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 F Johnson
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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. 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
- British Association of Psychopharmacology www.bap.org.uk
- Scottish Government Model of Care Polypharmacy Working Group. Polypharmacy Guidance (3rd edition). March 2018. Scottish Government.
- Banerjee S. The use of antipsychotic medication for people with dementia: Time for action. 2009:1-65.
- Glass J, Lanctot KL, Herrmann N, et al. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. BMJ 2005;331(7526):1169.
- Sterke CS, van Beeck EF, van der Velde N, et al. New insights: dose-response relationship between psychotropic drugs and falls: a study in nursing home residents with dementia. J Clin Pharmacol 2012;52(6):947-955.
- 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:

Issues to Consider. Quick Reference Guide.

Useful references and resources

- Delirium diagnosis, Risk Reduction, and Management in Acute Services (081) 2023 [link]
- Scottish Government Polypharmacy Model of Care Group. Polypharmacy Guidance, Realistic Prescribing 3rd Edition, 2018. Scottish Government [link]
- The Abbey Pain Scale: For measurement of pain in patients who cannot verbalise [link]
- Meeting needs and reducing stress. Guidance on the prevention and management of clinically related challenging behaviour in NHS settings [link]
- Managing Behaviour and Psychological Problems in Patients with Diagnosed or Suspected Dementia, in Primary and Secondary Care. NHS Nottingham and Nottinghamshire Area Prescribing Committee. July 2023 [link]
- Antipsychotics prescribing in dementia. NHSGGC 2022 [link]
- British Geriatric Society: Care Homes Group [link]
- SIGN 168: Assessment, diagnosis, care and support for people with dementia and their carers 2023. [link]

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.

Psychotropic Medicines: Reviewing with Care Home Residents

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, prior to utilising psychotropic medication. (Adapted from Quick Reference Guide NHS Forth Valley)

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 –** 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 blood s (see above); 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 e.g. Bristol Stool chart
- **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**

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 of 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

For patients transitioning from their home to care home - consider if medication review is needed.

All patients prescribed antidepressants should be reviewed at regular intervals in line with current National and local guidance.[1 2] Antidepressants demonstrate moderate benefits in treating depression in people with dementia,[3-5] The evidence for antidepressant efficacy in the symptoms of stress and distress in dementia is mixed and limited, however citalopram (max 20mg per day, QTc risk allowing) and sertraline may be considered.[6] Whilst a small trial (n=30) reported in a Cochrane review indicated that trazodone 50mg at night helped to improve sleep and was well tolerated.[7]

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/anxiety-type symptoms, e.g. benzodiazepines, z-hypnotics, beta-blockers, etc.
- Selective serotonin re-uptake inhibitors (SSRIs) demonstrate a flat dose-response for the treatment of depression. Standard doses of citalopram/fluoxetine/paroxetine 20mg daily and sertraline 50mg daily provide efficacy while minimising avoidable adverse effects.[1]
- Mirtazapine is more sedating at 15mg than at higher doses; may help sleep, agitation, anxiety, weight gain. Doses of 30mg per day have been shown to be effective for the treatment of depression in younger adults.[9]
- 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.
- **Exclusions:** Where patients receive mental health input, consider discussing with their mental health team at the annual and/or 6 monthly review, or more frequently if appropriate. In line with '[My Health, My Care, My Home - healthcare framework for adults living in care homes]'. To aid clarity and continuity of longer-term care for secondary and primary care teams, consider tailoring patient treatment plans and recording clearly where antidepressants should continue long-term, where needed, due to previous history.

How to withdraw antidepressants - See NHSGGC Depression Treatment, for Adults, in Primary Care (Appendix 3) [link]

- 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 dose.
- Antidepressants can usually be stopped by reducing the dose or frequency over a 4 week period or longer. **However,** slow reduction over a period of months may be required and more appropriate for some patients; especially for those receiving longer courses of antidepressants (>9 months) 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.
- SSRIs and selective serotonin and noradrenaline re-uptake inhibitors (SNRIs) may cause discontinuation symptoms: flu-like, electric shocks, vivid dreams, insomnia, etc. These are more common with paroxetine and venlafaxine due to their short half-life's.

