Managing Symptoms of Stress and Distress in Dementia

TARGET AUDIENCE	All NHSL clinicians and care home teams caring for patients with dementia.
PATIENT GROUP	All adults with dementia experiencing stress and distress symptoms

Clinical Guidelines Summary

This guide has been designed to be used by all staff 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 psychotropic medicines or referring to Old Age or Learning Disability Mental Health Services (as appropriate). It is accepted that not all interventions will be practical/ suitable in all circumstances.

Contents

Managing Symptoms of Stress and Distress in Dementia

Aim

- To provide guidance to support the safe, effective and person-centred management of patients presenting with Symptoms of Stress and Distress in Dementia.

Introduction

- The prescribing of pharmacological treatments for Stress and Distress in Dementia, also referred to as Behavioural and Psychological Symptoms of Dementia (BPSD), or behaviours that challenge in dementia, can be challenging due to a lack of comprehensive clinical trials and studies as well as the increased potential for adverse effects associated with the medications commonly prescribed.
- Non-pharmacological treatments should always be prioritised as first line agents in the treatment of stress and distress behaviours.
- Pharmacological treatments should be initiated with the lowest starting dose and titrated slowly if clinically indicated and tolerated. Target symptoms should be specifically identified and documented and the efficacy of any pharmacological treatments managing these symptoms should be regularly assessed.
- Where appropriate, psychotropic medicines should be withdrawn gradually and patients should be monitored closely for re-emergence of target symptoms or discontinuation symptoms.
- In general, a review should occur at least every 7 days for inpatients and approximately every 7-14 days for community patients after initiating treatment or making dose adjustments.
- Where delirium is suspected or diagnosed, NHS Lanarkshire's delirium guideline[1] should be referenced for prescribing guidance and management.
- For patients with co-morbid mental illness or those under the care of Older Adult or Learning Disability Mental Health Services, specialist advice should be sought before prescribing or altering psychotropic medications.

Target symptoms

Symptoms of stress and distress in dementia (or non-cognitive symptoms of dementia)[2]	
Agitation	Verbal or physical aggression
Hallucinations	Apathy
Delusions	Depression
Irritability	Disturbance of sleep/wake cycle
Sexual disinhibition	Anxiety

The target symptoms being treated should be specifically documented within the clinical notes to allow for the efficacy and response to both pharmacological and non-pharmacological treatments to be thoroughly assessed. Non-pharmacological treatment options should be prioritised prior to considering a trial of medications.

Pharmacological treatment for the management of target symptoms[2-6]

Depression and/or anxiety	➢ Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia, unless they are indicated for a pre-existing severe mental health problem. ➢ In the absence of other evidence, a trial of an SSRI should be considered in moderate to severe depression (sertraline 1st line and mirtazapine 2nd line due to their favourable cardiovascular and side-effect profiles and low anticholinergic burden). ➢ Robust evidence is limited regarding the use of AChEIs /memantine for depression/anxiety in Alzheimer's/mixed dementia (not recommended in vascular/fronto-temporal dementia (FTD)). They may offer mild benefits for symptoms but should not be prescribed as a primary treatment option. Suitable to continue if already prescribed for management of cognitive symptoms.
Agitation	➢ Consider adding paracetamol even in the absence of overt pain. ➢ Antipsychotic use is only recommended for severe agitation. ➢ Benzodiazepines indicated short term (e.g. lorazepam) for acute stress/agitation.[7] ➢ The AChEIs are not specifically indicated for agitation but may be continued if already prescribed for cognitive symptoms in AD, mixed dementia or Lewy Body/Parkinson's dementia (caution as AChEIs may worsen agitation upon initiation or following dose increases). ➢ There is limited evidence for the use of memantine in agitation but it is suitable to continue if already prescribed for management of cognitive symptoms.
Hallucinations/ delusions causing severe distress	➢ In Alzheimer's, vascular, mixed and FT dementias, risperidone is the recommended 1st line antipsychotic. In Lewy Body disease (LBD)/Parkinson's dementia (PD), antipsychotics should be used with caution and under expert supervision. See section on Lewy body disease and Parkinson's dementia. ➢ Optimise AChEIs and memantine (except for FTD).
Aggression/severe agitation causing significant distress or risk of harm to the patient/others	➢ Antipsychotics- risperidone is the 1st line licensed treatment for up to 6 weeks, or trial olanzapine/quetiapine if risperidone is not tolerated or is contraindicated. In LBD/PD, antipsychotics should be used with caution and under expert supervision. See section on Lewy body disease and Parkinson's dementia. ➢ There is limited evidence for the use of antidepressants to reduce aggression, but use may be appropriate if severe agitation is linked to depression/anxiety. ➢ Very limited evidence for using AChEIs or memantine specifically for aggression or severe agitation (however, AChEIs should continue if already prescribed for management of cognitive symptoms). ➢ Benzodiazepines short term (e.g. lorazepam) for acute stress/agitation.[7]
Sexual disinhibition	➢ The current evidence base is poor for all treatments and is limited to individual case series/reports. Non-pharmacological agents should be prioritised and specialist advice should be sought prior to commencing pharmacological treatments.

