

Optimising treatment and care for people with behavioural and psychological symptoms of dementia

A best practice guide for health
and social care professionals

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About this guide

This best practice guide has been developed in consultation with an advisory group of leading clinicians specialising in dementia. It aims to provide evidence-based support, advice and resources to a wide range of health and social care professionals caring for people with dementia who have behavioural and psychological symptoms. It has been designed to be a practical, informative tool, with an emphasis on alternatives to drug treatment.

These best practice principles and supporting materials are intended to be applicable to all professional groups, except in acute general hospital settings. We hope they will be helpful to practitioners in environments where this aspect of clinical practice will increasingly come under scrutiny. For practitioners who are specialists or who require information beyond the scope of this document, links to additional resources are provided (see 'Resources' on page 24).

'Getting prescribing right for people with dementia, who are among the most vulnerable in our society, is a clinical imperative. A proper assessment and a thorough understanding of the role of the array of interventions available for people with dementia is essential so the correct and safest treatment can be delivered. We hope that this guidance will help achieve that aim.'

**Professor Alistair Burns,
National Clinical Director for Dementia
in England, Department of Health**

'The potential serious adverse events associated with antipsychotics in people with dementia has become increasingly evident over the last decade. Achieving a change in prescribing practice has been challenging because of the complex issues involved in the treatment of behavioural and psychological symptoms in people with dementia. The political imperative to reduce antipsychotic use has been extremely important, but it is vital that this is achieved within a context that enables better overall management and treatment of symptoms as well as responsible and safe prescribing of antipsychotics and other psychotropic drugs when indicated. Alzheimer's Society hopes that this best practice guide provides a practical, evidence-based framework to support health and social care professionals to provide the best available treatment and care for people with dementia.'

**Professor Clive Ballard,
Director of Research, Alzheimer's Society**

The advisory group was co-chaired by Professor Alistair Burns and Professor Clive Ballard. Dr Anne Corbett, Research Communications Manager at Alzheimer's Society, led the development of the resource with Alistair Burns and Clive Ballard based upon the recommendations and feedback of the advisory group.

Advisory Group: Clive Ballard, Sube Banerjee, Nina Barnett, Donald Brechin, Dawn Brooker, Alistair Burns, Peter Connelly, Anne Corbett, Jane Fossey, Clive Holmes, Julian Hughes, Gill Livingston, Deborah Sturdy, Simon Wright

Introduction

This guide has been designed to support health and social care professionals to determine the best treatment and care for people experiencing behavioural and psychological symptoms of dementia (BPSD).

There are currently 750,000 people with dementia in the UK, approximately one third of whom live in care homes. People with dementia experience a range of symptoms. Some can affect their behaviour, others are personal, inner experiences. These include agitation, aggression, hallucinations and delusions. There are many ways of describing this varied group of symptoms. For clarity and convenience they are referred to throughout this guide as 'behavioural and psychological symptoms of dementia' or 'BPSD', an umbrella term devised by the International Psychogeriatric Association.

More than 90 per cent of people with dementia will experience BPSD as part of their illness and nearly two thirds of people with dementia living in care homes are experiencing these symptoms at any one time. BPSD cause distress to the individual, add considerably to the stresses experienced by family and professional carers and can result in serious risks to the person and others. Many individuals experiencing these symptoms do not have the legal capacity to make informed decisions about their treatment. Care should therefore be taken to use this guide within the context of the Mental Capacity Act.

Good practice recommendations, such as the NICE dementia guidelines, recommend psychosocial interventions as the first line approach and emphasise the importance of assessing medical conditions and pain, which often underpin the development of these symptoms. The value of not rushing into treatment is also important, as many people with BPSD will experience significant improvement or resolution of symptoms over a 4–6 week period.

In practice, pharmacological interventions, and in particular antipsychotic medication, are often used as a first line treatment. While atypical antipsychotics do confer modest benefits in treating aggression and psychosis over 6–12 weeks, they are associated with a number of major adverse outcomes and side-effects including sedation, parkinsonism, gait disturbance, dehydration, falls, chest infections, accelerated cognitive decline, stroke and death.

It was estimated in a report for the Department of Health that 180,000 people with dementia are receiving antipsychotic drugs in the UK.

The consequences include 1,800 additional strokes and 1,600 additional deaths each year in the UK among people with dementia.

Although there are many principles of good practice outlined in numerous guidelines, these documents are lengthy and often lack the practical detail required to enable implementation by clinicians.

This guide aims to provide a simple and practical pathway to enable the implementation of the principles outlined in best practice guidelines for the treatment of BPSD in everyday clinical settings. It has been designed to be used for reference where needed. It is not intended for use in acute general hospital settings.

