before stopping.
- Tricyclic antidepressants may need slower reduction to minimise the risk of cholinergic rebound (nausea, vomiting, headache, restlessness); using smallest tablet strengths or alternate day dosing.

Follow up review

- Review patient after 1-2 weeks to assess for discontinuation symptoms (paraesthesia, anxiety, dizziness, vivid dreams, stomach upsets, flu-like symptoms, headache, suicidal thoughts, insomnia).
- If no symptoms continue on current dose for 4 weeks, review again and reduce if still symptom free.
- If mild symptoms continue on current dose for 4 weeks and review for ongoing discontinuation symptoms. If none, reduce dose again at 4 weeks.
- If severe symptoms then increase antidepressant dose to original dose for a week then consider trying again with a more gradual reduction.
- At each point in the dose reduction, if severe symptoms occur then step back to the previous dose for a week then proceed with a smaller dose reduction. An alternative strategy is to start an antidepressant with a longer half-life from the same class instead, and then reduce this. For example paroxetine 20mg daily to fluoxetine 20mg daily for 7 days then reduce to alternate for 2 weeks and then stop.
- Where appropriate consider referral to Old People's Mental Health Services if further advice is required.

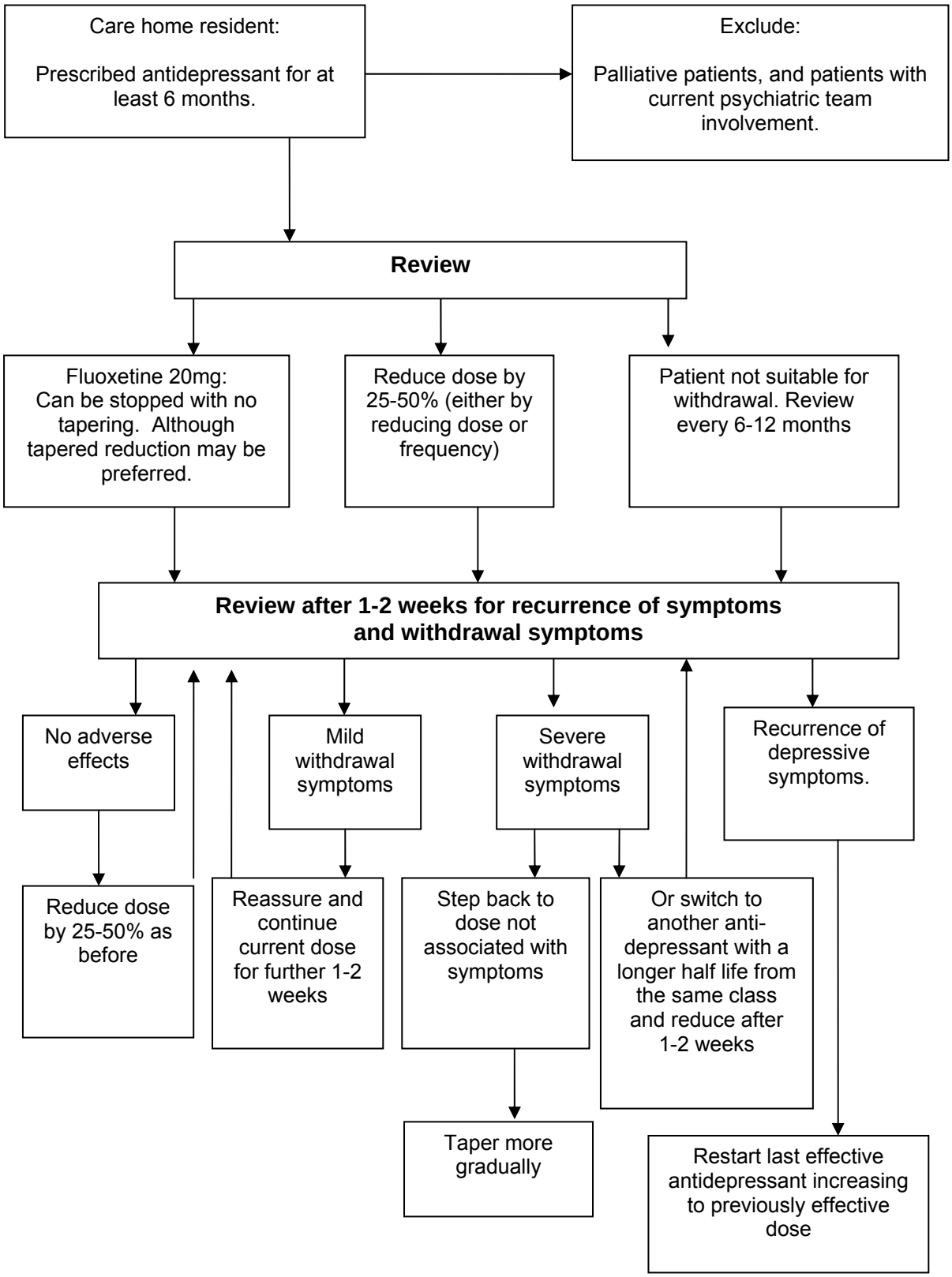
Links

- Wellbeing services south Glasgow
- Clinical Knowledge Summaries NICE: stopping antidepressants

References

1. NICE Clinical Guideline 90. Depression : the treatment and management of depression in adults. 2009.
2. Depression Treatment in Primary Care – NHS GG&C guideline 2014.
3. Bains J, Birks J, Dening T. Antidepressants for treating depression in dementia. Cochrane Database of Systematic Reviews 2002(4):003944.
4. Nelson JC, Devanand DP. A systematic review and meta-analysis of placebo-controlled antidepressant studies in people with depression and dementia. J Am Geriatr Soc 2011 59(4):577-585.
5. Banerjee S, Hellier J, Dewey M, et al. Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomised, multicentre, double-blind, placebo-controlled trial. Lancet 2011 30;378(9789):403-411.