The prescribing of antipsychotics for stress and distress in dementia

➢ Only offer antipsychotics for people living with dementia who are either at risk of harming themselves or others, or experiencing agitation, hallucinations or delusions that are causing them severe distress.[2]
➢ Antipsychotics have only limited benefit in treating symptoms of stress and distress in people with dementia and advice from the relevant local mental health service should be sought if considering an antipsychotic for patients with dementia.
➢ Prior to commencing treatment, the benefits and risks of treatment should be discussed with the patient and/or family/carer.
➢ The NICE decision aid[8] can be used to guide these discussions and patient information leaflets can be provided (from resources such as NHS Lanarkshire's Antipsychotic in Dementia information pack[9] or Choice and Medication[10]) to support patients and/or carers/family when deciding on treatment options.
➢ For each patient the individual symptoms being specifically targeted should be clearly documented so that the impact of prescribing decisions can be closely monitored.
➢ NHS Lanarkshire's Review of Antipsychotic Prescribing in Dementia[11] guideline supports a rational approach for the review of antipsychotic prescribing in patients with dementia in NHS Lanarkshire hospitals, care homes and community settings. ➢ At review, discontinuation of the antipsychotic should be considered unless there is ongoing significant risk and/or distress.
➢ Antipsychotic treatment may be effective for psychosis, persistent physical aggression or severe agitation. It may be appropriate to consider a short course of an antipsychotic in delirium.
➢ Patients with dementia are at risk from serious and life-threatening side-effects when treated with antipsychotics (MHRA Drug Safety Update 2014)[12] e.g. delirium, cerebrovascular events, falls and all-cause mortality.
➢ Antipsychotic medication should be used as a last resort with priority given to psychological therapies. Other possible causes of symptoms should have been investigated (e.g. psychological, physical or environmental factors) before initiating antipsychotic medication. See "Causes of stress and distress" on page 14.
➢ Antipsychotics should be commenced at the lowest possible dose, titrated carefully, and reviewed within the first four weeks and after 6-12 weeks

