Practical Tips for Psychotropic Gradual Dose Reduction

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Learning Objectives

- Explain the CMS requirements for gradual dose reduction
- Recognize the elements of appropriate documentation of psychotropic therapy
- Understand how changes in a medication dose can have delayed effects on behavioral expression
- Identify special precautions for residents taking benzodiazepines and sleep medications

What is Gradual Dose Reduction?

The stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued

What is Gradual Dose Reduction?

Doses reductions should occur in ***modest*** increments over ***adequate periods of time*** to minimize withdrawal and to monitor symptom recurrence

GDR Requirements

For all scheduled (routine) psychotropic medications

GDR should be done within the first year of therapy

- Two separate quarters with at least a month in between attempts
- In other terms: every 6 months

After the first year

- Annually

Drugs Requiring GDR

For *any* Indication

- Antidepressants
- Anxiety Medications
- Antipsychotics
- Lithium
- Sedative-Hypnotics*

Under Certain Conditions

- Carbamazepine (mood, behaviors)
- Diphenhydramine (sleep, anxiety)
- Gabapentin (anxiety)
- Hydroxyzine (anxiety)
- Oxcarbazepine (mood, behaviors)
- Lamotrigine (mood, behaviors)
- Valproic Acid (mood, behaviors)

*Melatonin is NOT considered a psychotropic and does not require GDR (although may be clinically appropriate

What To Do When GDR Is Due

The dose should be modestly reduced over several weeks*

*your pharmacist can help to develop a tapering schedule

OR

The provider should document the clinical rationale for why gradual dose reduction is not appropriate or contraindicated

GDR Contraindications

- Recent previous failed GDR (within the facility)
- GDR is likely to cause increased resident distress
- GDR is Likely to impair function
- Underlying psychiatric disorder

Inappropriate Justification

- Resident, family, or DPOA declined GDR
- More convenient for care staff
- Hospice Status

Additional Documentation

1. Appropriate Diagnosis
2. Informed Consent
3. Side effect Monitoring
4. Target Behaviors
5. Formal Assessment of Efficacy
6. Non-pharmacological Interventions

Target Behaviors

- ***specifically identified in the care plan***
- monitored objectively and quantitatively
- evaluated at least quarterly
- sufficient to provide the prescriber with the necessary information to determine antipsychotic medication effectiveness

Target Behaviors

Appropriate Target Behaviors	Inappropriate Target Behaviors
Persistent anger toward self or others	Anger (non-specific or situational)
Biting	Agitation
Continuous pacing	Anxiety
Crying/teats (inconsolable)	
Delusions (specify)	
Inappropriate robing/disrobing	Inattention
Hallucinations (specify)	Nervousness
Head Banging	Poor self-care
Hitting	
Kicking	
Restlessness (continuous, inconsolable)	General Restlessness
Scratching	Sadness/depressed mood
Self-abusive acts (thoughts or actions)	Uncooperativeness
Throwing/smearing food or feces	Unsociability
Verbal threats	Wandering
Wandering into inappropriate places	

Assessment of Efficacy

Answer the questions

1. Are target behaviors better/worse/unchanged while on psychotropic medications?
2. Which non-medication interventions have been used and how effective are they?
3. Have medication side effects been observed?
4. When and what was the outcome of the last GDR
5. GDR recommendation

Non-pharmacological Interventions

- Aromatherapy
- Massage
- Music therapy
- Pet therapy
- Environmental modification
- Redirection and diversion

