**Fact Sheet on Use of Antipsychotics, Gradual Dose Reduction, and**

**Non-Pharmacological Approaches for BPSD in Long Term Care**

***Who is more likely to be prescribed an antipsychotic medication in post-acute and long-term care?***

People who are *younger age, male or have moderate to severe dementia*.

***What facility characteristics predict rate of antipsychotic use?***

Larger facilities, non-profit status and high RN staffing ratios are all associated with lower rates.

Facility characteristics associated with higher antipsychotic use in long term care include: central south, northeast, metropolitan location; smaller facilities; for-profit status; dementia special care units; low occupancy; low RN staffing; presence of mental health professionals; independent ownership; and minimal competition.

***For what conditions are antipsychotics approved for use by the Food and Drug Administration?***

Bipolar disorder (not an exclusion from denominator), schizophrenia, adjunct to antidepressants for major depressive disorder (aripiprazole), Tourette’s syndrome (conventional antipsychotics only), and Huntington’s disease.

***What risks are associated with taking an antipsychotic?***

Falls and fracture; sedation; delirium; functional decline; extrapyramidal symptoms (Parkinsonism, dyskinesias); anticholinergic side effects (orthostatis, constipation, blurry vision, etc.); hyperglycemia; hyperlipidemia; drug interaction (40% chance); pneumonia; cardiovascular risks; and death (mortality is highest in first 30-40 days).

***If an antipsychotic is prescribed, what documentation is required?***

F-tag 329 provides the definition of an unnecessary drug. According to Centers for Medicare and Medicaid guidelines, in order to remain in compliance with F-tag 329 specific to antipsychotic use, documentation must include: *indication for use, effectiveness of non-pharmacologic interventions, risk benefit discussion, side effect monitoring and gradual dose reduction.*

***What are the recommended maximum daily doses for antipsychotics when used for BPSD?***

|  |  |
| --- | --- |
| **Antipsychotic** | **Maximum Recommended Total Dose (mg) per Day for BPSD** |
| Haloperidol | 2mg |
| Aripiprazole | 10mg |
| Clozapine | 50mg |
| Olanzapine | 5mg |
| Quetiapine | 150mg |
| Risperidone | 2mg |
| Ziprasidone | No data available in older adults with dementia |
| *Bach, Lazzaretto, Young, Lofholm, 2017* | |

***What are some non-pharmacological alternatives to antipsychotics?***

Rule out medical cause (delirium screening, vigilant medical care); address unmet needs; communication strategies; routine & constituency with activities and caregivers; environmental modifications; maximize sensory input (glasses, hearing aids, plenty of light); involve in functional & physical activities; incorporate personal preferences; supervision & safety; and specific therapies such as art, music, aromatherapy, etc.

***We would like to reduce our antipsychotic use and increase use of nonpharmacologic approaches. How should we start?***

* + Assess facility policies, the environment and culture, and gather your baseline data
  + Educate staff and family about limits of meds, risks, and non-pharmacological interventions
  + Create an interdisciplinary team of champions
  + Start with the low hanging fruit
  + Continue with ongoing mentoring and motivation

***Be clear about the goal of using nonpharmacologic approaches. What behavior are you trying to address?***

When considering whether or not to use antipsychotics to treat behavioral and psychological symptoms of dementia, it is important to clearly identify the target symptom and be able to accurately describe the behavior to the health care provider. Include information such as **frequency, intensity, and/or timing of the behavior**. Avoid using non-descriptive words such as “agitated” which can mean different things to different people. Instead, **describe the specific behavior** that the resident is engaging in.

***What topics are important to include in staff education before beginning a Gradual Dose Reduction(GDR)?***

The inclusion of staff education, appropriate documentation, use of assessment tools, data analysis, and identification of prescribing and de-prescribing trends are all important elements for reducing inappropriate use of antipsychotics in nursing home settings.

***What are some common challenges associated with GDR?***

* Silo approach—pharmacist recommendations alone do not change prescriber behavior; need open and ongoing communication across disciplines
* Misunderstanding of CMS regulation
* Unfamiliar with assessment tools to monitor antipsychotic use—a good resource: <https://www.nhqualitycampaign.org/professionalDementia.aspx>
* GDR is done without emphasis on non-pharmacological approaches
* No consensus on GDR

***What strategies should we consider using for a GDR?***

* + Go slow
  + Strategize with your clinician prescribers
  + Reassess
  + Realize it won’t always be successful
  + Put a non-pharmacologic plan in place and involve family

Bach, L. L., Lazzaretto, D. L., Young, C. F., & Lofholm, P. W. (2017). Improving Nursing Home Compliance via Revised Antipsychotic Use Survey Tool. The Consultant Pharmacist: The Journal of the American Society of Consultant Pharmacists, 32(4), 228–238. https://doi.org/10.4140/TCP.n.2017.228 3. Cioltan, H., Alshehri, S., Howe, C., Lee, J., Fain, M., Eng, H., … Mohler, J.