- Fluoxetine can be stopped at 20mg daily due to its long half-life. However, slower reductions may be appropriate for some patients using fluoxetine liquid, see NHSGGC Depression Treatment, for Adults, in Primary Care (Appendix 3) [link]
- Tricyclic antidepressants may need slower reduction to minimise the risk of cholinergic rebound (nausea, vomiting, headache, restlessness, diarrhoea); using lowest 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 discontinuation symptoms continue on current dose for 4 weeks and review for ongoing discontinuation symptoms. If none, reduce dose again at 4 weeks.
- If severe discontinuation 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 days 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
- NHSGGC Depression Treatment, for Adults, in Primary Care (Appendix 3 Antidepressant reduction advice) [link]

References

1. National Institute for Health and Care Excellence. National Guideline 222: Depression in adults: treatment and management, 2022.
2. NHS Greater Glasgow and Clyde. Depression treatment, for adults, in primary care: Clinical Guideline., 2020.
3. Dudas R, Malouf R, McCleery J, et al. Antidepressants for treating depression in dementia. Cochrane Database of Systematic Reviews 2018(8):CD003944. doi: 10.1002/14651858.CD003944.pub2
4. Seibert M, Mühlbauer V, Holbrook J, et al. Efficacy and safety of pharmacotherapy for Alzheimer's disease and for behavioural and psychological symptoms of dementia in older patients with moderate and severe functional impairments: a systematic review of controlled trials. Alzheimer's Research & Therapy 2021;13(1):131. doi: 10.1186/s13195-021-00867-8
5. National Institute for Health and Care Excellence. Dementia: assessment, management and support for people living with dementia and their carers, 2018.
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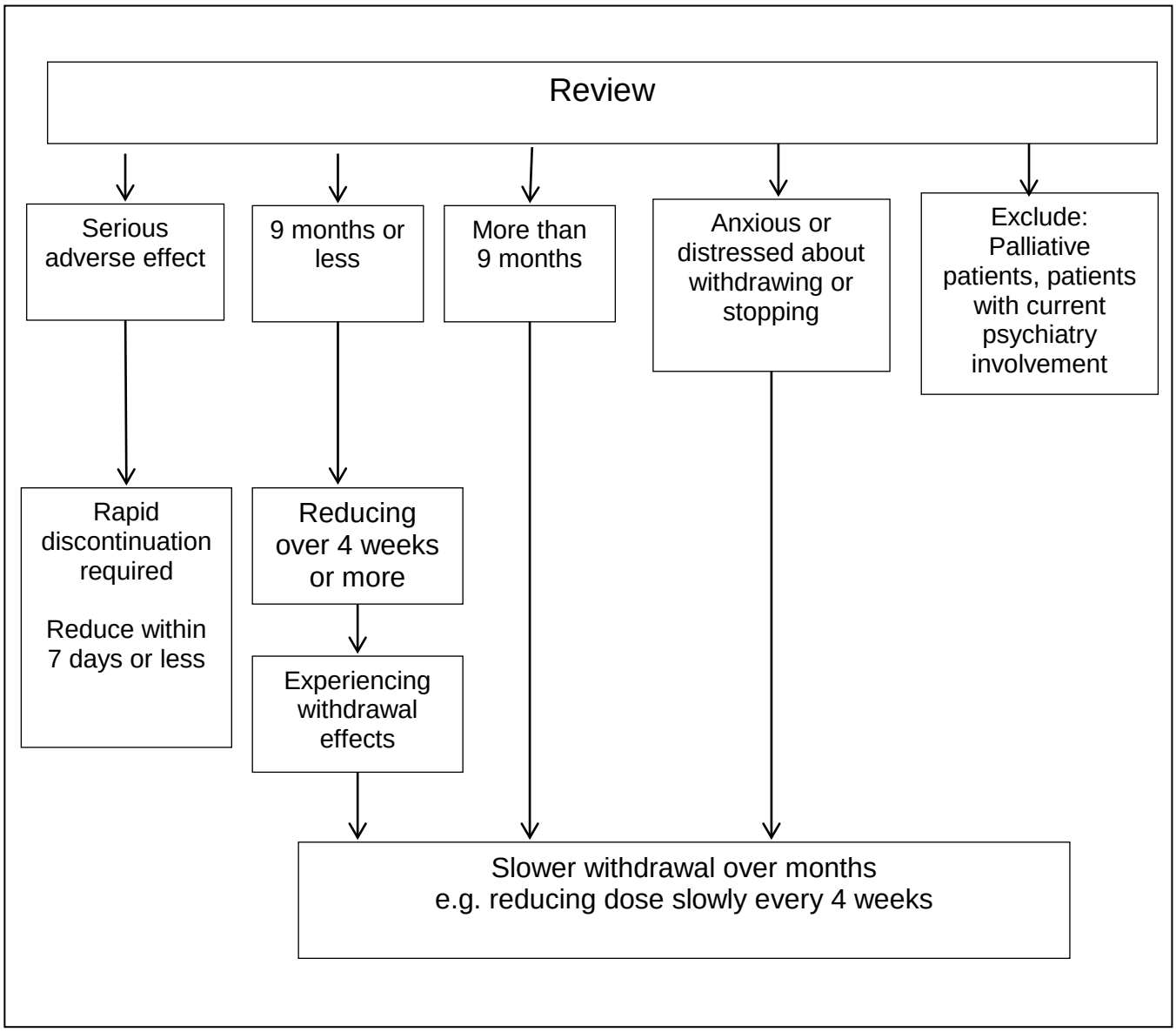
8. Johnson CF, Maxwell M, Williams B, et al. Dose-response effects of selective serotonin reuptake inhibitor monotherapy for the treatment of depression: systematic review of reviews and meta-narrative synthesis. BMJ Medicine 2022;1(1):e000017.
9. Furukawa TA, Cipriani A, Cowen PJ, et al. Optimal dose of selective serotonin reuptake inhibitors, venlafaxine, and mirtazapine in major depression: a systematic review and dose-response meta-analysis. Lancet Psychiatry 2019;6(7):601-09. doi: https://doi.org/10.1016/S2215-0366(19)30217-2

