

Antipsychotics Collaborative

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co-chairs Drs Lisa VanBussel and
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Antipsychotics Collaborative

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Today's Session

Introductions and Purpose of today's Session (10:00 am – 10:20 am) -Today's discussion is meant to surface our present landscape and activities and move forward;

At the end, sharing where we want to go by discussing

- **What are the skills and tools needed for persons with lived experience?**
- **What are the skills and tools needed for providers / practitioners?**
- **How do we ensure a person-centred care in day to day practice?**
- **How do we ensure that persons with lived experience are involved in continuous evaluation of these best practices?**

Provide background and context (10: 20 am – 10:30 am):

- Define Antipsychotics and risks associated with their use in older adults
- Give examples of the most commonly-used Antipsychotics (include both generic and brand names; clarifying the difference between the two) and the categories they fall under.
- Discuss the role Antipsychotics play in the management of severe responsive behaviors (possible mention the Canadian Coalition for Seniors Mental Health Guidelines)

Today's Session

Identify Trends / Themes – (10:30 am – 10:45 am): What's happening in the community and what do we want to get on the radar? - National, Provincial and Health Quality Ontario update

Mini Panel : (10:45 – 11:10 am)

Strategies for Research Transfer

- CCCNA / CFHI: (D Sietz)

Practice Improvement Tools

- Alberta Appropriate Use of Antipsychotics (AUA) Toolkit for Care Teams (M Cole)

- De-prescribing Guidelines for the Elderly (**Bruyere / Jamie Conklin**)

- Confidential Practice Report (**Andrea**)

- Academic Detailing – Centre for Effective Practice toolkit (**Andrea**)

Discussion- (11:10- 11:40) Break out groups

– What other things should be considered when transferring knowledge to practice re: anti-psychotics?

Final Wrap up – next Steps

Antipsychotics: indications

- Severe and persistent behavioral and psychological symptoms which are distressing to the patient or put the patient at risk and do not respond to non-pharmacological intervention
- Acute management of delirium
- Continuation of treatment of psychotic disorders that preceded the dementia

Antipsychotics -Risks

- Increased risk of stroke and Mortality
- Side effects – sedation, hypotension(low blood pressure), worsening cognitive impairment/ confusion, change in bowel and bladder function, weight gain
- Increased risk of Parkinsonism, changes in mobility, increased falls, tremor, rigidity, swallowing difficulties

Canadian National Guidelines

- Canadian Coalition for Seniors Mental Health: Assessment and treatment of mental health issues in long term care homes
 - Evaluate for medical conditions and diagnostic tests as indicated
 - Detailed interdisciplinary assessment for antecedents/causes
 - If BPSD does NOT pose imminent risk to patient or others – non-pharmacologic Rx (psychosocial interventions)
- Canadian Consensus Conference on Diagnosis and Treatment of Dementia (CCCDTD4), 2012
 - ‘for severe agitation, atypical antipsychotics are recommended but risks of therapy must carefully weighed against potential benefits “

Antipsychotics

Generic Name	Brand Name	Dose Range	Form	Type
Risperidone	Risperdol	0.125-2mg	Po/liquid/depot	Atypical
Olanzapine	Zyprexa	2.5-10 mg	Po/wafer/short acting injection	Atypical
Quetiapine	Seroquel	12.5-200 mg	Po/short acting and extended release	Atypical
Aripiprazole	Abilify	2- 10mg	Po/depot	Atypical
Haloperidol	Haldol	0.25 – 1mg	Po/IM/depot	Typical
Loxapine	Loxapac	2.5- 10mg	Po/IM/liquid	Typical

Special Populations

Dementia with Lewy bodies and Parkinson's Disease Dementia

- Individuals with Parkinson's disease dementia or dementia with Lewy bodies may be particularly susceptible to EPS with antipsychotics.
- Reductions in dopaminergic medications (e.g. levodopa or ropinirole) should first be attempted for psychotic symptoms in Parkinson's disease if possible.
- Cholinesterase inhibitors and memantine should be considered as first-line treatment for agitation, psychosis and aggression in these populations.
- Low dose quetiapine may be considered for significant psychosis, agitation or psychosis (starting dose 6.25 mg BID – gradually increased to a total of 100 – 150 mg daily as needed).

