Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide

This tool is designed to help providers understand, assess, and manage patients in primary care with behavioural and psychological symptoms of dementia (responsive behaviours), with a focus on antipsychotic medications. This tool integrates best-practice evidence with clinical experience, and makes reference to relevant existing tools and services wherever possible.

Important principles include:

- Being patient-centred,
- Being mindful of benefits, risks, and safety concerns,
- Using an interprofessional team approach and validated tools,
- Prescribing conservatively, and,
- Reassessing regularly for opportunities to deprescribe medications that are no longer needed.

As always, efforts must be made to individualize any treatment decisions for the patient, with consideration given to caregivers and family members.

Identify BPSD Symptom Clusters[1, 2]

Psychosis

Delusions
Hallucinations
Misidentification
Suspicious

Aggression

Defensive
Resistance to care
Verbal
Physical

Agitation

Dressing/undressing
Pacing
Repetitive actions
Restless/anxious

Depression

Anxious
Guilty
Hopeless
Irritable/screaming
Sad, tearful
Suicidal

Mania

Euphoria
Irritable
Pressured speech

Apathy

Amotivation
Lacking interest
Withdrawn

Overview of BPSD Management

Treatment for dementia is an ongoing process. Since dementia is a progressive disease, regular follow-ups are necessary to ensure that the patient is receiving the best possible treatment for his or her symptoms. The sections in this tool should each be ***considered*** at each follow-up (even if some of the treatments discussed, such as drug therapy, will not be necessary for every patient at every stage of treatment).

Section A: Evaluate BPSD

Before beginning any sort of treatment (e.g. drug or non-drug therapy), it is important to evaluate the patient's symptoms.

This section discusses:

- Tools for discussing and documenting BPSD
- How to use the P.I.E.C.E.S.™ tools to assess risks to the patient and others
- Clinical evaluations that should take place in order to identify any underlying physiological causes of BPSD

Section B: Initiate Non-Drug Therapy for BPSD

Non-drug therapy is an important part of managing BPSD, regardless of whether drug therapy is initiated. It is an ongoing process that involves the care team, family, and caregivers.

This section discusses:

- Safety, environmental, and caregiver approach considerations that are core components of non-drug therapy
- Possible solutions to behavioural symptoms, including those identified within the Dementia Observation System (DOS)

Section C: Consider Drug Trial(s)

In some cases, when non-drug therapy approaches alone are not sufficient to manage BPSD, it may be necessary to initiate drug therapy to manage symptoms.

This section discusses:

- Determining the best drug therapy to treat the patient's symptoms
- What symptoms are and are not likely to respond to antipsychotic therapy
- General principles for monitoring, documenting, and following-up on patients receiving medications

Section D: Additional Information on Antipsychotic Therapy

When BPSD are particularly distressing or disturbing, pose an imminent risk of harm to the patient or others, and are likely to respond to antipsychotics (see section C), it is sometimes beneficial to initiate antipsychotic therapy.

This section expands on the information about antipsychotics introduced in Section C, and includes:

- The benefits and harms of antipsychotic therapy
- A table comparing the efficacy of different antipsychotics for treating BPSD, some common side effects, and the cost of treatment
- General guidelines for assessing antipsychotics for possible deprescribing

Section A: Evaluate BPSD

Remember: *Engage the family/caregiver at every step. Discuss any history that may help the care team understand and manage the behaviour (e.g., preferences, activities, routine).*

1 Assess & Document

- Document **behaviour or symptom clusters**, including frequency, severity, triggers, and consequences
- Document any potential **reversible causes (e.g. delirium, depression)**
- Designate specific members of the care team or family who will be responsible for coordinating day-to-day assessment and management
- Standardized clinical assessment tools, such as the Antecedent, Behaviour, Consequence (ABC) Chart Form[3] and Dementia Observation Scale (DOS)[4] can be helpful for monitoring and documenting symptoms
- Examples of standardized clinical assessment tools can be found on **Page 7**

