
# Antipsychotic Use and Gradual Dose Reduction Strategies in the Long-Term Care Setting

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# Objectives

- Review antipsychotic medications and their use in practice
- Examine the role of antipsychotics in the long-term care setting
- Analyze the risks associated with antipsychotic use in long-term care
- Understand the concept of gradual dose reduction (GDR) and its use to manage antipsychotics
- Apply concepts of appropriate antipsychotic use and GDR strategies to patient case scenarios

# Indications for Antipsychotic Medications

- Psychosis is a symptom of mental illness characterized by a distorted sense of reality
- Antipsychotic medications are commonly used in practice
- Primarily used for labeled or FDA-approved indications
  - Schizophrenia/schizoaffective disorders
  - Bipolar Disorders
  - Agitation
  - Major Depressive Disorders (adjunctive)
- Also used off-label, typically in the inpatient setting
- Associated with risks and benefits that providers and care-givers must understand



Reus VI. Overview of Psychiatric Disorders. In: Jameson J, Fauci AS, Kasper DL, Hauser SL, Longo DL, Loscalzo J. eds. *Harrison's Principles of Internal Medicine, 20e*. McGraw Hill; 2018
Schneiderhan ME, Nelson L, Bishop JR, Bauer S. Evaluation of Psychiatric Disorders. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.

# On-Label vs. Off-Label Uses

'Label' refers to the FDA-approved package insert of the medication of interest. FDA-approved indications are 'on-label' and other uses are deemed 'off-label'

- On-Label (FDA-approved)
  - FDA carefully evaluated benefits and risks for that specific use
  - Use of the medication is supported by strong data
  - Approved labeling for safe and effective use of the medication for that indication
- Off-Label
  - Use of a medication for an indication that is not specifically FDA-approved
  - Provider judges medical appropriateness of use (risk/benefits)
  - Data on use may exist but hasn't been evaluated by FDA



Some information at: https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label

# On-Label vs. Off-Label Uses

- Examples
  - A medication given in a different form than that which is FDA-approved
  - A medication given with different dosing than that which is FDA-approved
  - A medication that pre-dates the FDA approval process
  - A medication in the same class as other medications FDA-approved for use in an indication is used (assumed mechanism of action or class effect)
    - Antimicrobials
    - Oncology agents
    - Antipsychotics



Some information at: https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label

# Antipsychotic Medications

- General class of medications with activity in patients with various forms of psychosis
  - Most act on dopamine and serotonin pathways with other hypothetical effects
- Differ from other agents used in psychosis treatment
  - Sedatives, mood stabilizers, anti-depressants, etc
- Further defined as:
  - First-generation (or typical) antipsychotics
  - Second-generation (or atypical) antipsychotics

Schneiderhan ME, Nelson L, Bishop JR, Bauer S. Evaluation of Psychiatric Disorders. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.
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Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com.

# Antipsychotic Medications

| First-Generation (Typical) Antipsychotics | Second-Generation (Atypical) Antipsychotics | |
|---|---|---|
| Chlorpromazine (Thorazine) | Aripiprazole (Abilify) | Lurasidone (Latuda) |
| Droperidol (Inapsine) | Asenapine (Saphris) | Olanzapine (Zyprexa) |
| Fluphenazine (Prolixin) | Brexpiprazole (Rexulti) | Paliperidone (Invega) |
| Haloperidol (Haldol) | Cariprazine (Vraylar) | Quetiapine (Seroquel) |
| Perphenazine (Trilafon) | Clozapine (Clozaril) | Risperidone (Risperdal) |
| Thioridazine (Mellaril) | Iloperidone (Fanapt) | Ziprasidone (Geodon) |
| Thiothixene (Navane) | | |

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# 1st Generation Antipsychotic Medications

- Historically the standard of care for management of psychosis disorders

- Generally, higher side effect profile compared to atypical antipsychotics
  - More cardiac conduction effects → QT prolongation
  - More extra-pyramidal effects (EPS) → diskinesias, involuntary movements, etc
  - More anti-cholinergic effects
  - More sedation and disassociation

