The Appropriate Use of Mood Altering Medications in the Elderly

"The Uncomfortable Truth" About Chemical Restraint

By L. Carol Edwards

The issues:

One of the more troubling challenges of my geriatric care management (GCM) practice has evolved from the widespread, liberal and inappropriate use of medications to subdue the resistive behaviors of the elderly client in both the acute hospital and long-term care facilities.

The hope is that this article can stimulate thought and discussion between fellow GCMs on the scope and appropriateness of this practice. Included are the opinions of research geriatricians on the effects of these medications, the moral and legal implications and ideas for developing an effective method of reducing the need and use of antipsychotic medications in the elderly.

My first encounter with this troubling practice was in connection with my own father. I did not realize that a diagnosis of Pick's disease carried such a significant penalty in the healthcare system.

Yes it's true that I had already encountered and attempted to cope with his irrational, resistive and out-of-character behaviors for in-excess of two years in the retirement residence where my parents lived independently. The only advice I got from healthcare professionals was that my father would be best suited in a long-term care facility where they specialized in treatment of this condition.

As I embarked on this journey with my father, little did I know that as power of attorney for both finance and health, I would be performing the tasks and developing the skills of a geriatric care manager when I had never heard of the profession.

Upon admission to the long-term care facility, several incidents involving my father's behavior resulted in the home requesting a family meeting. As a solution they recommended sedation and transfer to a locked down unit. My initial instinct, as advocate for my father, was to reject this option and to protect my mother who was soon to be admitted along with their cat to shared accommodation.

After a period of relative calm, my father's behavior continued to deteriorate and rumors of staff unrest led to another meeting when another solution was presented to me. This time I was less resilient, especially because I was dissatisfied with the nursing home staff response and felt that a second opinion to the situation was required.

How right I was. Upon admission to the psycho-geriatric-unit, the geriatric psychiatrist painstakingly explained to me that he would undertake to preserve my fathers "gentlemanly qualities" while establishing the best medication regime at the lowest dose to manage his anxieties. This is exactly what I wanted to hear, since the treatment had potential to both preserve my father's dignity while managing his behaviors.

While this story does not have a happy ending due to other circumstances, I witnessed and learned enough to understand and recognize the reoccurrence of these events with both my mother, and subsequently many of my clients.

The lesson learned was that it is always best to acknowledge the situation as it develops and make preparation for avoiding the same unfortunate sequence of events.

Dementia care and antipsychotic medications:

While many of us are involved in the complex challenge of dementia care, it is important to balance the needs of the elderly client with the moral responsibilities of the power of attorney and craft our role to assist them to protect the elderly from any form of abuse.

The challenge is communicating this point to members of the healthcare team and physician sufficiently, to deter them from a harmful course of action for our elderly client while maintaining a cooperative, functional relationship with our other client, the power of attorney, usually their adult children.

It is difficult to understand why caregivers in the healthcare situation are in such a rush to administer care that they actually increase the anxieties of the cognitively impaired client, thus neccessitating the use of antipsychotic medications to calm their anxieties. In a perfect world, the ideal caregiver would take the time to carefully administer care while recognizing when their client needs to be left alone or the need to proceed with slow but reassuring care.

Currently, physicians have in their arsenal of treatments a number of antipsychotic drugs that appear to be the best forms of treatment for unconventional behaviors; however, only the specialists realize how and when to use these drugs and the right dose when all other treatments fail.

This principle is recognized by many professional bodies, such as nursing and geriatrics; however, when other acute care professionals and family physicians are involved, the treatments may be administered with less precision and for longer than necessary.

Geriatric Research:

It is always important to involve the geriatric specialist perspective in treatments of the elderly, and current geriatric research suggests that the use of antipsychotic treatments for the elderly identifies that the risks arising from the use of antipsychotic therapies often outweigh the benefits. In light of this information, antipsychotic medications should only be used in extremely limited situations.

Dr. Rochon of Baycrest Centre for the Elderly, Toronto, stresses that it is important to first attempt treatment without drugs in order to manage psychosis, aggression, and agitation in patients with dementia. Her recommendations (as described Rochon & Gurvitz, 1995, *Lancet,* 1997, *BMJ,* Rochon, 2006, www.uptodate.com) involve six steps.

The "stepwise approach" suggests that the current regime of medications be reviewed.

Possible changes may include discontinuing a long-time medication for a condition that the client no longer requires treatment, assessing safer drug therapies than the current regime and, if a drug is required, reducing the dose to its lowest effective level. Consider also adverse drug events as a potential cause for a new symptom. The review may reveal the need to add a new beneficial drug to the regime.

To improve prescribing practices for older adults, physicians always need to consider non-pharmacological approaches before prescribing drugs, as well ruling out any adverse drug events. When a drug is prescribed, physicians need do so only when absolutely required and at its lowest possible clinically effective dose.

The role of the power of attorney (POA):

In Canada, the duties of the POA for personal care are very specific when it comes to "monitoring devices, confinement, or physical and chemical restraint on the incapable person or consent to their use, unless doing so is essential to prevent serious bodily harm to the incapable person or allows the incapable person greater freedom or enjoyment" (Substitute Decisions Act, Ontario 1992/Healthcare Consent Act, 1996).

While the POA takes effect when the person is deemed incapable, it is very important that any issues are shared with the incapable person or that their wishes are represented in the decision-making process. It is expected that the POA fully understands and accepts the elder person's philosophies of life since they may be required to represent them by resisting treatments and opinions including those of healthcare professionals and physicians.

It is always important to involve the geriatric specialist perspective in treatments of the elderly and current geriatric research suggests that the use of antipsychotic treatments for the elderly identifies that the risks arising from the use of antipsychotic therapies often outweigh the benefits, and in light of this information, antipsychotic medications should only be used in extremely limited situations.

The GCM approach:

This is where the role of the GCM can be most helpful and effective, by providing an objective opinion and supporting the POA as they execute this role for their loved one. The advocacy role of the POA can also be supported by the GCM, such as negotiating persuasively with healthcare professionals and physicians.

While the responsibilities of the GCM role are many and varied, the objective interpretation of medical issues, including diagnosis, prognosis and ensuring prompt intervention in the delivery of healthcare services to ensure optimum outcomes, is pivotal in managing this situation to the benefit of both our elderly and POA clients.

Participation in family meetings and assisting in interpretation of medical issues will be helpful in preventing the use of unnecessary drug therapies by communicating with physicians and educating both families and the public are an ongoing responsibility of the GCM who is in a unique position to assist and influence future attitudes.

The GCM can also assist by hiring and training the staff who care for their elderly clients and help them find ways to reduce agitation and anxieties with the cognitively impaired that reduce the need for these treatments.

The GCM has the additional responsibility to understand her/ his strengths and limitations when assisting with these delicate issues and seek advice and help from his/ her cohorts to cope with this situation involving physicians and other health care professionals.

Once we gain experience and confidence in coping with these difficult situations it is encumbent on us to share, support and educate one another, something we do so well, in order for us to move forward as a united and strong professional healthcare resource.

Refrences

Rochon & Gurvitz, 1995, *Lancet.*

Rochon & Gurvitz, 1997, *BMJ*

Rochon, P. Drug prescribing for older adults, www.uptodate.com.

Solutions Magazine. Power of attorney. "Do you have what it takes?" Carol Edwards www.solutionsmagazine.ca.

L. Carol Edwards, RN, SRN is the President of Careable Inc., a geriatric care management practice in Toronto, Canada. She can be contacted at careable@sympatico.ca.