THE CMS INITIATIVE: Alternatives to Decrease Atypical Antipsychotics

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Learning Objectives:
- Discuss the CMS mandate to decrease antipsychotic use in long-term care settings
- Compare and contrast pharmacologic options that address agitation in the long-term care population
- Review non-pharmacologic strategies that can be implemented to reduce agitation in adults living in residential care

DISCLOSURE OF COMMERCIAL SUPPORT
Marianne McCarthy, PhD, PMHNP does not have a significant financial interest or other relationship with manufacturer(s) of commercial product(s) and/or provider(s) of commercial services discussed in this presentation, but will talk about off-label use for medications commonly used in the geriatric population to address agitation.
The CMS Initiative: Alternatives to Decrease Atypical Antipsychotic Use

U.S. Centers for Medicare and Medicaid Services (CMS)
- Partnership to Improve Dementia Care in Nursing Homes
  - On 3/29/12, CMS launched an initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use.
  - Aim was to decrease the utilization of antipsychotics in long-term care by 15% by December 2012 with further reduction initiatives expected in 2013.

So what does that mean?
- A 15% reduction in that rate would mean a national prevalence of 20.3%.
- This does not mean that each facility across the country should have a prevalence of 20.3% but that the national average should not be higher than that.
- The initial target for the national partnership was to ensure that we made rapid progress and put systems and infrastructure in place to continue to work toward lower antipsychotic medication use.

(Senft, 2012)
Partnership to Improve Dementia Care in Nursing Homes Initiative

- Multidimensional approach including public reporting, raising public awareness, regulatory oversight, technical assistance/training and research
- The action plan targeted at enhancing person-centered care for nursing home residents
- Involves federal and state officials, nursing homes and other providers, advocacy groups and caregivers
- Training emphasizes high-quality care
- Making data on antipsychotic drug use at nursing homes available on the website Nursing Home Compare
- Suggesting alternatives to antipsychotics such as exercise, outdoor time, pain management and planned activities for patients (Mitka, 2012)

Performance Metrics

- Development of quality measures on unjustified antipsychotic medication use:
  - Overall reduction in the number of beneficiaries who are taking antipsychotic medication
  - Reduction in the number of beneficiaries who are prescribed a potentially inappropriate medication (PIM) by 25% from baseline at 18 months, and a final target reduction of 50% from baseline

Audience Participation

- What percentage of nursing home residents living in the U.S receive antipsychotic drugs?
  - a. 80%
  - b. 70%
  - c. 50%
  - d. 25%
Audience Participation

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Antipsychotic Drug (APD) Use

- In the United States, 25.2% of nursing facility residents receive antipsychotic medications, according to data from the Centers for Medicare and Medicaid Services (CMS, 2012).
- In a survey of more than 4,000 nursing home residents in eight European countries, the rate of APD use was similar (26.4%).

(http://biomedgerontology.oxfordjournals.org/content/67A/6/698.aabstract)

Evolution of Antipsychotic Drug Use in the U.S.

- The first APDs were produced as a treatment for schizophrenia in the 1950s.
- This first generation is known as the “typical” antipsychotics.
- Their use was limited to several psychiatric diagnoses:
  - Schizophrenia
  - Bi-Polar Disease
Introduction of Atypical APDs

- Atypical (2nd generation) agents were introduced in the 1990s.
- They have become much more commonly used than the conventional agents because of their relatively favorable side effect profile.
- Associated with lower rates of Parkinsonism and Tardive Dyskinesia.

Shift from Conventional to Atypical APDs

- During the 1990s:
  - APD use shifted from conventional to atypical agents
  - APD off-label use increased
  - Used to treat depression, anxiety, eating disorders, ADHD, autism, behavioral and psychological symptoms in dementia (BPSD)

Antipsychotic Drug Use in the U.S.

- Increased from 6.2 million treatment visits in 1995 to 16.7 million in 2006
- Declined to 14.3 million visits by 2008
- Estimated cost associated with off-label APD use in 2008 was $6 billion

(Alexander et al, 2011)
Audience Participation

- Why did APD use begin to decline?
- What happened in 2005?

Audience Participation

- U.S. Food and Drug Administration issued a Black Box Warning for risperidone regarding mortality in elderly patients with dementia-related psychosis.
- Since then, a cascade of warnings for the entire class of agents has ensued.