Frontotemporal Dementia (FTD)

- First-line treatments for FTD may include SSRI antidepressants such as citalopram or sertraline (see table 1).
- Trazodone may also be used to treat NPS in FTD starting at 25 mg PO BID/TID and gradually increasing as tolerated to a maximum of 100 - 300 mg daily.

Resources

CANADIAN:

Canadian Coalition for Seniors Mental Health: www.ccsmh.ca

Download free copies of the National Guidelines for The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms)

Tool on the Assessment & Treatment of Behavioral Symptoms of Older Adults in Long Term Care Facilities

<http://www.ccsmh.ca/en/projects/ltc.cfm>

Tool on Depression: Assessment and Treatment for Older Adults

<http://www.ccsmh.ca/en/projects/depression.cfm>

Alzheimer's Knowledge Exchange:

Long Term Care:

<http://www.akeresourcecentre.org/LTC>

Murray Alzheimer Research & Education Program:

www.marep.uwaterloo.ca

INTERNATIONAL:

International Psychogeriatric Association

Behavioral and Psychological Symptoms of Dementia Education Pack

http://www.ipa-online.net/ipaonline4/main/programs/task/task_BP_SD.html

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Tool on Pharmacological Treatment of Behavioral Symptoms of Dementia in Long Term Care Facilities for Older Adults

Based on:

Canadian Coalition for Seniors' Mental Health (CCSMH)

National Guidelines: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes



For more information or to order additional brochures, visit the Canadian Coalition for Seniors' Mental Health website: www.ccsmh.ca

This pocket card was supported by a Canadian Institutes of Health Research Knowledge Synthesis Grant: KRS #103345: "Interventions for Neuropsychiatric Symptoms of Dementia in Long-Term Care".

DISCLAIMER: This tool, prepared in April 2012, is an aid for healthcare providers. It is not a substitute for a physician's diagnosis and treatment and is not medical advice. Use at your own risk. ©Dallas P. Seitz 2012



Canadian Coalition for Seniors' Mental Health

To promote seniors' mental health by connecting people, ideas and resources.

Coalition Canadienne pour la Santé Mentale des Personnes Âgées

Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

Table 1: Medications for Agitation or Psychosis

Medication	Initial Dose	Titration & Maximum Dose	Formulations	Adverse Events	Comments
Atypical Antipsychotics					
Risperidone*	0.25mg BID or 0.5 mg OD	0.5mg every 3-7 days, 2mg max. total daily dose. May use 0.5 mg PO BID as prn	Tablet (0.25, 0.5, 1.0, 2.0 mg), oral dissolving, liquid, ointment, long-acting injection.	Most likely of atypicals to cause EPS	Best supported atypical antipsychotic for NPS
Olanzapine*	2.5mg QHS	2.5mg every 3-7 days, 10mg max. total daily dose. May use 2.5mg PO BID as prn	Tablet (2.5, 5.0, 7.5, 10.0 mg), oral dissolving, short-acting IM.	More sedating than risperidone or aripiprazole	Most likely to cause metabolic side-effects
Aripiprazole*	2mg PO OD	2-5mg every 3-7 days, max 10 mg total daily dose	Tablet (2.0, 5.0, 10 mg), short-acting IM.	Most likely to cause akathisia	
Quetiapine	12.5mg PO BID	12.5mg BID every 3-7 days to max. total daily dose of 200mg	Immediate & extended release formulations. (25,50, 100, 200mg, XR not available in 25 mg)	More sedating than a risperidone or aripiprazole	May be used for Parkinson's disease dementia or dementia with Lewy bodies at lower doses
Antidepressants					
Citalopram**	10mg PO OD	10mg every 1-2 weeks, max 20mg	Tablet, liquid forms	May cause hyponatremia	Best supported SSRI for NPS
Escitalopram**	5mg PO OD	5mg every 1-2 weeks, max of 10mg	Tablet	Same as citalopram	
Sertraline**	25mg PO OD	25mg every 1-2 weeks, max of 100mg	Tablet	Same as citalopram	
Anticonvulsants					
Carbamazepine	50mg PO OD	50mg every 1-2 weeks, given BID-QID, max. 500 mg	Tablet, liquid forms	Sedation, gait disturbance, neutropenia, hyponatremia	High potential to cause drug interactions, therapeutic drug level monitoring required
Typical Antipsychotics					
Haloperidol	0.5mg PO BID	0.5mg BID every 3-7 days, max 1.5mg BID	Oral, short-acting intramuscular, long-acting depot formulations	Most likely to cause EPS	May be used in emergency treatment where other IM medications are not available

