Clinical Solutions

A joint publication of the Illinois Health Care Association and CE Solutions

June 2016

Risks of Antipsychotic Medication Usage in People with Dementia

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Mae, 84, whose primary diagnosis is dementia, wanders hour after hour through the halls of the nursing facility where she resides. Usually, Mae seems happy; she is often seen smiling and singing to herself. Occasionally, though, she becomes agitated and belligerent while demanding that staff call her "father" to come and pick her up. She sometimes strikes out at others. It can be difficult for staff to redirect Mae when this behavior occurs. Family members of other residents have started to complain that Mae is dangerous to residents and have requested that something is done to prevent these incidents. Her primary care physician has prescribed Risperidone.

As dementia progresses so do associated behaviors, some of which can be challenging to manage. Providers often prescribe antipsychotic medications to modify undesirable behaviors. However, research indicates that antipsychotics are frequently overused in people with a dementia diagnosis; not only are these drugs less effective than some providers believe, but their use can also put people with dementia at risk.

It is important to note that use of antipsychotic medications to treat many behaviors associated with dementia is not supported clinically and is considered off-label by the U.S. Food & Drug Administration (FDA) (Antipsychotics, 2015). Since 2005, the FDA has notified health care providers that both conventional and atypical antipsychotics usage have been associated with increased risk of mortality in elderly patients with dementia. Causes of death were varied, but most deaths were either cardiovascular or infectious in nature. (FDA, 2013)

Studies show that in addition to increased risk of death, there are many other risks associated with dementia patients taking antipsychotics: they are more likely to fall, experience fractures, develop urinary incontinence, have an unsteady gait and be at higher risk for strokes. (AHCA, 2013)

Atypical Antipsychotic medications

Atypical Antipsychotic (Second Generation) is a newer class of

antipsychotic medication approved by the U.S. Food and Drug Administration (FDA) primarily for the treatment of schizophrenia and bipolar disorder. There are currently 11 FDA-approved atypical antipsychotic drugs:

1. Aripiprazole (Abilify) - schizophrenia, bipolar, and as added therapy for major depressive disorder
2. Asenapine Maleate (Saphris) - schizophrenia and bipolar disorder
3. Clozapine (Clozaril) - schizophrenia (restricted distribution)
4. Iloperidone (Fanapt) - schizophrenia
5. Lurasidone (Latuda) - schizophrenia, depressive episodes associated with bipolar I disorder (bipolar depression), as monotherapy and as adjunctive therapy with lithium or valproate
6. Olanzapine (Zyprexa) - schizophrenia, bipolar I disorder
7. Olanzapine/Fluoxetine (Symbyax) - schizophrenia, bipolar, and as added therapy for treatment-resistant major depressive disorder
8. Paliperidone (Invega) - schizophrenia and schizoaffective disorder
9. Quetiapine (Seroquel) - schizophrenia, bipolar, and as added therapy for major depressive disorder (Seroquel-XR)
10. Risperidone (Risperdal) - schizophrenia and bipolar
11. Ziprasidone (Geodon) - schizophrenia and bipolar (FDA, 2016)

Although no atypical antipsychotic is FDA-approved for treatment of dementia, the largest number of prescriptions for these drugs among the elderly is written for neuropsychiatric symptoms (NPS). NPS symptoms, such as delusions and agitation, affect up to 97 percent of people with dementia. Large-scale meta-analyses of clinical trials have consistently demonstrated a 1.5-1.7 times increased risk of mortality with their use in dementia. (Steinberg, 2012)

Antipsychotic usage by the numbers

Antipsychotic medication can play a significant role in treating geriatric patients, e.g., for optimal care in selected psychotic or manic patients. (Antipsychotics, 2015). People with dementia who experience hallucinations or delusions may also benefit (FAST FACTS: Antipsychotic Drugs, n.d.).