Ninety per cent of people with dementia will experience BPSD

How to use the toolkit

The toolkit follows a basic stepped care model based on a colour-coded traffic light system. The traffic light colours represent:

	Green – No symptoms. Simple preventative measures	Prevention
	Amber – Mild or moderate symptoms. Low intensity, general interventions	Watchful waiting
	Red – Severe symptoms. Specific interventions and guidance for antipsychotic use	Specific interventions Antipsychotic prescription

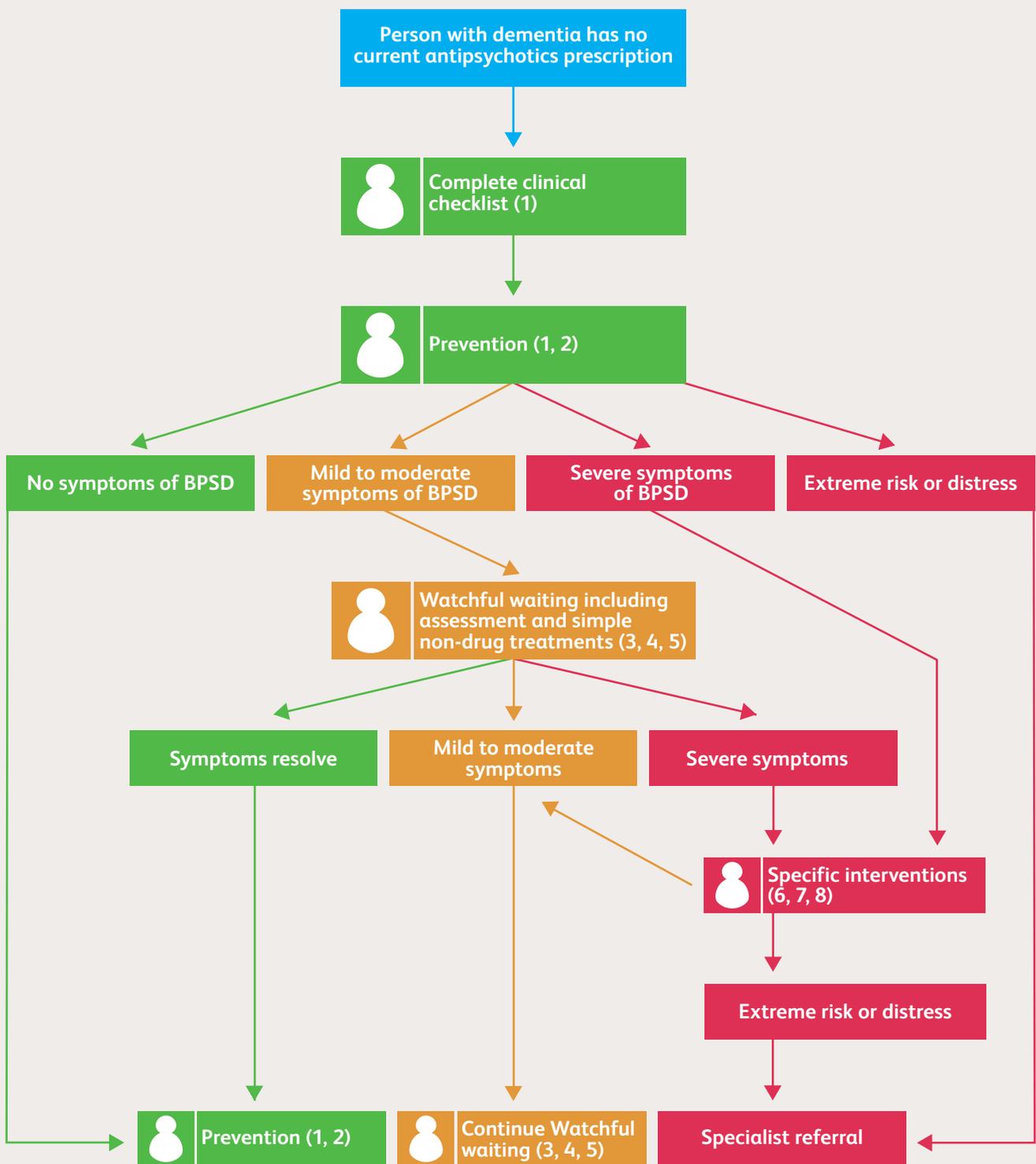
Two simple flow diagrams are provided to be used depending on whether the person with dementia is already prescribed antipsychotics or not. The flow diagrams should be used to determine the best care and treatment for each person with dementia. Additional guidance, charts and care plans are colour coded and numbered for use in each corresponding step if needed.