National Initiatives

- Research - Canadian Consortium on Neurodegeneration in Aging (CCNA)
- Canadian Institute for Health Information(CIHI)public reporting
- Choosing Wisely Canada
- BC Guidelines and toolkit
- Alberta Toolkit

Best practices in the management of
behavioural and psychological symptoms
of dementia in residents of long-term
care facilities in Alberta -2014

[http://www.health.alberta.ca/docum
ents/AHTDP-Antipsychotics-LTC-
UofC.pdf](http://www.health.alberta.ca/documents/AHTDP-Antipsychotics-LTC-UofC.pdf)

Alberta



24/7 Health Advice
HEALTHLink Alberta
1-866-408-5465

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AUA Toolkit

- AUA Toolkit
- Back to Seniors Health SCN

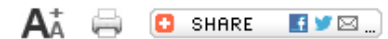
Home > About AHS > Strategic Clinical Networks > Seniors Health SCN > AUA Toolkit

AUA Toolkit

The Alberta Guideline on the Appropriate Use of Antipsychotic (AUA) Medications (2013) and accompanying resources provide health care professionals with direction regarding assessment and management of responsive behaviours associated with dementia.

+ /- Expand and collapse headings for resources

AUA Guideline	+
Consent for Treatment with Antipsychotic Medication	+
Responsive Behaviours	+
Person-Centred and Non-Pharmacologic Approaches	+
Care Planning to Prevent & Manage Responsive Behaviours	+
Clinical Indications for Prescribing Antipsychotic Medication	+



'There's joy again'



Fewer dementia patients using antipsychotic medications. [Read the story, watch the video...](#)

