THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

ANTIPSYCHOTICS

Deprescribing in older people: A clinical practice guideline

dRx™

ANTIPSYCHOTICS

Amisulpride, aripiprazole, asenapine, brexpiprazole, cariprazine, chlorpromazine, clozapine, droperidol, flupentixol, haloperidol, lurasidone, olanzapine, paliperidone, periciazine, quetiapine, risperidone, trifluoperazine, ziprasidone, zuclopenthixol.

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people who are taking antipsychotics when: • There is no clear indication, that a contraindication exists, or prescribing is inappropriate (e.g. use for vocal disruption or conditions other than primary psychotic illness); • Adverse effects or drug interactions outweigh potential benefits (e.g. Parkinson's disease or Lewy body dementia without psychotic symptoms, risk of QT prolongation, history of stroke, extrapyramidal side effects, recurrent falls, or significant weight gain); or • It is used for the management of changed behaviours beyond 12 weeks, if there is limited response to the treatment, symptoms have resolved, are unlikely to recur, or remain stable.
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	**Changed behaviours** If deprescribing is unsuccessful despite multiple attempts and non-pharmacological options have been considered, we suggest maintaining the lowest effective dose, provided this aligns with the individual preferences, goals and overall treatment plans, and that the benefit clearly outweighs the harm and that potential underlying causes for changed behaviours (e.g. pain, constipation, depression) have been considered and/or addressed. However, we suggest reassessing the need for long-term therapy periodically at least every three to six months or more frequently if symptoms change and additional monitoring for cardiometabolic risks in people using antipsychotics (weight, blood pressure, lipids, diabetes screening, cardiovascular risk calculation).

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms and/or symptoms indicative of relapse before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.

GPS Healthcare providers should consider and offer adequate non-pharmacological management options such as psychosocial practices, structured care protocols, and sensory practices during and after deprescribing (ungraded good practice statement).

GPS Healthcare providers should consider and offer appropriate management strategies to the individual's families and care providers (e.g. verbal de-escalation, psychological intervention, increased staff-to-patient ratio, increased staff training in behaviour management) (ungraded good practice statement).

MONITORING

CBR We suggest closely monitoring for individual responses and tolerance to antipsychotic tapering, paying specific attention to changes in psychological withdrawal effects (e.g. agitation, hallucinations, anxiety) and physical withdrawal symptoms (e.g. dyskinesia), function, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to report symptoms as needed.

GPS Healthcare providers should use validated assessment tools to evaluate changes in neuropsychiatric symptoms, functional status, and quality of life (e.g. Neuropsychiatric Inventory for neuropsychiatric symptoms, Functional Status Questionnaire for functional status, and EQ-5D for health-related quality of life) (ungraded good practice statement).

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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