

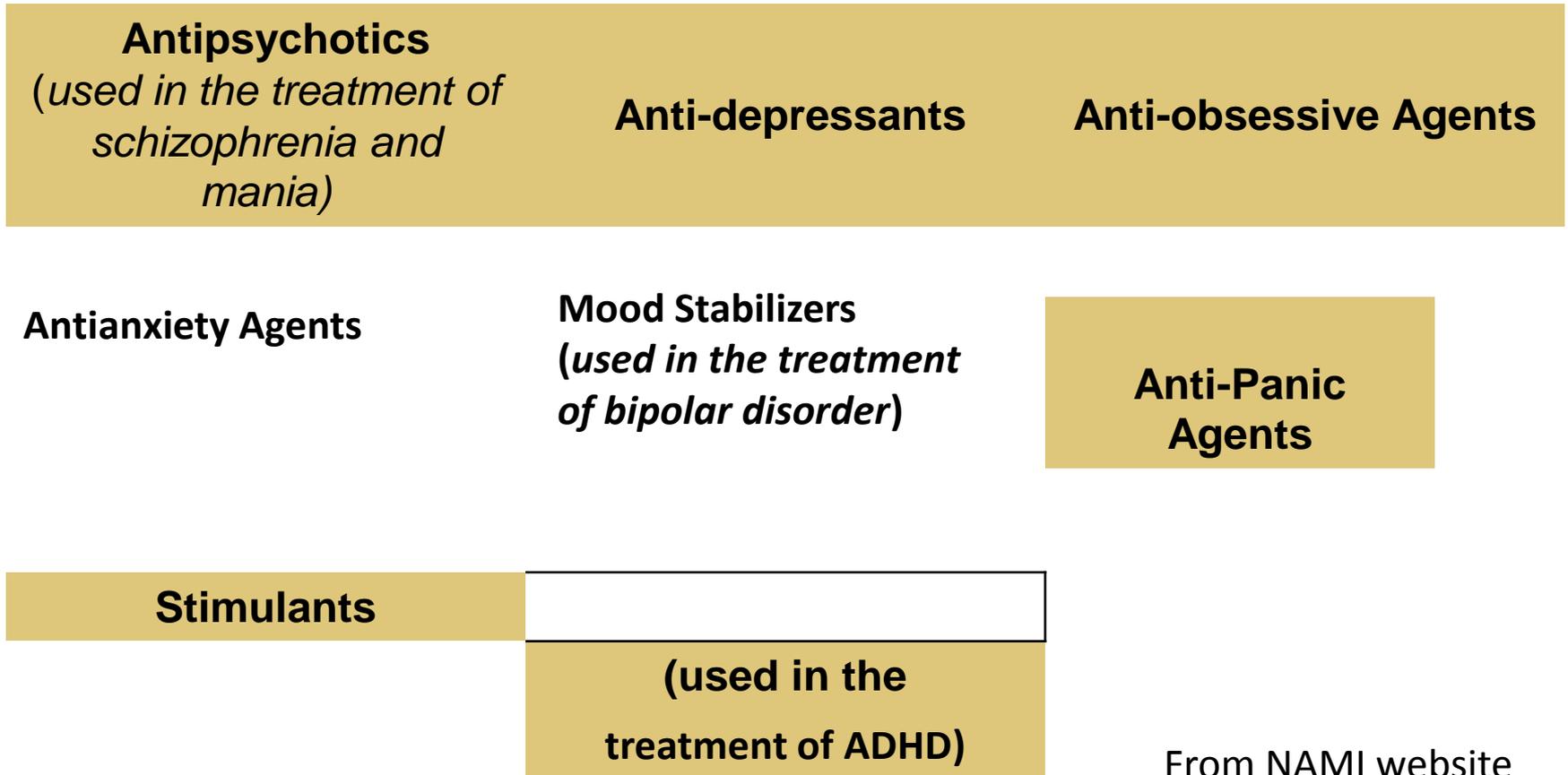
Psychotropic Medication

Including Role of Gradual Dose
Reductions

What are they?