6. The Maudsley: Prescribing Guidelines in Psychiatry 11th ed. Wiley-Blackwell: Chichester; 2012.
7. NICE Clinical Guideline 42. Dementia: Supporting people with dementia and their carers in health and social care. 2007.
8. Sultzer DL, Gray KF, Gunay I, et al. Does behavioural improvement with haloperidol or trazodone treatment depend on psychosis or mood symptoms in patients with dementia? J Am Geriatrics Society 2001;49(10):1294-1300.
9. Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011 1:(2)-2011.

Flow chart: Reviewing antidepressants for Care Home residents.



Benzodiazepine and z-hypnotic long-term (>4 weeks) use

Benzodiazepines and z-hypnotics (B&Z) are indicated and licensed for the short-term (2 to 4 weeks) management of anxiety or insomnia that is severe, disabling or causing the patient extreme distress (1,2) with z-hypnotics demonstrating no advantages over benzodiazepines (3).

28% of care home residents aged ≥65 years old received B&Zs in Scotland in 2011 and were three times more likely than non-care home residents to receive them (4). Even although B&Zs are not advised for routine use in the management of behavioural and psychological symptoms of dementia (BPSD) (5) as they are associated with an increased risk of dementia (6), cognitive impairment (7), depressive symptoms (8) and falls in the elderly (7,9).

Priority for review

- Long-term benzodiazepines and/or z-hypnotics prescribed for anxiety, insomnia or agitation.
- Those at higher risk of adverse effects: cognitive impairment, depressive symptoms, falls, etc.

Caution

- Current or past involvement with psychiatric team(s).
- Unresolved anxiety, insomnia or agitation.
- Initiated by Neurology.
- A history of alcohol or other drug use or dependence.
- A history of drug withdrawal seizures — these generally occur in people who suddenly stop high doses of the drugs. Slow tapering is recommended for these individuals.

Exclude

- Palliative care patients
- Older people receiving B&Zs for epilepsy, chronic conditions where muscle spasms are an issue such as multiple sclerosis, and older people with Parkinson's disease.