Contact Us

For further information:
AUA@albertahealthservices.ca



Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care

A Person-Centered Interdisciplinary Approach

October 25, 2012

British Columbia- Best Practice Guideline

Part 1

Interdisciplinary Decisional Support for BPSD

 **Assessment**



 **Problem Solving**



 **Care Planning / Evaluation**




Part 2

Reassessment with Family Physician or Nurse Practitioner for BPSD

 **Assessment**



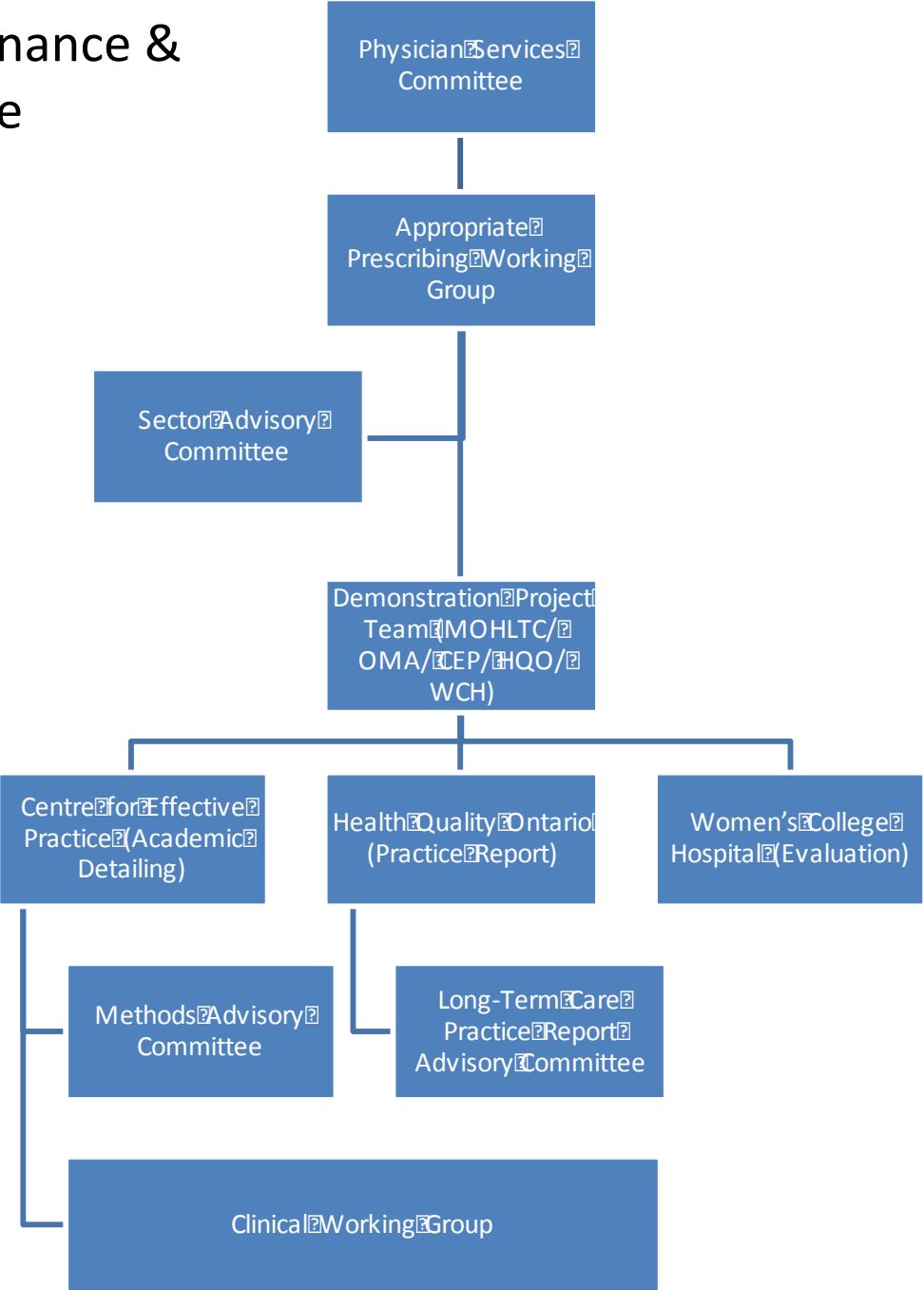
 **Medication Options**



 **Care Planning / Evaluation**



Program Governance & Structure



Provincial Reports: Ontario

- HQO report – Looking for Balance
 - Range of 0-60% utilization in LTC
 - Appropriateness
 - Benefits versus side effects
- ODPRN antipsychotic review
 - 5% decreased utilization in LTC
 - 25% increased utilization in community

Looking for Balance

Antipsychotic medication
use in Ontario long-term
care homes



Ontario

Health Quality Ontario

Percentage of residents using an antipsychotic medication

Across Ontario, the percentage of long-term care home residents using an antipsychotic medication has decreased over the last four years for which we have data, from 32.1% in 2010 to 28.8% in 2013 (Figure 2.1).

FIGURE 2.1

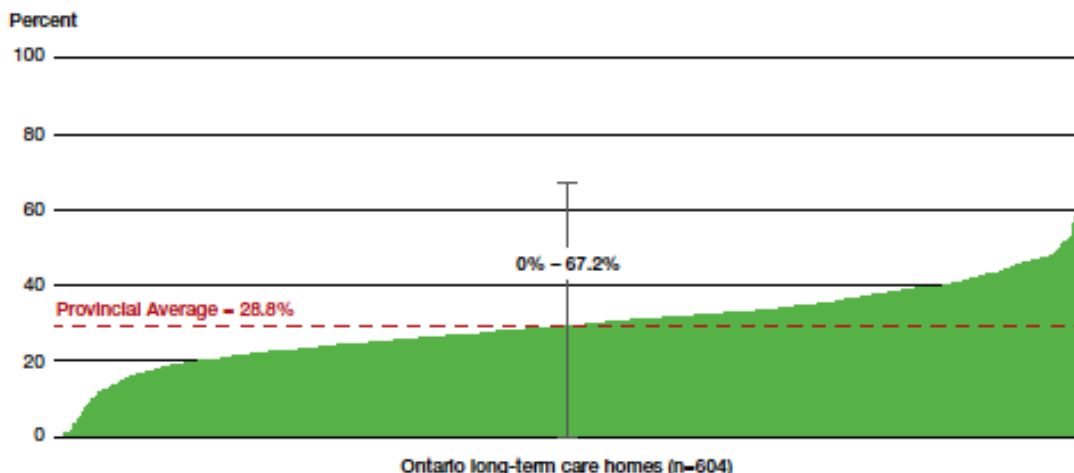
Percentage of long-term care home residents 65 years or older using an antipsychotic medication on March 31 of each year, 2010 to 2013, in Ontario