Licensed antipsychotic treatments

	Risperidone	Haloperidol
Licensed Indication	➢ Treatment of dementia-related behavioural disturbances and then only specifically for short-term (up to 6 weeks) treatment of persistent aggression in Alzheimer's dementia unresponsive to non-pharmacological approaches and where there is a risk of harm to the patient or others.[13]	➢ Treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others (and also acute delirium where non-pharmacological treatments are ineffective)[14] ➢ *(Please note that despite its licensed indication, prescribing haloperidol for patients with dementia should generally be avoided due to higher rates of adverse outcomes[15])*
Dosing	➢ Initially 250 micrograms twice daily, then increased in steps of 250 micrograms twice a day on alternate days. The usual dose is 500 micrograms twice daily, with a maximum dose of 1mg twice daily.[13] ➢ For those at higher risk of side effects (e.g. elderly or frail adults), consideration should be given to commencing treatment at a lower dose of 250 micrograms once daily.	➢ Initially 500 micrograms daily, dose adjusted gradually according to response up to maximum 5 mg daily.[14] ➢ Reassess treatment after no more than 6 weeks, doses above 5 mg daily should only be considered in patients who have tolerated higher doses and after reassessment of the individual benefit-risk.
Formulation	➢ Risperidone 1mg/ml oral solution is the preferred formulation when prescribing low doses of risperidone (<1mg) across all settings. ➢ There is a significant cost burden associated with the use of risperidone 250 micrograms and 500 micrograms tablets in comparison to the 1mg/ml oral solution.	➢ Haloperidol 1mg/ml oral solution is the preferred formulation if prescribing low doses of haloperidol across all settings. ➢ There is a significant cost burden associated with the use of haloperidol 500 micrograms tablets in comparison to the 1mg/ml oral solution.

Contra-indications to prescribing haloperidol include: Parkinson's Disease or Lewy Body Dementia, prolonged QTc or congenital Long QT syndrome; already prescribed QTc prolonging medication; recent acute myocardial infarction or uncompensated heart failure; uncorrected hypokalaemia[16]

Antipsychotic monitoring

- A baseline ECG should be completed (where practical) prior to commencing any antipsychotic treatment and thereafter if clinically indicated.
- Haloperidol's summary of product characteristics[16] mandates a pre-treatment ECG, dose reduction if QTc is prolonged, and to discontinue haloperidol if the QTc exceeds 500ms. Cardiology advice should be sought if significant abnormalities are detected.
- If longer-term antipsychotic treatment is appropriate following thorough assessment, a personalised and pragmatic approach to antipsychotic monitoring is recommended and physical health tests completed only if the results will change management. Please refer to the British National Formulary (BNF)'s antipsychotic monitoring recommendations[17] for details.
- Older patients may have increased frailty, co-morbidities and sensitivity to prescribed medications and thus the monitoring and management of physical health is different to those of the general population.
- The anticholinergic burden calculator tool[18] can be utilised to support safe prescribing decisions and to review and reduce the anticholinergic burden which can be harmful to older adults, particularly those with dementia.
- The pharmacokinetic response (absorption, distribution, metabolism and excretion) may also be significantly different and close monitoring for anticholinergic effects (e.g. constipation and impact on cognition), extrapyramidal side effects, blood pressure or heart rate changes, sedation and falls risk is essential.

Benzodiazepines

- There is limited evidence to support the prescribing of benzodiazepines in the treatment of stress and distress symptoms compared to placebo or other pharmacological treatment options.
- For acute stress and distress or agitation that hasn't improved following non-pharmacological interventions, consider the short term use of benzodiazepines with the rationale for prescribing clearly documented.
- Benzodiazepines may also be used to manage agitation or aggression associated with delirium however there is very limited evidence to support this.

- Benzodiazepines can potentially worsen delirum and underlying cognitive impairment.
- Additionally, paradoxial agitation can occur which may lead to an increase in agitation soon after administration.
- These risks should be carefully considered against any potential benefits in terms of reducing risks and/or distress.[1]

- Due to the high risk of adverse effects (increased falls risk, sedation, cognitive decline), benzodiazepines should only be used on **a short term basis** with regular reviews to ensure that continued prescribing remains clinically appropriate.
- Only if the oral route is not possible and there are significant risks to the patient and/or others should the use of IM benzodiazepines be considered.[1]