Figure 1. Reviewing, reducing and stopping antidepressants



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

For patients transitioning from their home to care home - consider if medication review is needed.

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] Z-hypnotics demonstrating no advantages over benzodiazepines.[3]

Care home residents aged ≥65 years in Scotland are 3 times more likely than non-care home residents to receive B-Zs.[4] Although B-Zs are not routinely advised for managing the symptoms of stress and distress in dementia,[5 6 2 3] as they are associated with an increased risk of dementia, cognitive impairment, depressive symptoms 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 these 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 (See cautions below)

- **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.
- To switch B-Z or not?
    - Nitrazepam reduction using liquid preparation is possible, by reducing by 1mg every 4 weeks.
    - Consider 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 10% every 4 weeks using a planned reduction schedule.
    - 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.
- Diazepam only: reduce total daily dose by 1-2 mg every 4 weeks using a planned reduction schedule. For example 20mg diazepam (total daily dose) reduce by 2mg every 4 weeks until 10mg total daily dose reached, then reduce in 1mg steps every 4weeks until stopped.[10]
- Slower reductions may be required for some patients who have received longer term treatment with a B-Z.

- 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 – see Ashton Manual.[10] Consider discussing with mental health team where appropriate.
- 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 (e.g. older patients may experience cumulative effects with longer acting drugs), and variations in individual patient's characteristics: sensitivity, age, hepatic function, 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.
- **Multiple B-Z medicines.** Consider discussing with mental health teams where appropriate.

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 10]