- The phrase “**psychotropic drugs**” is a technical term for psychiatric medicines that alter chemical levels in the brain which impact mood and behavior.

Types of Psychotropic Medication



From NAMI website

Choosing Wisely®

An initiative of the ABIM Foundation

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From Choosing Wisely

- **Lists**
- The *Choosing Wisely* lists were created by national medical specialty societies and represent specific, evidence-based recommendations clinicians and patients should discuss. Each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation.
- In collaboration with the partner organizations, Consumer Reports has created resources for consumers and providers to engage in these important conversations about the overuse of medical tests and procedures that provide little benefit and in some cases harm.
- *Choosing Wisely* recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, providers and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.
- [For Clinicians](#)
- [Specialty society lists of things clinicians and patients should question](#)
- [For Patients](#)
- [Patient-friendly resources from specialty societies and Consumer Reports](#)

Choosing Wisely – from ABIM

- **American Geriatrics Society**
- Released February 21, 2013; revised April 23, 2015
- **Don't use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia.**
- People with dementia often exhibit aggression, resistance to care and other challenging or disruptive behaviors. In such instances, antipsychotic medicines are often prescribed, but they provide limited and inconsistent benefits, while posing risks, including over sedation, cognitive worsening and increased likelihood of falls, strokes and mortality. Use of these drugs in patients with dementia should be limited to cases where non-pharmacologic measures have failed and patients pose an imminent threat to themselves or others. Identifying and addressing causes of behavior change can make drug treatment unnecessary.

Choosing Wisely – from ABIM

- **AMDA – The Society for Post-Acute and Long-Term Care Medicine**
- Released September 4, 2013
- **Don't prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior.**
- Careful differentiation of cause of the symptoms (physical or neurological versus psychiatric, psychological) may help better define appropriate treatment options. The therapeutic goal of the use of antipsychotic medications is to treat patients who present an imminent threat of harm to self or others, or are in extreme distress—not to treat nonspecific agitation or other forms of lesser distress. Treatment of BPSD in association with the likelihood of imminent harm to self or others includes assessing for and identifying and treating underlying causes (including pain; constipation; and environmental factors such as noise, being too cold or warm, etc.), ensuring safety, reducing distress and supporting the patient's functioning. If treatment of other potential causes of the BPSD is unsuccessful, antipsychotic medications can be considered, taking into account their significant risks compared to potential benefits. When an antipsychotic is used for BPSD, it is advisable to obtain informed consent.

From ConsumerReports Health

- People with Alzheimer's disease and other forms of dementia can become restless, aggressive, or disruptive. They may believe things that are not true. They may see or hear things that are not there. These symptoms can cause even more distress than the loss of memory.
- Doctors often prescribe powerful antipsychotic drugs to treat these behaviors:
 - Aripiprazole (Abilify)
 - Olanzapine (Zyprexa and generic)
 - Quetiapine (Seroquel)
 - Risperidone (Risperdal and generic).

From ConsumerReports Health

- In most cases, antipsychotics should not be the first choice for treatment, according to the American Geriatrics Society. Here's why:
- **Antipsychotic drugs don't help much.**
Studies have compared these drugs to sugar pills or placebos. These studies showed that anti-psychotics usually don't reduce disruptive behavior in older dementia patients.

From ConsumerReports Health

- **Antipsychotic drugs can cause serious side effects.**
- Doctors can prescribe these drugs for dementia. However, the Food and Drug Administration (FDA) has not approved this use. The side effects can be serious. Therefore, the FDA now requires the strongest warning labels on the drugs.
- Side effects include:
 - Drowsiness and confusion—which can reduce social contact and mental skills, and increase falls
 - Weight gain
 - Diabetes
 - Shaking or tremors (which can be permanent)
 - Pneumonia
 - Stroke
 - Sudden death

From ConsumerReports Health

- **Other approaches often work better.**
- It is almost always best to try other approaches first, such as the suggestions listed below.