Music Therapy

Enhances the effects of reminiscence therapy for anxiety and depression

Improve cooperation during bathing or other difficult times

Improves mood

Improve global cognition

Music Therapy

- Get family input
- Personalize
- Resources: 100 Years Book – Playlist for Life

Antidepressant Considerations

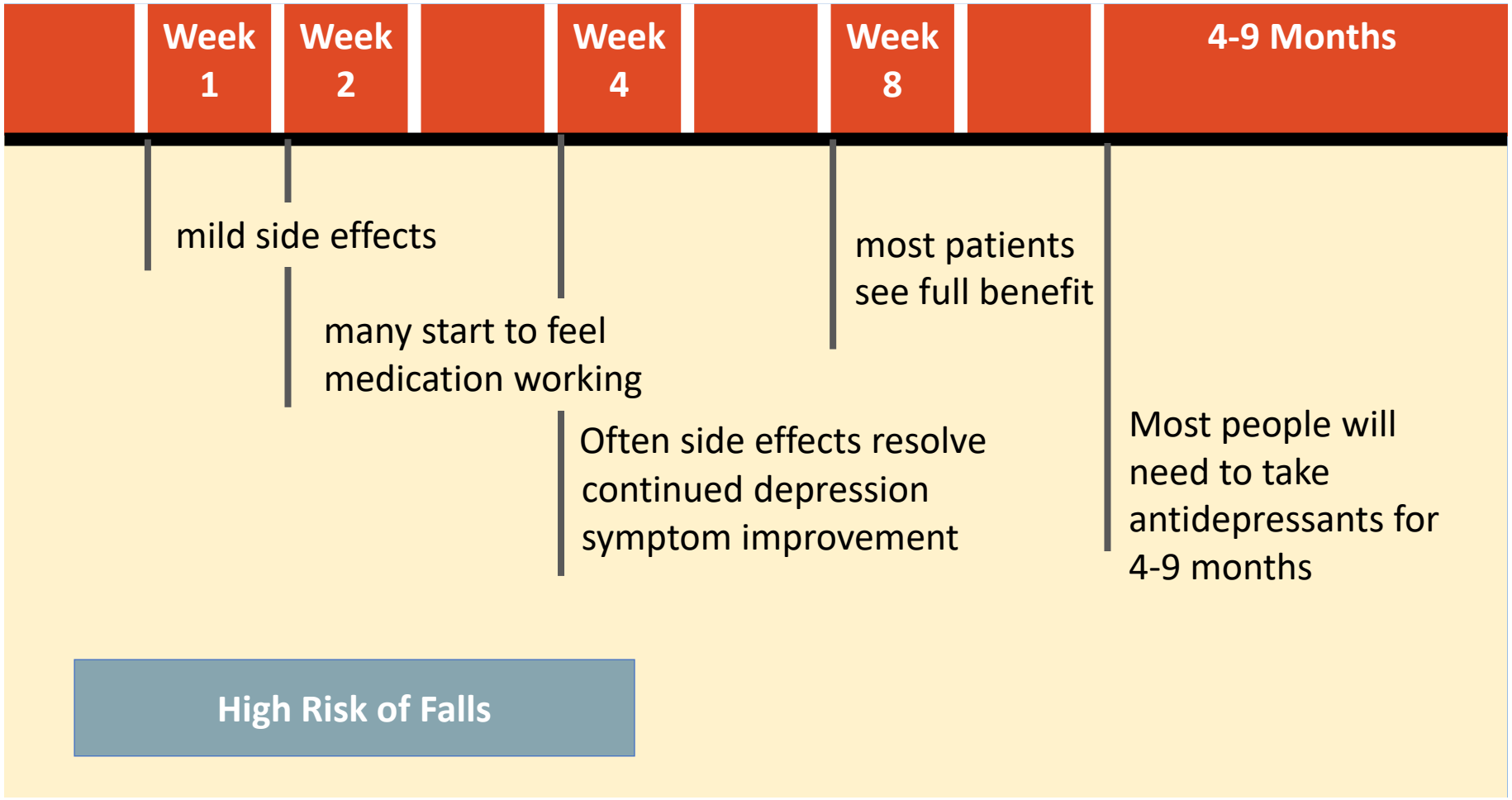
1. Optimize the Dose
2. Be Patient
3. Choose Wisely

Understanding Dosing

Antidepressant	Lowest Effective Dose	MAX daily dose
Bupropion	150mg	300mg
Citalopram [a]	10mg	20mg
Desvenlafaxine	50mg	50mg
Duloxetine [a]	40mg	120mg
Escitalopram [a]	10mg	10mg
Fluoxetine [a]	20mg	80mg
Fluvoxamine	50mg	300mg
Mirtazepine	7.5mg	45mg
Sertraline [a]	50mg	200mg
Trazodone	25mg	400mg
Venlafaxine [a]	75mg	225mg
Vortioxetine	10mg	20mg

a. Used first-line for generalized anxiety or panic disorder

Antidepressant Timeline



Antidepressant Double Duty

Antidepressant	Additional Indications
Bupropion	Smoking cessation, weight loss
Duloxetine	Pain
Venlafaxine	Hot flashes, pain
Escitalopram, Fluvoxamine, Fluoxetine, Paroxetine, Sertraline	Obsessive-compulsive disorder
Trazodone	Insomnia
Mirtazapine	Insomnia, appetite
Nortriptyline	neuropathy

Antidepressants for Anxiety

Many antidepressants are FDA approved for treatment of anxiety

The American psychiatric association recommends SSRI-type antidepressants are first line medication therapy

Studies have shown that higher doses of these are sometimes needed to manage anxiety

When an Antidepressant is Not Working

Switch

- The first antidepressant trial
- Initial choice of med is not well-tolerated
- There is no response
- There is time to wait for a response

