3.3 Stopping (deprescribing) antipsychotics in patients with dementia

Reproduced from Mental Welfare Commission for Scotland, 2014.

Medication and management of stressed and distressed behaviours:

- Medication should be used as last, not first resort, to manage distress
- People with dementia on psychotropic medicines should be prioritised for multidisciplinary review
- People with dementia on psychotropic medicines should be reviewed every three months
- Psychotropic medicines should be withdrawn gradually

Antipsychotic drugs are frequently prescribed with the aim of reducing symptoms of stress and distress in people with dementia. In Scotland in 2007, 17.7% of people with a diagnosis of dementia were prescribed an antipsychotic, compared to approximately 12% in 2005–2007 in one US study. Despite this high rate of use, antipsychotics have only limited benefit in treating symptoms of stress and distress in older people with dementia and carry significant risk of harm (delirium, cerebrovascular events, falls and all-cause mortality). In 2009, antipsychotics were estimated to cause approximately 1800 deaths and 1620 cerebrovascular events in people with dementia in the UK annually. However, clinical trial evidence in nursing home patients with dementia indicates that chronically prescribed antipsychotic drugs can be safely discontinued in most patients, with longer term follow-up suggesting a significant reduction in mortality.

Which patients should be prioritised for review?

Patients who have dementia and who have been on antipsychotics for more than 3 months and have stable symptoms should be reviewed with a view to reducing or stopping antipsychotic medication. Priority groups for reducing antipsychotic medication include:

- People in care homes
- People with vascular dementia
- People with dementia plus history of cardiovascular disease

When should antipsychotic medication NOT be stopped?

Patients who have a co-morbid mental illness that is treated with antipsychotic medication, such as schizophrenia, persistent delusional disorder, psychotic depression or bipolar affective disorder should not have antipsychotic medication reduced without specialist advice.

How to reduce antipsychotic medication?

- Slow reduction (25% daily dose) with close monitoring
- Review the effect after one week to assess for: the re-emergence of the initial 'target' symptoms of stress and distress
- Discontinuation symptoms include nausea, vomiting, anorexia, diarrhoea, rhinorrhoea, sweating, myalgia, paraesthesia, insomnia, restlessness, anxiety and agitation. Generally begin within 1 to 4 days of withdrawal and abate within 7 to 14 days
- If either of the above occurs the clinician should make an assessment of the risks and benefits of re-instating the previous dose of antipsychotic. Further attempts to reduce the antipsychotic should be made one month later with smaller decrements (10% daily dose)
- If there are no particular problems after week 1 then the dose should remain the same with further review after week 2 to 4 weeks.
- If the reduction has been tolerated without any of the effects described above then reduce by a further 25% and repeat the process
- There may be practical issues when reducing the dose, for example the availability and form of small doses of medication. It is recommended that this is discussed with a pharmacist
- It is suggested that once the total daily dose is reduced to the recommended starting dose for the individual antipsychotic, it may be stopped

A best practice guide for optimising treatment and care for behavioural and psychological symptoms of dementia is also available from Alzheimer's Society.