A list of further resources and full referencing for this guide is available at alzheimers.org.uk/bpsdguide

**Around one quarter
of people in care
homes are on an
antipsychotic drug**

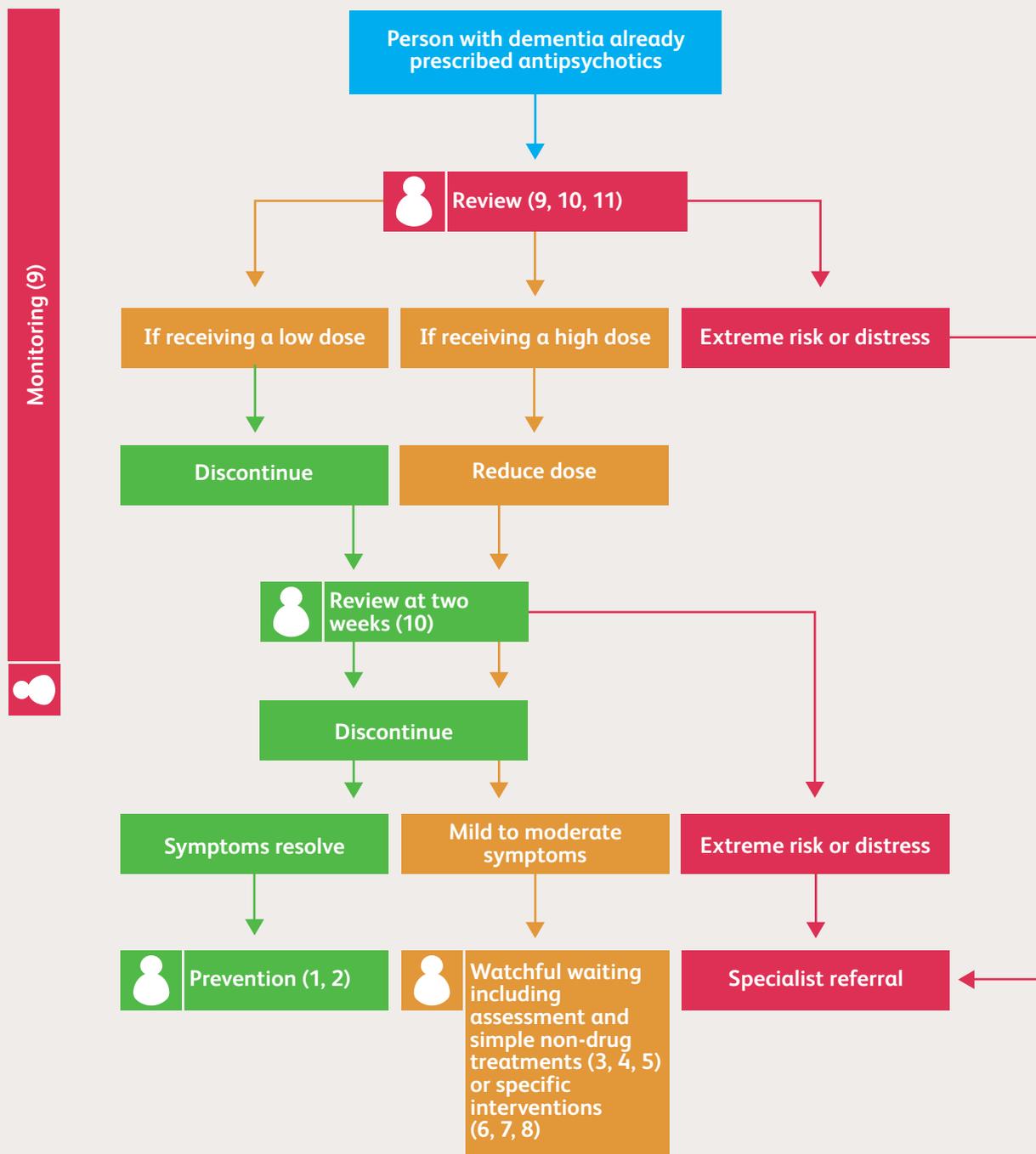
Pathway for a person who does not have a current antipsychotic prescription

Numbers in brackets refer to the numbered guidance and charts contained in this guide.



Pathway for a person who has already been prescribed antipsychotic drugs

Numbers in brackets refer to the numbered guidance and charts contained in this guide.





Prevention Clinical checklist

This checklist should be completed for each person with dementia.
Keep this chart with the person's corresponding paperwork.

