Reducing Antipsychotic Prescribing for Behavioural and Psychological Symptoms of Dementia (BPSD)

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

For more detailed information please see the full guideline available in the HWEICB website

Does the patient have any BPSD symptoms including agitation, aggression, wandering, hoarding, shouting, depression, anxiety, distress during care, sleep disturbance, hallucinations, apathy, delusions, and psychosis?

YES

Initiate nonpharmacological intervention for patient with or without antipsychotics. **See Appendix 1.**

Explore Other causes of BPSD including physical health issues (pain/infection), environmental factors, drug induced side effects, unmet needs and other mental health issues.

Treat Underlying Acute Conditions
This usually resolves the behavioural problems and if patient no longer shows BPSD symptoms consider deprescribing antipsychotics.

No other causes

Default Management
Unless there is extreme distress, the recommended default management is to discontinue the antipsychotic with monitoring.

Consider risk and benefit of continuing antipsychotic in the decision making. Think about deprescribing. **See Appendix 1.**

Can it be deprescribed?

Yes

No

Deprescribing is recommended after short term (6 weeks) treatment. If symptoms are not controlled antipsychotics must be stopped. Antipsychotics can be withdrawn safely for 50-70% BPSD patients without any detrimental effects.

Monitor response to treatment, symptoms and side effects in the following 6 weekly reviews.

Dose reduction
Implement small decreases in dose, one step down at a time. Follow the guideline in Appendix 1.

If there is more risk than benefit at any of this 6 weekly follow up review, antipsychotic can be deprescribed at that stage.

If symptoms reappear or withdrawal symptoms occur, *withdraw the drug more gradually*.

If original prescribed dose is higher than usual (outlined in the table 1), *seek specialist advice.*

If antipsychotic is not stopped after 6 weeks
Health check should be carried out at 3, 6 and 9 months for the first year. Then at least annually and if abnormality of physical health emerges, health check can be done at that point of care.

Antipsychotic deprescribed
Continue non-pharmacological interventions based on the person's needs, abilities and interests.

Appendix 1: Suggested tapering protocol for reducing and stopping antipsychotics used for BPSD

Table 1: The following is a tapering guide for the commonly prescribed antipsychotics for BPSD. Individual patient circumstances need to be taken into consideration in dose reduction.

Antipsychotic	Usual dose range in dementia (oral)	Suggested regime for reduction/discontinuation (generally reduce the daily dose every 2 weeks and ideally deprescribed in 8 weeks)
Amisulpride	25-50mg/day	Reduce by 12.5-25mg every 2 weeks, then stop.
Aripiprazole	5-15mg/day	Reduce by 5mg every 2 weeks (depending on dose), then stop. If patient is on 5mg daily, reduce to 2.5mg for 2 weeks; however, note that tablets are not scored, and liquid is expensive – contact local pharmacy and medicine optimisation team for the integrated care board.
Haloperidol	0.5mg-5mg/day	Reduce by 0.25–0.5mg every 2 weeks (depending on dose) then stop.
Olanzapine	2.5mg- 10mg/day	Reduce by 2.5mg every 2 weeks (depending on dose) then stop.
Quetiapine	12.5mg-300mg/day	For doses 12.5–100mg/day, reduce by 12.5–25mg every 2 weeks (depending on dose) then stop. For doses >100–300mg/day, reduce by 25–50mg every 2 weeks (depending on dose) then stop. If dose is 300mg/day, reduce to 150–200mg/day for 2 weeks then by 50mg per reduction (every 2 weeks).
Risperidone	0.25mg-2mg/day	Reduce by 0.25–0.5mg every 2 weeks (depending on dose) then stop.

(Adapted from the Maudsley Prescribing Guideline, 2021)

Top tips to help dose reductions

- Implement small decreases in dose. In some cases, it may be necessary to reduce the drug more slowly, particularly if symptom reappear.
- Where the antipsychotic is given more than once daily, decrease only one dose to start with, choosing the dose where patient likely to be least affected.
- Allow sufficient time for the patient to adapt to the new dose (usually 2 weeks) before considering the next small reduction in dose.
- When the lowest dose has been achieved daily then administer on alternate days before stopping completely.
- Abrupt discontinuation of antipsychotics can result in adverse withdrawal effects (especially after prolonged use). Withdrawal effects can include psychosis, hallucinations, delusions, aggression, agitation, nausea, vomiting, sweating, insomnia, headache, restlessness, and anxiety.
- For those with worsening of symptoms, the first four weeks are the most challenging. Monitoring, ongoing assessment of contributing factors and non-pharmacological treatments may prevent the need to restart antipsychotics.
- The risk of recurrence of symptoms after discontinuation may be more likely if previous discontinuation has caused symptoms to return, or the person currently has severe symptoms.
- Review at every stage of dose reduction to evaluate patient response. Expected benefits may include improved alertness, reduction of weight loss or gain (e.g. with olanzapine), reduced number of falls and extrapyramidal side effects.
- Non-pharmacological treatments in managing behavioural symptoms, based on the person's needs, abilities and interests should continue after the antipsychotic has been stopped.
- **Always consider before continuing an antipsychotic that long term treatment with antipsychotic carries cumulative risks of increased mortality, cognitive decline, falls and other adverse effects.**

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