2 Identify Risks

- Use the **P.I.E.C.E.S.™ RISKS** mnemonic to assess risks to the patient and others:[9]
  Roaming: Is risk greater due to patient roaming?
  Imminent: Is significant risk imminent?
  Suicide: Does the patient display any suicidal tendencies?
  Kin: Is the health or safety of caregivers/family affected?
  Self-neglect: Is patient's self-neglect a risk to themself or others?
- Interview family/caregiver independently to ask about **family/caregiver strain and risk of abuse by patient**
- Be mindful of any suggestions of **patient abuse by family/caregivers**

3 Identify BPSD Causes

- Obtain **history** from caregivers, family, and friends[10]
- Consider environmental factors and triggers, including possible role of care team
- Consider using **P.I.E.C.E.S.™** to identify causes (see box on right)

4 Clinical Evaluation[10]

The differential diagnosis of the syndrome of behaviour change in dementia is broad. Careful examination of history, physical examination and appropriate investigations may help identify contributing factors. A full, rather than targeted, physical examination is indicated, **within the bounds of patient cooperation.**

History (include family/caregivers):

- ☐ Recent changes to environment, routine, sleep pattern, family/social situation
- ☐ **Medication Review:** Adherence, prescription and OTC medications, anticholinergic load, drugs that may increase agitation (e.g. cholinesterase inhibitors), medication induced hypotension or orthostatic hypotension, medication that may contribute to constipation and urinary retention, drugs and/or alcohol

Physical Examination:

Be mindful of sources of:

- ☐ Pain (e.g. dental, skin, joint, feet)
- ☐ Hydration (e.g. dehydration)
- ☐ Sensory loss (hearing, vision)
- ☐ CNS change (e.g. new stroke)
- ☐ Infection (e.g. pneumonia, urosepsis)
- ☐ Hypo-perfusion (e.g. new atrial fibrillation, heart failure)
- ☐ Constipation and urinary retention

Laboratory and Imaging (as guided by physical exam/history):

- ☐ **Blood:** Glucose, calcium, complete blood count (CBC), creatinine, electrolytes, TSH, others as appropriate
- ☐ **Urine:** Any urinary symptoms? (Note: Caution not to send urine for culture if no urinary symptoms or sudden change in status as "asymptomatic bacteriuria" without lower urinary tract symptoms or symptoms of urosepsis/bacteremia are rarely the cause of increased behavioural symptoms)
- ☐ **Imaging:** If appropriate (e.g. chest x-ray if suspected pneumonia based on physical exam; CT head if new concerning neurologic findings)

Use P.I.E.C.E.S.™ to Identify Causes[9]

Use the P.I.E.C.E.S. 3-Question Template™ to ask:

1. What has changed?
2. What are the **RISKS** and possible causes?
3. What is the action?

Consider...

Physical
think "the 5 Ds"

Delirium
Disease (cardiovascular, infectious, insomnia, metabolic, nocturia, renal, respiratory, sleep apnea, urinary retention, etc)
Drugs (e.g. acetycholinesterase inhibitors, anticholinergics, anticonvulsants, anti-Parkinson, benzodiazepines, digoxin, fluoroquinolones, lithium, opioids, systemic corticosteroid)
See Reference List of Drugs with Anticholinergic Effects[41]
Discomfort (e.g. pain, constipation, fecal impaction, urinary retention, hunger, thirst)
Disability (e.g. sensory loss)

Intellectual
think "the 7 As"

Amnesia (memory)
Aphasia (speech)
Apathy (initiative)
Agnosia (recognition of people or things)
Apraxia (purposeful movement)
Anosognosia (insight/self-awareness)
Altered Perception (sensory information)

Emotional
think "the 4 Ds"

Disorder Adjustment (e.g. related to losses)
Disorders of Mood (e.g. depressive symptoms, anxiety)
Delusional (e.g. suspiciousness, psychosis)
Disorders of Personality