Blame it on Janssen

- In 2003, during industry-sponsored clinical trials of typical antipsychotics for the treatment of BPSD, higher rates of mortality and cerebrovascular adverse events (CVEs) were noted among patients with dementia (Brodaty et al., 2003).
- Since then, the use of antipsychotics for BPSD has been discouraged on the basis of advisory warnings issued by regulatory authorities in several countries.
In 2004....
- The U.K. Committee of Safety of Medicines (CSM) informed clinicians that risperidone and olanzapine should not be used to treat BPSD because of increased risk of strokes with both drugs and an increased risk of mortality with olanzapine.

A year later....
- The U.S. FDA issued a general warning:
  - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis.

How the agencies make their decisions....
- Both agencies conducted meta-analyses or pooled analyses using simple methodology to calculate risks of mortality or CVE based on combined tables summing up results across different studies.

(CSM, 2004; FDA, 2005)
U.S. Food and Drug Administration (FDA)

- Pooled 17 placebo-controlled trials relating to the use of olanzapine, ripiprazole, risperidone and quetiapine in dementia patients with BPSD (N=5106)
- The mortality of the drug-treated group was 1.6 or 1.7 times that of the placebo group (4.5% vs. 2.6%)
- Death was predominantly due to heart-related or infectious causes (FDA, 2005).

Black Box Warning

- Based upon that meta analysis, the FDA issued a public health advisory warning alerting health care providers and the public about new safety information regarding all atypical antipsychotic medications.
- Similar warning was issued in 2008 for conventional APDs.

U.S. FDA Black Box Warning
Data that rocked the boat...

- Absolute risk difference was generally 1–2% between antipsychotic and placebo-treated patients.
- The relative risk was approximately two times higher due to the overall low prevalence of these events in both groups.

(FDA, 2005)

Contradictions

- Although early published and unpublished data indicated a risk, few subsequent publications have supported the initial finding.
- There have been reports from non-experimental studies which contradict those of the U.K.’s CSM and the U.S.A.’s FDA.

Simpson’s Paradox

- Simpson’s paradox causes us to throw doubt on conclusions based on meta-analyses or pooled-analyses.
- When combining groups and looking at data in aggregate form, correlation may reverse itself.
- Most often due to lurking variables that have not been considered, but sometimes it is due to the numerical values of the data.
Criticism of the CSM and FDA Meta-analyses (2004, 2005)

- There is no rationale for considering all atypical antipsychotics to be the same.
- Profiles of adverse events vary widely across different atypical antipsychotics.
- Even socio-demographic and clinical characteristics of the active treatment group and the comparator group vary widely across RCTs.
- The meta-analyses seem to assume that all atypical antipsychotics have the same efficacy and safety.
- In addition, none of the RCTs were initially designed to look for CVEs or mortality.

Higher Mortality Among Non-Users

- In 2005, Suh and Shah reported results of a one-year prospective study comparing antipsychotic users and antipsychotic non-users in a nursing home (N=273).
- Mortality rate in those who had not received antipsychotics (26.8%) was higher than that in those who had received antipsychotics (20.8%).
- The mortality rates of the two groups were statistically significantly different, even after controlling for possible confounding factors.

(Suh and Shah, 2005)

Clinical Antipsychotic Trials of Intervention Effectiveness-Alzheimer's Disease (CATIE-AD)

- In 2006, Schneider and his colleagues reported results of a multi-center double-blind, placebo-controlled trial supported by the U.S. National Institute of Mental Health (NIMH).
- In this study, doses were adjusted as needed, and 421 out-patients with AD, agitation, aggression, or psychoses were followed for up to 36 weeks.
- Neither the incidence of CVE (four cases; p=0.92) nor mortality rates (eight; p=0.68) were statistically different in the overall comparison.

(Schneider et al., 2006b).
Clinical Antipsychotic Trials of Intervention Effectiveness-Alzheimer’s Disease (CATIE-AD)

- The study reported that the sum total of the risk/benefit equation of atypical antipsychotic therapy was no greater than that achieved by placebo.
- Effect of olanzapine (mean dose 5.5 mg per day) and risperidone (mean dose 1.0 mg per day) in treating neuropsychiatric symptoms was equally beneficial.
- Superior to the effect of placebo and quetiapine (mean dose 56.5 mg per day).
- It is uncertain whether the results can be generalized to the populations of dementia patients residing in nursing homes with more severe cognitive and behavioral impairment.

(Schneider et al., 2006b).