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 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. London: BMJ Group, Pharmaceutical Press 2023.
2. Committee on Safety of Medicines. Benzodiazepine dependence and withdrawal symptoms. Current Problems 1988(21):1-2.
3. National Institute for Health Care Excellence. Guidance on the Use of Zaleplon, Zolpidem and Zopiclone for the Short-Term Management of Insomnia. 2004
4. Johnson CF, Frei C, Downes N, et al. Benzodiazepine and z-hypnotic prescribing for older people in primary care: a cross-sectional population-based study. British Journal of General Practice 2016;66(647):e410-e15.
5. National Institute for Health and Care Excellence. Dementia: assessment, management and support for people living with dementia and their carers, 2018.
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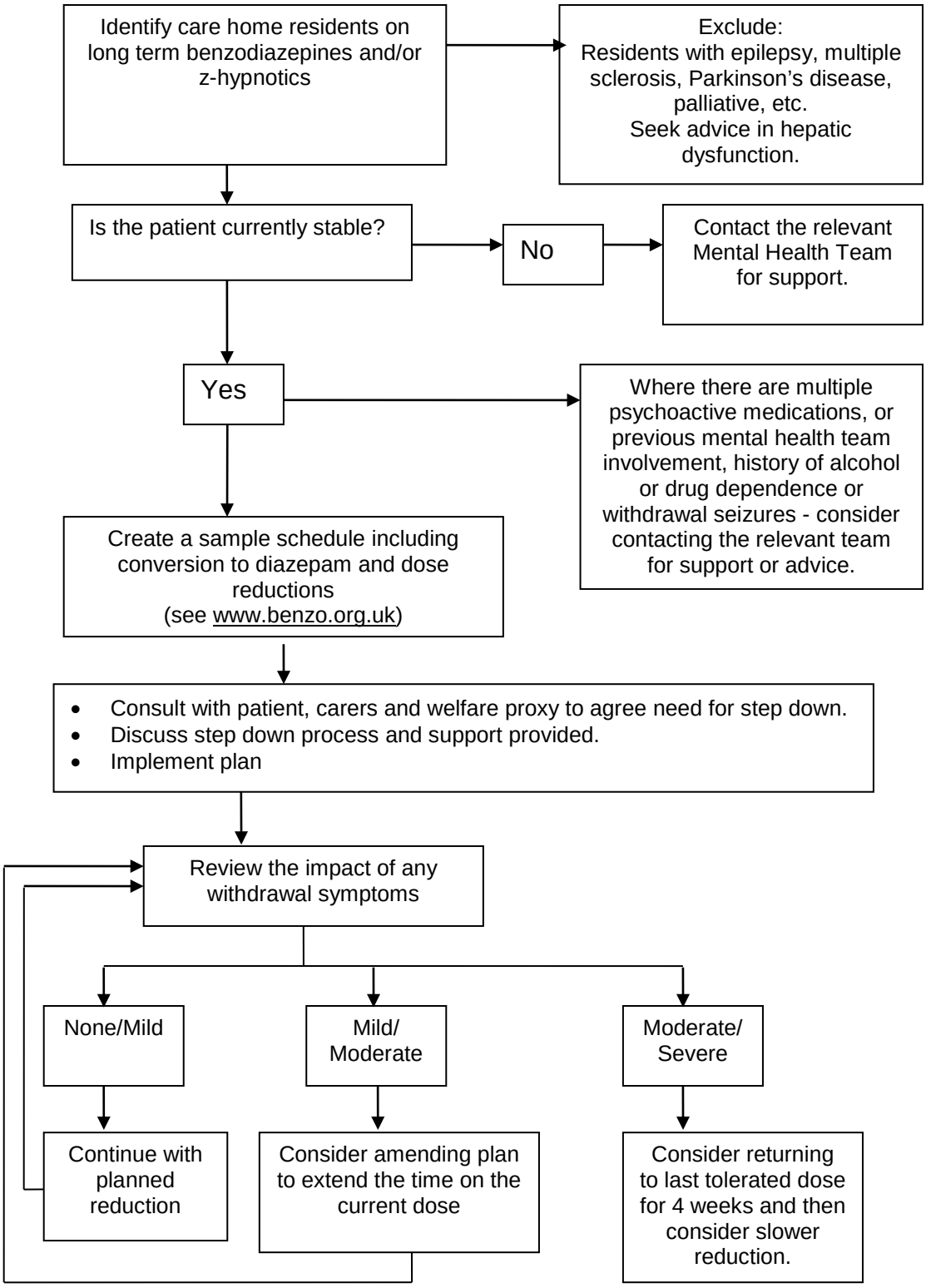
9. Glass J, Lanctôt KL, Herrmann N, et al. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. 2005;331:1169.
10. Ashton H. The Ashton Manual. Benzodiazepines: how they work and how to withdraw.

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



Cognitive Enhancers

For patients transitioning from their home to care home - consider if medication review is needed.

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 symptoms of stress and distress in dementia. 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. Do not routinely stop as benefits may be rapidly lost when treatment is interrupted and not fully regained when treatment is restarted,[1 2] 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.

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.[3]

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, or dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated.[4] 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 can result in a significant decline in cognitive function and symptoms of stress and distress in dementia.[1 2]

- 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 an assessment – Communication difficulties may limit the resident's capability to express hunger, thirst, discomfort or pain. Consider issues highlighted in Managing Symptoms of Stress and Distress in Dementia flow chart above.

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, with ongoing assessment and monitoring of function and cognitive decline. If any cognitive decline occurs increase dose back up to reduce further cognitive 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.