Capabilities

Capability too low to meet demands of environment (catastrophic reactions) or not utilized enough (boredom)
Maximize remaining strengths; avoid unnecessary disability

Environment

Consider over-/under-stimulation, relocation, change in routine, noise, lighting, colours, social interactions with caregivers/others

Social

Consider social network, life story, cultural/spiritual heritage

Section B: Initiate Non-Drug Therapy for BPSD[11, 12, 13]

Tips for Successful Non-Drug Therapy

- As a general principle, individualize your approach as much as possible. Behavioural triggers and effective ways to treat them will vary from one patient to the next.
- Take advantage of any available system supports, such as the Alzheimer's Society of Canada's First Link program.[14]
- Even if non-drug therapy is successful at managing symptoms (i.e. drug therapy is unnecessary), monitor targeted behaviours for changes and follow-up regularly based on the needs of the patient/caregiver and severity of symptoms.

Safety

- Ensure the patient's safety and the safety of others
- Make sure you are safe (exit near, chair between you and patient)
- Remove ongoing triggers
- Remove potentially dangerous objects
- Educate caregivers in safe approach and indications of need to withdraw for safety

Environmental Considerations

Eliminate misleading stimuli

- Clutter, TV, radio, noise, people, reflections in mirrors/dark windows, pictures/décor, patterned floors

Reduce environmental stress

- Extra/new people, holiday decorations, overhead glare, temperature control, privacy
- Avoid unsafe furniture and fixtures (sharp edges, hot water pipes, etc.)

Adjust stimulation

- If over-stimulated, reduce noise, activity, confusion

Enhance function

- Increase lighting, to reduce misinterpretation

Adapt the physical setting in order to prioritize patient comfort

- Discrete safety features (hand rails, grab bars, etc.)
- Promote an environment that encourages the involvement of family and friends (comfortable and close seating, family/caregiver resources)
- Provide familiar and comforting items such as photo albums, favourite music, magazines

Caregiver Approach Considerations

Personal approach

- Be calm and compassionate (use/avoid touch as indicated)
- Distract by engaging in individualized activities
- Focus on patient's wishes, interests, concerns
- Approach slowly; look for signs of increased agitation
- Approach patient's private space slowly and ask permission prior to entering
- Withdraw and re-approach later if patient becomes distressed

Daily routines

- Keep to the same routine to reduce uncertainty; use cues (e.g. music or song) specific to each of the day's major activities as prompts
- Use long-standing history and preferences to guide
- Individualize social and leisure activities to reduce boredom

Communication style

- Most communication is non-verbal, use positive non-verbal cues
- Make eye contact unless perceived as aggressive
- Use short simple words and phrases (patients with dementia have trouble processing multiple words or complex grammar)
- Speak clearly and use a positive tone
- Wait for answers (be patient)

	Behaviour	Possible Solutions
DOS Colours*[4]	**Noisy** (Yellow)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Restless (Orange)	• Distract, engage • Adapt environment to reduce ex-it-seeking, physical exercise, outdoor activities
	Exit-seeking (Brown)	• Distract, engage • Adapt environment to reduce exit-seeking, physical exercise, outdoor activities • Register the individual with MedicAlert and Alzheimer's Society Safety Home program (contact information will be on bracelet or necklace) • Hide exits with curtains, or paint a black circle on the floor (the individual will think it is a hole and will not exit)
	Verbal aggression (Pink)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Physical aggression (Red)	• Distract, keep calm, remain warm and supportive • If possible, give the person some space and try to approach later
Other	**Delusion/ hallucination**	• Understand this is their reality and do not confront the false belief • Focus efforts on how the patient feels, not the content; offer distraction, avoid clutter, TV, radio
	Agitated/ irritated	• Calm, soothe, distract • Individualized music, aromatherapy, pet therapy, physical exercise, outdoor activities
	Resistant to care	• Identify source of threat (e.g. pain); change routines and approaches
	Repetitive questions/ mannerisms	• Reassure, address underlying issue, distract • Put the answer to the same repetitive question on a piece of paper or card and ask the patient to read the card instead
	Hoarding	• Remove items gradually, re-organize and clear paths in the case of emergency; be compassionate
	Inappropriate behaviour (e.g. disrobing, masturbation, verbally inappropriate,)	• Distract, re-direct • Keep an active and regular schedule to avoid boredom • Try increasing the level of appropriate physical attention • Provide personal space if possible and come back when the patient is calmer • Allow the individual privacy for intimate/personal activities