- Current use is mostly acute symptom control, adjunctive, or historically effective
  - Must assess risks/benefits and drug interactions with other medications

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# 1st Generation Antipsychotic Medications

- Chlorpromazine (Thorazine)
  - Typically dosed at 50-150mg daily to start with titration up to 300-1000mg daily in divided doses
  - Characteristic side effects for 1st generations (sedation, EPS, anti-cholinergic effects)
  - Causes weight gain and metabolic effects
  - Used off-label for nausea/vomiting and severe hiccups.
- Haloperidol (Haldol)
  - Variety of dosing options including a long-acting depot injections
  - Characteristic side effects for 1st generations
  - More sedation and dissociation, especially with cumulative dosing
  - High risk of cardiac conduction effects
  - Used in acute agitation/mania/delirium
    - Also in patients not carrying a formal diagnosis

Schneiderhan ME, Nelson L, Bishop JR, Bauer S. Evaluation of Psychiatric Disorders. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.
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# 2nd Generation Antipsychotic Medications

- Mainstays of therapy for psychosis-related disorders
- Side effect profile is lower than 1st-generation antipsychotics
  - Less cardiac conduction effects although still a concern
  - Less EPS effects
  - Less anti-cholinergic effects
  - Less sedation and disassociation
- Higher incidence of metabolic effects (weigh gain and diabetes)
  - Some within the class may have lower incidence
- Commonly used for chronic management of established disease states
- Off-label use (especially in hospitalized and long-term care) increasing

Schneiderhan ME, Nelson L, Bishop JR, Bauer S. Evaluation of Psychiatric Disorders. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.
Crismon M, Smith T, Buckley PF. Schizophrenia. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.
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# 2nd Generation Antipsychotic Medications

- Aripiprazole (Abilify)
  - Commonly used agent
  - Once daily dosing
  - Low risk of metabolic effects comparatively
  - Lower incidence of sedation and EPS effects
- Clozapine (Clozaril)
  - Used for refractory schizophrenia/mania
  - Risk Evaluation and Mitigation Strategy (REMS) program required by FDA due to hematologic side effects
  - High risk of metabolic effects comparatively
  - Uncommonly used

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# 2nd Generation Antipsychotic Medications

- Olanzapine (Zyprexa)
  - Various dose forms including oral disintegrating, parenteral, and long-acting depot
  - High risk of metabolic and anticholinergic effects comparatively
  - Commonly used in practice for labeled and off-label use
- Quetiapine (Seroquel)
  - Only available as an oral agent
  - High risk of metabolic effects at high doses comparatively
  - More sedation and hypotension than other atypical agents
  - Lower incidence of movement side effects (EPS, akathisias)

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# 2nd Generation Antipsychotic Medications

- Risperidone (Risperdal)
  - Available for oral administration or long-acting intramuscular depot
  - Especially effective for mania and bipolar, adjunctive for major depressive disorder
  - Relatively less sedation and hypotension
  - Moderate metabolic effects
- Ziprasidone (Geodon)
  - Available as oral or short-acting intramuscular administration
  - Once daily dosing (food aids absorption)
  - Lower metabolic effects comparatively
  - Effective for acute mania and acute agitation

Schneiderhan ME, Nelson L, Bishop JR, Bauer S. Evaluation of Psychiatric Disorders. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V. eds. *Pharmacotherapy: A Pathophysiologic Approach, 11e*. McGraw Hill; 2020.
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# 2nd Generation Antipsychotic Medications

- Honorable Mentions
  - Asenapine (Saphris) → can only be given sublingually
  - Brexpiprazole (Rexulti) → specific benefits as adjunct for depression
  - Cariprazine (Vraylar) → benefits in bipolar I; low side effects comparative to class
  - Lurasidone (Latuda) → Very low side effect profile (anticholinergic, sedation, metabolic, hypotension)