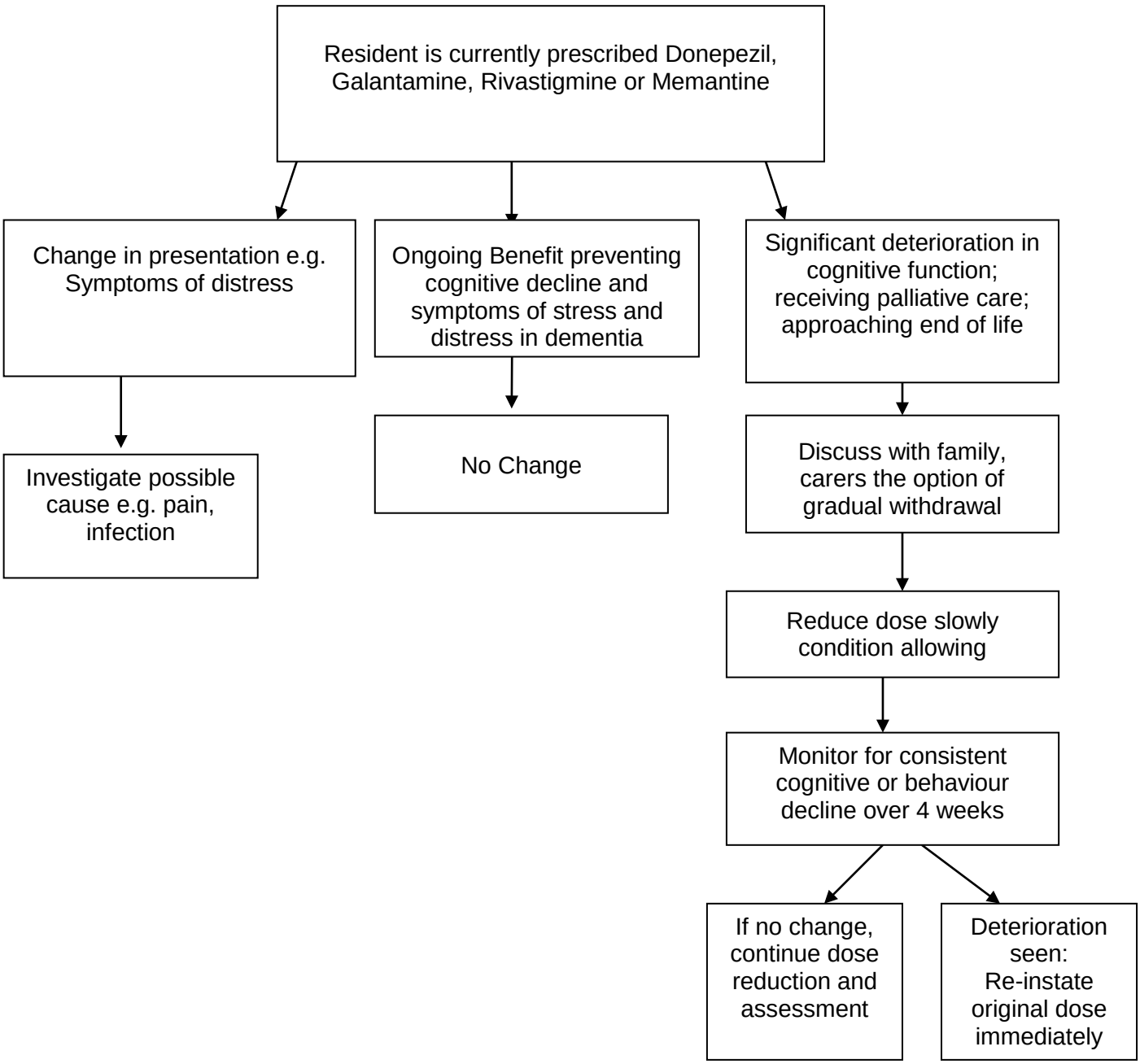
References

1. O'Brien JT, Holmes C, Jones M, et al. Clinical practice with anti-dementia drugs: A revised (third) consensus statement from the British Association for Psychopharmacology. Journal of Psychopharmacology 2017;31(2):147-68.
2. National Institute for Health and Care Excellence. Technology Appraisal Guidance 217: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease, 2018.
3. National Institute for Health and Care Excellence. NICE Guideline 71: Parkinson's disease in adults, 2017.
4. National Institute for Health and Care Excellence. NICE Guideline 97: Dementia: assessment, management and support for people living with dementia and their carers, 2018.

Resources

- British National Formulary. http://www.medicinescomplete.com
- Medicines Compendium UK. www.medicines.org.uk/emc
- My life with dementia: Dying well with dementia October 2012
- New dementia strategy for Scotland: Everyone's Story. 2023

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 symptoms of stress and distress in dementia. Use may very rarely be justified where other treatments are contraindicated or ineffective.

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 symptoms of stress and distress in dementia, 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 DM, Barnes TRE, Young AH. The Maudsley Prescribing Guidelines in Psychiatry. 14th ed. Chichester: Wiley Blackwell 2021.