OR

Add a Second Agent

- Third antidepressant used
- No side effects
- Partial Responders
- Severe functional impairment or urgent need to stabilize

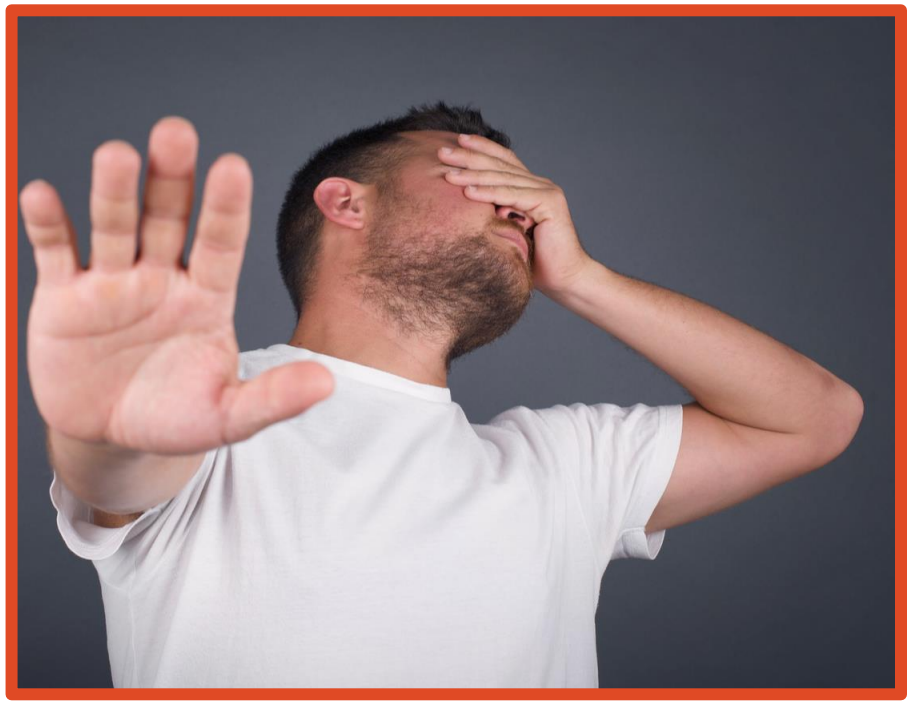
Antidepressants to Avoid

Paroxetine

- can cause drowsiness, increased risk of delirium

Amitriptyline, Imipramine, Nortriptyline, Doxepin

- risk of physical dependence, risk of overdose at low doses



Antipsychotic Considerations

1. **Know When to say No**
2. **Understand Timing**
3. **Weigh Risks**

Understanding Efficacy

Symptom or Behavior of Dementia	Demonstrated Efficacy		
	Yes	No	uncertain
Agitation			X
Agression	X		X
Delusions	X		
Delirium	X		
Eating Inedible Materials		X	
Hallucinations	X		
Insomnia		X	
Repetitive vocalizations		X	
Resisting Personal Care		X	
Restlessness		X	
Spitting		X	
Wandering /Exit Seeking		X	

Understanding Efficacy

For every 11 patients with dementia *without* psychosis

Only 1 will have a reduction in behavioral or psychological symptoms after 12 weeks

Understanding Efficacy

Clinical trial data is limited

The lowest effective dose for antipsychotics in the elderly has not been established. Consult your pharmacist for each case

Medication	Lowest Effective Dose	MAX daily dose
Aripiprazole (Abilify)	5mg	20mg
Olanzapine (Zyprexa)	2.5mg	10mg
Quetiapine (Seroquel)	25mg	300mg
Risperidone (Risperdal)	0.25mg	2mg

Antipsychotic Timeline

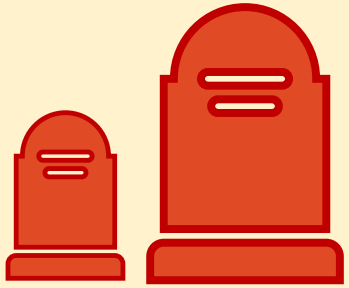
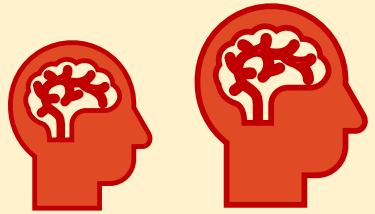
Within Hours	Week 2	Week 4	Week 6	Week 8	Week 16 (4 months)
dizziness drowsiness	Some residents *may* start to see improvement in target behaviors	*Should* at least see partial improvement If no change or worse: taper		If no change: taper If better: continue	STOP Recommend taper (even if effective)

