Antipsychotics in I/DD: The Challenges and Opportunities

The use of antipsychotics among adults with intellectual and developmental disabilities (I/DD) ranges between 21% and 45%. In some people, these drugs are used to treat psychiatric disorders such as schizophrenia; for others, they are employed to manage behaviors. As in other patient populations, antipsychotic medications should be used cautiously and in the lowest dose and for the shortest duration possible. They should be carefully monitored and never employed as a 'quick fix' or substitute for safer medications or nonpharmacologic interventions.

Here are 10 things to know about antipsychotics and their use in people with I/DD:

1. **An antipsychotic may help keep some individuals safe.** For example, there may be a psychiatric condition that results in behavior such as banging one's head against the wall, and a helmet isn't enough to be protective. Medication may be necessary to prevent cranial or brain damage.

2. **Mental health disorders and social disabilities may look different in this population** because these individuals are cognitively challenged and may not be able to communicate effectively. Because of cognitive limitations, these individuals may not understand their illness and act out with cursing, hitting, pushing, or even disinhibited sexual behavior.

3. **Concurrent use of behavioral supports and psychotropic/psychiatric medication is not uncommon.** This is particularly important in situations where an individual may lose their placement in the community because of aggressive behaviors.

4. **Regular efforts to reduce doses or stop antipsychotics are required under the Centers for Medicare and Medicaid Services conditions of participation.** It is important to put a behavioral plan in place with interventions designed to decrease the frequency and/or severity of behaviors without pharmacologic interventions. These should be very specific to each individual, such as the use of long sleeves to keep someone from picking at their skin. The patient or their guardian need to be part of this and sign off on the plan.

5. **It is important to note the side effects of psychotropic medications.** Both first- and second-generation agents have side effects that may have a negative impact on individual patients. For instance, first-generation antipsychotic medications typically come with things like pill-rolling tongue movements or eye-blinking; and these need to be treated with another medication. Second generation antipsychotics typically come with side effects such as weight gain or metabolic syndrome; so if the person is already diabetic or obese, it is not necessarily the right choice for that individual.

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6. **Psychiatrists may prefer antidepressants and antianxiety medications to help with behavioral plans** to help with desensitization and de-escalation of behaviors. Benzodiazepines may be added in response to something like a trip to the dentist. Mood stabilizers are used less and less, but you see the anti-epileptic medications used very frequently in this population. One such drug is Depakote, which is used to treat seizures, migraines and bipolar disorder but also has a side benefit of calming agitation. However, this drug can have significant negative side effects such as serious liver and pancreatic problems and suicidal thoughts.

7. **An Abnormal Involuntary Movement Scale (AIMS) assessment should be completed at least quarterly for any individual taking antipsychotic medications.** This should look at particular side effects that a person may exhibit and possibilities to reduce dosages or change medications. At the same time, any patient on antipsychotic medications should be seen by a psychiatrist every three months; and there should be some sort of ongoing physical assessment for that individual from a health care provider on a regular interval. It is important to note that state requirements do vary. For instance, some states require monthly assessments and quarterly physical assessments by a clinician or a nurse, as well as an annual physical assessment by a physician or mid-level practitioner.

8. **The old adage "start low and go slow" applies to antipsychotic use in this population.** Dosages should be increased only until you hit efficacy.

9. **A licensed pharmacist who has the ability to see all of a person's medications on a monthly basis should perform quarterly medication regimen reviews in intermediate care facilities.** They look at the safety of the medications, their risks and benefits, and their cost-effectiveness (as some of these drugs, especially injectables, can be expensive). Consultant pharmacists are definitely partners that round out the clinical care team.

10. **It is essential to normalize the idea of prioritizing nonpharmacologic interventions first** and not jump to antipsychotics to address behavioral issues. We need to teach, coach and train team members to seek person-centered nondrug approaches that reduce behaviors and enable quality of life for people with I/DD.

If you're following all these tips, as well as federal and state guidance, you can stay on a path of managing behaviors safely and effectively; and you're providing good oversight and medical care. And that is what's most important.

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