Name:

Current diagnosis:

General symptoms

Include known symptoms and information based on person-centred care (see 2: Prevention guidance)

A recommended rating scale is the Clinical Global Impression of Change (CGIC) Scale (Appendix 1). If completed, enter score here:

Other symptoms

Note any other significant symptoms in the relevant box. Optional rating scales are suggested for information (see 'Resources' on page 24).

Pain (Scale: Pain Rating Chart)

Depression (Scale: Cornell Scale)

Neuropsychiatric symptoms (Scale: Neuropsychiatric Inventory)

Delirium and confusion (Scale: Confusion Assessment Method)

Other relevant health problems

Signed:

Date:



Prevention Guidance

People with dementia often experience behavioural and psychological symptoms (BPSD). Many people are prescribed dangerous antipsychotic drugs. However, there are a number of simple approaches that may prevent these symptoms from developing before medication needs to be prescribed.

This guidance outlines the key steps to take to actively prevent symptoms.

Medical review

A thorough medical review is essential to detect any general health problems that could impact on the person's quality of life, well-being or other symptoms. In particular, pain can be a major trigger for agitation and aggression, and infections (eg urinary tract infection) can increase a broad range of BPSD. Other key triggers include dehydration, constipation and malnourishment. A record should also be kept of any clinically significant behavioural symptoms.

For each person with dementia complete:

- a medical review (including medication review)
- the checklist for specific clinically significant symptoms (see 1: Prevention – Clinical checklist).

Understanding of dementia

It is important that all care staff are aware and understand the needs of a person with dementia, including aspects of person-centred care (see overleaf). Dementia affects people in different ways, causing a broad range of symptoms. This means that there is not a 'one-size-fits-all' care strategy.

Different types of dementia may also require different approaches to treatment depending on the symptoms and types of drugs that are suitable for that type of dementia.

It is also important to recognise that behavioural and psychological symptoms are not 'bad behaviour' on the part of the person. These symptoms are often associated with chemical changes in the brain or by social and environmental triggers. Simple adjustments to social interactions and environment can make a difference.

Recognition of triggers and early signs

Recognition of triggers and early signs that may precede behavioural and psychological symptoms is crucial. In most cases developing simple approaches to address these early signs can help prevent symptoms from developing at all. Key signs to look out for are:

- pain, discomfort, malnourishment, dehydration, boredom and physical illness – these are very common triggers which are often overlooked
- stress, irritability, mood disturbance and suspiciousness
- increased levels of distress
- early signs may be noticed at certain times of the day and may indicate a specific trigger.
- although not the most common trigger, it is important to be aware of any signs of abuse or neglect.

Pharmacological treatments

Acetylcholinesterase inhibitors (Aricept, Exelon, Remyntyl) and memantine are licensed for mild – moderate and moderate – severe Alzheimer's disease, respectively. There is some evidence that both groups may delay the onset of BPSD, providing additional benefit to using these currently available treatment options.

Pain is one of the most common causes of BPSD



Prevention Guidance

Person-centred care

This approach to care is based on understanding the person's history and experiences (their work, life, hobbies, family, environment and religious beliefs) their likes and dislikes, and taking their perspective into account. It is also important to ensure that the person has the opportunity for human contact and warm relationships with others. Key questions to ask are:

- Is the person treated with dignity and respect?
- Do you know about their history, lifestyle, culture and preferences?
- Do the carers try to see the situation from the perspective of the person with dementia?
- Does the person have the opportunity for relationships with others?
- Does the person have the opportunity for stimulation and enjoyment?
- Has the person's family or carer been consulted?
- Does the person's care plan reflect their communication needs and abilities?

More detailed approaches to person-centred care are outlined in **4: Watchful waiting guidance**. Staff training in person-centred care can be helpful.

Physical environment

It is important to consider the person's environment and how it might affect them. Key questions to ask are:

- If the person is being cared for in a bed or chair, are they comfortable and free of pressure sores?
- Is the TV or radio playing something that the person can relate to and enjoy?
- If the person is mobile, can they move around freely and have access to outside space?
- Does the person recognise the environment as home? Does it contain things to help them feel at home?
- Could assistive technology be used to improve freedom or safety?
- Does the person have the correct eye glasses, and are they clean?
- Is their hearing aid turned on and working correctly?
- Is it too hot or too cold?
- Is the person hungry? People may forget to eat.

Sudden emergence of BPSD often has a physical trigger. Longer onset emergence can be linked to depression



First line interventions, ongoing assessment and **watchful waiting** Clinical checklist

Watchful waiting is an active process over four weeks involving ongoing assessment of contributing factors and simple non-drug treatments. It does not mean 'doing nothing'. A high proportion of people with dementia who have behavioural and psychological symptoms experience significant improvement over four weeks with no specific treatment. Watchful waiting is the safest and most effective therapeutic approach unless there is severe risk or extreme distress. This checklist will give you some ideas for assessment and non-drug treatments that can further improve the likelihood of a favourable outcome during watchful waiting.