How to reduce B&Zs

- **Do not stop suddenly.**
- Gain agreement with the patients, carers, and/or welfare guardians.
- Patients with current or past psychiatry involvement consider asking psychiatry to review ongoing B&Z use and reduction.
- Plan and manage withdrawal at a reduction rate that is tolerable for the patient.
- Patients prescribed diazepam. Reduce total daily dose by 1-2 mg every 4 weeks using a planned reduction schedule (1). Slower reductions may be required for some patients who have received longer term treatment with a B&Z.
- Transfer non-diazepam patients to an equivalent dose of diazepam, see BNF and Ashton Manual, and follow up after 7 days or sooner. Then reduce by 1-2mg every 4 weeks using a planned reduction schedule (1).
    - Slightly lower doses may be appropriate due to diazepam longer half-life and the increased risk of sedation, eg temazepam 10mg at night to diazepam 4mg at night with follow up review at 7 days or sooner, and then reduce by 1mg every 4 weeks. If over sedation is problematic quicker managed reduction may be appropriate.
- When two or more B&Zs are prescribed consider converting to diazepam, in a stepwise manner, at an interval of 7 days with follow up at 7 days (10), e.g. lorazepam and temazepam used in combination change lorazepam to diazepam equivalent, then if patient is stable at 7 days consider changing temazepam to diazepam equivalent and review at 7 days before reducing.
- Consider four weekly reductions to run in line with care home medication cycles

Caution

- Dose equivalences are ***approximate*** dose equivalences.
- Due to variations in individual drug potency and half-lives, and variations in individual patient's characteristics: age, hepatic function, sensitivity, response, expectations, etc, patient response may vary.
- Older people can be more susceptible to accumulation effects of longer acting B&Zs when transferring from shorter acting B&Zs.
- **Seek specialist advice (preferably from a hepatic specialist) before switching to diazepam in people with hepatic dysfunction** as diazepam may accumulate to a toxic level in these individuals. An alternative benzodiazepine without active metabolites (such as oxazepam) may be preferred.

Withdrawal effects

May develop at any time up to 3 weeks after stopping a long-acting B&Z, but may occur within a day of stopping a short-acting B&Z. Withdrawal syndrome is characterised by insomnia, anxiety, loss of appetite and body weight, tremor, perspiration, tinnitus and perceptual disturbances. Some symptoms may be similar to the original complaint and encourage further prescribing (1).

Follow up review

- Review patients transferred to diazepam at 1-2 weeks, or earlier, to check for excessive sedation during waking hours or intolerable withdrawal symptoms.
- If the initial step down is tolerated review and reduce every four weeks.
- If there is excessive sedation review the reduction schedule and reduce the dose to the next step earlier than planned. Review this weekly (or earlier) until over sedation is controlled.
- If there are intolerable withdrawal symptoms review with patient and agree any amendment to the reduction schedule. Consideration should be given to returning the patient to the last tolerated dose of B&Z for 4 weeks then consider slower reduction.

Useful Links

- Benzodiazepines: how they work and how to withdraw - benzo.org.uk
- Wellbeing services south Glasgow

