Dementia Antipsychotic Prescribing Guide

General Guidelines:

1. **Rule out reversible causes** prior to using a drug.
2. **Try non-drug management strategies first.**
3. **Clearly document treatment targets** (symptoms) before and after a treatment strategy is tried.
4. **Justify use of an antipsychotic.** The treatment target symptom must present **a danger to the person or others**, or cause the patient to experience one of the following:
   - inconsolable or persistent distress
   - a significant decline in function
   - substantial difficulty receiving needed care
5. **See Guidance for Special Populations,** if the patient has fronto-temporal dementia, Parkinson's disease, Lewy body dementia, renal impairment, or hepatic impairment.
6. **Consider the impact of side effects on comorbidities** when choosing a drug, and **start with a low dose.**
7. **If the drug doesn't help, stop it** (use appropriate tapering).

Appropriate antipsychotic treatment targets:*

- Aggressive behavior (especially physical)
- Hallucinations (if distressing)
- Delusions (note: memory problems are often mistaken for delusions, e.g. thinks people are stealing lost items)
- Severe distress as described above in #4 General Guidelines

Inappropriate antipsychotic treatment targets:*

- Wandering
- Unsociability
- Poor self-care
- Restlessness
- Nervousness
- Fidgeting
- Mild anxiety
- Impaired memory
- Uncooperativeness without aggressive behavior
- Inattention or indifference to surroundings
- Verbal expressions or behaviors that do not represent a danger to the resident or others

*According to CMS regulations for long-term care facilities

Antipsychotic Efficacy

Evidence supports modest symptom improvements with **aripiprazole**, **haloperidol*, olanzapine, quetiapine, and risperidone**, but not with use of other antipsychotics in dementia. All antipsychotics appear to increase risk of death. The table below summarizes the strength of evidence supporting the efficacy of each **atypical antipsychotic** for different symptom domains.

	Aripiprazole	Olanzapine	Quetiapine	Risperidone
Dementia overall	+ +	+	+	+ +
Dementia psychosis	+	+ / -	+ / -	+ +
Dementia agitation	+	+ +	+ / -	+ +

+ + = moderate or high evidence of efficacy
+ = low or very low evidence of efficacy
+/ - = mixed results

*Haloperidol has shown efficacy for aggression in randomized trials

Adverse Effects Comparison Table

Drug *Brand Name* (daily dose range)	Aripiprazole *Abilify* (2-10 mg)	Haloperidol *Haldol* (0.25-2 mg)	Olanzapine *Zyprexa* (2.5-7.5 mg)	Quetiapine *Seroquel* (12.5-150 mg)	Risperidone *Risperdal* (0.25-2 mg)
***Movement Side Effects*[1]**	■■	■■■	■■	■	■■
Central Nervous System					
Sedation	■■	■■	■■■	■■■■	■■
Confusion, delirium, cognitive worsening	■	0	■■	■	■
Worsening psychotic symptoms	0	0	■	0	0
Cardiovascular/Metabolic					
Orthostatic hypotension	■?	■■	■	■?	■?
Edema	■?	0	■	0	■■
Weight gain/glucose ↑	0	■?	■■■	■	■■
Triglyceride ↑	0	0	■■■■	■■■	0
Urinary incontinence, UTI	■■■	■■	■■	■■	■■

■ = more boxes indicates greater risk. Colors are darker with increasing risk.
■? = evidence poor in dementia, but evidence in other conditions indicates some risk
0 = no clear evidence that the drug causes this side effect in a clinically important way, or very rarely
[1] Movement side effects = Parkinsonism, akathisia (restlessness), dystonia, tardive dyskinesia