Name:

Current diagnosis:

General symptoms

Include known symptoms and information based on person-centred care
(see 4: Watchful waiting guidance)

A recommended rating scale is the Clinical Global Impression of Change (CGIC) Scale (Appendix 1). If completed, enter score here:

Other Symptoms

Note any other significant symptoms in the relevant box. Optional rating scales are suggested for information (see 'Resources' on page 24).

Pain (Scale: Pain Rating Chart)

Depression (Scale: Cornell Scale)

Neuropsychiatric symptoms (Scale: Neuropsychiatric Inventory)

Delirium and confusion (Scale: Confusion Assessment Method)

Other relevant health problems

Signed:

Date:



First line interventions, ongoing assessment and **watchful waiting** Guidance

Medical review

Any person showing onset of BPSD should receive a full medical review.

Person-centred care:

The first approach for behavioural and psychological symptoms is to develop a simple **Clinical care plan (5)** for simple non-drug treatments based on person-centred care. It is important to design the plan around the person's needs, abilities and interests. Key considerations are:

- Do the carers understand how the person is feeling? Are plans based on their point of view?
- What are the person's preferences and opinions?
- Consider the person's relationships with others. How are these supported?
- Do the carers help the person to feel socially confident and not alone?
- How is the person included in conversations and care?
- How are they shown respect, warmth and acceptance?
- Are the person's fears recognised and addressed?
- What are their life history, culture and interests?
- Do they have any sensory problems (eg with hearing or sight)?
- Do they have communication problems?
- Do they have any physical needs or mobility issues?
- Have carers considered ways to help them with perceptual or memory problems?

Working with carers or care staff to develop a specific person-centred care plan and activity program can make a substantial difference.

Consult with the family

It is essential to discuss the person's symptoms and possible treatments with their family or carer. They may be able to shed light on the reasons for their symptoms and ways to engage them in activities.

Soothing and creative therapies

Although there is not necessarily a robust evidence base to support them, aromatherapy and massage can help to soothe, as can warm towels or smells of cooking, or having one's hair brushed or a manicure. Music can help improve a person's mood. Music from the past can bring back good memories. Singing and dancing can energise people and lift spirits. It may be helpful to try these if they are available in the care setting.

Simple non-drug treatments

These might include:

- developing a life story book
- frequent, short conversations (as little as 30 seconds has proven effective)
- using personal care as an opportunity for positive social interaction.

Sleep hygiene

It may help to consider:

- reducing daytime napping
- increasing activities during the day
- agreeing realistic expectations for sleep duration.

Most BPSD will stop after four weeks without pharmacological treatment



First line interventions, ongoing assessment and **watchful waiting** Clinical care plan (week 0)

This chart should be completed when mild to moderate behavioural and psychological symptoms appear. This should be accompanied by a medical review and used alongside 4: Watchful waiting guidance.

Name:

Current diagnosis:

Week 0

What are the symptoms?

How severe are they?

Mild

Moderate

Severe

What are the risks:

to the person

to others

How distressed is the person?

How would the person benefit if these risks were addressed?

What watchful waiting tools are in place for the care plan?

Watchful waiting assessment completed (give brief summary of outcome of assessment)

Brief summary of watchful waiting care plan (based on 4: **Watchful waiting guidance**)

What would be a sign of improvement for this person (to be used as an outcome measure)?

What is the plan for further review and support?

Signed:

Date:



First line interventions, ongoing assessment and **watchful waiting** Clinical care plan (week 1–4)

Weeks 1–4: Progress log

This space is for staff to enter notes on interventions and any changes in behaviour.

Week 2: Clinician review completed

Signed:

Date:

Week 4

Have the symptoms improved? Has the sign of improvement (identified at week 0) been seen?

Is there any risk to the person or to others? Has this improved or worsened during watchful waiting?

Is the person distressed? Has this improved or worsened during watchful waiting?

What is the ongoing care plan?

- Prevention
- Referral
- Continue watchful waiting (give details of plan):

Signed:

Date:



Specific interventions Clinical checklist

If behavioural and psychological symptoms have not improved through watchful waiting it is appropriate to try a specific intervention that is more tailored to the individual. This Clinical checklist should be completed using the Specific interventions guidance (7) followed by the development of a Clinical care plan (8).