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# Antipsychotic Use in Practice

- Agents of choice for:
  - Schizophrenia/schizoaffective disorders
  - Bipolar Disorders
  - Acute agitation/mania
  - Other psychosis-related conditions

- Adjunctive agents for:
  - Major Depressive Disorders
  - Depression
  - Some Major Neurocognitive Disorders



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# Antipsychotic Use in Practice – Off-Label Uses

- Selected Off-Label Indications
  - Anxiety
  - Attention-deficit hyperactivity disorder (ADHD)
  - Dementia
  - Depression
  - Eating Disorders
  - Insomnia
  - Obsessive-compulsive disorder (OCD)
  - Personality disorder
  - Post-traumatic Stress Disorder (PTSD)
  - Substance abuse
  - Tourette's Syndrome

**TABLE 3** Efficacy of Atypical Antipsychotics by Condition and Strength of Evidence

| | Aripiprazole | Olanzapine | Quetiapine | Risperidone | Ziprasidone |
|---|---|---|---|---|---|
| **Anxiety** | | | | | |
| Generalized anxiety disorder | o | - | ++ | - | - |
| Social phobia | o | + | - | o | o |
| **Attention-deficit hyperactivity disorder** | | | | | |
| No co-occurring disorders | o | o | o | + | o |
| Bipolar children | - | o | o | o | o |
| Mentally retarded children | o | o | o | + | o |
| **Dementia** | | | | | |
| Overall | ++ | + | + | ++ | o |
| Psychosis | + | +- | +- | ++ | o |
| Agitation | + | ++ | +- | ++ | o |
| **Depression** | | | | | |
| MDD augmentation of SSRI/SNRI | ++[a] | +[a] | ++[a] | ++ | + |
| MDD monotherapy | o | - | ++ | o | o |
| **Eating disorders** | o | -- | - | o | o |
| **Insomnia** | o | o | - | o | o |
| **Obsessive-compulsive disorder** | | | | | |
| Augmentation of SSRI | o | + | -- | ++ | - |
| Augmentation of citalopram | o | o | + | + | o |
| **Personality disorder** | | | | | |
| Borderline | + | +- | + | o | - |
| Schizotypal | o | o | o | +- | o |
| **Post-traumatic stress disorder** | o | +- | + | ++ | o |
| **Substance abuse** | | | | | |
| Alcohol | -- | - | - | o | o |
| Cocaine | o | - | o | - | o |
| Methamphetamine | - | o | o | o | o |
| Methadone clients | o | o | o | - | o |
| **Tourette's syndrome** | o | o | o | + | - |



Maher AR, Maglione M, Bagley S, et al. *JAMA.* 2011;306(12):1359-1369
Maher AR, Theodore G. *J Manag Care Pharm.* 2012;18(5-b):S3-S20.

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# Antipsychotic Use in Practice – Off-Label Uses

- Inpatient Delirium Prevention/Treatment
  - Historically antipsychotics were thought to be beneficial
  - Still some use in practice
  - A systematic review and meta analysis by Neufeld et al provided evidence that antipsychotics should **not** be used routinely
  - The Prevention and Management of Pain, Agitation/Sedation, Delirium Guidelines recommend **against** routine use of antipsychotics for prevention/treatment of delirium
- Insomnia
  - Insufficient evidence to support antipsychotic use for insomnia
  - Utilizing side-effect of sedation to help with sleep
  - Sedation **does not** promote sleep quality!
- Acute agitation
  - Some evidence for efficacy
  - Should not be continued without a formal evaluation/diagnosis

Neufeld KJ, Yue J, Robinson TN, et al. *J Am Geriatr Soc.* 2016;64:705-714.
Devlin JW, Skrobik Y, Gelinas C, et al. *Crit Care Med.* 2018;46(9):e825-e873

