



GUIDELINES

GUIDELINES FOR USE OF PSYCHOTHERAPEUTIC MEDICATIONS IN OLDER ADULTS

Preamble

The American Society of Consultant Pharmacists has developed these guidelines for use of psychotherapeutic medications in older adults. It is our hope that these guidelines will promote the efforts of health professionals in the screening and assessment of psychiatric disorders, and in the rational and judicious use of psychotherapeutic agents in older adults.

This document is intended to convey general principles for the use of psychotherapeutic medications. It is not intended to provide specific and detailed guidelines on the use of specific medications or classes of medications.

Background

Psychotherapeutic medications are among the most commonly prescribed medications in older adults. Until recently, few studies have explored the role and use of these agents in older adults. When used appropriately, these agents can play a key role in maintaining functional status and improving the quality of life of older adults. However, studies have demonstrated that these medications are often used inappropriately. For example, depression is often underdiagnosed and undertreated in older adults¹.

Some psychotherapeutic medications are overused or given in excessive dosages. In nursing facilities, regulations from the Health Care Financing Administration have increased attention and oversight regarding use of these agents. In the assisted living arena, several preliminary studies have shown that the problems that existed in nursing facilities a few years ago are prevalent in that environment². Studies have also documented similar problems among

community dwelling elderly³. Whatever the environment, there is a need for greater education and awareness regarding the appropriate use of psychotherapeutic medications.

Definitions

Psychotherapeutic medication: Any medication intended to affect mood, mental status or behavior.

Guidelines

I. Older adults should be screened for presence of affective, cognitive and other psychiatric disorders.

Older adults are at higher risk for affective and cognitive disorders. Health professionals, including physicians and pharmacists, who interact with older adults, should be alert for signs of common psychiatric disorders among older adults, including depression and dementia. When appropriate, the health professional should administer the screening tools or the patient should be referred to another health professional for screening. These screening tools are used to determine the need for further assessment. Commonly used screening instruments for this population include:

- Folstein Mini-Mental Status Exam (MMSE)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia

Psychiatric disorders are especially common among the frail elderly who reside in nursing facilities and assisted living facilities. It has been estimated that 25-30% of nursing facility residents have depression. Some level of cognitive impairment is present in over half of nursing facility residents, with some studies showing that up to 80 - 90% of nursing facility residents exhibit at least one psychiatric disorder⁴. Residents of assisted living facilities also have a high prevalence of depression and cognitive impairment. The average age of assisted living residents is similar to that of the nursing facility population.

Therefore, residents should be screened soon after admission for depression and cognitive impairment. Those who fail the screening should be referred for more thorough evaluation by a qualified health professional. In addition, screening instruments should be administered when undiagnosed residents exhibit possible manifestations of dementia or depression.

II. Older adults who exhibit symptoms of psychiatric disorders should be thoroughly assessed by a qualified health care professional.

A qualified health professional should be consulted for assistance in evaluating older adults with behavioral symptoms or other psychiatric symptoms. Health professionals and caregivers of older adults should be trained to recognize common symptoms of underlying psychiatric disorders. In many cases, the initial symptom or problem may be an indication of an underlying psychiatric disorder. For example, insomnia can be an indicator of depression.

Behavioral manifestations should be recognized as symptoms, rather than as a distinct problem. All behavior is purposeful. Problem behaviors, such as hitting, require thorough evaluation to investigate an underlying cause. The explanation may be a physical problem, such as a toothache or fecal impaction in a demented person. In other cases, the problem may be a manifestation of an adverse reaction from a medication. For this reason, older adults who exhibit behavioral symptoms should always have an evaluation of their drug regimen to identify possible medication-related causes of these symptoms.

As part of the comprehensive assessment process, treatment goals should be established. These goals should be specific to the individual patient, and should be based upon the assessment and the patient's diagnosis.

In the institutional setting, an interdisciplinary approach is often best suited to evaluating and treating psychiatric and behavioral disorders. The attending physician, nurse, consultant pharmacist, social worker, medical director, and geriatric psychiatrist each have a contribution to make in evaluating and managing these symptoms. In addition, input from caregivers, facility staff, and relatives of the older adult can all be useful.

III. Behavioral symptoms in older adults should be objectively and quantitatively monitored by caregivers or facility staff and documented on an ongoing basis. When possible, psychiatric symptoms should also be monitored in this fashion.

When behavioral or psychiatric symptoms are observed, it is important to carefully define and document the behavior. All persons with behavioral symptoms should be monitored, even if not taking medications. Objective and quantitative monitoring of target behaviors will permit evaluation of whether the behaviors are improving or getting worse over a specified time frame. Behavior monitoring also permits evaluation of the effectiveness of interventions, including medication.

Documenting the details surrounding each episode of the behavioral symptom provides information to assist in evaluation of underlying causes of the behavior. The behavior monitoring system should capture information about the location

and time of behavior symptoms and allow for the determination of precursors to the behavior. For example, does the target behavior always occur in the same room? Does it always happen at the same time of day? Does the behavior always happen when the same person is present? What is the pattern to the behaviors?

When multiple persons are observing the resident, such as in a long-term care facility, a specific definition or description of the target behavior will ensure that all observers are documenting the same behavior. The use of vague descriptors, such as the term “agitation”, should be avoided. Whether a behavior monitoring form is used, or the information is documented in progress notes, the important factor is that adequate information be captured to allow analysis of the behaviors. Simply counting the number of episodes of target behaviors does not usually provide sufficient information to examine patterns and underlying causes of behaviors.

