

Evidence-based best practice for Antipsychotic Medications

Antipsychotic medications are often started in the community setting to treat psychosis (i.e., hallucinations, delusion, or paranoia) and/or the agitation (i.e., aggression and irritability) associated with dementia. Both psychosis and agitation greatly contribute to caregiver burden and depression in the community setting and are frequently cited as factors for nursing home placement. Drug-first treatment approaches often carry over from the community and hospital settings into nursing facilities. However, antipsychotic medications should not be considered a first-line therapy except in circumstances of extreme distress or harm.

Input from an established interdisciplinary team of clinicians and nursing staff can have a great influence on how antipsychotics are prescribed. A study published within the Archives of Internal Medicine found that more than one third of residents in nursing homes lacked a clinical indication for the appropriate use of an antipsychotic. Residents who were newly admitted to facilities with high percentages of antipsychotic use were more likely to receive an antipsychotic, than those admitted to facilities with lower percentages. This study suggests that prescribing rates are greatly influenced by facility level factors.

Initial approaches start with a detailed assessment of the individual to identify any treatable causes of the behavioral and psychological symptoms of dementia (BPSD) such as infections, delirium, pain, depression, sleep disorders, etc. Assess residents with dementia who develop psychological symptoms or behavioral issues which cause significant distress at the earliest opportunity to establish the likely factors that may trigger, aggravate, or lead to such behaviors. A comprehensive assessment includes:

- The person's physical health
- Depression screening
- Possible undetected pain or discomfort
- Review of medication regimen side effects
- Individual biography, including spiritual beliefs and cultural identity factors
- Emotional and psychosocial predispositions
- Physical, functional, and environmental factors
- Social and cognitive factors
- Interpersonal relationship issues

The specific type of healthcare provider responsible for prescribing antipsychotics can vary greatly between nursing homes. In some nursing facilities only the attending or primary care physician was solely responsible for prescribing antipsychotics. However, most nursing facilities obtain either full or partial input was the consideration of a psychiatric consultant.

Family can have a great deal of information to offer regarding the likes and dislikes of their loved ones. Structure person-centered non-pharmacological interventions and therapeutic approaches through discussions with the family. Additionally, commonly used alternative methods which are valid yet unfamiliar to the general public should also be discussed to educate family members/representatives.

Standards

There is no approved treatment for behavioral and psychological symptoms of dementia (BPSD). Cholinesterase inhibitors and memantine can have beneficial effects on dementia, but are often not beneficial in curbing behavioral disturbances. Some antipsychotics have shown minimal positive effects on anger, aggression, and paranoid ideas.

In 2008, the National Institute of Mental Health conducted the Clinical Antipsychotic Trials of Intervention Effectiveness – Alzheimer’s disease (CATIE-AD) project. The CATIE-AD study concluded that atypical antipsychotics are risky and only modestly effective. Atypical antipsychotics are associated with increased risk of seizures, development of diabetes, with some causing life-threatening prolonged QT interval. Other side effects can cause a significant decrease in quality of life, such as somnolence, extrapyramidal effects, edema, and increased risk of infection (urinary and upper respiratory). Controversy has arisen over the benefit versus risk of antipsychotics. This mainly stems from the notion that BPSD can contribute to greater morbidity and mortality.

According to the CATIE-AD study antipsychotic use in dementia is associated with increased mortality and decreased cognition. The study further suggested that all antipsychotics can cause steady and significant decline in most cognitive areas over time. The study showed that decline was greater than placebo for multiple cognitive areas with a 2.4 point increase on the Mini-mental State Examination (MMSE) and 4.4 points on the Alzheimer’s disease Assessment Scale-cog as measured over 36 weeks. The conclusion stating that functional ability, care needs, and quality of life do not appear to improve with the use of antipsychotics.

Stabilization of a resident with dementia may be of paramount concern, with considerations of secondary risk factors. An example of this would be with palliative care and with hospice. Careful assessment should evaluate the resident’s remaining life expectancy and goals of care. Close to the end of life, sedation may be a desirable effect and may be the reason to choose an older (typical) antipsychotic agent over a newer (atypical) one. Towards the end of life, goals of care will shift to maintaining comfort; at this stage antipsychotics can show an increased benefit over risk. Yet even in palliative care, the principle of start low and go slow still applies.

Place the focus on the risk versus benefit of these agents, along with alternative non-pharmacological methods. Clinicians and caregivers may wish to develop policies which are focused on improving quality of life to limit inappropriate treatments. Algorithms can be very helpful with implementing these policies.

[Psychotropic Medication Tracking Tool for Nursing Homes](#)

[Antipsychotic Education Form](#)

[Approved Indications for Antipsychotic Medications](#)

[Behavioral or Psychological Symptoms of Dementia \(BPSD\)](#)

[Antipsychotic Medication Education Form](#)

[Antipsychotic Care Plan Example Template](#)

[Basic Guidelines for Quarterly Psychotropic Medication Evaluation and Effectiveness of Non-Pharmacological Behavioral Interventions](#)

[Basic Guidelines for Behavior and Side Effect Monitoring](#)

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