References

1. Joint Formulary Committee. British National Formulary 70. BMJ group and Pharmaceutical Press: London.
2. Committee on Safety of Medicines. Benzodiazepine dependence and withdrawal symptoms. Current Problems 1988(21):1-2.
3. NICE. Guidance on the use of zalepon, zolpidem and zopiclone for the short-term management of insomnia. 2004.
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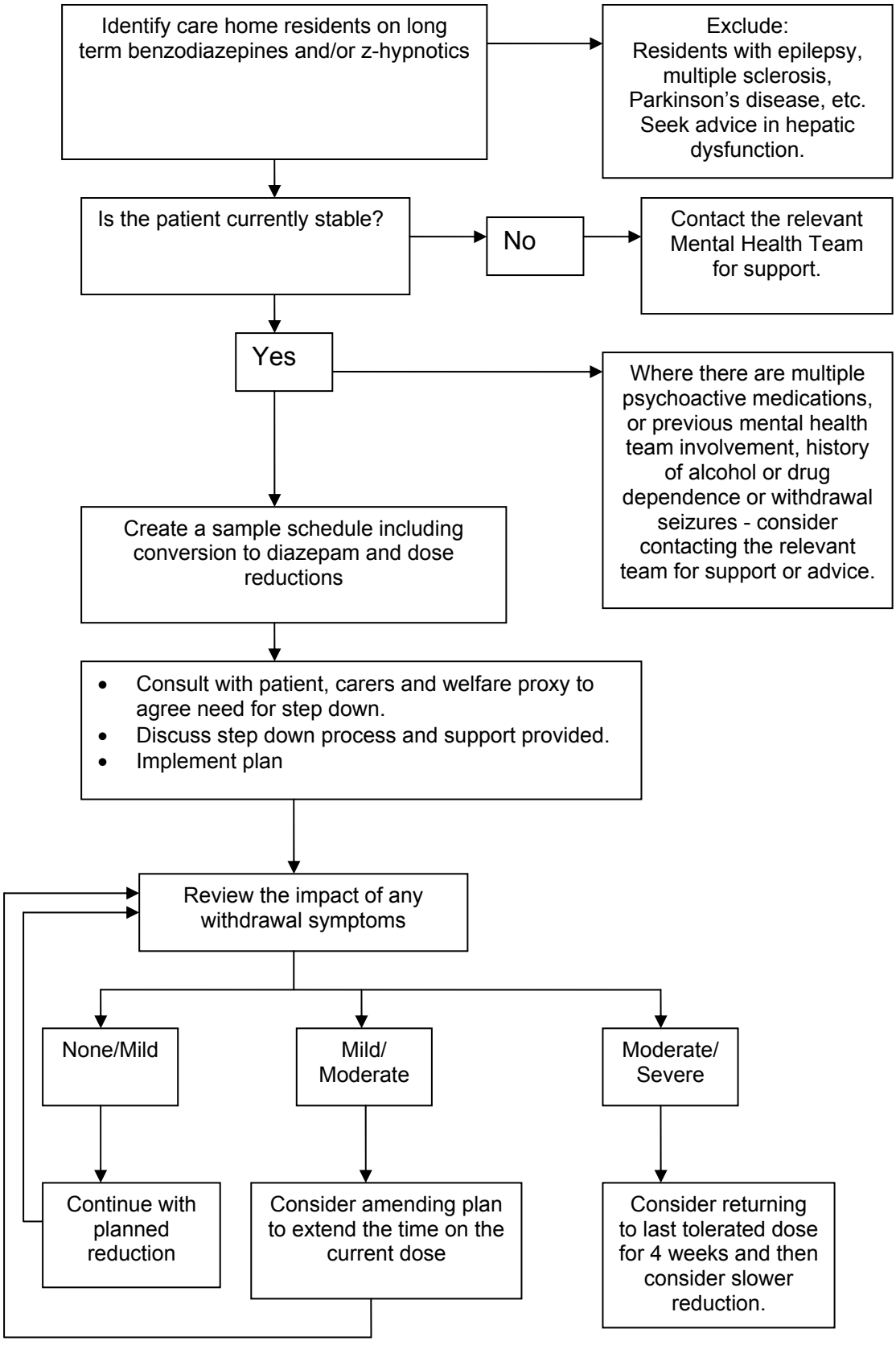
7. Glass J, Lanctot KL, Herrmann N, et al. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. BMJ 2005 19;331(7526):1169.
8. Kripke DF. Greater incidence of depression with hypnotic use than with placebo. BMC Psychiatry 2007 2007;7:42.
9. Cumming RG, Le Couteur DG. Benzodiazepines and risk of hip fractures in older people: a review of the evidence. CNS Drugs 2003;17(11):825-837.
10. The Ashton Manual. 2011. www.benzo.org.uk

Flow chart: Reviewing benzodiazepines and z-hypnotics for Care Home residents.



Cognitive Enhancers

Dementia is a broad term description which includes the most common forms of dementia, namely Alzheimer's disease, dementia with Lewy bodies and vascular dementia and is a chronic, progressive condition.

Cognitive enhancers are a small group of medicines for the treatment of dementia with up to half of the patients given these drugs demonstrating a slower rate of cognitive decline. They can also help to reduce some of the behavioural and psychological symptoms of dementia (BPSD). Drug effectiveness is assessed within the first months by the initiating specialist: psychiatrist, neurologist or physician experienced in the management of dementia, or by the Community Mental Health Team for Older People. Treatment is normally continued for as long as a therapeutic benefit exists, however if there are issues with:

- Adverse drug effects,
- Lack of effect on cognitive,
- Global functional or
- Behavioural symptoms

it may be appropriate to review ongoing need.

