National report: **The use of antipsychotic medicines in older people**

KEY PRACTICE POINTS:

- In 2019, approximately 4% of people aged ≥ 65 years were dispensed antipsychotics from community pharmacies. The number of people dispensed antipsychotics was 9% higher than in 2018. The highest dispensing rate was in people aged ≥ 85 years (8% of this group).
- The rate of antipsychotic dispensing by ethnicity was approximately the same as the national rate (4%) in Europeans and Māori, but 2% in Asian people and 3% in Pacific peoples
- Older people are particularly vulnerable to the adverse effects associated with antipsychotic medicines. Antipsychotics should only be prescribed if they have proven benefit for the condition being treated. Treatment should be initiated as a trial at the lowest dose likely to provide therapeutic benefit and should ideally not exceed three months duration (unless prescribed for a long-term psychiatric condition)

Overview

The purpose of this report is to provoke thought and discussion about how and why antipsychotic medicines are prescribed to older patients. There is a concerning increase in the use of antipsychotics in older people, which are often prescribed off-label and sometimes for inappropriate indications, e.g. for insomnia. A 2018 audit of prescribing including 270 general practitioners in New Zealand found that 72% of prescriptions of quetiapine to people aged ≥ 14 years were for an off-label indication.[1]

Older people are particularly vulnerable to the adverse effects associated with antipsychotic medicines. Antipsychotics should be prescribed at the lowest effective dose, for the shortest possible time, and only if there is evidence that they are beneficial for the condition being treated. The patient should be closely monitored for the development of intolerable or serious adverse effects and treatment reviewed regularly to ensure ongoing benefit. In most cases, indefinite treatment is not appropriate.

Antipsychotics are not "bad medicines"; they just need to be prescribed to the right people for the right reason and for the right period of time. Antipsychotics do work for many people, sometimes very well. The caution is that antipsychotics can cause serious harm, particularly in older people, so a measured approach is necessary.

For further information on prescribing antipsychotics, see: **www.bpac.org.nz/BPJ/2011/november/antipsychotics.aspx**

Antipsychotics are not recommended for the treatment of insomnia

Antipsychotic medicines, particularly quetiapine, are frequently prescribed off-label in New Zealand to treat insomnia.[1] Antipsychotics are not indicated for treating insomnia, but the sedative effects may be useful in some cases, e.g. patients with psychosis.

"Sleep hygiene" is the first-line treatment for insomnia, e.g. establishing a bedtime routine, avoiding alcohol and stimulants before bedtime and not staying in bed when not sleeping. Zopiclone or a short-acting benzodiazepine may be considered for the short-term pharmacological treatment of insomnia, but only if non-pharmacological interventions are ineffective. However, strong caution is required when prescribing these medicines to older people due to the increased risk of adverse effects, e.g. falls.

For information on managing insomnia, see: **https://bpac.org.nz/2017/insomnia-1.aspx** and **https://bpac.org.nz/2017/insomnia-2.aspx**

Antipsychotics may be used in the short-term for anxiety or depression if other medicines have been ineffective

Anxiety and mood disorders are a common reason for prescribing antipsychotic medicines off-label, although the proportion of older adults prescribed antipsychotics for this reason is not known.[1] While there is some evidence that antipsychotics may be effective for generalised anxiety disorder or depression, the risk of adverse effects, particularly in older people, means that they are generally not recommended for these conditions.

Non-pharmacological interventions are the first-line treatment for mild to moderate anxiety and depression. Selective serotonin re-uptake inhibitors (SSRIs) are recommended if behavioural interventions have been ineffective alone. Older adults should be carefully monitored for the adverse effects of SSRIs, e.g. sedation, hypotension, anticholinergic effects, sleep disturbance and hyponatraemia.

For further information on the pharmacological management of depression, see: **www.bpac.org.nz/2017/depression.aspx**

Antipsychotics are a second-line treatment for the behavioural and psychological symptoms of dementia

Antipsychotics may be considered for patients with behavioural and psychological symptoms of dementia (BPSD) if aggression, agitation or psychotic symptoms are causing severe distress or an immediate risk of harm to the patient or others. They are not useful for treating symptoms such as wandering, shouting, touching or social withdrawal, or intermittent symptoms related to a specific trigger. Antipsychotics should be avoided in patients with Lewy body dementia or Parkinson's disease with dementia.