*DOS = Dementia Observation System (Colours used in table are taken from the DOS system, though you may use different colours in your practice)

Section C: Consider Drug Trial(s)

1 Ensure Drug Trial is Necessary

- Treat underlying causes (e.g. pain, constipation, delirium)
- Ensure that non-drug therapy options have been attempted, and have been unsuccessful

Note: In acute BPSD, if there is a safety risk to patient or others, there may not be time to try non-drug approaches before trying pharmacological management.

2 Select Appropriate Drug Trial

- Select an appropriate drug based on symptoms (see chart at right)
- Identify which behaviour(s) you wish to target (e.g. see symptom clusters on cover page and to right)

- **If you are considering initiating antipsychotic therapy, first ask:**
  a. Are symptoms likely to respond to antipsychotics? (see below right)
  b. Is there imminent risk of harm to self and/or others?
  c. Are symptoms particularly disturbing, distressing or dangerous?
  d. Have you weighed the potential benefits and harms? (see page 6)
- See page 6 for a detailed comparison of antipsychotics

- Obtain and document informed consent (see Psychotropic Medication Consent Discussion Tool)[19]
- Start with a low dose, and gradually titrate as necessary/tolerated

3 Maintain and Review

- Monitor change in targeted behaviour as well as side effects (see DOS Tool)[4]
- Assess over 1-3 weeks, documenting any benefits and harms realized. If lack of response and/or tolerability, adjust therapy. Increase dose (if not yet maximized) or taper/discontinue[15]
- Continue to reassess on an ongoing basis for effectiveness and tolerability
- Consider dose reduction or discontinuation if the drug:
  a. Is not effective,
  b. Has intolerable side effects, or;
  c. Behaviours have been manageable and stable for 3-6+ months[17]
- **If considering dose reduction/discontinuation for an antipsychotic, see "Reassessing Antipsychotics for Possible Deprescribing" on page 6**

4 Follow-Up

- Follow-up is important for any drug regimen
- **If antipsychotics used, reassess need at least every 3 months** [16]

5 Consider Referral to a Specialist if Drug Trial is Unsuccessful

- If symptoms persist or worsen, consider referral to a specialist

6 Continue Non-Drug Approaches

- Continue using non-drug approaches to prevent further BPSD symptoms

Tips for Drug Trials and Deprescribing

- In all drug trials, unless clinically indicated, start at a low dose and increase or decrease slowly.
- For more tools and resources, visit effectivepractice.org/dementia.
- For more information about antipsychotic deprescribing, including a deprescribing algorithm, visit deprescribing.org.

Selecting an Appropriate Drug Therapy for the Patient's Symptom(s)