Acetylcholinesterase (AChE) inhibitors:
Donepezil: Indicated for the symptomatic treatment of mild to moderately severe Alzheimer's disease. There is also evidence to suggest its efficacy may extend to the treatment of people with more severe forms of Alzheimer's disease. Age and severity of Alzheimer's disease should not be a contraindication to its use.

Galantamine: Indicated for the symptomatic treatment of mild to moderately severe Alzheimer's disease. SIGN Dementia guideline advises it can be used to treat cognitive decline in people with Alzheimer's disease and people with mixed dementias, and also for the management of associated symptoms in people with Alzheimer's disease.

Rivastigmine: Indicated for the symptomatic treatment of mild to moderately severe Alzheimer's disease or in patients with Parkinson's disease dementia; and can also be used for the management of associated symptoms.

If discontinuation of these drugs is considered when evidence of a therapeutic effect is no longer present, then treatment with memantine may be considered.

Memantine is a glutamate receptor antagonist indicated for treatment of moderate to severe Alzheimer's disease. It is recommended for managing moderate Alzheimer's disease for people who cannot tolerate AChE inhibitors, and as an option for the management of severe Alzheimer's disease. Maintenance treatment can be continued as long as a therapeutic benefit is favourable.

Withdrawal of cognitive enhancers
The uncertain course of dementia makes it difficult to give a prognosis, as individuals vary in their symptoms and rates of progression. Any decision to withhold or discontinue treatment requires careful consideration which must involve the individual's family and carers, as this could result in a significant decline in cognitive function and BPSD.

- If the resident is under the care of mental health services, their advice should be sought around any decision to withdraw treatment with a cognitive enhancer.

- If the decision to withdraw treatment is due to side effects, it is important to rule out whether this is a manifestation of progressing dementia; for example weight loss is a common feature of dementia, however is also listed as a possible side effect of the medication.
- A change in presentation of behaviour should prompt a medical assessment, as difficulty in communication may limit the resident expressing hunger, thirst, discomfort or pain (See Managing Symptoms of Stress and Distress in Dementia (BPSD): Issues to consider. Quick Reference Guide).

Withdrawal and follow up review

- If withdrawal of the cognitive enhancer is due to side effects, however there has been evidence of ongoing benefit, then an alternative cognitive enhancer from the group could be considered.
- If the acetylcholinesterase inhibitors are no longer tolerated due to side effects, or lack of ongoing therapeutic benefit, then a trial of memantine may be considered.
- If it has been agreed with medical staff, family and carers that the cognitive enhancer is to be withdrawn altogether, then this should be carried out as a gradual dose reduction, allowing four weeks between dose changes. During this time there should be an ongoing assessment to monitor for any functional or cognitive decline, and if any deterioration becomes evident the dose should be increased back up immediately to halt any further decline.
- If no deterioration is observed from monitoring, then ongoing gradual dose reduction with careful assessment should continue until it has been discontinued.