Unless immediate treatment is required, non-pharmacological approaches should always be tried first and continued concurrently with antipsychotics. Antipsychotics are only modestly effective in managing BPSD, and the level of effectiveness varies between patients. Even short courses of antipsychotics can cause significant adverse effects in people with dementia, e.g. sedation, increased risk of falls, extrapyramidal effects, pneumonia, stroke, cardiovascular events and increased mortality. Therefore, a careful risk versus benefit assessment is essential.

Risperidone is the most extensively studied antipsychotic for the treatment of BPSD and is the only atypical antipsychotic approved for this use in New Zealand. Risperidone is, therefore, the first-line choice when an antipsychotic is prescribed for BPSD. Treatment should be initiated as a trial at the lowest dose likely to provide therapeutic benefit. Review treatment regularly. If the patient does not respond, review adherence and consider dose optimisation and whether treatment has been continued for an adequate length of time (i.e. four to six weeks). If there has been no improvement in the patient's symptoms following this timeframe, the antipsychotic should be withdrawn. Patients who do respond to treatment should have their symptoms stabilised within three months and withdrawal of treatment should be trialled. If risperidone is not tolerated or not appropriate other antipsychotics (e.g. quetiapine) may be considered.

For further information on managing BPSD, see: **www.bpac.org.nz/2020/bpsd.aspx**

Reference

1. Huthwaite M, Tucker M, McBain L, et al. Off label or on trend: a review of the use of quetiapine in New Zealand. N Z Med J 2018;131:45–50.

Antipsychotic prescribing in primary care

The national dispensing data provide an overview of antipsychotic prescribing to people aged ≥ 65 years in New Zealand. Data have not been provided for practices or individual prescribers due to many prescribers having only small numbers of patients dispensed these medicines, making interpretation of any trends difficult and comparison less meaningful.

If you are a prescriber, consider how you prescribe antipsychotics to older people, if at all. Points for reflection are available at the end of the report, along with a clinical audit.

Trends in antipsychotic prescribing over the past five years

In 2019, antipsychotics were dispensed to 29,115 people aged ≥ 65 years (approximately 4% of this age group). The number of people receiving these medicines (adjusted for population growth) remained relatively stable between 2015 and 2018, before increasing by 9% between 2018 and 2019 (Figure 1). The reason for this increase is not known, but given the vulnerability of this population to the adverse effects of these medicines, it is concerning.

Antipsychotic dispensing in older people by age and ethnicity

Dispensing increased with age, with the highest rates in people aged ≥ 85 years (8% of this group – Figure 2). Dispensing rates were comparable between Europeans and Māori (approximately 4% in each ethnic group); dispensing rates were approximately half of this rate in Asian and three quarters of this rate in Pacific peoples (Figure 3). Interpretation of these data are challenging as the ideal level of prescribing is not known, i.e. this may represent undertreatment of some groups and overtreatment of others. Differences in the accessibility of healthcare services and acceptability of pharmacological treatment may in part help to explain the differences in prescribing rates.

Figure 1: The number of patients aged 65 years or over, per 1,000 enrolled patients, who were dispensed antipsychotic medicines from community pharmacies from 1 January to 31 December, 2015–2019.

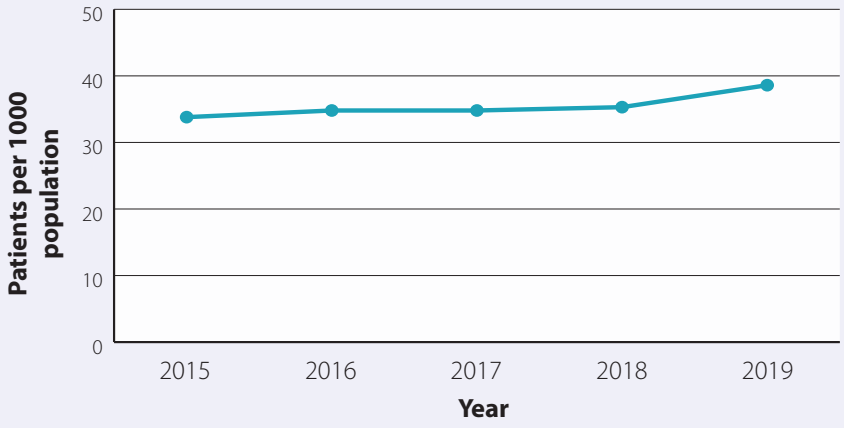


Figure 2: The number of patients aged 65 years or over, per 1,000 enrolled patients, by age, who were dispensed antipsychotic medicines from community pharmacies from 1 January, 2019, to 31 December, 2019.