- If benzodiazepines are to be prescribed, **lorazepam** is the recommended 1st line agent due to its preferable pharmacokinetics (e.g. quick onset of action and short half-life).
- The recommended dose is 500 micrograms (0.5mg) as required up to 2mg/24 hours.
- For cost-effective prescribing the 1mg tablets can be halved for doses of 0.5mg.
- Oral lorazepam tablets can be given sublingually. However, if the oral route is not available or accepted then IM administration may be considered.
- Dosing is the same for IM administration as when given orally.[1]

Antidepressants

➢ Depression is potentially both a risk factor and consequence of Alzheimer's disease. ➢ Supporting evidence for antidepressant prescribing in dementia is very limited and there is insufficient data to conclude the effectiveness of specific antidepressant medications or their efficacy in different subtypes of dementia. ➢ Where patients present with depression or anxiety, antidepressant treatment can be prescribed to specifically target these symptoms
➢ Despite the limited evidence, antidepressants are still commonly prescribed for people with dementia (particularly stress and distress), with the current literature illustrating that antidepressants may be most beneficial for treating agitation when compared to apathy, depression, anxiety or psychosis.[19,20]
➢ Based on their favourable tolerability, the SSRIs or mirtazapine are the preferred antidepressant treatment options.
➢ Due to the potential side effects from antidepressant prescribing, clinicians should have an awareness of individual side effect profiles for different antidepressant classes.
➢ Trazodone is frequently prescribed for the management of irritability and agitation, primarily due to its sedative effect, and has shown efficacy in improving sleep in those with dementia and insomnia and for reducing stress and distress symptoms in fronto-temporal dementia.[21]
➢ Care should be taken if prescribing citalopram due to the risks of dose-dependent QTc prolongation and its cardiovascular safety profile. ➢ Citalopram is contraindicated with any other medications that prolong QTc and a pre-treatment baseline ECG is recommended.[22]
➢ In general, the prescribing of tricyclic antidepressants is not recommended due to the high risks of adverse effects and anticholinergic burden profile from this class of medication, potentially leading to worsening cognition, increased falls, and cardiovascular side effects.

Cognitive Enhancers

- The acetylcholinesterase inhibitors (AChEIs) donepezil, rivastigmine and galantamine are recommended for managing mild-moderate dementia in Alzheimer's disease (AD).[23]
- Memantine, an NMDA-receptor antagonist, is recommended for managing moderate-severe dementia in Alzheimer's disease, and can be used in conjunction with an AChEI in moderate-severe AD, or as monotherapy if an AChEI is not tolerated or is contraindicated.[23]
- Donepezil or rivastigmine can be prescribed in mild-moderate or moderate-severe dementia with lewy bodies (DLB) (or galantamine if either are not tolerated in mild-moderate DLB), with memantine reserved for those with DLB if AChEIs are not tolerated or are contraindicated.[23]
- If not already prescribed, consideration should be given to prescribing the cognitive enhancers for the management of non-cognitive symptoms and/or behaviours that challenge and are causing significant distress or potential harm to the individual (see **'**Pharmacological treatment for the management of target symptoms')
- The dose should be optimised to the maximum tolerable and clinically appropriate dose.

- AChEIs and memantine are not recommended in patients with vascular or fronto-temporal dementia subtypes.[23]
- Only consider AChEIs or memantine for people with vascular dementia if they have suspected co-morbid AD, Parkinson's disease dementia or DLB.

- The role of the AChEIs and memantine in the acute treatment of stress and distress in dementia may be limited as evidence shows a clinical effect may not be seen until 3-6 months after commencing treatment.
- However, due to their ability to slow cognitive decline, both the AChEIs and memantine may be effective interventions in reducing the distressing behaviours associated with stress and distress in dementia.[23,24]
- Although the current evidence base is limited for supporting the efficacy of AChEIs in treating agitation or aggression in Alzheimer's/mixed dementia, they may improve other symptoms of stress and distress including anxiety, dysphoria, depression and apathy.[23] Caution is advised as agitation may be increased in some cases.