Behaviour	Drug Therapy
Psychosis, Aggression, Agitation (severe)	• Atypical antipsychotics (such as risperidone, aripiprazole, olanzapine, quetiapine as discussed in detail on **page 6**)[10,14]
Agitation (severe), unlikely to respond to antipsychotics	• SSRIs such as citalopram or trazodone (however, evidence is lacking for trazodone)[15, 16,44]
Agitation (severe) in Lewy Body Dementia or Parkinson's	• Possible cholinesterase inhibitors • Very low dose quetiapine[15, 16]
Anxiety (short term/ intermittent)	• A short-acting benzodiazepine such as lorazepam prior to anxiety provoking events such as bathing[17]
Anxiety (chronic)	• Antidepressants (such as SSRIs, SNRIs) • Buspirone[10]
Depression (severe)	• Antidepressants such as SSRIs (e.g., citalopram, sertaline), SNRIs (e.g., venlafaxine, duloxetine), other antidepressants (bupropion, mirtazapine, moclobemide) • Secondary TCAs (nortriptyline or desipramine) may be suitable if coexisting indication like neuropathic pain, etc., but caution regarding anticholinergic load, etc.[10, 16, 18]
Mania	• Addressing any possible drug causes is of primary importance • Evidence for specific recommendations lacking • Mood stabilizers are an option, but take caution regarding tolerability and drug interactions
Apathy	• Limited role for drug therapy but sometimes cholinesterase inhibitors may be helpful • Methylphenidate also sometimes used, but limited by concerns such as stimulant effect on behaviour and risk of diversion[15, 18]

Symptom Likelihood to Respond to Antipsychotic Therapy

Cluster	Likely	Unlikely
Psychosis	• Delusions • Hallucinations • Misidentification • Suspicious	
Aggression	• Defensive • Physical	• Verbal • Resistance to care
Agitation	• Restless/anxious	• Dressing/undressing • Pacing • Exit seeking[17] • Repetitive actions[45-47]
Depression	• see below*, **	• see below*, **
Mania	• see below*	• Euphoria [46-48] • Irritable [46-48] • Pressured speech
Apathy[46,48,49]		• Amotivation • Lack of interest • Withdrawn
Other		• Hiding or hoarding[45] • Wandering without aggression[17,45] • Disinhibition (e.g., sexual)[45-47]

* The role of antipsychotics in those with dementia and depression is beyond the scope of this evidence review.
**In cases where depression treatment may be indicated, consider psychiatric consultation to determine appropriate pharmacotherapy options.

Section D: Additional Information on Antipsychotic Therapy

Potential Benefits and Harms of Antipsychotic Therapy

Potential benefits tend to be over-appreciated, while harms are underappreciated. Nevertheless, when harmful behaviours are severe and distressing, an antipsychotic trial may be reasonable.

Antipsychotics: Potential Benefits	**Antipsychotics:** Potential Harms
Limited benefit: modest improvement seldom observed • **effect size:** 0.12-0.2 • **NNT variable**: ~5-14 (i.e. at best, compared to placebo, antipsychotic therapy results in targeted behaviour benefit in 1 out of 5 people treated)[20, 21]	**Side effects:** sedation, falls, postural hypotension, QT prolongation, confusion, EPS (rigidity, stiffness, akinesia), tardive dyskinesia, diabetes, weight gain[22, 23] **Stroke:** increased risk **Death:** possible increase Health Canada Advisory noted a 1.6 fold increase in mortality (mostly related to heart failure, sudden death, pneumonia). Some data suggests that there will be 1 extra stroke or death for every ~100 people treated (NNH=100).[24, 25, 26]

KEY: **EPS:** extrapyramidal symptoms (Parkinson's-like); **NNT:** number needed to treat to see one extra benefit; **NNH:** number needed to treat to see one extra harm

Comparison of Antipsychotics [20, 21, 30, 31, 32, 33, 34]

Many effects are dose dependent and direct comparisons are limited. Thus, the following table is intended only as a general guide.