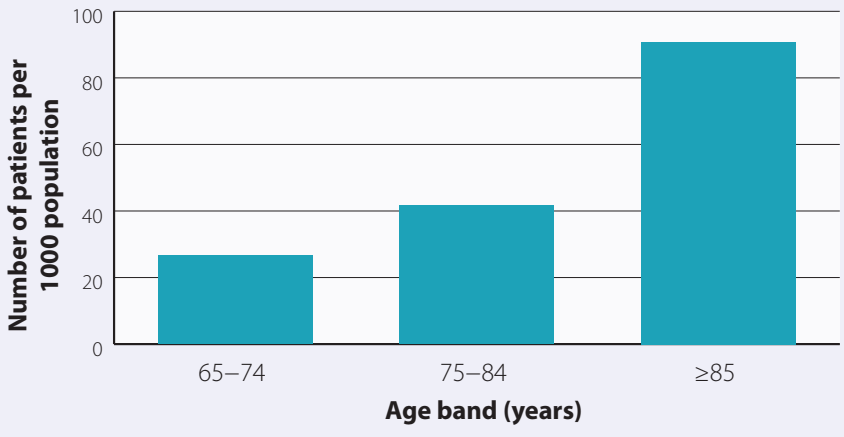
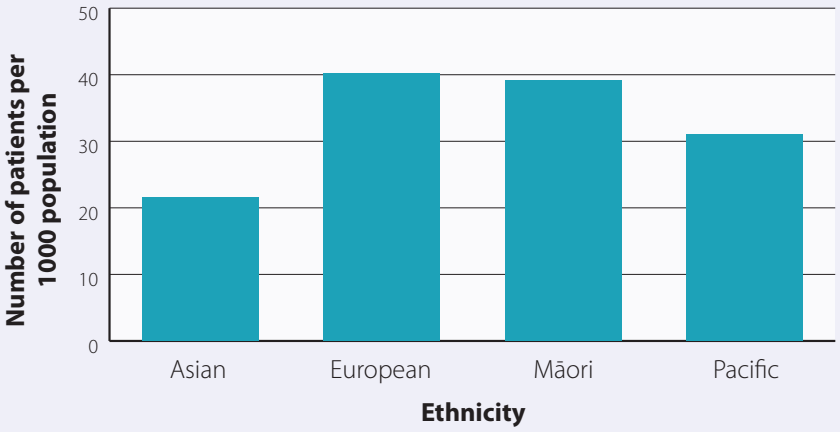


Figure 3: The number of patients aged 65 years or over, per 1,000 enrolled patients, by ethnicity, who were dispensed antipsychotic medicines from community pharmacies from 1 January, 2019, to 31 December, 2019



Dispensing data indicate a high proportion of long-term antipsychotic use

Nationally, 65% of people aged ≥ 65 years who were dispensed an antipsychotic in 2019 were using these medicines long-term.* Antipsychotics should generally only be used short-term in older patients, e.g. trial withdrawal within three months in patients with BPSD with stable or improved behaviour . The long-term use of antipsychotics should be limited, where possible, to patients with serious mental illness, e.g. schizophrenia or bipolar disorder. The national dispensing data suggest there may be a number of people who have remained on treatment inappropriately.

* Defined as one prescription in at least three out of four quarters (this accounts for patients who are continually using antipsychotics but did not have prescriptions dispensed precisely every three months).

Points for reflection:

- Do you prescribe antipsychotics to older people? What conditions do you prescribe these medicines for and do you find them to be effective?
- Have you noticed any ethnic or cultural differences in the willingness of patients to use antipsychotics?
- When prescribing antipsychotics for BPSD, how often do you review patients to assess their response? Do you routinely withdraw treatment after three months?
- What non-pharmacological treatment options do you recommend to older people instead of prescribing antipsychotics? Do you find these to be effective? Do you find difficulties implementing these strategies in this patient group?

A clinical audit of antipsychotic prescribing will be available soon from: **www.bpac.org.nz/audits**

This article is available online at:
www.bpac.org.nz/report/2020/antipsychotic-medicines.aspx