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# Appendix

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**It is posted as supplied by the authors.**

Appendix to: Westbury JL, Gee P, Ling T, et al. RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities. *Med J Aust* 2018; 208: 398-403. doi: 10.5694/mja17.00857.

**1. RedUSe treatment guidelines for reducing antipsychotic agent use**

RedUSe
Reducing Use of Sedatives

UNIVERSITY of TASMANIA

# Antipsychotics in dementia

## What are antipsychotics licensed for?

- Antipsychotics (e.g. risperidone, olanzapine) are used to treat schizophrenia and bipolar disorder
- Antipsychotics have modest effects (improve symptoms in one in five people) to treat severe aggression and psychosis associated with dementia

## Why reduce antipsychotics?

- Use is associated with confusion, sedation and movement disorders (e.g. tremors)
- Antipsychotic use in people with dementia increases the risk of stroke and death
- Stopping treatment is safe
    - In a study of 100 RACF residents stopping antipsychotic treatment, researchers found that:
        - over two thirds of residents experienced no worsening of their behavioural symptoms 1 and 3 months after stopping treatment.[1]

## Quality use of antipsychotics to treat behavioural symptoms of dementia

- Determine other causes of behaviour before prescribing and treat accordingly
- Psychosocial strategies should be first-line and continued when antipsychotics are used (e.g. activities, pet therapy, aromatherapy, one-to-one attention)
- Use in residents with severe aggression psychosis that may cause distress and harm
- If an antipsychotic is used, then:
    - start with a low dose and increase slowly according to response
    - review regularly for efficacy and side effects
    - trial dose reduction/cessation, at least every 3 months

## How to RedUSe antipsychotics?

***The suggested rate of withdrawal is to reduce the current daily dose by 50% every two weeks, with medication stopped after two weeks on the minimal dose.[2]***

| | Number of tablets to be taken | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
| Week 1 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Week 2 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Week 3 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 |
| Week 4 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 | 0.25 |
| Week 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### A sample withdrawal schedule

**for a resident taking**
**1 x 1mg risperidone tablet a day**

References:
1. Ballard C et al. (2008) A randomised, blinded, placebo-controlled trial in dementia patients continuing or stopping neuroleptics (the DART-AD Trial). PLoS Med 5(4): e76. doi:10.1371/journal.pmed.0050076
2. DVA Veterans' Mates Therapeutic brief 12 – Antipsychotics in dementia 2007

*The RedUSe project is funded by the Australian Government Department of Social Services under the Aged Care Service Improvement and Healthy Ageing Grant Fund*

**2. RedUSe treatment guidelines for reducing benzodiazepine use**

RedUSe
Reducing Use of Sedatives

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# Benzodiazepines

## What are benzodiazepines licensed for?

- **Short-term (less than 2 weeks) for management of insomnia (e.g. temazepam)**
- **Short-term (less than 2 weeks) for the treatment of severe anxiety and agitation (e.g. oxazepam), with later use on an 'as required' basis**

## Why reduce benzodiazepines?

- **Regular use (longer than 2 weeks) in older people is associated with:**
  - **impairment of memory and an increased risk of falls**
- **Stopping treatment is safe**
  - **In a study of 139 older adults stopping benzodiazepines, researchers found that subjects:**
    - **had no long-term adverse effects on insomnia or anxiety symptoms**
    - **reported improved memory, alertness and improved quality of life.[1]**

## How to avoid withdrawal symptoms?

- **The key steps for a successful withdrawal are:**
  - **assess suitability for withdrawal at the present time**
  - **gradually reduce benzodiazepine dose**
  - **ensure the withdrawal schedule is flexible and tailored to the individual**

## How to RedUSe benzodiazepines?

***The suggested rate of withdrawal is to reduce the daily dose by 25% per fortnight.[2]***

| | Number of tablets to be taken | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
| Week 1 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 |
| Week 2 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 |
| Week 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Week 4 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Week 5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Week 6 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Week 7 | 0.5 | 0 | 0.5 | 0 | 0.5 | 0 | 0.5 |
| Week 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### A sample withdrawal schedule

**for a resident taking**
**2 x 10mg temazepam tablets**

## Supporting the resident during and after withdrawal

- **Provide encouragement and support to resident, relatives and nursing staff**
- **Consider slowing g withdrawal if symptoms become troublesome**

References:
1. Curran H et al. Older adults and withdrawal from benzodiazepine hypnotics in general practice. Psychol Med 2003;33(7):1223-37
2. Oude Vosha R et al. Tapering off long-term benzodiazepine use. Br J Psychiatry 2003;182: 498-502

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