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ANTIPSYCHOTICS AND BENZODIAZEPINES

High rates of antipsychotic and benzodiazepine prescribing in residential aged care facilities (RACFs) has been well documented. A recent study concluded that only 10% of psychotropic agents prescribed for RACF residents with dementia were completely appropriate, particularly with respect to indication and therapy duration.

Significant reductions in the proportion of residents prescribed antipsychotics and benzodiazepines has been shown through the Reducing Use of Sedatives (RedUSe) study. Targeted interventions comprising psychotropic medication audit and feedback, staff education, and interdisciplinary medication reviews reduced use, without any increase in as-needed (prn) prescribing of psychotropic drugs.

The Department of Health has recently released a quick reference infographic outlining the 6 steps for safe prescribing of antipsychotics and benzodiazepines in residential aged care.

BPSD

Behavioural and psychological symptoms of dementia (BPSD) is a commonest complication of dementia, including Alzheimer's disease. Symptoms will vary considerably between persons and may fluctuate or escalate over time. The variety of symptoms can be grouped into 3 clusters:

- Depression, withdrawal, adynamia (lack of strength or vigor), amotivation, anhedonia (loss of interest in normally pleasurable activities), tearfulness, hopelessness, ruminations
- Delusions, hallucinations, misidentifications, perseverations, bizarre behaviour, agitation and anxiety
- Aggression (verbal/physical), restiveness (impatient or hard to control), wandering, intrusiveness, inappropriate urinating, sexualised behaviours, disrobing, shadowing, calling out, sleep disturbance

Medications

Many different medicines have been used for managing BPSD. There is limited evidence for antipsychotics, antidepressants, benzodiazepines, anticonvulsants, hormonal treatments, cholinesterase inhibitors and memantine. Choice of therapy should be guided by the resident's presenting symptoms. Hallucinations and delusions are likely to be responsive to antipsychotics. Behaviours such as wandering, undressing, urinating inappropriately, shadowing staff or calling out are unlikely to respond the drug therapy, and use of these medicines for this purpose may constitute chemical restraint. Anxiolytics such as benzodiazepines may be beneficial for short-term management of agitation and anxiety.

Risperidone is the only atypical antipsychotic subsidised on the PBS for the treatment of psychotic symptoms and aggression. Since 2015, the approved duration of treatment has been limited to 12 weeks. From January this year, the PBS listing changed again with the aim to reduce inappropriate prescribing, specifically beyond 12 weeks of therapy. The requirement to request authority approval for PBS-subsidised therapy beyond 12 weeks is intended to prompt trial dose reduction or cessation. Antipsychotic drugs are associated with increased risks of falls, stroke and death. Other adverse effects include extrapyramidal symptoms, constipation, dry eyes, dry mouth, confusion and drowsiness. Benzodiazepines are associated with increased risks of falls, pneumonia and death, especially in higher doses and longer duration of use.

Combinations of psychotropic medicines in older people are associated with a risk of falls and hip fracture. Antidepressants, opioids, antiepileptic drugs, benzodiazepines and antipsychotics all increase the risk of hip fracture. The highest risk of hip fracture is when a benzodiazepine and an SSRI antidepressant are started together; a common combination used to treat anxiety and depression.

6 steps for safe prescribing

The Department of Health infographic details 6 steps for safe prescribing of antipsychotics and benzodiazepines to manage the behavioural and psychological symptoms of dementia. A key message is that prescribing antipsychotics or benzodiazepines should be the exception, not the norm.

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1. Consult the team – discuss the resident's behaviours, triggers, likes and dislikes with family and carers
2. Assess the person – consider behavioural triggers such as pain, infection, depression, recent events or changes
3. Use other strategies – consider other interventions such as physical activity, reassurance, music therapy

4. Get informed consent – discuss the risks and benefits with the resident/decision maker
5. Start low and go slow – if necessary, start antipsychotics or benzodiazepines on a low dose and measure the response against the documented behaviours; increase dose very gradually if needed
6. Plan a review – review regularly (every 4-12 weeks) and keep measuring the response

Symptoms can change over time, so the need for regular review against documented behaviours is important. Alternate medicines may be more appropriate for different symptoms. Best practice guidelines and PBS requirements recommend reducing the dose after a period of time. If symptoms do not return, deprescribing is recommended.

Deprescribing

Psychotropic drugs including antipsychotics and benzodiazepines should usually be tapered gradually so that adverse effects can be minimised. If deprescribing, it is prudent to stop one medicine at a time.

Deprescribing of antipsychotics for BPSD should be considered after 3 months use or if unacceptable adverse effects occur. Residents and/or decision-makers should be involved in the decision to deprescribe. In general, a dose reduction of 25% of the daily dose is recommended every 1 to 4 weeks. If serious adverse effects are present, a faster tapering is recommended. If recurrent or withdrawal symptoms occur the previous tolerated dose should be maintained, rather than reverting to the starting dose.

Common withdrawal symptoms of antipsychotics include irritability, insomnia, anxiety and sweating. A slower weaning rate (e.g. 5% to 12.5% of daily dose each month) is recommended. Behavioural management strategies should be supported concurrently. NPS MedicineWise has developed a tool to facilitate multidisciplinary review of antipsychotic medicines prescribed for patients experiencing BPSD, including advice on how and when to taper.

Continued use of benzodiazepines for the treatment of insomnia and BPSD is considered inappropriate.

In general, benzodiazepines and Z-drugs (zopiclone, zolpidem) can be successfully weaned by 25% of the daily dose every 1 to 4 weeks. Slower weaning may be necessary when reducing to the final lowest dose.

The Therapeutic Guidelines (eTG) recommends stabilisation on an equivalent dose of diazepam (Valium) for people taking high dose benzodiazepines. eTG includes a table of comparative oral doses of benzodiazepines; for example, 0.5mg alprazolam and 15mg oxazepam are equivalent to 5mg diazepam. Common symptoms of benzodiazepine withdrawal include anxiety, insomnia, irritability, myoclonic jerks, palpitations, and sensory disturbances. Abrupt discontinuation of high doses may cause seizures.

Summary

Antipsychotics should not be used as the first choice to treat behavioural and psychological symptoms of dementia. Benzodiazepines and other sedative/hypnotics should not be prescribed as first choice for insomnia, agitation or delirium. Antipsychotics and benzodiazepines should not be continued for more than 3 months without a review. Non-pharmacological management is the first-line treatment option for BPSD.

Resources

Infographic is available at:
https://www.health.gov.au/resources/publications/6-steps-for-safe-prescribing-antipsychotics-and-benzodiazepines-in-residential-aged-care

Department of Health resources:
https://www.health.gov.au/resources/publications/prescribing-psychotropic-medications-to-people-in-aged-care-information-and-resources

NPS MedicineWise resources:
https://www.nps.org.au/professionals/antipsychotic-medicines

References

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