Name:

Current diagnosis:

General symptoms

Include known symptoms and information based on person-centred care
(see 7: Specific interventions guidance)

Summary of risks and distress:

A recommended rating scale is the Clinical Global Impression of Change (CGIC) Scale (Appendix 1). If completed, enter score here:

Other symptoms

Note any other significant symptoms in the relevant box. Optional rating scales are suggested for information (see 'Resources' on page 24).

Pain (Scale: Pain Rating Chart)

Depression (Scale: Cornell Scale)

Neuropsychiatric symptoms (Scale: Neuropsychiatric Inventory)

Delirium and confusion (Scale: Confusion Assessment Method)

Other relevant health problems

Signed:

Date:



Specific interventions Guidance

If symptoms persist after watchful waiting it is appropriate to attempt specific interventions. Psychosocial interventions should be attempted before any pharmacological treatment is recommended.

Medical review

All people with persistent BPSD should receive a full medical review.

Psychosocial interventions

Psychosocial interventions are more tailored, systematic approaches to person-centred care (than those outlined earlier in watchful waiting).

The following steps should be taken to develop a **Specific intervention care plan (8)**:

- Complete medical and mental health review including **6: Clinical checklist**
- Consider all aspects of person-centred care (see **4: Watchful waiting guidance**)
- Consult with family or carers on the best approach
- Design specific interventions (the brief and simple approaches below have been shown to be effective and can be administered by care staff with support from any clinician)
- Consider whether care staff require specific dementia training (person-centred care training for staff can reduce antipsychotic use and improve agitation).

Improving social interactions

Brief psychosocial therapies help to engage people in ways that they find interesting and enjoyable. These should generally include 10–30 minutes of daily one-to-one conversation or activity based on the person's interests, hobbies, history and ability, and feedback from their carer and/or family.

Promoting positive activities and exercise

Evidence indicates that exercise and promotion of pleasant events improves physical function, cognition and mood. A range of ideas for this are presented in the Seattle Protocols (See Resources on page 24). Some options include:

- exercises – gentle stretching, strength training, balance and endurance
- pleasant activities – build an understanding of the person's likes and interests to engage them in the exercise or activity
- problem-solving – asking the person to suggest ways to make their exercise activity more enjoyable or effective.

Personalised activities

Create a menu of pleasant activities that are tailored to the person and that can be completed with care staff. For example:

- looking at photographs or pictures from their past
- playing specific games or doing puzzles
- creating a scrap book or similar simple craft project
- going for a walk.

Specialist psychosocial interventions

There is good evidence for the value of specific interventions delivered by a clinical psychologist or equivalent health professional. Appropriate approaches include the Antecedent Behaviour Consequence (ABC) approach to develop individualised intervention plans. These approaches are effective but require specialist referral.

Two thirds of people in care homes have dementia



Specific interventions

Guidance (continued)

Pharmacological treatments

The following pharmacological approaches could be attempted if appropriate for the symptoms (based on **6: Clinical checklist**).

Depression

The effectiveness of pharmacological treatment for depression in people with dementia has not been established. Evidence shows positive events and exercise are effective for mild to moderate depression. For severe depression pharmacological treatment may be appropriate.

Citalopram 10 mg/day (max 20 mg/day)*

Sleep disturbance

When sleep disturbance is the main problem and sleep hygiene measures have failed, short term treatment (4 weeks) with a hypnotic such as Zopiclone (3.75 mg/day (max 7.5 mg/day) or Zolpidem (5 mg/day) can be helpful. However, this is only supported by anecdotal evidence.**

Agitation, aggression and psychosis

Where all other specific interventions have been unsuccessful and symptoms are causing extreme distress or risk, a trial of pharmacological treatments specifically targeted at behavioural and psychological symptoms may be attempted. There is only very preliminary evidence for the benefit of non-antipsychotic drugs although they may have a better safety profile (see reference 14).

Analgesic

Based on assessment of pain, Paracetamol 1g (up to 4 times a day)***

Alzheimer's treatments

There is evidence that acetylcholinesterase inhibitors (Aricept, Exelon, Reminyl) and memantine may improve cognition in people with agitation. Evidence indicates that acetylcholinesterase inhibitors do not specifically improve agitation.

Antipsychotic

Risperidone is the only antipsychotic licensed for people with dementia. License indication states that risperidone should be used for no longer than six weeks before review or specialist referral. NICE guidance states similar principles but gives a maximum treatment time of 12 weeks. A cardiac risk assessment is recommended prior to starting a prescription.

- Start dose 0.25mg (250 micrograms) twice a day
- Minimum therapeutic dose 0.5mg (500 micrograms) twice a day
- Maximum dose 1mg twice a day****

It is important to work up to a therapeutically effective dose from a low starting dose.

Caution: antipsychotics should not be used in someone with Lewy Body Dementia (LBD) without specialist advice.

