Practice Recommendations for Initiation, Titration and Tapering of Antipsychotic Medications [1][2][3]

1. **Diagnosis –** type of dementia: ____

Do not routinely stop antipsychotic medication when prescribed for another indication like schizophrenia or mood disorders

2. **Initial Target Systems** (Physical, Verbal, Psychotic (hallucinations/delusions), other)
   - Describe all symptoms: ____
3. **Confirmation:** Assessment of target symptoms has been completed per BC BPSD Algorithm (www.bcbpsd.ca). Behaviour has not responded to comprehensive non-pharmacologic treatment plan, including removal of possibly offending drugs, and/or behaviour is dangerous, distressing, disturbing, damaging to social relationships and persistent.

Examples of BPSD Usually Not Amenable to Antipsychotic Treatment

- Wandering
- Hiding and hoarding
- Repetitive activity
- Vocally disruptive behaviour
- Inappropriate (un)dressing
- Tugging at seatbelts
- Inappropriate voiding
- Eating inedible objects
- Pushing wheelchair-bound co-residents

Note: avoid use of antipsychotics if possible for clients with dementia due to Parkinson's or Lewy Body. Cholinesterase Inhibitors are first line treatment for clients with psychosis associated with these dementias.

Part 1: Initiate (Regular and/or PRN) – For Responsive Symptoms

4. Choose the regular dose, and PRN if necessary including indication, interval and maximum daily dose
5. Monitoring: Review effectiveness and S/E's in one week
6. Consent for treatment – Emergency 'OR' risk/benefits discussion with resident (if capable) or Substitute Decision Maker (SDM) (if incapable) - consent should be ahead of monitoring

Risks to be discussed with patient (if capable) and/or SDM should include, but not limited to, the following side effects:

- Oversedation
- Risk of falls
- Confusion
- Tardive dyskinesia
- Extra pyramidal symptoms
- Metabolic syndrome
- Stroke
- Prolonged QTc
- Increased mortality
- Postural hypotension

Examples of Commonly Used Antipsychotic Dosages for Elderly*

**This information is intended as a guide only. For full prescribing information, please see product monograph for each drug.*

Medication	Starting Dose (mg)	Dosing Frequency	Incremental Dose (mg)	Average Total Daily Dose
Risperidone	0.25	Daily / BID	0.25 Q3 – 7 days	1 mg
Olanzapine	1.25 to 2.5	HS / BID	1.25 to 2.5 Q3 – 7 days	5 mg
Aripiprazole	2	Daily	2 to 5 Q Weekly	10 mg
Quetiapine	12.5 to 25	BID/ TID / HS (if XR)	12.5 to 25 Q3 – 7 days	150 mg
Loxapine	2.5	BID	2.5 to 5 Q3 – 7 days	20 mg
Haloperidol	0.25 to 0.5	Daily / BID	0.25 to 0.5 Q3 – 7 days	2 mg

Part 2: Titration/ Review

7. **Indications for review:**

- New Admission
- Current antipsychotic and dose requires review
- Or, other
- Drug related problem
- Initial target symptoms haven't improved in frequency and/or intensity

8. **Medication/Dose Options** (see incremental doses in chart above)

- Titrate dose
- Titrate PRN
- Continue same dose &/or PRN
- Discontinue (see Part 3)
- Start new medication and /or PRN <u>if current is ineffective after therapeutic trial or person unable to tolerate</u>

9. **Monitoring:**

Reassess effectiveness and S/E's q2 to 4 weeks.

Part 3: Dose Reduction Trial

If target symptoms are stable at 3 to 6 months, then consider tapering dose 'OR' Dose Reduction Trial

Rapid or abrupt decrease may cause withdrawal dyskinesia. Gradual dose reduction is safe and may improve function.

- Aripiprazole – reduce daily dose by 1mg
- Loxapine – reduce daily dose by 2.5mg
- Olanzapine – reduce daily dose by 1.25 to 2.5mg
- Quetiapine – reduce daily dose by 12.5 to 25mg
- Risperidone – reduce daily dose by 0.25mg
  a. Observe daily for target symptom recurrence
  b. Review every 2-4 weeks for further dose reduction if target symptoms are reduced or manageable.

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[1] The information in this practice sheet is adapted with permission from: *IH BPSD Antipsychotic Preprinted Order Series (2014)*, created by the Interior Health Antipsychotic/BPSD Working Group, and approved for clinical practice within Interior Health. Grateful acknowledgement is made to Dr. Carol Ward for her expertise in guiding the development of these PPOs.

[2] This information sheet is a resource of the BC BPSD Algorithm (2014) (www.bcbpsd.ca), a clinical practice decision support tool within the BC Best Practice Guidelines for Managing and Accommodating BPSD in Residential Care (2012), and is best used within this context.

[3] *Disclaimer*: Information is intended for general clinical direction only, and doesn't replace individual professional judgment. No liability