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Guidelines for Antipsychotic Use in Elderly Nursing Home Patients

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As providers it is our responsibility to reduce the use of antipsychotics in elderly patients with dementia. The careful withdrawal of antipsychotics in these patients is an essential part of our routine clinical practice.

The Center for Medicare and Medicaid Services (CMS) has, through the National Partnership to Improve Dementia Care in Nursing Homes, set forth guidelines for the reduction of the use of antipsychotics in long term nursing home residents.

See **https://www.nhqualitycampaign.org/files/Physician_Package.pdf**

The only diagnoses approved for the use of antipsychotics in elderly nursing home residents are schizophrenia, Tourette's, and Huntington's Disease. Antipsychotics have a FDA Black Box Warning. See below:

> ‘Increased mortality in elderly patients with dementia-related psychosis: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug-treated patients of between 1.6 and 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5% compared with a rate of approximately 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Risperidone is not approved for the treatment of patients with dementia-related psychosis.’
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> A case controlled study published in May 2015 concluded ‘The absolute effect of antipsychotics on mortality in elderly patients with dementia may be higher than previously reported and increases with dose.' View the entire abstract here:
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> JAMA Psychiatry. 2015 May; 72(5):438-45.
> **Antipsychotics, other psychotropics, and the risk of death in patients with dementia: number needed to harm.**
> Maust DT, Kim HM, Seyfried LS, Chiang C, Kavanagh J, Schneider LS, Kales HC.

Guidelines for practice:

1. You will see many new patients who are taking either typical or atypical antipsychotics and occasionally both. First through a careful history from the patient, nursing home staff and family establish whether the patient has a history of schizophrenia, Tourette's or Huntington's Disease for which the antipsychotics may have been described. A patient with hallucinations or delusions must be assessed for possible schizophrenia. Agitation as well as hallucinations or delusions may due to delirium associated with infection, dehydration or adverse medication effects. Eliminate these diseases as a possible cause.

2. Remember there is a late-onset schizophrenia that is not common but is seen in the nursing home population. See http://www.currentpsychiatry.com/the-publication/past-issue-single-view/late-onset-schizophrenia-make-the-right-diagnosis-when-psychosis-emerges-after-age-60/570f27bea91ee8705cab88f0bd0b1ce2.html It is essential to consider this diagnosis in patients with delusions and/or hallucinations. These patients will have the positive much more frequently than the negative symptoms of schizophrenia. They may have been incorrectly diagnosed with schizoaffective disorder. It is essential to make the correct diagnosis in these patients so they can receive the treatment they need.

3. There may be resistance from family members or nursing home staff when tapering the antipsychotic drugs is mentioned. Explain to the family the increased risk of early death from the drugs. Ask the family if the patient is having hallucinations or delusions. Usually the answer is no and then it can be explained that since the patient is not schizophrenic the medications are not useful. Staff may be concerned combative or aggressive behavior may return. Reassure them the taper will be slow and that an Encounter provider will be available should an urgent situation arise. Read the Cochrane Review below for evidence for the withdrawal of antipsychotics in patients with dementia
and agitation. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007726.pub2/full
'The evidence suggests that older nursing home residents or outpatients with dementia can be withdrawn from long-term antipsychotics without detrimental effects on their behavior.'

4. A taper of antipsychotics must be over at least several weeks depending on the dose and the drug. Importantly patients with Extra Pyramidal Symptoms (EPS) must be withdrawn very slowly over more than four weeks or the EPS may increase. An abrupt or rapid withdrawal, especially of a first generation antipsychotic like haloperidol or clozapine, can cause or increase EPS which may not resolve with restarting the drug.

5. Exceptions: There are times when patients are severely agitated, combative and are endangering other residents and staff. If the patient does not respond to either oral or injectable lorazepam a very short use of haloperidol either in oral or injectable haloperidol may be necessary to ensure the patient's and other's safety. Injectable haloperidol and lorazepam are usually kept in the facility's emergency drug box. Be sure to review the dosing of these drugs and the patient's prior response to the drug before use.

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