

DEPRESCRIBING GUIDE FOR ANTIPSYCHOTICS FOR TREATMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

(including typical [e.g. haloperidol, periciazine] and atypical [e.g. risperidone, quetiapine, olanzapine])

This guide provides deprescribing information that can be applied to written and/or verbal communication (in the form of "preferred language") between clinicians, patients and/or carers. Adapt appropriately for individual patients.



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CONSIDER TWO STEPS WHEN DEPRESCRIBING:

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Should I deprescribe?

2

How do I deprescribe?

STEP 1: SHOULD I DEPRESCRIBE? (PATIENT ASSESSMENT)

Deprescribing triggers:

- Inappropriate indication, no current indication, presence or risk of adverse events, drug interaction, drug-disease interaction, high drug burden index (DBI),¹ poor adherence, or patient preference.

1a) Is there a documented indication or symptoms supporting continued use?

Inappropriate indication for continued use:

- Incomplete assessment of physical and environmental triggers for behavioural disturbances with lack of non-pharmacological trial.
- Behavioural and psychological symptoms of dementia (BPSD) treated ≥ 3 months.⁵
- Being used to treat BPSD that are likely to be unresponsive to medications (e.g. wandering).
- Potential for improvement in cognitive function due to adverse events (see section 1b).

Do not deprescribe if:

- Pre-existing psychiatric comorbidity such as Schizophrenia or Bipolar Disorder without discussing with psychiatrist.
- Severe BPSD such as violent aggression without discussing with psychiatrist.

1b) Are there adverse effects?

Consider potential adverse effects:

- Falls, dizziness, extra-pyramidal symptoms such as dystonia, akathisia (motor restlessness), parkinsonism (e.g. rigidity, bradykinesia, tremor), tardive dyskinesia (irregular, jerky movements), constipation, dry eyes, dry mouth, confusion, or drowsiness.²
- Assess if adverse effects present for > 1 week (e.g. over-sedation, confusion, extrapyramidal side effects, postural hypotension, worsening behaviour, absence of psychotic or other neuropsychiatric symptoms).
- Anticholinergic effects, decompensated and drug-resistant diabetes, cardiomyopathy.

1c) Is this medication likely to cause more harm than benefit?

See [Evidence-based advice](#) for additional information on risks of harm and benefits of continued use.

1d) Does the patient/carer agree with the recommendation to deprescribe?

Following provision of information, discussion and shared-decision making, the patient or carer has communicated that they would like to proceed with or decline the deprescribing recommendation.

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

_____ is currently taking _____
(patient name) (drug name: e.g. risperidone 1mg daily)

for _____, and is currently experiencing/at risk of _____
(indication: e.g. restlessness) (patient issue: e.g. adverse effects)

The _____ outweighs the _____ for continued use of _____
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. risperidone)

Discussed with _____ and _____ deprescribing recommendation.
(patient /carer name) (agreed/willing to trial/considering/declined)

STEP 2: HOW DO I DEPRESCRIBE? (RECOMMENDATION AND MANAGEMENT)

2a) How to wean

Key Points

- Establish a supportive and trusting relationship with the patient to engage in complex/sensitive discussions.
- Accompany weaning with commencement of relevant non-pharmacological therapy based on person-centred psychosocial assessment. See [Alternative management](#) recommendations.
- In general, wean gradually by 25% of the daily dose every 1-4 weeks.
- If reason for deprescribing is due to serious adverse effects, consider weaning faster.
- Provide advice to patient/carer on self-monitoring and what to do if symptoms re-occur.
- Organise appropriate follow up appointments with general practitioner (GP) (frequency determined by rate of weaning).

Initiation

Reduce dose slowly by 25-50% of the daily dose each week to month.

Adjustments depend on response

Adjust according to response (see [Monitoring](#) recommendations).

- If no withdrawal symptoms occur, continue to wean and stop.
- Consider slower weaning (e.g. 12.5%) when reducing to the final lowest dose. End treatment 2 weeks after administering the lowest dose.
- Consider alternate day dosing to aid with weaning if dosage forms are limited.

Adjustments in the case of recurrent symptoms

In the case of recurrent/withdrawal symptoms, revert to the previous lowest tolerated dose and consult psychiatrist for review.

Recommence weaning after 6-12 weeks at a lower weaning rate (e.g. 5-12.5% of daily dose each month) then stop.

(Based on recommendations in [References](#)²⁻¹⁰)

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

Recommend non-pharmacological replacement therapy to reduce reliance on antipsychotics.

Recommend gradually reducing to _____ for _____ and reassess,
(drug: e.g. risperidone 0.75mg daily) (timeframe: e.g. 2 weeks)
then reduce to _____ for _____ and reassess,
(e.g. temazepam 5mg daily) (e.g. 2 weeks)
then reduce to _____ for _____ and reassess,
(e.g. risperidone 0.5mg daily) (e.g. 2 weeks)
then reduce to _____ for _____ and reassess,
(e.g. risperidone 0.25mg daily) (e.g. 2 weeks)
then reduce to _____ for _____ and stop.
(e.g. risperidone 0.125mg daily) (e.g. 2 weeks)
Follow up with GP _____ after discharge.
(e.g. fortnightly)

2b) Alternative management

Non-pharmacological support

Use behavioural management strategies concurrently.