Alternative antipsychotic drugs include olanzapine, aripiprazole and quetiapine. The evidence relating to these drugs is more limited. Of particular note, evidence shows that quetiapine is ineffective in treating behavioural and psychological symptoms in dementia and cholinergic side-effects may be a particular concern.

Other than treatments highlighted in reference 14, pharmacological options (eg benzodiazepines) carry no evidence of benefit and may increase other adverse events such as falls.

* Preliminary evidence of benefit in two RCTs, even in absence of depression

** Increased risk of renal and hepatic impairment, and confusion.

*** Evidence from RCT of stepped analgesic treatment in agitation

**** Substantially more severe side-effects



Specific interventions

Clinical care plan (Week 0)

Name:

Current diagnosis:

Week 0

What are the symptoms?

What are the risks:

to the person

to others

How distressed is the person?

Why does this level of risk and distress require a specific treatment?

How would the person benefit if these risks were addressed?

Medical review completed

Clinical checklist completed

Person-centred care assessed

Summarise outcome of person-centred care assessment:



Specific interventions

Clinical care plan (Week 0) continued

Main features of risk and distress:

Objectives of care plan (what would a sign of improvement be for this person?):

How will progress be measured?

What is the reason for selecting the intervention (specifically psychosocial v pharmacological)?

What safety monitoring is in place?

Signed:

Date:

If antipsychotic treatment is selected please refer to
9: Antipsychotics prescription – safety monitoring guidance.



Specific interventions

Clinical care plan (Weeks 6–12)

Week 6–12

Have the symptoms improved? Has the 'sign of improvement' (identified at Week 0) been seen?

Is there any risk to the person or to others? Has this improved or worsened during the specific intervention?

Is the person distressed? Has this improved or worsened during the specific intervention?

What is the ongoing care plan?

Watchful waiting

Referral

Continue specific intervention (give details of plan):

Signed:

Date:

If antipsychotic treatment is selected please refer to
9: Antipsychotics prescription – safety monitoring guidance.



Antipsychotics prescription

Safety monitoring guidance and Monitoring plan

Antipsychotic drugs are known to be harmful and can have severe side-effects. It is vital that any person prescribed these drugs is monitored for side-effects and progression of symptoms. This plan should be completed for each person with dementia when a prescription of antipsychotics is started.

Adverse effects of antipsychotic drugs

The most important adverse effects associated with antipsychotics are parkinsonism, falls, dehydration, chest infections, ankle oedema, deep vein thrombosis/pulmonary embolism, cardiac arrhythmia and stroke (highest risk in first four weeks of treatment).

Antipsychotics are also associated with increased mortality in the long term (often related to pneumonia and thrombo-embolic events) which can be caused by over-sedation and dehydration.

Weekly monitoring of sedation, fluid intake and early indicators of chest infection is strongly recommended.

Caution: antipsychotics should not be used in someone with Lewy Body Dementia (LBD) without specialist advice.

Name:

Current diagnosis:

Current prescription:

Monitoring by GP / practice nurse:

Daily monitoring by care staff:

Overall plan for monitoring and review:

Signed:

Date:



Antipsychotics prescription

Review guidance

All antipsychotic prescriptions should be reviewed at six and/or 12 weeks. Discontinuation should be default except in extreme circumstances. This guidance should be used when reviewing prescriptions and used to complete 11: Review chart overleaf.

Discontinuation of antipsychotics

Seventy per cent of people have no worsening of symptoms when antipsychotics are discontinued.

For those with worsening of symptoms the first four weeks are the most challenging but are often effectively managed with watchful waiting, preventing the need to restart antipsychotics. The risk of recurrence of behavioural and psychiatric symptoms after discontinuation may be more likely if:

- previous discontinuation has caused symptoms to return
- the person currently has severe symptoms.

If the person is receiving a low dose proceed directly with discontinuation and monitoring*

- Risperidone low dose = 0.5mg (500 micrograms)
- Olanzapine low dose = 2.5mg
- Quetiapine low dose = 50mg
- Aripiprazole low dose = 5mg

*This is suggested dosage. It is recommended to consult the BNF.

If the person is receiving a higher dose

taper the dose over one month

- Reduce to half dose for two weeks
- GP review at two weeks
- Discontinue immediately after a further two weeks

Unless there is severe risk or extreme distress the recommended default management is to discontinue the antipsychotic and monitor/assess using watchful waiting or specific interventions (see watchful waiting/specific interventions guidance (3, 4, 5, 6, 7, 8)).