# Initiating Antipsychotic Therapy

- Indication for use
  - FDA-approved indication
  - Off-label data for use
- Patient-specific factors
  - Side effect profile and patient risk
  - Comparative efficacy based on patient symptoms
- Some level of trial and error in order to individualize patient care



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# Antipsychotic Use in Long-Term Care

- Differentiating patients with documented psychiatric conditions
  - Ensuring correct documentation for use
  - FDA-approved indication vs. Off-label use
- Individualized benefit and risk assessment
  - Re-assessment at set intervals
- Assessment of transitions of care
  - Medications added in the hospital that should be stopped
  - Medications not continued in the hospital that should be continued
- Polypharmacy assessment
- Adverse Drug Effects

# Antipsychotic Risks in Long-Term Care


- General Medication Risk Factors:
  - Often geriatric
  - Multiple comorbidities
  - Increased risk for polypharmacy
  - Limitations to independent activities of daily living
  - Increased risk for falls, depression, etc
  - Limitations to real-time multidisciplinary care
    - In comparison to other healthcare settings
  - Limited resources for care
  - Issues with transitions of care

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Meyer JM. Pharmacotherapy of Psychosis and Mania. In: Brunton LL, Hilal-Dandan R, Knollmann BC. eds. *Goodman & Gilman's: The Pharmacological Basis of Therapeutics, 13e*. McGraw Hill; 2017.



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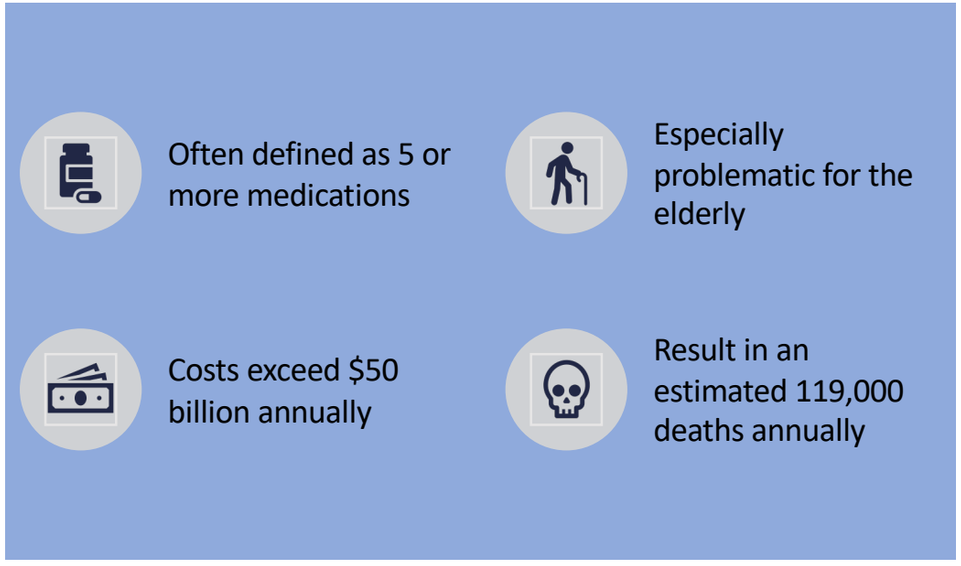
# Polypharmacy and Antipsychotics

- Polypharmacy
  - Using/prescribing more medications than clinically indicated (typically defined as 5 or more)
  - Created/worsened by:
    - Multiple comorbidities
    - Multiple providers and pharmacies
    - Transitions of care
    - Cascading of medication additions
  - Increases risk of ADE and drug interactions
  - Vicious cycle




Hoel RW, Giddings RM, Takahashi PY. *May Clin Proc*. 2021;96(1):242-56.
Lahteenvuo M, Tiihonen J. *Drugs*. 2021;81:1273-84
Gnjdic et al. *J Clin Epidemiol.* 2012;65(9):989-95.