From ConsumerReports Health

- **Make sure the patient has a thorough exam and medicine review.**
- The cause of the behavior may be a common condition, such as constipation, infection, vision or hearing problems, sleep problems, or pain.
- Many drugs and drug combinations can cause confusion and agitation in older people.

From ConsumerReports Health

- **Talk to a behavior specialist.**
- This person can help you find nondrug ways to deal with the problem. For example, when someone is startled, they may become agitated. It may help to warn the person before you touch them.

From ConsumerReports Health

- **Consider other drugs first.**

Talk to your healthcare provider about the following drugs that have been approved for treatment of disruptive behaviors:

- Drugs that slow mental decline in dementia.
- Antidepressants for people who have a history of depression or who are depressed as well as anxious.

From ConsumerReports Health

- **Consider antipsychotic drugs if:**
- Other steps have failed.
- Patients are severely distressed.
- Patients could hurt themselves or others.
- **Start the drug at the lowest possible dose.**
Caregivers and healthcare providers should watch the patient carefully to make sure that symptoms improve and that there are no serious side effects. The drugs should be stopped if they are not helping or are no longer needed.

Now what?

- If avoiding them is 'Best Practice', what do we do if all else fails?

From CMS State Operations Manual: guidance for surveyors

MEDICATION MANAGEMENT Medication management is based in the care process and includes recognition or identification of the problem/need, assessment, diagnosis/cause identification, management/treatment, monitoring, and revising interventions, as warranted. The attending physician plays a key leadership role in medication management by developing, monitoring, and modifying the medication regimen in conjunction with residents and/or representative(s) and other professionals and direct care staff (the interdisciplinary team).

From CMS State Operations Manual: guidance for surveyors

- This guidance is intended to help the surveyor determine whether the facility's medication management supports and promotes:
- Selection of medication(s) based on assessing relative benefits and risks to the individual resident;
- Evaluation of a resident's signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of medications;
- Selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms;
- The use of non-pharmacological interventions, when applicable, to minimize the need for medications, permit use of the lowest possible dose, or allow medications to be discontinued; and
- The monitoring of medications for efficacy and clinically significant adverse consequences.

From CMS State Operations Manual: guidance for surveyors

- V. Tapering of a Medication Dose/Gradual Dose Reduction (GDR) The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences. The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms.

From CMS State Operations Manual: guidance for surveyors

- Sometimes, the decision about whether to continue a medication is clear; for example, someone with a history of multiple episodes of depression or recurrent seizures may need an antidepressant or anticonvulsant medication indefinitely. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline

From CMS State Operations Manual: guidance for surveyors

- The **time frames and duration of attempts to taper any medication depend on factors** including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. Some medications (e.g., antidepressants, sedative/hypnotics, opioids) require more gradual tapering so as to minimize or prevent withdrawal symptoms or other adverse consequences.
- NOTE: If the resident's condition has not responded to treatment or has declined despite treatment, it is important to evaluate both the medication and the dose to determine whether the medication should be discontinued or the dosing should be altered, whether or not the facility has implemented GDR as required, or tapering.

From CMS State Operations Manual: guidance for surveyors

- Considerations Specific to Antipsychotics. The regulation addressing the use of antipsychotic medications identifies the process of tapering as a “gradual dose reduction (GDR)” and *requires* a GDR, unless clinically contraindicated. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

From CMS State Operations Manual: guidance for surveyors

- For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, **the GDR may be considered clinically contraindicated if:**
 - • The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and
 - • The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.

- For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:

The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or

The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

CMS SOM

- Tapering Considerations Specific to Sedatives/Hypnotics.
- For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. Clinically contraindicated means:
 - The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or
 - The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

- CMS SOM

- Considerations Specific to **Psychopharmacological Medications (Other Than Antipsychotics and Sedatives/Hypnotics)**.
- During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated. The tapering may be considered clinically contraindicated, if:
 - The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or
 - The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

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Additional Resource

- **When and How to Taper Antipsychotics for Nursing Home Residents: Lessons from Wisconsin**
- **Musicandmemory.org/2015/07/06 blog**

