Minimising antipsychotic medicines for changed behaviours

* This guide is not intended to be used for the support of people with acute severe behavioural disturbance.

Stage One
Identify the target changed behaviour and **liaise with the prescriber**

1. **Exclude delirium/depression, adverse medicine effects or interactions, infection or pain by liaising with the prescriber**. Consider a medication review. Refer to appropriate guidelines to manage any identified causes.
2. If available, contact your in-house dementia specialist for advice regarding **first-line non-medicine** interventions. For further advice contact Dementia Support Australia (DSA) on **1800 699 799**.
3. **Review** and **amend** the current care plan and Behaviour Support Plan, ensuring a focus on individualised, person-centred care strategies.
4. Should these measures adequately support the person, **maintain** care provision using the amended care plan and Behaviour Support Plan, with regular **monitoring** and **review**.

Unresolved changed behaviour

If modification of care provision does not adequately support the person, **liaise with the prescriber**. Whilst antipsychotic medicine **may** be considered at this time; **non-medicine** approaches should be maintained throughout.

An antipsychotic medicine should only be considered for use in a person with dementia for:

a. Distressing psychosis or

b. A behaviour that is harmful/severely distressing to the individual or puts others at risk.

Most other symptoms are unlikely to respond to treatment with an antipsychotic medicine.

Remember: Non-medicine strategies must be trialled first and maintained throughout; antipsychotics are **NOT** first-line; use the **lowest effective dose** for the **shortest period of time**; use antipsychotics with **extreme caution** in people with dementia with Lewy bodies or Parkinson's disease dementia.

Stage Two
Suggested Plan: If an antipsychotic is to be trialled

1. Restrictive practices must only be used as a **last resort** and in the **least restrictive form.**
2. Where restrictive practices are used, approved providers must meet a number of conditions. Refer to the Aged Care Quality and Safety Commission website for the latest information.
3. Commence antipsychotic medicine using a **regular low dose** (refer to ***FOR PRESCRIBERS: STARTING AN ANTIPSYCHOTIC*** card).
4. **Monitor** for ongoing response and **potential side-effects** (refer to ***POTENTIAL SIDE-EFFECTS*** card):
   a. If **side-effects** develop **at any stage**, immediately contact the prescriber.
   b. **Maintain non-medicine** approaches: refer to allied health professionals.
5. **Review** after **2 to 4 days** for effectiveness:
   a. If no/inadequate response, contact prescriber and consider increasing the dose.
   b. If tolerated and effective, continue.
6. At **1 to 2 weeks**, prescriber to **review** for response and **side-effects**:
   a. If the antipsychotic is ineffective/not tolerated, **cease** it. Should an alternative antipsychotic be trialled, return to Step 1.
   b. If the antipsychotic is tolerated and effective, continue. **Monitor** for response and **side-effects**, **maintain non-medicine** approaches.
   c. Discuss and develop a **withdrawal** plan with the prescriber. Prescriber to initiate **withdrawal** plan; aiming to cease no later than **12 weeks** (refer to ***WITHDRAWAL PLAN*** card).
7. At **6 weeks**, prescriber to **review** for response and **side-effects**. Repeat Step 6a and 6b. Consider **withdrawal** if not already initiated.
8. At **12 weeks**, prescriber to **review** for resolution of the target changed behaviour.
9. If the target changed behaviour reoccurs after dose reduction or cessation refer to ***WITHDRAWAL PLAN*** card.
10. **REMINDER STICKERS** are available to assist; place them in the Communication Book or Resident Notes as appropriate.

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