RESPONDING TO BEHAVIOURS THAT CHALLENGE (BPSD) IN OLDER PEOPLE & THOSE WITH DEMENTIA
(Does not cover rapid tranquillisation of acutely disturbed)

Patient being treated for
Schizophrenia, Persistent
Delusional Disorder, psychotic
Depression or Bipolar Disorder

Yes

No

Patient also has dementia or is at
increased risk of stroke or cerebrovascular
events.

Risk factors for cerebrovascular disease:
Previous history of stroke or Transient
Ischaemic Episodes (TIAs)
Hypertension
Diabetes
Smoker
Atrial fibrillation

Do ECG (caution if long QTc or AF
identified). Monitor blood pressure

Yes

No

Address potential causes and triggers:
Physical health incl pain and infection
Anaemia
Cognitive abilities
Perceptual deficits – sensory loss
Mental health – depression, psychosis
Medication side effects
Personality incl beliefs, preferences and
life experiences
Environment and care practices
Lack of stimulation

Yes

No

If there is dementia the antipsychotic of
choice is risperidone, which is licensed
for BPSD at a dose of up to 1mg b.d. for
up to 6 weeks. This drug (or any other
antipsychotic) must be used with extreme
cautions as all antipsychotics have been
shown to increase risk of CVA in this
patient group. Patients must be regularly
reviewed and treatment beyond 6 weeks
should not occur without full, documented
review of ongoing clinical need.

If antipsychotic treatment is indicated: Cautiously consider risperidone as first-line medication for persistent
aggression in dementia that is not responsive to non-drug approaches, where there is risk of harm to the patient
or others. Starting dose is 0.25mg b.d. adjusted on alternate days to not more than 1mg b.d.

In the event of continuing problems, telephone
advice can be obtained from the CMHT-OP.

Use low dose antipsychotics, (atypical
or conventional), and
closely monitor for
cerebrovascular risks.

Full medication review if
patient is on long-acting
injections or mood
stabilisers

Yes

No

Patient has Behavioural and
Psychological Symptoms of Dementia
(BPSD) causing distress to self and
others, eg. delusions, aggression,
hallucinations, verbal disruption,
disinhibition, apathy and depression.

No

Yes

Patient has Delirium
(Short history, <2 wks, of
confusion, hallucination,
delusion with fluctuating
cognition)

Treat underlying acute medical
problems, e.g. UTI, chest infection,
side effects of drugs, alcohol and
drug withdrawal etc. This usually
resolves the behaviour problems.
(See NICE Guidance – July 2010).

Keep off anti-
psychotic medication

Use psychosocial interventions as first-line
approach to meet unmet needs. Include
environmental modification, preventative
therapeutic activities and formulation-led
approaches, (based on functional and behavioural
analyses). Actively involve carer / relatives
throughout assessment and interventions.

Only consider pharmacological treatment if there is
psychosis, depression or behaviour that is
significantly distressing or harmful to the patient
or others. Where possible, this treatment should be
short-term and must be kept under close review.

IMPORTANT - when reducing or stopping psychotropic medicines, only reduce or stop one at a time.
Consider reducing or stopping anticholinergic drugs (e.g.procyline), tricyclic antidepressants, drugs for urinary
incontinence (e.g. oxybutynin) antihistamines (e.g. promethazine), opioids, Parkinson’s drugs (e.g. Sinemet), GI
drugs (metoclopramide, ranitidine, hyoscine). Acetylcholinesterase inhibitors themselves may sometimes cause
agitation. If newly prescribed consider reducing or stopping them to see if behavioural problems resolve.

Note – in the treatment of
BPSD, the
use of an
antipsychotic,
(other than
risperidone),
is an ‘off
licence’ use of
the medicine.

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