Switching within drug class or consider alternative therapy

If severe BPSD relapses and non-drug approaches fail, restart the antipsychotic at the lowest possible dose with retriial of deprescribing in 3 months.

All antipsychotics have been associated with an increased risk of death compared with placebo in people with dementia; deaths in studies were largely due to cardiovascular events (especially stroke) and the greatest risk was in the first 40 days, with higher doses, and with older agents (e.g. haloperidol).

Newer antipsychotics (e.g. risperidone, olanzapine, aripiprazole and low dose quetiapine), have a lower risk of tardive dyskinesia but sedation and postural hypotension can occur.

Risperidone is the only newer antipsychotic with a TGA-approved indication for use in behavioural disturbance (in moderate-to-severe Alzheimer's dementia) and is subsidised under the PBS for this indication for a maximum duration of 12 weeks.

To consider other options, refer to [\[AMH-Antipsychotics\]](#).

PREFERRED LANGUAGE:

Use **behavioural management strategies** concurrently.

If there is a current indication, consider **dose reduction** or consider **switching** to an *atypical antipsychotic* (e.g. risperidone, olanzapine, aripiprazole and quetiapine). These medicines may have a lower risk of tardive dyskinesia, but sedation and postural hypotension can occur.

2c) Monitoring

Monitor short term (within 1-3 days)	Monitor long term (> 7 days)
<p>Monitor for withdrawal symptoms Symptoms can occur within 1-3 days of dose reduction.</p>	<p>Monitor for recurrence of symptoms Recurrence of previous or new symptoms (e.g. anxiety, depression) may occur within 1-2 weeks of dose reduction.</p>
<ul style="list-style-type: none"> • Common withdrawal symptoms (e.g. irritability, anxiety, insomnia, and sweating) are usually mild, highly variable and can last up to 6-8 weeks. • If severe symptoms (e.g. dysphoria, nightmares, memory impairment, hallucinations, hypertension, tachycardia, psychosis, tremors and seizures, profuse and persistent sweating, severe anxiety, or severe insomnia) occur, restart at the previous lowest effective dose. 	

PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal** symptoms which can be **mild** (e.g. *dizziness, nausea, vomiting, headache, insomnia, anxiety*) or **severe** (e.g. *aggression, psychosis, agitation, delusions, hallucinations, severe anxiety, or severe insomnia*).

Monitor for **recurrence** of symptoms within 1-2 weeks of dose reduction, including psychosis, agitation or aggression. Restart at the lowest effective dose with retrial weaning at 3 months and consult with psychiatrist for review.

EVIDENCE-BASED ADVICE

Effectiveness and safety

Overall, there was no statistically significant impact on mortality when an antipsychotic was withdrawn. However, there was heterogeneity between studies.⁷ A randomised-controlled trial of withdrawing antipsychotics (thioridazine, chlorpromazine, haloperidol, trifluoperazine, or risperidone) in people with BPSD, followed up over 24-54 months, found a survival benefit, with a 42% reduction in risk of mortality compared to those who continued use (Hazard ratio [HR] 0.58; 95% CI 0.35-0.95).⁸ Whereas, in a study discontinuing risperidone after 16 weeks of treatment, no effect was found on mortality after a further 16 weeks.¹⁰

A meta-analysis estimated that 4–12 patients with BPSD needed to be treated (NNT= 4-12) with atypical antipsychotics, over 10-12 weeks, in order to obtain a benefit in BPSD. However, for every 100 people treated for 10–12 weeks, approximately 1 person died (number needed to harm [NNH=100, 95% CI; 53-1000]).^{12,13}

Antipsychotic use in people with BPSD is associated with significant harm from adverse effects (e.g. falls, fractures, confusion, extrapyramidal side effects, and two-fold increased risk of cerebrovascular events).^{11,12}

Over 90% of people would be willing to stop their medicines if recommended by their physician.¹⁴

Recommended duration of use

Limit drug treatment to short-term use. Long-term use is not recommended, especially in older adults.

SUMMARISED PHRASING DURING HOSPITAL ADMISSION AND/OR AT DISCHARGE

When communicating deprescribing decisions to GPs at discharge, written and verbal communication should include information in the sequence of:

“Medicine, Intention, Rationale, Clear Plan (dose change, duration, follow up), Patient agreement”

PREFERRED LANGUAGE

(write in GP follow up plan and medication list):

_____ : _____ due to _____ outweighing effects _____.
current medication (e.g. risperidone) stopped/ reduced with aim of stopping specific rationale (e.g. sedation) of/on current indication (e.g. on BPSD)

_____ reduced to _____ for _____, then _____. Patient/Carer agreed.
If weaning, old dose changed to new dose (risperidone 1mg nocte reduced to risperidone 0.5mg nocte) if weaning, time frame (e.g. 2 weeks) follow-up action (e.g. GP consider further reduction over 8 weeks)

Refer to www.nswtag.org.au/deprescribing-tools/

Example:

Risperidone: Reduced with aim of stopping due to sedation outweighing effects on BPSD.

Risperidone 1mg nocte reduced to risperidone 0.5mg nocte for 2 weeks then GP to consider further reduction over 8 weeks. Carer agreed. Refer to www.nswtag.org.au/deprescribing-tools/



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