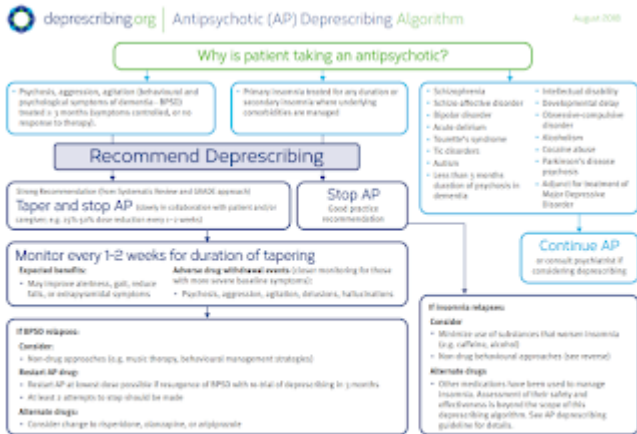




<https://deprecating.org/wp-content/uploads/2018/08/AP-deprescribing-algorithm-2018-English.pdf>



After this, you need to be aware. We do not intend to, or we do not intend to, be involved in any other activities. We do not intend to be involved in any other activities. We do not intend to be involved in any other activities.



deprecating.org | Antipsychotic (AP) Deprescribing Notes August 2018

**Commonly Prescribed Antipsychotics**

Antipsychotic	Form	Dosage
Chlorpromazine	50, 100, 200 mg tablets	25, 50, 100 mg
Haloperidol (Haldol)	1, 2, 5, 10, 20, 50 mg tablets, 100, 200 mg tablets, 100, 200 mg tablets, 100, 200 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Levomepromazine (Levomepril)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Molindone (Molindone)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Olanzapine (Zenerol)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Quetiapine (Seroquel)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Risperidone (Risperdal)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Seroquel XR	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg
Zuclopentixol (Zuclopentixol)	1, 2, 5, 10, 20, 50 mg tablets	0.5, 1, 2, 5, 10, 20 mg

**AP = intramuscular, B = intravenous, C = tablet, S = suspension, SR = sustained release, T = tablet, D = transdermal patch, CR = extended release, IR = intrathecal release, SA = long acting, PR = prolonged release**

**Antipsychotic side effects**

- APs associated with increased risk of:**
  - Metabolic disturbances, weight gain, dry mouth, dizziness
  - Tardive dyskinesia, seizures, falls, rigidity, Parkinson's, abnormal gait, urinary tract infections, cardiovascular adverse events, death
- Risk factors:** Higher dose, older age, Parkinson's, Lewy Body Dementia

**Engaging patients and caregivers**

**Patients and carers should understand:**

- The rationale for deprescribing (risk of side effects of continued AP and withdrawal symptoms, including BPSD, insomnia relapse, etc.)
- 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 10%, 5%, 1% of original dose on a weekly or bi-weekly basis and then stop at 10% (or 5% or 1% if tolerated)
  - 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**

**Practical tips:**

- Go to bed only when sleepy
- Do not use your bed or bedroom for anything but sleep and intimacy
- If you do not fall asleep within about an hour at the beginning of the night or after an awakening, get the bed out
- If you do not fall asleep within 30 minutes on waking to bed, leave the bedroom
- Use your alarm to awaken at the same time every morning
- Do not nap
- Avoid caffeine after noon
- Avoid exercise, alcohol, and big meals within 3 hrs of bedtime

**Behavioural tips:**

- Get up earlier during the day to obtain bright light exposure
- Keep alarm noise to a minimum
- Increase daytime activity and discourage daytime sleeping
- Reduce number of naps (no more than one nap and no naps after 3pm)
- Other ways about sleep, such as using a white noise machine, caffeine, smoking before bedtime
- Have the window blind before going to bed
- Encourage regular bedtime and rising times
- Good timing of naps to provide direct light on other factors, gentle massage

**BPSD management**

- Consider interventions such as: medication, social contact, sensory (music or aromatherapy), 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