

Resource Document on the Use of Antipsychotic Medications to Treat Behavioral Disturbances in Persons with Dementia

APA Council on Geriatric Psychiatry

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Despite incomplete evidence about the safety and effectiveness of antipsychotic medication use in patients with dementia, there remain specific clinical situations in which their use may be appropriate. In considering use of these medications, the following points may be important to note:

1. Medical conditions or environmental factors may trigger behavioral or psychotic symptoms. Frequently, addressing unmet needs (e.g. pain, need for social support, stimulation) or treating underlying medical conditions (e.g. constipation, urinary tract infections) that may be triggers for psychosis and agitation may alleviate these symptoms (5).
2. Agitation and aggressiveness endanger the patients themselves or others and may not be responsive to other treatments; recent longitudinal findings indicate that it may, in fact, be the symptoms of psychosis and agitation that lead to increased rates of mortality (and institutionalization) rather than antipsychotic medications themselves (15).
3. Non-pharmacological behavioral treatment strategies should typically be attempted as first-line approaches. However, at this time the evidence that nonpharmacological approaches are safer or more effective than antipsychotics in the treatment of dementia-related psychosis or behavioral disturbance is limited. In part, this is because no study to date has had an adequate control group with a duration of patient-caregiver exposure to clinical staff comparable to that of the intervention group (2, 8). Furthermore, barriers to the successful implementation of non-pharmacological interventions are significant (5). In addition, it may be impractical and even unsafe to withhold pharmacologic treatment in favor of psychosocial interventions when patients exhibit acute, severe and dangerous behaviors that require immediate amelioration. In such circumstances, first-line use of antipsychotics may be appropriate.
4. Delusions, hallucinations, agitation and hostility tend to increase in frequency and severity as dementia progresses (19). While alternative classes of medications (e.g., cholinesterase inhibitors, antidepressants, mood stabilizers) are being used more extensively for management of these symptoms (21) due to the perception of fewer adverse effects, there is less evidence (and, as compared to placebo, no evidence) of efficacy (8, 20). In light of this, antipsychotics—for which efficacy data, however modest, do exist—continue to have a role in management of these symptoms (8, 13).
5. While the FDA has not approved use of antipsychotic or any other medications specifically for behavioral and psychotic symptoms of dementia, these medications are approved for other comorbid psychiatric disorders. Use of psychotropic medications in dementia patients may be as high as 82% (11). It has been shown that patients who experience symptomatic improvement with antipsychotic medications may relapse if and when they are discontinued (9).
6. There is an association between adverse events and higher dose/longer use of antipsychotic medication in this population, especially among those living in nursing homes (8, 12). It remains unclear whether certain medications are more likely to be associated with adverse effects than other medications (8, 12, 14). Overall, studies consistently recommend that medications be used at the lowest possible dose and for the shortest possible duration (1, 10).
7. The use of appropriate treatments, including antipsychotic medications, for management of agitation holds the potential to relieve caregiver stress and improve the patient's care environment. The presence of behavioral symptoms increases caregiver stress (3). Conversely, a higher caregiver burden and a deteriorating caregiver-patient relationship are associated with agitation (16). One survey assessing subjective beliefs among physicians, nurses and caregivers indicated that, despite the existing concerns about safety and efficacy, almost 50% of caregivers and care providers expected patients to benefit from use of these medications and felt that the potential benefits outweighed concerns about safety and efficacy (6).

ANTIPSYCHOTIC MEDICATIONS TO TREAT BEHAVIORAL DISTURBANCES IN PERSONS WITH DEMENTIA

When antipsychotic medications are used, it is important to:

1. Identify and enumerate specific target symptoms prior to initiation of antipsychotic medication. Discuss the targeted symptoms for antipsychotic treatment with the patient and/or appropriate surrogate decision-maker and document their understanding.
 2. Clinicians should obtain consent for these medications in the same way that they obtain consent for other medications. The consent process should include discussion of the purposes and potential adverse effects of medications with patients and/or surrogate decision-makers; the FDA warnings regarding the use of antipsychotics in dementia should be included in these discussions (4). The process for consent may range from formal discussions to less formal notifications, and should be well documented.
 3. Monitor patients frequently for evidence of effectiveness and toxicity. Frequent dose adjustments may be necessary. Use the lowest effective dosages, and increase dosages slowly and only if indicated clinically.
 4. Consider the use of standardized measures of agitation or of behavioral symptoms in dementia to monitor the effects of treatment and adjust medications accordingly. Several such scales (e.g. Pittsburgh Agitation Scale, Cohen-Mansfield Agitation Inventory) can be obtained free of cost (17, 18).
 5. Consider tapering and discontinuing these medications when the target symptoms remit. While there is a risk of symptomatic relapse (9), evidence indicates that these medications may often be tapered without adverse clinical events, particularly if the symptoms were not severe (7).
 6. Monitor patients closely for evidence of relapse if and when the medications are tapered and/or discontinued.
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Comment

This resource document was prepared by the members of the Council on Geriatric Psychiatry and reflects their views based on the studies cited. It should be noted that the Council did not review the literature using a systematic methodology involving rating the strength of the evidence and the risk of bias.

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