IV. If the behaviors do not present an immediate serious threat to the patient or others, the initial approach to management of behavioral symptoms in older adults should focus on environmental modifications, behavioral interventions, psychotherapy or other nonpharmacologic interventions.

Once the older adult has been assessed and goals of therapy have been established, strategies for reducing behavioral symptoms should be planned and implemented. General nonpharmacologic interventions can often be successful in preventing or reducing behavioral symptoms⁵⁻⁶.

A general principle of managing behavioral symptoms in older adults is to use the least intrusive strategies first. If these are ineffective, or only partially effective, then medications may be added to the other strategies that are in place. The adjunctive use of psychotherapeutic medications may improve the overall response to non-pharmacologic interventions or psychotherapy. Medications would only be used as first line therapy in acute situations where the resident is at immediate risk of harming himself or others.

V. When medications are indicated, select an appropriate psychotherapeutic agent, considering effectiveness of the medication and risk of side effects.

Older adults are especially vulnerable to adverse drug effects as a result of their multiple chronic diseases, use of multiple concomitant medications, and the pharmacokinetic and pharmacodynamic changes that accompany aging. For these reasons, prescribers need access to the full armamentarium of psychotherapeutic agents in order to customize drug therapy for each individual. For example, the atypical antipsychotics generally have fewer side effects than the typical antipsychotics. The atypical agents are often preferable in older adults, especially for long-term use.

Some of the older psychotherapeutic medications should be avoided for use in older adults. For example, amitriptyline and doxepin have been noted to be no more effective than other agents but have high anticholinergic side effects. The use of antihistamines (e.g. diphenhydramine) as hypnotic agents should be avoided in the elderly for the same reason.

Accurate diagnosis of the psychiatric disorder is a necessary first step in the selection of an appropriate psychotherapeutic agent. The agent selected should be indicated for the condition that has been diagnosed. In addition, each patient's drug regimen should be evaluated for potential contraindications and clinically significant drug interactions prior to initiating psychotherapeutic medication.

From among the effective agents available, the agent with the least potential for intrusive side effects should be selected. If two or more agents are considered equivalent on the basis of efficacy and side effects, cost may be considered in making the final selection.

An important factor in selection of an appropriate pharmacologic agent is consideration of the patient's ability to adhere to the prescribed therapy. Factors that may affect patient adherence to therapy include the number of times per day the medicine must be administered; the patient's ability to afford the cost of the therapy; and side effects of therapy.

Prior to initiation of therapy, the patient and/or caregiver should be informed of potential benefits and risks of medications, sufficient to participate in the decision making process.

VI. Begin medication at the lowest appropriate dosage and increase the dose gradually.

A general principle of geriatric pharmacotherapy is to start low and go slow. This is especially applicable to psychotherapeutic agents. Except in urgent situations, these medications should be started at a low dose and gradually increased until the therapeutic effect is achieved.

It is also important to recognize that in some cases, the onset of full therapeutic effect may be delayed. Adequate time should be allowed before concluding that dosage increases are warranted or that the medication is ineffective.

Certain psychotherapeutic medications may be used on a PRN (as needed) basis. These include short acting benzodiazepines (e.g. lorazepam, oxazepam) and hypnotics (e.g. temazepam). When psychotherapeutic medications are used PRN, the circumstances for use of the medication should be clearly delineated. Vague orders, such as "PRN agitation", should be avoided. In general,

appropriate nonpharmacologic interventions should be attempted prior to use of PRN medications.

VII. Monitor the patient for therapeutic response from the medication and for adverse drug reactions.

Individuals who take psychotherapeutic medications should be monitored to determine whether the medication is effective. Therapeutic goals should be established at the beginning of therapy. Symptoms and target behaviors should be identified and monitored on an ongoing basis.

Individuals taking psychotherapeutic medications should be continually monitored for adverse drug reactions. Monitoring tools, such as the Abnormal Involuntary Movement Scale (AIMS) in patients taking antipsychotic medications, can be useful for evaluating adverse drug reactions. The prescriber should be informed when significant adverse effects are noted.

In nursing facilities, the Minimum Data Set can be an effective tool for monitoring effectiveness and adverse effects of psychotherapeutic medications. Consultant pharmacists should take advantage of available resources to learn to use the MDS as part of the drug regimen review process⁷⁻⁹.

Patients, caregivers, and health professionals should be educated regarding the expected therapeutic goals, common side effects, and infrequent but serious adverse effects of psychotherapeutic medications, such as neuroleptic malignant syndrome. Input from all caregivers and health professionals is helpful for effective monitoring of the patient.

9 The psychotherapeutic medication regimen should be routinely re-evaluated for the need for continued use of medication, dosage adjustments or a change in medication.

Particularly in cognitively impaired individuals, psychiatric and behavioral symptoms tend to resolve over time. However, individuals diagnosed with psychiatric disorders such as bipolar disorder or major depressive disorder may require long term psychotherapeutic drug therapy to maintain their highest functional abilities.

Because of the variability of many psychiatric disorders and the potential for adverse drug reactions, it is important to re-evaluate the psychotherapeutic drug regimen at appropriate intervals. When a dosage reduction is indicated, medication doses should be reduced gradually to prevent acute exacerbations of the underlying condition. In many cases, the patient can be maintained on a lower dose of the medication, or it may be possible to discontinue the medication entirely.

References

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