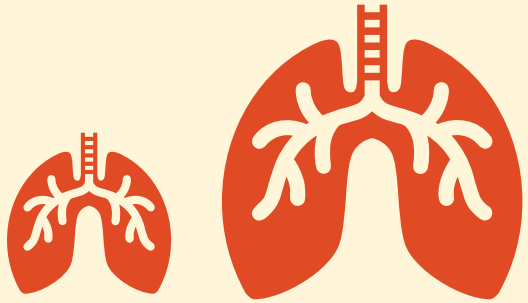
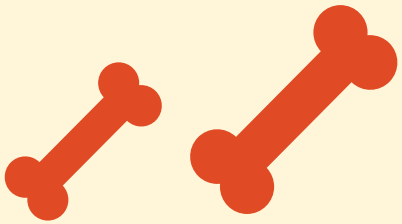
Week 4-8 is a Key Decision Window

Seek input from front-line care staff (Nursing aids)

Antipsychotic Risks

When given to patients with dementia antipsychotics increase the risk of several adverse events

DEATH	STROKE
	
1.7 times the risk	1.2 times the risk

HOSPITALIZATION	PNEUMONIA	HIP FRACTURE
		
1.5 times the risk	1.8 times the risk	1.3 times the risk

Antipsychotic Monitoring

Every 6 months

- Abnormal Involuntary Movement Scale (AIMS)

At least quarterly

- blood pressure, weight, fasting glucose

Annually

- Fasting Lipid Panel
- A1c

Anxiolytics Considerations

1. **Use Extreme Caution When Stopping**
2. **Understand Risk**

Tapering Benzodiazepines

- Routine use of benzodiazepines for more than one month can cause withdrawals
- Reduce by approximately 25% every 2-3 weeks
- Anticipate and educate regarding rebound insomnia
- Plan additional psychological support during taper
- Points of dosing schedule changes (e.g. TID to BID) can be psychologically challenging

Withdrawal Symptoms

- tremor or muscle spasms
- disturbed sleep
- sweating
- mood changes
- increased sensitivity to noise
- dizziness
- ***seizures***
- confusion
- ***hallucinations***
- paranoia

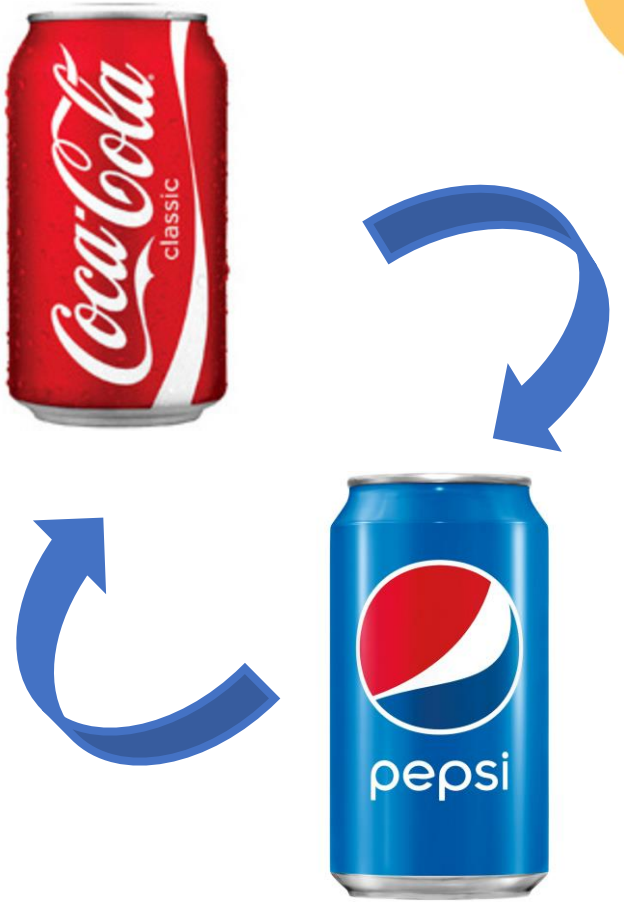
Avoid Substitutions

Resist the temptation to start

- Diphenhydramine
- Hydroxyzine
- Sedatives (eszopiclone, zolpidem, zaleplon)

Reasonable to start

- Buspirone
- Melatonin



Benzodiazepine Risks

- Increased risk of delirium in dementia patients
- Possible paradoxical response in elderly
- Respiratory depression (especially used in combination with opioids)

Takeaways

- It can take weeks or even months to see effects of med changes – be patient
- Optimize the dose of the first agent before adding more
- Have a purpose and make it clear exactly why the resident is on the medication
- Don’t’ forget about non-pharmacological interventions

Presenter info

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