Data sources: CCRS, DAD, ODB claims database and RPOB, provided by ICES. Note: Values were adjusted for sex, age group and comorbidity. There was a statistically significant difference between the percentages in 2012 (29.5%) and 2013 (28.8%) and the percentage in 2010 (32.1%; reference). See the online technical appendix for descriptions of risk adjustment and statistical significance.

FIGURE 2.2

Percentage of long-term care home residents 65 years or older using an antipsychotic medication, by individual home (ordered lowest to highest) on March 31, 2013, in Ontario



Data sources: CCRS, DAD, ODB claims database and RPOB, provided by ICES. Notes: Values were adjusted for sex, age group and comorbidity. Homes with fewer than 25 ministry-designated long-term care beds were excluded from the figure. See the online technical appendix for a description of risk adjustment and calculation of home level results.

Across long-term care homes, the percentage of residents using an antipsychotic medication varies from a low of 0% to a high of 67.2%

Across Local Health Integration Network regions in Ontario, there was modest variation in the percentage of residents using an antipsychotic medication in 2013, from a low of 25.4% to a high of 32.4%, compared to the provincial rate of 28.8%.^[19]

Across the 604 long-term care homes, there was substantially more variation in the percentage of residents using an antipsychotic medication, from a low of zero to over two-thirds (67.2%) (Figure 2.2).

Care teams (medical directors, attending doctors, nursing staff, pharmacists and personal support workers) in a number of long-term care homes have managed to decrease the use of antipsychotic medications using a range of approaches, such as tracking medication data, assessing individual residents on a case-by-case basis and engaging families (see sidebar: Changes for the Better on page 11).

Provincial Initiatives: Ontario

- Quality Improvement Plans, LTC
 - Request to include antipsychotic use
- CIHI public reporting
 - Home level, region level
- Appropriate Prescribing Demonstration Project
 - Confidential personalized practice reports
 - Academic Detailing
- De-prescribing Guidelines

Group Discussion

Given the trends, tools and strategies for transfer – how do we ensure that Antipsychotic Best Practices & critical elements are shaped by an understanding and active involvement of persons and partners with lived experience? (11:10 – 11:40 am)

- What are the skills, tools and resources that people and families with Lived Experience need to be actively engaged in their health and health care as it pertains to the use of anti-psychotics?
- What are the skills, tools and resources needed of practitioners in order to have a conversation that will actively involve the individual and care partner re: the use of antipsychotics?
- How can practitioners implement and build these required skills on a day to day basis in their practice?
- What are strategies that will help to actively inform and engage the person and family?
- What can we learn from persons with Lived Experience?

Antipsychotic Collaborative Resources

Presentations:

- [Antipsychotics in Older Adults](#), Dr. Paula Rochon, MD, MPH, FRCPC.
- [Drugs and Older Women](#), Dr. Paula A. Rochon, MD, MPH, FRCPC
- [Strategic Use of Antipsychotics in Patients with Dementia](#), Kiran Rabheru, MD, CCFP, FRCP, Geriatric Psychiatrist

Antipsychotic Collaborative Resources

Resources:

- [Appropriate Use of Antipsychotics \(AUA\) Toolkit for Care Teams](#), Alberta Health Services
- [Drugs approved for Alzheimer's disease](#), Alzheimer Society of Canada
- [Medication Utilization: Understanding Potential Medication Problems of the Elderly](#), NICE

Antipsychotic Collaborative Resources

Resources (cntd):

- [Looking for Balance: Antipsychotic medication use in Ontario long-term care homes](#), Health Quality Ontario (HQO)
- [Antipsychotic Use in the Elderly](#), Ontario Drug Policy Research Network (ODPRN)
- [BC BPSD Algorithm](#)
- [Tool on the Assessment & Treatment of Behavioural Symptoms of Older Adults Living in Long Term Care](#), CCSMH