If symptoms remain severe (with associated severe risk and/or distress) and further treatment with antipsychotics is considered clinically necessary, a referral to specialist services is advised. For ongoing safety monitoring refer to **9: Antipsychotics prescription – safety monitoring guidance and monitoring plan.**

At least 30 per cent of antipsychotic prescriptions could be reduced or stopped without any ill effects



Antipsychotics prescription Review chart

This chart should be completed for any patient prior to discontinuation or continued prescription of an antipsychotic. All prescriptions should be reviewed at six weeks (recommended) or 12 weeks.

Name:

Current diagnosis:

Current prescription:

What are the symptoms?

How severe are they?

Mild

Moderate

Severe

What are the risks:

to the person

to others

How distressed is the person?

How would the person benefit if these risks were addressed?

Clinical treatment decision:

Discontinue Continue prescription details:

What would be a sign of ongoing improvement or stabilisation for this person?

What is the plan for further review?

If antipsychotics are discontinued, what additional support is needed for the first four weeks of discontinuation?

Signed:

Date:

Resources

Assessment scales

A full range of assessment scales is available in *Assessment Scales in Old Age Psychiatry*, 2nd edition (2004) Editors: Alistair Burns, Brian Lawlor and Sarah Craig, Martin Dunitz: Taylor and Francis Group, London. Some of these scales will be available online free of charge but we recommend checking the copyright status before use.

Best practice guidelines

Dementia (CG42): Supporting people with dementia and their carers in health and social care (2006) National Institute for Health and Clinical Excellence. Available online at <http://egap.evidence.nhs.uk/CG42/>

Good practice in prescribing medicines – guidance for doctors. General Medical Council. Available online at www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp This document also includes guidance on off-license prescribing.

British National Formulary. Available at www.bnf.org

Intervention protocols for non-drug treatments

The Seattle protocols: www.ncbi.nlm.nih.gov/pmc/articles/PMC2518041/?tool=pubmed

Simple Pleasures: A multilevel sensorimotor intervention for nursing home residents with dementia (1999) Linda L. Buettner. Available by emailing rth@uncg.edu

For more information on the Simple Pleasures intervention: www.uncg.edu/rth/faculty/lindabuettner.html

Antecedent behaviour consequence (ABC) approach: www.specialconnections.ku.edu/cgi-bin/cgiwrap/speconn/main.php?cat=behavior§ion=main&subsection=fba/abc

Focussed intervention for training of staff (FITS) programme manual: Evidence-based approaches for improving dementia care in care homes. Jane Fossey and Ian James (2008). Available through Alzheimer's Society by emailing research@alzheimers.org.uk

Further interventions and key references are included in the reference list at www.alzheimers.org.uk/bpsdguide

Our partners

Alzheimer's Society is working with a number of organisations to reduce the use of antipsychotic drugs for the treatment of the behavioural and psychological symptoms of dementia:

Dementia Action Alliance

Dementia Action Alliance is made up of over 40 organisations committed to transforming the quality of life of people living with dementia in the UK and the millions of people who care for them.

www.dementiaaction.org.uk

Department of Health

The Department of Health is committed to improving the quality and convenience of care provided by the NHS and social services. Its work includes setting national standards, shaping the direction of health and social care services and promoting healthier living.

www.dh.gov.uk

Royal College of General Practitioners (RCGP)

The Royal College of General Practitioners (RCGP) is a membership body of family doctors committed to delivering excellence in general practice and patient care, in the UK and overseas.

www.rcgp.org.uk

Royal College of Psychiatrists (RCPsych)

The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the UK. The College sets standards and promotes excellence in psychiatry and mental health. It leads, represents and supports psychiatrists in the UK, and works with service users, carers and like-minded organisations.

www.rcpsych.ac.uk

Appendix 1 Watchful waiting When does it happen? chart

Name:

Current diagnosis:

Description of symptom/incident (including time of day and people present)

Any possible triggers?

Action taken:

Signed:

Date:

Description of symptom/incident (including time of day and people present)

Any possible triggers?

Action taken:

Signed:

Date:

Alzheimer's Society is the UK's leading support and research charity for people with dementia, their families and carers. We provide information and support to people with any form of dementia and their carers through our publications, National Dementia Helpline, website, and more than 2,000 local services. We campaign for better quality of life for people with dementia and greater understanding of dementia. We also fund an innovative programme of medical and social research into the cause, cure and prevention of dementia and the care people receive.

If you have any concerns about Alzheimer's disease or any other form of dementia, visit alzheimers.org.uk or call the **Alzheimer's Society National Dementia Helpline** on **0845 3000 336** or on **028 9066 4100** in Northern Ireland. (Interpreters are available in any language. Calls may be recorded or monitored for training and evaluation purposes.)

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