Modena Cohort Study

- Using data from a population-based cohort study conducted in Modena, Italy.
- Nonino and his colleagues reported that the long-term survival of 294 dementia patients with BPSD treated with atypical antipsychotics was not significantly different from that of dementia patients not treated with these drugs.

(Nonino et al., 2006)

Using VA Databases

- In a retrospective review of the clinical outcomes of a large cohort (14,029) of elderly patients admitted to hospital for pneumonia or for dementia, researchers found:
- CVE risk did not differ whether patients were receiving a first-generation antipsychotic, SGA, or no antipsychotic therapy.
- Patients with vascular dementia had an increased risk in hospitalization for a CVE.
- No increase in risk for patients treated with quetiapine, olanzapine, or risperidone relative to haloperidol.
- No increase in risk for patients receiving olanzapine or risperidone relative to quetiapine.
- No increased risk of mortality in pneumonia patients treated with atypical antipsychotics.
- No increased risk for CVE-related hospital admission in dementia patients treated with atypical antipsychotics.

(Bennett et al., 2007)
Finland Prospective Study
- In 2007, Raivio and her colleagues reported results of a two-year prospective study with 254 very frail dementia patients from seven nursing homes and two hospitals in Finland.
- Neither atypical nor conventional antipsychotics increases mortality or hospital admissions among patients with dementia.

(Raivio et al., 2007)

Population-based Retrospective Cohort Study
- A population-based retrospective cohort study (1997–2002) in Canada that included 11,400 patients...
- Found no difference in the rate of strokes requiring hospitalization among users of the conventional antipsychotics - risperidone and olanzapine (Herrmann et al., 2004)
- The same research group reported an increased risk of death in the use of atypical antipsychotics compared to nonuse among dementia patients, using data including the additional year of 2003 (1997–2003) (Gill et al., 2007).

Summary of Evidence
- Almost all non-experimental clinical studies have shown no increase in the risk of CVE and mortality associated with use of atypical antipsychotics and the results also suggest that they may be associated with a lower mortality rate than conventional antipsychotics.
A Note of Caution

- Since few of these studies were prospectively designed to study behavioral symptoms, results must be interpreted cautiously.
- Treatment of behavioral symptoms in AD and other dementias is challenging.
- The limitations of current approaches drive the search for effective, well-tolerated therapies.

Indications for APD

- In the nursing facility resident population, antipsychotics are generally used for these indications:
  1. Treatment of psychotic disorders (e.g. schizophrenia)
  2. Treatment of psychotic symptoms (e.g. delusions, hallucinations) associated with other conditions (e.g. Alzheimer’s disease or delirium)
  3. Treatment of behavioral and psychological symptoms associated with dementia (BPSD), when these symptoms present a risk of harm to the resident or others.
- Occasionally used for other purposes, such as in conjunction with an antidepressant in the treatment of refractory depression.

FDA Indication

- Which of the preceding indications for APD use is backed by FDA approval?
Indications for APD

- In the nursing facility resident population, antipsychotics are generally used for three purposes:
  1. Treatment of psychotic disorders (e.g., schizophrenia)
  2. Treatment of psychotic symptoms (e.g., delusions, hallucinations) associated with other conditions (e.g., Alzheimer’s disease or delirium)
  3. Treatment of behavioral and psychological symptoms associated with dementia (BPSD), when these symptoms present a risk of harm to the resident or others
- Antipsychotics are also occasionally used for other purposes, such as in conjunction with an antidepressant in the treatment of refractory depression.

Off-Label Use

- APDs are used “off-label” for all other indications
- Off-label is NOT synonymous with inappropriate
- The practice is both legal and necessary, given our peculiar system of drug development and approval
- Fanning the fire of controversy
- APDs are not approved for management of BPSD
- NOTHING IS!!!!!!

Behavioral and Psychological Symptoms of Dementia (BPSD)

- A wide spectrum of non-cognitive manifestations of dementia
- May include: verbal and physical aggression, agitation, depression, apathy, psychotic symptoms (hallucinations, paranoia, illusions, and delusions), sleep disturbances, oppositional behavior, wandering, etc.
Prevalence of BPSD
- More than half of nursing home residents have dementia, and many of these residents experience BPSD.
- Up to 90% of patients with dementia may present at least one of these symptoms.
- Estimated that about one-third of patients have severe problems.
- Considerable impact on the functional status.
- Many symptoms are very invasive and difficult to manage by the caregivers and the care teams.