- Memantine has proven efficacy in both reducing the symptoms of stress and distress in dementia and delaying the onset of symptoms in people who are symptom free at baseline.[25]
- Memantine has also been shown to improve behavioural disturbances in stress and distress cases with no adverse effects on negative symptoms.[24]

- There is some evidence to support the use of AChEIs in a range of stress and distress symptoms in Dementia with Lewy Bodies, including hallucinations (see Lewy Body disease and Parkinson's disease dementia section).

- For all patients commenced on a cognitive enhancer it is recommended that basic monitoring of physical health parameters[26] is completed.
- Although often well tolerated, these medications can have significant side effects and physical health monitoring is required to mitigate some risks (e.g. bradycardia and weight loss with acetylcholinesterase inhibitors, hypertension with memantine).

- It is not recommended to stop treatment with AChEIs unless clear evidence exists that they are the cause of any stress or distress symptoms or an adverse effect.
- If planning to stop, all AChEIs should be reduced gradually where possible

Lewy Body disease and Parkinson's disease dementia

- AChEIs are considered 1st line treatment for neuropsychiatric symptoms in LB dementia.[27]

- First generation antipsychotics should not be prescribed in LB or PD dementias due to the risk of movement disorders.
- If there is no clinical benefit from AChEIs treatment, a cautious trial of a second generation antipsychotics (aripiprazole, olanzapine, quetiapine) can be prescribed due to the reduced risk of causing movement disorders with this class of medications compared to first generation antipsychotics.
- Careful consideration must be given to individual risks/benefits before prescribing antipsychotics.[27]

- Clozapine is the only antipsychotic licensed for psychosis associated with Parkinson's Disease.[28]
- It is essential that specialist advice be sought from the mental health pharmacy team prior to commencing clozapine.

Mood Stabilisers

- Limited evidence is available to support the prescribing of mood stabilisers in stress and distress in dementia and their use cannot currently be recommended.[23]

Analgesia

- Agitation may occur secondary to pain in people with cognitive impairment. Therefore, effective treatment of pain symptoms is important in the management of agitation.
- A trial of simple analgesia (e.g. paracetamol) is a recommended first line treatment option in this patient group.
- NICE guidance[29]should be referenced for any escalation of analgesia required with careful consideration given to individual risks/benefits before any prescribing decisions are made.
- Weak opioids such as tramadol, codeine and dihydrocodeine are associated with side effects including constipation and confusion in older adults.
- Non-steroidal anti-inflammatory drugs should generally be avoided due to the potential for cardiovascular side effects and increased bleeding risks (although topical application may be appropriate in individual cases).

Capacity and Consent

- Changes to medications must be discussed with the patient if they have capacity.
- Where capacity is absent and there is an existing legal proxy i.e. welfare attorney or guardian, the decision to prescribe medications must be discussed with them, risks outlined and agreement sought.
- If the patient lacks capacity and if there is no formal legal welfare proxy, the principles of the Adults with Incapacity (Scotland) Act 2000 apply and treatment options should be discussed with relevant others, such as next of kin, carer or patient advocate.
- In either circumstance, an appropriate Section 47 certificate of incapacity is required.

- If a patient is subject to the Mental Health (Care and Treatment) (Scotland) 2003 Act, check that any psychotropic medication is included on a current T2/T3 certificate.

- In patients who consistently refuse prescribed medications and lack capacity then consideration may be given to utilising the covert medication pathway. Please refer to the NHS Lanarkshire covert administration of medication guidance (Covert Medication Pathway[30]) for further information.
- For covert administration to occur the appropriate legal safeguards must be present and clearly documented.
- A pharmacist must always be consulted on the appropriateness and method of covert administration of medication.

Managing Symptoms of Stress and Distress in Dementia

When reviewing the patient, consider what the potential causes of distress are for the individual. Consider whether there are underlying unmet needs and how to meet the individual's needs using the flowchart below. Should you require consultation or assistance in considering some of these factors please consider making a referral.

