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Editorial

Pursuing appropriate psychotropic treatment for older people with dementia in long-term care facilities

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Kim, et al., reported substantial psychotropic drug utilization among Koreans with dementia living in long-term care facilities (LTCFs) – 40% of prescriptions were inappropriate to the indication;[1] these results raise suspicion of 'chemical restraint' among institutionalized older people with dementia in Korea. Although the prevalence of antipsychotic prescription among LTCF residents in Korea may be high, the results were commensurate with previous reports.[2] Despite US FDA alerts against using antipsychotics among older people with dementia, antipsychotics remain a common tool for managing behavioral and psychotic symptoms of dementia (BPSD).[3] This evidence implies widespread use of psychotropics as chemical restraints in long-term care settings globally. On the other hand, it may also reflect an overwhelming burden of dementia care in LTCFs due to insufficient staff or resources to offer non-pharmacological support. Whatever the cause, psychotropic drug use is strongly associated with adverse outcomes of dementia care. A typical scenario for inappropriate use of psychotropics is adding or up-titrating medication when an older person with dementia is hospitalized for acute care of illness aggravated by existing BPSD and psychotropics.[4] After discharge, LTCF staff might maintain the psychotropic prescription unless it is modified by onsite physicians. This may partly explain the high rate of inappropriate antipsychotics prescription in Korean LTCFs.[1]

Notwithstanding modest benefit of a 12-week course of antipsychotics in treating aggression and psychosis among people with dementia, adverse events have been widely reported; these include extrapyramidal symptoms, sedation, falls, accelerated cognitive decline, stroke, pneumonia, and death.[5] Despite well-known adverse effects of psychotropics on people with dementia, prescription rates remain high worldwide. This may reflect the burden of dementia care in long-term care settings, and may also be attributable to lack of knowledge or resources to conduct evidence-based non-pharmacological intervention.[6] Use of physical or chemical restraints has been reported to be more likely among the most physically and cognitively frail LTCF residents.[7] As such residents impose the heaviest burden of care, the prescription of antipsychotics may also depend on the adequacy of care resources.

Reducing antipsychotic prescriptions among LTCF residents with dementia may require public sector intervention; directives issued by the Swedish government authorities successfully decreased the use of antipsychotics in LTCFs [8]. Clear practice guidelines for LCTFs or government directives may be the most forceful ways to reduce the utilization of antipsychotic drugs among people with dementia. However, since the prescription of antipsychotics to LCTF residents with dementia is influenced by multiple complex factors, involving different stakeholders, more holistic approach to reducing the use of antipsychotics in LTCFs is needed.[6] Besides government's directives, physicians

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practicing in LTCFs should be aware of the potential risks associated with long-term antipsychotic use for residents with dementia. Promoting quality of dementia care requires concerted efforts involving all stakeholders to reach a consensus on quality standards for dementia care.

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