Antipsychotic medication use and deprescribing in people living with dementia: A guide for Primary and Community Care

Nottinghamshire Area Prescribing Committee

Both typical and atypical antipsychotics **worsen cognitive function**, increase risk of **stroke (3x)** and **death (2x)** as well as significantly reducing quality of life when used to control behavioural and psychological symptoms of dementia (BPSD). They should therefore only be prescribed if there is no other option. Risk increases with age, with vascular risk factors, and in established cerebrovascular disease.

Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia are particularly vulnerable to antipsychotic sensitivity reactions and extrapyramidal side effects so extreme caution is required.

Patients who have been newly commenced on an antipsychotic medication and respond to treatment should be reviewed after 6 weeks by secondary care to consider withdrawal.

If commenced by a non-psychiatric team and follow-up is not in place (i.e. treatment commenced during an acute medical admission), review should be undertaken in Frailty MDT meeting with a Community Geriatrician or mental health team representative present. In this situation, formal review with a Community Geriatrician should also be strongly considered.

What about patients who are discharged to GP led care on 'long-term' antipsychotic medication?

Over half of behavioural and psychological problems in patients with dementia resolve within 6 months. However, such problems can persist and longer term antipsychotic treatment may be needed. Due to the risks, **treatment should be reviewed 3 monthly.**

How should review be done?

An appropriate setting for review is the practice/PCN MDT meeting, but ensuring a Community Geriatrician is in attendance if there is no representation from Mental Health.

Information gathering from the patient/family/carers and involved clinicians should be undertaken prior to this discussion to explore:

- The presence of sedation, falls, anticholinergic side effects and extrapyramidal side effects
- The extent of ongoing and previous behavioural and psychological problems
- Relevant social information i.e. forthcoming regular carers' holidays etc. which may influence timings of any proposed changes to medication.

· What else needs to be considered?

- If a patient was deemed to need >6weeks of treatment, review and a supported withdrawal of medication should be undertaken no later than after a further 3 months
- Patients and their carers should be actively involved in discussions so they understand the potential benefits of weaning medications even though there is a risk of deterioration
- A clear plan for what to do should a patient deteriorate should be provided so family/carers can independently reinitiate treatment to ensure safety is maintained
- Family/carers should be asked to keep a diary of the patient's behaviour from a week before stopping or reducing the dose to a week after the reduction or stop date to assess the impact more objectively of reducing and/or stopping the treatment
- Consider leaving family/carers with a small supply of the drug, which can be reinstated if detrimental worsening occurs
- If withdrawing of treatment fails at 3-6 months, a re-attempt should be undertaken after a further 3-6months.
- For patients who have been taking antipsychotics long-term a more cautious reduction over 4-6 weeks or longer is recommended. The PrescQIPP Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf (link in resources) suggests dose reduction regimes along with more in depth clinician support.
- **Due to the significant risk of these medications in this patient group, it is recommended to keep revisiting the situation even if initial reduction/withdrawal attempts fail.**
- If problems are ongoing, refer to Community Mental Health, or the care home Dementia Outreach Teams (via Single Point of Access).

Monitoring of blood pressure, pulse, weight, HbA1C, lipid profile, renal and liver function, FBC, prolactin and ECG should be done at baseline, after 3 months and then annually for all patients requiring antipsychotic therapy (physically frail patients may need more frequent physical health monitoring).

References and useful resources:

1. https://www.nottsapc.nhs.uk/media/p0jlee5o/bpsd-guideline.pdf Managing behavioural problems in patients with Dementia Nottinghamshire APC
2. https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2022/10/Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf Yorkshire and the Humber Clinical Network and London Clinical Network NHS England
3. index Reducing Antipsychotic prescribing in dementia toolkit, PrescQIPP
4. https://www.bgs.org.uk/PragmaticPrescribing British Geriatrics Society

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