U.S. Trends
- According to 2012 data from CMS, the use of APDs has been stable in recent years.
- Significant variation exists when state-level data from the CMS Online Survey Certification and Reporting (OSCAR) database is reviewed.
- The proportion of nursing home residents receiving an antipsychotic medication ranges from a low of 12.4% in Hawaii to a high of 33.5% in Louisiana.

How are we doing in Arizona?
- What proportion of Arizona’s LTC residents receive antipsychotic drugs?
  a. 30%
  b. 25%
  c. 20%
  d. 15%
How are we doing in Arizona?

- What proportion of Arizona’s LTC residents receive antipsychotic drugs?
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So now what?

- Given that there is a small but well-established increase in the risk of death and stroke when using atypical antipsychotics in older adults with dementia....
- Clinicians and patients/caregivers are left with a seemingly “no-win” clinical conundrum of how to deal with serious dementia-related psychosis and aggression, which are themselves associated with serious morbidity.

(Meeks, 2008)

Disclaimer

- The preferred therapies for management of BPSD are non-pharmacologic, including environmental modifications.
- If an underlying cause or reason for the behaviors can be identified, a non-pharmacologic approach that addresses this underlying cause can be effective and safe.
Non-pharmacologic strategies

- Non-pharmacologic strategies should be implemented in routine clinical practice.
- It is not realistic to assume that non-pharmacological approaches, although preferred, will always carry the day.

Although studies have shown effective non-pharmacological interventions, overall the data are incongruent on the benefits of specific interventions.
- Study outcomes are not always reproduced with the same results.
- Common themes of non-pharmacological interventions include: calming music, aromatherapy, physical activity, environmental modification, pain treatment, and staff education.

(Gilten, 2012; King, 2012; O’Connor, et al., 2009; Seitz et al., 2012)

Psychological & Behavioral Therapies

- Level A Evidence
  - Caregiver psycho-education & support
    - Several positive RCTs
Psychological & Behavioral Therapies

- **Level B Evidence**
  - Cognitive stimulation therapy
    - ¾ of RCTs showed some benefit
  - Snoezelen therapy
    - 3 RCTs with positive short term benefits
  - Staff training/education
    - Several positive studies of fair-to-good methodological quality

Psychological & Behavioral Therapies

- **Level D Evidence**
  - Reality orientation therapy
    - Best RCT showed no benefit
  - Teaching caregivers behavioral management techniques
    - Overall inconsistent results
  - Simulated presence therapy
    - Only one RCT which was negative

Psychological & Behavioral Therapies

- **Level D Evidence**
  - Validation therapy
    - 1-year RCT with mixed results
  - Reminiscence therapy
    - A few small studies with mixed methodologies
  - Therapeutic activity programs
    - Varied methods (e.g. exercise, puzzle play) and inconsistent results
Psychological & Behavioral Therapies

- **Level D Evidence**
  - Physical environmental stimulation (e.g., altered visual stimuli, mirrors, signs)
  - Generally poor methodology and inconsistent results
  - Best results with obscuring exits to decrease exit-seeking

The American Psychiatric Association

- Issued practice guidelines for the treatment of patients with Alzheimer's disease and other dementias in 2007:
  - The use of antipsychotics is supported in this guideline when non-pharmacologic strategies are inadequate.
  - The guideline concludes, “On the basis of good evidence, antipsychotic medications are recommended for the treatment of psychosis in patients with dementia and for the treatment of agitation.”
  - “These medications have also been shown to provide modest improvement in behavioral symptoms in general.”

Agency for Healthcare Research and Quality (AHRQ)

- Evaluated the off-label use of atypical antipsychotic agents in 2011
  - They found “moderate or high” evidence of efficacy for risperidone to treat psychosis and agitation in older adults with dementia
  - Some evidence to support use of olanzapine and aripiprazole for these purposes

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Cochrane Review 2012
- Evaluated 16 RCTs with atypical antipsychotics versus placebo
- Only 9 had sufficient data to include in meta-analysis
- Statistically significant improvement in aggression with risperidone and olanzapine when compared to placebo
- Statistically significant improvement in psychosis with risperidone
- Significant increase in drop-outs in risperidone (2 mg) and olanzapine (5-10 mg) treated patients
- Low dose aripiprazole and quetiapine effectiveness are unknown