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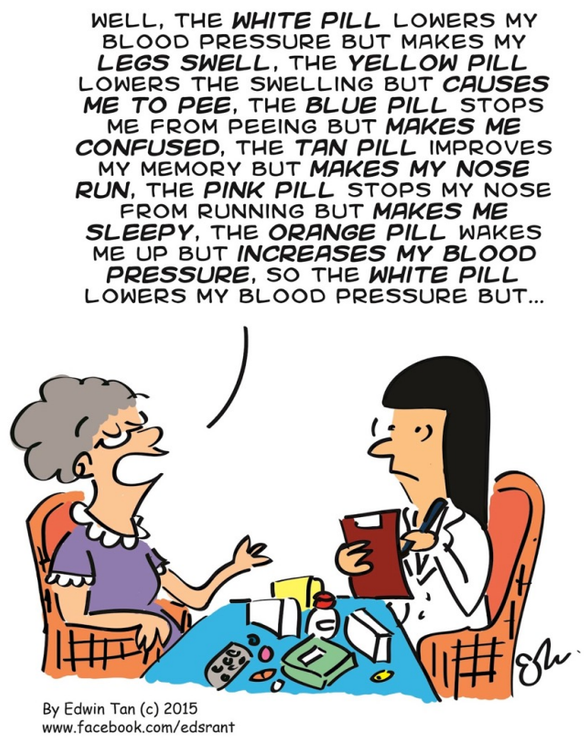
# Polypharmacy and Antipsychotics

- Antipsychotic polypharmacy (multiple agents) **may** be beneficial in some patient scenarios
- Focus should be on minimizing drug interactions with other medications
- Are we treating side effects of medications with more medications?

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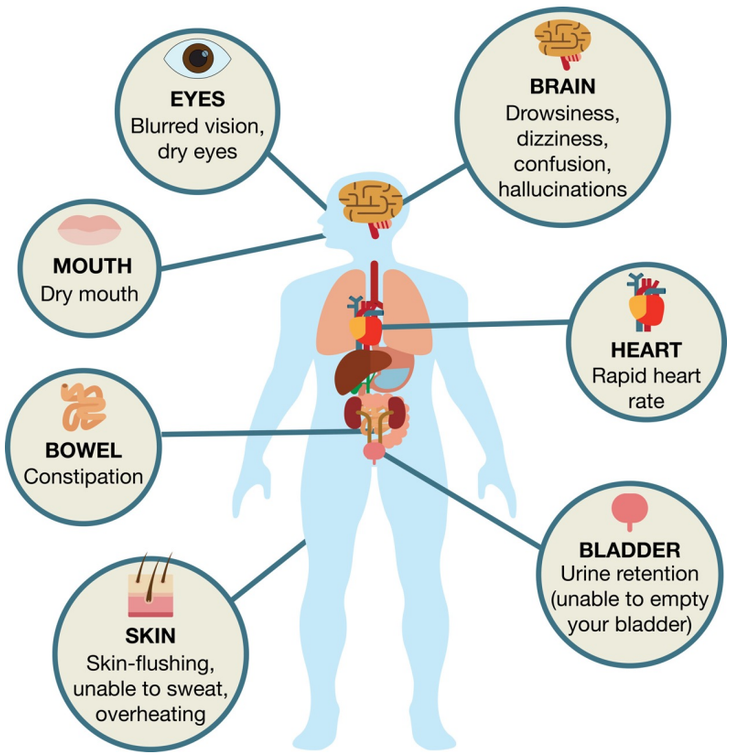
# Antipsychotic Risks in Long-Term Care

- Adverse Drug Event Risk is Elevated in Long-Term Care Patients
  - Falls risk → sedation, hypotension, anticholinergic effects
  - Poor sleep → sedation, anticholinergic effects
  - Depression → sedation
  - Cardiovascular disease → worsening of metabolic syndrome and weight gain





