**Antipsychotic (AP) Deprescribing Algorithm**

**Why is patient taking an antipsychotic?**

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).
- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed.
- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Acute delirium
- Tourette’s syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Intellectual disability
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson’s disease psychosis
- Adjunct for treatment of Major Depressive Disorder

**Recommend Deprescribing**

**Taper and stop AP** (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1–2 weeks)

**Stop AP** Good practice recommendation

**Monitor every 1–2 weeks for duration of tapering**

- **Expected benefits:**
  - May improve alertness, gait, reduce falls, or extrapyramidal symptoms
- **Adverse drug withdrawal events** (closer monitoring for those with more severe baseline symptoms):
  - Psychosis, aggression, agitation, delusions, hallucinations

**If BPSD relapses:**

- **Consider:**
  - Non-drug approaches (e.g. music therapy, behavioural management strategies)
- **Restart AP drug:**
  - Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
  - At least 2 attempts to stop should be made
- **Alternate drugs:**
  - Consider change to risperidone, olanzapine, or aripiprazole

**Continue AP or consult psychiatrist if considering deprescribing**

- **If insomnia relapses:**
  - **Consider:**
    - Minimize use of substances that worsen insomnia (e.g. caffeine, alcohol)
    - Non-drug behavioural approaches (see reverse)
  - **Alternate drugs**
    - Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.

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Contact deprescribing@bruyere.org or visit deprescribing.org for more information.

**Commonly Prescribed Antipsychotics**

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Form</th>
<th>Strength</th>
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<tbody>
<tr>
<td>Chlorpromazine</td>
<td>T, IM, IV</td>
<td>25, 50, 100 mg, 125 mg/mL</td>
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<tr>
<td>Haloperidol (Haldol®)</td>
<td>T, L, IR, IM</td>
<td>0.5, 1, 2, 5, 10, 20 mg, 2 mg/mL</td>
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<td></td>
<td></td>
<td>5, 10, 20 mg/mL</td>
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<tr>
<td>Loxapine (Xylac®, Loxapac®)</td>
<td>T, L, IM</td>
<td>2.5, 5, 10, 25, 50 mg, 25 mg/L, 25, 50 mg/mL</td>
</tr>
<tr>
<td>Aripiprazole (Abilify®)</td>
<td>T, IM</td>
<td>2, 5, 10, 15, 20, 30 mg, 300, 400 mg</td>
</tr>
<tr>
<td>Clozapine (Clozaril®)</td>
<td>T</td>
<td>25, 100 mg</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa®)</td>
<td>T, D, IM</td>
<td>2.5, 5, 7.5, 10, 15, 20 mg, 5, 10, 15, 20 mg, 10 mg per vial</td>
</tr>
<tr>
<td>Paliperidone (Invega®)</td>
<td>ER T, PR IM</td>
<td>3, 6, 9 mg, 50mg/0.5mL, 75mg/0.75mL, 100mg/1mL, 150mg/1.5mL</td>
</tr>
<tr>
<td>Quetiapine (Seroquel®)</td>
<td>IR T, ER T</td>
<td>25, 100, 200, 300 mg, 50, 150, 200, 300, 400 mg</td>
</tr>
<tr>
<td>Risperidone (Risperdal®)</td>
<td>T, S, D, PR IM</td>
<td>0.25, 0.5, 1, 2, 3, 4 mg, 1 mg/mL, 0.5, 1, 2, 3, 4 mg, 12.5, 25, 37.5, 50 mg</td>
</tr>
</tbody>
</table>

IM = intramuscular, IV = intravenous, L = liquid, S = suppository, SL = sublingual. T = tablet, D = disintegrating tablet, ER = extended release, IR = immediate release, LA = long-acting, PR = prolonged release

**Engaging patients and caregivers**

**Patients and caregivers should understand:**
- The rationale for deprescribing (risk of side effects of continued AP use)
- Withdrawal symptoms, including BPSD symptom relapse, may occur
- They are part of the tapering plan, and can control tapering rate and duration

**Tapering doses**

- No evidence that one tapering approach is better than another

- Consider:
  - Reduce to 75%, 50%, 25% of original dose on a weekly or bi-weekly basis and then stop; or
  - Consider slower tapering and frequent monitoring in those with severe baseline BPSD

- Tapering may not be needed if low dose for insomnia only

**Sleep management**

**Primary care:**
1. Go to bed only when sleepy
2. Do not use your bed or bedroom for anything but sleep (or intimacy)
3. If you do not fall asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If you do not fall asleep within 20-30 min on returning to bed, repeat #3
5. Use your alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

**Institutional care:**
1. Pul up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity and discourage daytime sleeping
4. Reduce number of naps (no more than 30 mins and no naps after 2pm)
5. Offer warm decaf drink, warm milk at night
6. Restrict food, caffeine, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

**BPSD management**

- Consider interventions such as: relaxation, social contact, sensory (music or aroma-therapy), structured activities and behavioural therapy
- Address physical and other disease factors: e.g. pain, infection, constipation, depression
- Consider environment: e.g. light, noise
- Review medications that might be worsening symptoms

**Antipsychotic side effects**

- APs associated with increased risk of:
  - Metabolic disturbances, weight gain, dry mouth, dizziness
  - Somnolence, drowsiness, injury or falls, hip fractures, EPS, abnormal gait, urinary tract infections, cardiovascular adverse events, death
- Risk factors: higher dose, older age, Parkinson’s, Lewy Body Dementia