The concern is that nursing home residents with dementia receive antipsychotic medication even though there was no diagnosis of psychosis. In 2010, Centers for Medicare & Medicaid Services (CSM) found that this was true of 40 percent of nursing home residents with signs of dementia. (CMS Announces Partnership, 2012)

The goal of National Partnership to Improve Dementia Care in Nursing Homes, launched by CMS, is to achieve a 30 percent reduction by the end of 2016 as part of an overall effort to encourage non-pharmacologic approaches and person-centered dementia care practices. (CMS Partnership, 2016) At the end of last year, 16.8 percent of long-stay residents were taking antipsychotic medication (Antipsychotics, 2015). This usage represents a 29.2 percent reduction as the result of Partnership initiative (Antipsychotic Usage Down Nearly 30 Percent in Skilled Nursing Centers, 2016).

Assessing behavior

Many behaviors that caregivers find challenging in people living with dementia are natural responses to situations or perceptions and do not require medication. Skilled staff can respond to the needs of the person living with dementia in ways that minimize challenging behavioral responses. (AHCA, 2013)

The initial step to the evaluation of the behavior is to complete a thorough assessment of the behavior to determine the causes of the problem behavior or determine if it is a psychosis in dementia.

Conduct a thorough assessment of the behavior:

- What triggers it?
- How frequent is it?
- Are particular staff or residents present when these behaviors occur?
- Is it a critical behavior that needs to be addressed?
- Is it simply annoying behavior that can be easily redirected?

Causes of behavior can include:

- Environmental, which can include excessive stimulation, noise levels, disruption in usual schedule, etc.
- Unmet physical needs, such as basic human needs of hunger, pain, and need to urinate.
- Unmet psychological needs such as loneliness, worry, and fear.
- Psychiatric may appear to contribute to behavior such as delirium and psychosis.

Behavioral interventions

Behavioral interventions are individualized non-pharmacological approaches directed toward preventing, relieving or accommodating the behavior.

Activities should be patient-centered and match the need for social contact as well as provide a meaningful activity. Music therapy, regular exercise, touch therapies and pet therapy have all been proven to be helpful in reducing behaviors.

Consistent routine and regular stimulation can help manage many behavioral disturbances. Any changes in regular daily routine, staffing changes or changes in interactions with other residents can prompt behaviors.

Recommended Guidelines for GDR

Collaborate with practitioners to identify when drug therapy is considered appropriate therapy. When an antipsychotic medication is ordered, develop a plan for Gradual Dosage Reduction (GDR).

- Periodically review the progress of any resident receiving antipsychotic medications, including the frequency, duration and intensity of any symptoms.

- Review the resident's overall condition and symptoms to identify anything else that may be impairing behavior or mood stability.
- At any time if it is uncertain whether a psychopharmacological medication (including antipsychotic medications) is making a difference, consider initiating a trial reduction (e.g., lower dose, lesser frequency of administration) to see the effects.
- If behavior is worse or at least not stable within 72 hours of initiating a psychopharmacological medication (including antipsychotic medications), review the working diagnosis and treatment to see whether a change in treatment may be indicated.
- For an antipsychotic medication prescribed for an acute episode (e.g., during a recent hospital stay), consider a trial dose reduction if the medication's effectiveness or the need for continued treatment is uncertain.
- If the drug is currently at the lowest dose, consider a different approach to dose reduction (e.g., fewer doses per day, treatment every other day).
- It is prudent to reduce doses gradually (over several days to several weeks), to be able to observe for effects of medication reduction and to allow the brain to adjust to changes in chemical balances.
- For individuals taking an antipsychotic drug for one year, attempt dose reduction in two separate quarters with at least one month apart unless the individual is at optimal functioning.
- After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful after two or more attempts, further reduction may be clinically contraindicated. Documentation is needed in the individual's record why additional dose reduction will cause impairment, psychiatric instability, or exacerbate the underlying psychiatric disorder.
  (AHCA Antipsychotics Toolkit, n.d.)

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