Meta-analysis of 38 RCTs in Dementia
- A review of off-label use of antipsychotic agents in adults concluded:
  - Only risperidone, olanzapine, and aripiprazole had evidence of statistically significant benefits on total global outcome scores in older adults with dementia when compared to placebo
  - This includes symptoms such as psychosis, mood alterations, and aggression.
  (JAMA 306:1359-69 2011)

Meta-analysis of 38 RCTs in Dementia
- Quetiapine did not have a statistically significant effect
- Antipsychotics led to an average change/difference on the Neuro-Psychiatric Inventory (NPI) of 35% from a patient’s baseline
  - 3.41 point difference from placebo group
- No conclusive evidence was found regarding the comparative effectiveness of different antipsychotics.
  (JAMA 306:1359-69 2011)
Population Based Cohort Study
- Of nursing home residents in the U.S. concluded that use of haloperidol results in twice the all cause mortality rate compared with use of risperidone.
- Quetiapine had a lower all cause mortality rate than risperidone.
- However, an accompanying editorial notes that “there is no high quality evidence that quetiapine is effective for treating neuropsychiatric symptoms in dementia.”

(BMJ 2012; 344:e977)

Independent Drug Information Service (IDIS) 2012
- Olanzapine
  - 32% improvement
  - 24% discontinuation
- Quetiapine
  - 26% improvement
  - 16% discontinuation
- Risperidone
  - 29% improvement
  - 19% discontinuation
- Placebo
  - 21% improvement
  - 5% discontinuation


Other Classes of Medications
- Clinical trials have been conducted, with mixed results
  - Antiepileptic medications
  - Antidepressant medications
  - Cholinesterase inhibitors
  - Memantine
  - Benzodiazepines and hypnotics
- As of the end of 2012, the U.S. Food and Drug Administration has still not approved any medicines to treat BPSD.
- Canada has approved risperidone for this indication
Other Trends

- 5% increase in the use of antidepressants, anxiolytics, and anticonvulsants after the FDA black box warning

Anticonvulsants

- Evidence is limited:
  - Two positive trials for carbamazepine demonstrating that it may help agitation and aggression but problems with tolerability in both
  - Three trials showing divalproex equivalent to placebo
  - An unexpected finding from a retrospective review of almost 20,000 VA cases found an increased mortality rate among patients taking valproate as compared to all of the antipsychotics, including haloperidol.
  - Other agents only tried in case reports or open-label trials
    (Konovalov, et al., 2008; Muhundo, 2010)

Antidepressants - SSRIs

- No clear consensus exists on the role of antidepressants in managing behavioral and psychological symptoms of dementia.
  - Two positive studies with citalopram
    - 1- better for agitation than placebo and
    - 2- equivalent to risperidone for psychosis and agitation with better tolerability
  - Two negative trials with sertraline
Other Antidepressants

- One study showed trazodone equivalent to haloperidol for agitation with better tolerability
- Another study showed trazodone no different from placebo
- Other agents only have case reports/open-label trials

Benzodiazepines/Anxiolytics

- Recent evidence linking benzodiazepine and hypnotic use to 50% greater chance of development of dementia (BMJ, 2012)
- Three trials showing effects on agitation for oxazepam, alprazolam, diphenhydramine, and buspirone were equivalent to haloperidol
- No placebo control in any trial
- Problematic methodology in trials and worries over cognitive worsening with some of these agents (especially diphenhydramine) (Westbury et al, 2010)

Cholinesterase Inhibitors & Memantine

- Reductions in neuropsychiatric symptoms reported from trials of individual cholinesterase inhibitors, memantine monotherapy, and memantine combined with donepezil in AD patients.
- Studies of small numbers of patients in open trials of cholinesterase inhibitors and one double-blind placebo controlled trial have reported varying degrees of improvement of behavioral symptoms and psychosis of dementia with Lewy bodies (DLB).
Cholinesterase Inhibitors

- Cholinesterase inhibitors may be useful for symptoms such as apathy and psychosis, consistent with cholinergic deficit as a likely neurochemical cause.
- Initial reports that they may reduce agitation, a common and problematic symptom for which antipsychotics are often prescribed, were not confirmed by a large non-industry funded RCT, which showed no benefit of donepezil over placebo.

(Howard, et al., 2007)

Memantine

- Post hoc analysis of trials of memantine, an NMDA (N-methyl D-aspartate) antagonist, suggest possible benefits on agitation and aggression.