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

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

Exclude Physical Causes

- **Delirium/Infection including viral (e.g Covid-19 and influenza) -** check temperature, blood pressure, pulse and bloods e.g. FBC, U&E, LFT, TFT, CRP, Glucose, Vitamin B12, folate and ferritin levels, MSSU (Use 4AT tool)
- **Dehydration** – check blood as above; Commence on fluid balance chart
- **Pain** – complete appropriate pain assessment tool e.g. Abbey Pain Scale
- **Hunger** – monitor for changes in appetite, complete diet charts
- **Constipation** – monitor bowel habits
- **Tiredness** – chart sleep pattern
- **Medication** – side effects or withdrawals e.g. benzodiazepines, opiates
- **Sensory Impairment** – sight &/or hearing deficit – if so refer to appropriate service
- **Hypoxia** – cyanosis, laboured breathing, pre-existing conditions e.g. COPD

Consider Psychological Causes

- **Isolation**, loneliness, lack of meaningful contact with others
- **Feeling anxious,** angry or worried; feeling threatened or vulnerable. Adjusting to a recent life event or change
- **Depression** – observe for any mood or behavioural changes. Complete appropriate assessment tool
- **Hallucinations** – more commonly seeing and/or hearing things. (exclude delirium)
- **Delusions –** more commonly paranoid and/or suspicious. (exclude delirium)
- **Sundowning**- increased agitation and activity occurring in the late afternoon/ early evening

Consider Environmental Causes

- **Noise levels** – over stimulation/elevated noise levels can be antagonistic
- **Lack of social stimulation –** consider appropriate meaningful activities
- **Inappropriate music**
- **Environment/layout**
  - Is it conducive to the specific patient group?
  - Could it potentially increase confusion and disorientation in people suffering from cognitive impairment?

Consider Other Causes

- **Communication and interactional style of others** – is it tailored to the individual? tone of voice, approach, body language, poor verbal and/or non-verbal communication
- **Inflexible routines** – e.g. toileting, bathing, bedtimes – offer choice
- **Task orientated care**
  - lack of person-centred care
- **Client group**
  -do other individuals trigger behaviours?
- **Continuity of staff**
  - therapeutic relationships
  - team continuity
- **General comfort** – clothing, seating, movement

If there has been no improvement or further deterioration in the patient's behaviour, consider referral for specialist advice

Lead Author	**Scott Hamilton & Claire Osprey**	**Date approved**	
Version	**2.0**	**Review Date**	