	Drug **Generic** (Brand)	Efficacy or evidence in BPSD therapy	↑ BP[32]	Ach	Sedation	EPS	TD[33]	Diabetes	Weight Gain[27]	Usual Dose	$/Month
Atypicals	**Risperidone*** (Risperdal)[25, 26, 34]	• Indicated for severe dementia of the Alzheimer type (Health Canada) • Evidence for efficacy in agitation, aggression & psychosis	++	++	++	++	+	++	↑↑↑ (0.7lb/ month)	0.125mg – 2.0mg/d QHS (or divided BID)	$10-27
Atypicals	**Olanzapine*** (Zyprexa)[25, 26, 34]	• Off-label use in BPSD • Evidence for efficacy in agitation & aggression	+	+++	+++	++	+	+++	↑↑↑ (1.0lb/ month)	1.25mg – 7.5mg/d	$17-38
Atypicals	**Aripiprazole*** (Abilify)[34]	• Off-label use in agitation or aggression[18] • Evidence for efficacy in agitation & aggression • Not eligible for dementia or BPSD in the elderly (ODB criteria, Therapeutic Note) • Not for psychosis (same as placebo)	+	+	++	+	+	–	↑	2.0mg – 15mg QHS	$112-260
Atypicals	**Quetiapine** (Seroquel)[25, 26, 34]	• Off-label use in BPSD • Lacks evidence for efficacy in BPSD agitation, aggression & psychosis • Consider in Lewy Body dementia, Parkinson's (low EPS) • Note: although used, not indicated, and lacking evidence for insomnia	++	+++	+++	+	+	+++	↑↑ (0.4lb/ month)	12.5mg – 200mg/d (divided QHS-TID)	$10-59
Typicals	**Haloperidol** (Haldol)	• Useful short term in acute BPSD or delirium	+	+	+	+++	+++	++	↑↑	0.25mg – 2.0mg/d	$14-25
Typicals	**Loxapine** (Loxapac, Xylac)[2]	• Consider if other agents have failed and severe, persistent, dangerous behaviour continues • Severe, acute BPSD • Not to be used long-term due to adverse effects	++	++	+++	+++	+++	+	–	5.0mg – 10mg BID	$18-27

*Aripiprazole, olanzapine and risperidone were superior to placebo as treatment of behavioural symptoms as measured by total scores on BEHAVE-AD[36], Brief Psychiatric Rating Scale (BPRS)[37], and Neuropsychiatric Inventory (NPI)[20]

KEY: **Terminology**

Ach: anticholinergic
BID: twice daily
BP: blood pressure
ODB: Ontario Drug Benefit
EPS: extrapyramidal symptoms
lb: pound
TD: tardive dyskinesia
TID: three times daily
QHS: bedtime

Frequency (%) of Adverse Reactions of Antipsychotics at Therapeutic Doses

–: Negligible or absent (<2%)
+: Infrequent (>2%)
++: Moderate (>10%)
+++: Frequent (>30%)
↑: Increase

Tips for Reassessing Antipsychotics for Possible Deprescribing

- Stopping or tapering antipsychotics may decrease "all cause mortality"[27]
- Deprescribing may not be indicated where symptoms are due to psychosis, or where behaviour is especially dangerous or disruptive
- Evaluate reason for use and any recent changes in targeted behaviour
- Ensure suitable non-pharmacological measures for BPSD are optimized
- Due to the nature of responsive behaviours and the usual course of dementia, antipsychotics can often be successfully tapered and/or discontinued.[28] As some may worsen, approach cautiously, and monitor behaviour[29]
- Taper gradually, often by 25-50% every 2-4+ weeks and look for any resulting behaviour changes. Once on lowest dose, may discontinue in 2-4+ weeks
- Continue to reassess for emergence of responsive behaviours

Supporting Materials

These supporting materials are an inventory for primary care providers to help identify useful clinical aids and patient/family material. This list includes direct links (where available) to tools or materials, based on an environmental scan, appraisal by Clinical Leads, and focus groups with primary care providers. The materials below can be accessed at: **effectivepractice.org/dementia**.

Assessment Tools

Antecedent, Behaviour, Consequence (ABC) Chart Form[3]

Chart form to help providers determine and document the events/stimuli that impact behaviour.

BEHAVE-AD[36]

Clinical rating scale to measure behavioural and psychological symptoms of dementia based upon information obtained from caregivers/informants.