(Gauthier et al., 2005)

Nudexta

- NUEDEXTA® (dextromethorphan hydrobromide and quinidine sulfate) 20mg/10mg capsules are approved for the treatment of pseudobulbar affect (PBA).
- Though frequently mistaken for depression, PBA is the result of a ‘short circuit’ in the areas of the brain that control emotional expression.
- This causes episodes of crying or laughing that are often sudden and exaggerated or do not match what the person is feeling inside.
- NUEDEXTA is the first and only prescription medicine specifically approved to treat PBA.
- In a clinical trial, many patients experienced fewer PBA episodes after the 1st week of taking NUEDEXTA.
Conclusions Regarding RX

- Although the lifetime risk of developing significant psychopathology in dementia patients approaches nearly 100%, treatment options remain scant and controversial.
- Atypical antipsychotics for the treatment of BPSD are modestly effective when used judiciously.
- In the face of even more limited data for alternative pharmacotherapy, the use of atypical antipsychotics for the treatment of BPSD should not be suspended.
- Atypical antipsychotics will continue to be prescribed for BPSD in the absence of more effective, better tolerated and safer alternatives.

Recommendations for RX with APDs

- Decision to use antipsychotics to treat fragile dementia patients must be made on the basis of individual circumstances.
- Clinicians may first consider non-pharmacologic interventions.
- Use of atypical antipsychotics would follow failed attempts at treating BPSD with non-pharmacologic interventions.
- When using atypical antipsychotics, it is important to treat for a time-limited period and then taper and discontinue.

Bottom Line

- No solid evidence-based treatment exists for psychosis or agitation in dementia.
- Antipsychotics carry a black-box warning for increased risk of death and cerebrovascular events in dementia.
- When treatment becomes necessary, atypical antipsychotics are one of several off-label treatment options but, if chosen, should be used judiciously in the context of shared-decision making, close monitoring, and minimization of dose/treatment duration.
Suggested starting and target doses for atypical antipsychotics in dementia

<table>
<thead>
<tr>
<th>DRUG</th>
<th>STARTING DOSE</th>
<th>TARGET DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>2.5-5 mg/day</td>
<td>7.5-12.5 mg/day</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5-5 mg/day</td>
<td>5-10 mg/day</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>12.5-25 mg/day</td>
<td>50-200 mg/day</td>
</tr>
<tr>
<td>Risperidone</td>
<td>0.25-0.5 mg/day</td>
<td>0.5-1.5 mg/day</td>
</tr>
</tbody>
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Duration of Treatment

- Once initiated, the effectiveness and tolerability of antipsychotic therapy should be evaluated routinely.
- In dementia, the severity and frequency of behavioral symptoms often decrease as illness progresses.
- In a stable patient, it is prudent to attempt to taper and discontinue the antipsychotic after 2-8 months of therapy.

(Daiello, 2011)

Withdrawing APDs

- A RCT showed that antipsychotics can be safely withdrawn in many people with dementia who have taken them for prolonged periods, especially if symptoms have largely resolved.
- Staff and environmental factors are important, and targeted training and support reduced the use of antipsychotics from 42% to 23% over one year.

(Ballard, et al., 2008)
What conclusions can we draw?

- Evidence-based alternatives to antipsychotics are relatively few and limited to people with mild to moderate symptoms.
- In more severe cases, no treatment or non-evidence-based treatment is often not a clinical option.
- Antipsychotics, especially atypical ones, have the best evidence base, although their efficacy is more modest than previously supposed and their side effects more serious.
- Prescribing rates of up to 50% for people in residential care cannot be justified.
- However, given the lack of suitable alternatives, it is not reasonable to stop prescribing completely.

(Rochan & Anderson, 2012)

American Society of Consultant Pharmacists, March, 2012

- Treatment of BPSD is generally by trial and error, no matter which medicine is used, because each patient may respond differently (or not at all) to different medicines.

McCarthy’s Favorites

- Candy therapy
- Pal therapy
- Touch therapy
- Distraction & replacement
- Medications
- Stop all unnecessary medications
- Tylenol for pain
- Cholinesterase inhibitors for mild agitation
- Tiny doses of trazodone or hydroxyzine in compounded solutions for agitation and anxiety
- Nudexta for PPA
- Atypical antipsychotics for psychotic symptoms
- Mood stabilizers for mania
- Antidepressants (SSRIs & SNRIs) for depression and anxiety
- Sertraline for depression and agitation
- Mirtazapine for depression, insomnia, and anorexia
References


References