References

1) NHS Lanarkshire Delirium guideline: https://rightdecisions.scot.nhs.uk/media/zyqpmeeh/delirium-guidelines-final-june-24-upload-vers_michael-cooper-2.pdf
2) Recommendations | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE
3) International Geripsychiatric Association: The IPA Complete Guides to Behavioural and Psychological Symptoms of Dementia: IPA_BPSD_Specialists_Complete_Guide_Online_2015_Final.pdf[1]
4) Optimising treatment and care for people with behavioural and psychological symptoms of dementia A best practice guide for health and social care professionals Apex-nhs-dementia-best-practice-guide.pdf
5) Clinical practice with anti-dementia drugs: A revised (third) consensus statement from the British Association for Psychopharmacology: BAP_Guidelines-AntiDementia.pdf
6) Bidzan L, Grabowski J, Dutczak B, Bidzan M. [Impact of treatment with acetylcholinesterase inhibitors, valproic acid and antipsychotics on aggressive behaviour in Alzheimer's type dementia]. Psychiatr Pol. 2012 May-Jun;46(3):361-72. Polish. PMID: 23045890.
7) NHS Lanarkshire Guidance for the Prescribing and Administration of as required oral psychotropic medication in Mental Health & Learning Disability Inpatient Services
8) NG97 Patient decision aid on antipsychotic medicines for treating agitation, aggression and distress in people living with dementia
9) NHS Lanarkshire's Antipsychotic in Dementia information pack: dementia antipsychotic.pdf (1).crdownload.pdf
10) NHS 24 Home- Choice and medication
11) NHS Lanarkshire: Dementia- Review of Antipsychotic Prescribing in patients with dementia: antipsychotic-in-dementia-review-guidance-a_caroline-mclean.pdf (1).crdownload.pdf
12) Antipsychotics: initiative to reduce prescribing to older people with dementia - GOV.UK
13) Risperidone | Drugs | BNF | NICE
14) Haloperidol | Drugs | BNF | NICE
15) Lonergan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia. Cochrane Database Syst Rev. 2002;(2):CD002852. doi: 10.1002/14651858.CD002852. PMID: 12076456
16) Haloperidol 1mg/ml Oral Solution - Summary of Product Characteristics (SmPC) - (emc) | 10907
17) BNF antipsychotic monitoring guidance: https://bnf.nice.org.uk/treatment-summaries/psychoses-and-related-disorders/#monitoring
18) ACB Calculator
19) Dudas R, Malouf R, McCleery J, Dening T. Antidepressants for treating depression in dementia. Cochrane Database Syst Rev. 2018 Aug 31;8(8):CD003944. doi: 10.1002/14651858.CD003944.pub2. PMID: 30168578; PMCID: PMC6513376.
20) Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database Syst Rev. 2011 Feb 16;(2):CD008191. doi: 10.1002/14651858.CD008191.pub2. PMID: 21328305.

21) McCleery J, Sharpley AL. Pharmacotherapies for sleep disturbances in dementia. Cochrane Database of Systematic Reviews 2020, Issue 11. Art. No. Cd 009178. DOI 10.1002/14651858.CD009178.pub4. Accessed 09 July 2025
22) Citalopram 10mg Tablets - Summary of Product Characteristics (SmPC) - (emc) | 3722
23) Taylor D, Barnes T, Young A. Maudsley Prescribing Guidelines. Wiley Blackwell, 2021 14th edition. UK
24) Bazire S. Psychotropic Drug Directory. Lloyd-Reinhold Publications. 2020. Warwickshire, UK.
25) Tariot PN, Farlow MR, Grossberg GT, et al. Memantine Treatment in Patients With Moderate to Severe Alzheimer Disease Already Receiving Donepezil: A Randomized Controlled Trial. *JAMA.* 2004;291(3):317–324. doi:10.1001/jama.291.3.317
26) NHS Lanarkshire physical-health-monitoring-of-cognitive-enhancers.pdf
27) Management of Lewy Body Dementia- DIAMOND Lewy programme, Newcastle University, Institute of Neuroscience, Campus for Ageing and Vitality, Newcastle upon Tyne NE4 5PL, United Kingdom
28) Clozaril 25 mg Tablets - Summary of Product Characteristics (SmPC) - (emc) | 4411
29) Scenario: Choice of analgesic | Management | Analgesia - mild-to-moderate pain | CKS | NICE
30) Covert Medication Pathway

Appendices

1. Governance information for Guidance document

Lead Author(s):	Scott Hamilton & Claire Osprey
Endorsing Body:	NHS Lanarkshire ADTC
Version Number:	2.0
Approval date	December 2025
Review Date:	December 2028
Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	"With thanks to Shona Mackie and Ann Haugh, NHS Forth Valley, whose flowchart we have adapted"
Consultation Process / Stakeholders:	Care Home Governance & Guidance Group
Distribution	

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
		e.g. Review, revise and update of policy in line with contemporary professional structures and practice	1
December 2025	Scott Hamilton	Guideline updated to reflect the review and revision of the management of stress and distress symptoms in dementia guideline based on current evidence-based treatment recommendations (pharmacological and non-pharmacological). Target symptoms and antipsychotic monitoring recommendations are now included and references have also been updated.	2
			3
		.	4
			5