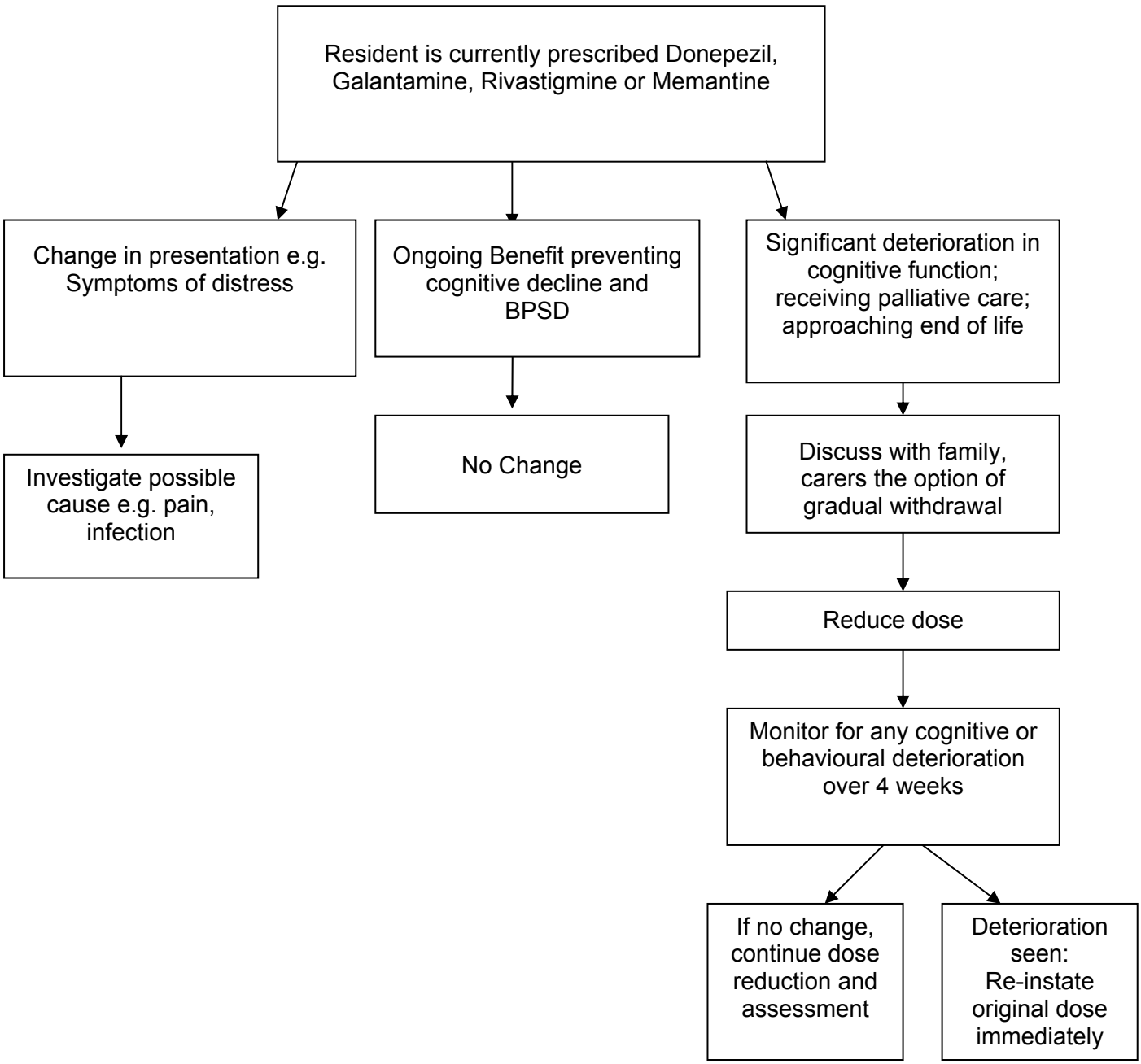
Any decision to withdraw cognitive enhancers should take into consideration the individual and their clinical circumstances.

References

1. BNF 72. Sept 2016.
2. Medicines Compendium UK. https://www.medicines.org.uk/emc/

My life with dementia: Dying well with dementia October 2012
Living well with dementia: UK national strategy
NICE technology appraisal (T217)

Flow chart: Reviewing cognitive enhancers for Care Home residents



Mood Stabilisers

There is very limited evidence to support the use of anticonvulsants which have mood stabilising activity in the treatment of behavioural and psychological symptoms of dementia (BPSD). Use may very rarely be justified where other treatments are contraindicated or ineffective.

They may be considered for the symptomatic treatment of seizures or myoclonus associated with dementia but are not recommended for other symptoms of dementia.

Trials involving this group of medication require to be undertaken to assess any evidence of efficacy although their use may be limited due to significant adverse effects.

Withdrawal and follow up review

If prescribed for BPSD, the medication should be reviewed with a view to discontinuation. Where prescribing changes are considered appropriate and implemented, follow up review and monitoring should be carried out to assess progress.

No changes should be made if prescribed for epilepsy, bipolar disorder or are under the care of a mental health specialist.

References

- Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry. 12th Edition Wiley-Blackwell. Chichester.