URL: dementia-assessment.com.au/behavioural

Brief Psychiatric Rating Scale[37]

Rating scale of 24 symptom constructs used to assess the positive, negative, and affective symptoms of individuals.

Cohen-Mansfield Agitation Inventory (CMAI)[5]

Inventory questionnaire of grouped agitated behaviours to assess the frequency and severity of these behaviours in elderly persons.

Confusion Assessment Method (CAM)[7]

Diagnostic algorithm/questionnaire for identification of delirium through formal cognitive testing.

Cornell Scale for Depression in Dementia[38]

Scale for assessing signs and symptoms of major depression in people with cognitive impairment.

Dementia Observation System (DOS)[4]

Behaviour assessment tool which captures the frequency and duration of behaviours of concern over 24 hour periods.

URL: piecescanada.com

General Practitioner Assessment of Cognition (GP-COG)[50]

Screening tool for cognitive impairment for patients and families/ caregivers.

URL: gpcog.com.au

Geriatric Depression Scale - 15 Item [51]

Self-administered assessment for depression in the elderly.

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)[52]

Short questionnaire for families/friends to determine cognitive decline.

Instrumental Activities of Daily Living Scale[53]

Scale to determine functional abilities for tasks, completed by patients and families/caregivers.

Kingston Standardized Behavioural Assessment (KSBA)[6]

Behaviour analysis tool designed to indicate the number of behavioural symptoms associated with dementia affecting an individual patient.

URL: kingstonscales.org/behaviour-assessment.html

Montreal Cognitive Assessment (MoCA)[54]

Tool to identify objective evidence of cognitive decline.

URL: mocatest.org

Neuropsychiatric Inventory [40]

Tool to characterize the neuropsychiatric symptoms and psychopathology of patients with Alzheimer's disease and other dementias to measure the impact of antidementia and psychotropic drugs.

URL: npitest.net

Pain Assessment in Advanced Dementia Scale (PAINAD)[8]

Pain assessment tool for individuals with advanced dementia including behaviour observation scores.

Patient Health Questionnaire (PHQ-9)[55]

Self-administered multipurpose instrument for depression diagnosis and monitoring.

Reference and Support Information

Atypical Antipsychotic Drugs and Dementia – Advisories, Warnings and Recalls for Health Professionals[24]

Advisory concerning atypical antipsychotic treatment of behavioural disorders in elderly patients, June 2005

URL: healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2005/14307a-eng.php

Dementia Toolkit for Primary Care[56]

Primary care toolkit with resources for delirium, caregiver support, high risk situations, and other materials.

URL: mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry

First Link Program[57]

Referral program to support newly diagnosed patients with dementia connecting to resources and other people living with Alzheimer's and other dementias.

URL: http://alzheimer.ca/en/We-can-help/Resources/For-health-care-professionals/first-link

PIECES™ Framework[9]

Interdisciplinary approach to understanding and enhancing care for individuals with complex physical/cognitive/mental health needs and behaviour changes.

URL: piecescanada.com

Psychotropic Medication Consent Discussion Tool[19]

Aid for initiating antipsychotic medications and key discussion items for informed consent from patients or substitute decision makers.

Reference List of Drugs with Anticholinergic Effects[41]

Reference list of drugs with low, moderate, and high anticholinergic effects, including side effects and preferred alternatives.

URL: rxfiles.ca/rxfiles

Risperidone - Restriction of the Dementia Indication[42]

Alert for the restriction of risperidone and related antipsychotic use for patients with severe dementia of the Alzheimer type unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others, February 2015

Note: *Although recent alert is specific for risperidone, other antipsychotics have similar concerns; however, unlike risperidone, others lack an official indication in BPSD.*

URL: healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2015/43797a-eng.php

Treating Disruptive Behaviour in People with Dementia (Patient Material)[43]

Statements on how to treat disruptive behaviours without antipsychotic drug use.

URL: choosingwisely.org

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