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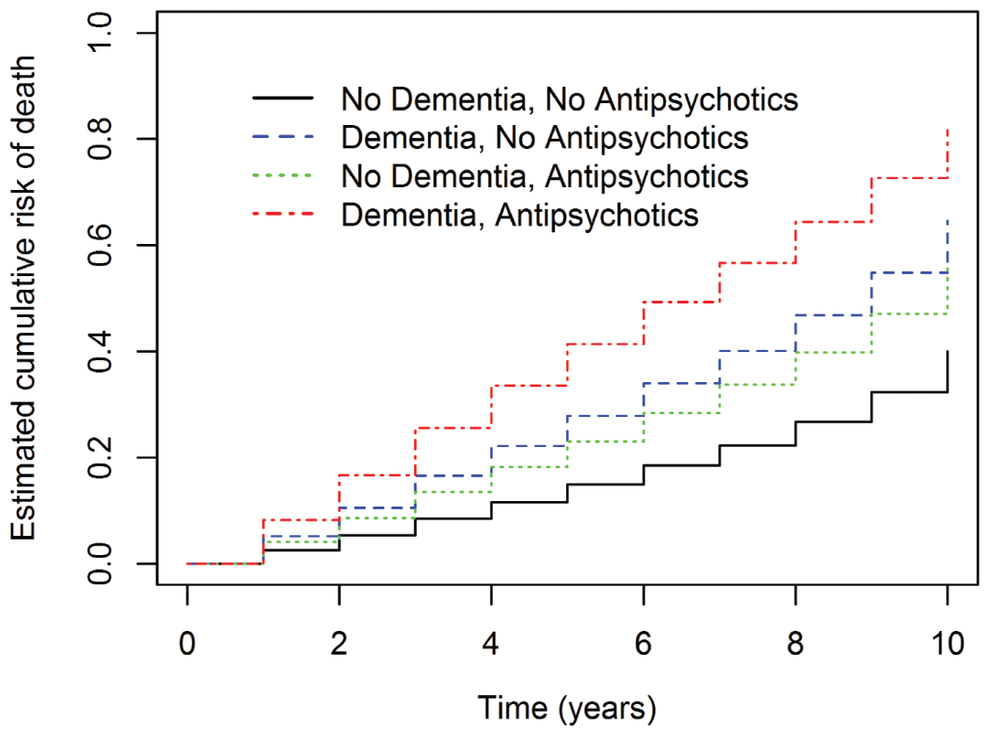
# Antipsychotic Risks in Long-Term Care

- Antipsychotic use in dementia patient is associated with an increased risk of mortality
- Association appears to be dose-related
  - Higher doses → increased mortality
- One study showed relative mortality based on agent
  - haloperidol > risperidone > olanzapine > quetiapine





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Ralph SJ, Espinet AJ. *J Alzheimers Dis. 2018;2:1-26*
Kheirbek RE, Fokar A, Little JT, et al. *J Gerontol A Biol Sci Med Sci.* 2019;74(12):1916–1921

# Antipsychotic Risks in Long-Term Care

- Inadequate control of psychosis-related symptoms also a risk for long-term care patients
  - Typically hypo-active or depression-related symptoms
- Transitions of care concern for missed medications/inaccurate dosing
- Other medications masking symptoms
  - Opiates, benzodiazepines, hypnotics
- Consider extra attention to these patients

# Medication Management Strategies

- Medication Reconciliation
- Identification of medication appropriateness
- Evaluation for deprescribing and under-prescribing opportunities
  - Engage gradual dose reduction strategies if appropriate
- Evaluation for drug interactions and dosing appropriateness

# Medication Management Strategies

- Medication Reconciliation
  - 'The process of comparing a patient's medication orders to all of the medications that the patient is taking.' – Joint Commission
  - Sources of information
    - Pharmacy fill history
    - Medication list from physician's office/hospital
    - Patient interview
    - Other sources
  - Goal → identify the most accurate list of medications the patient is actually taking

- Medication Appropriateness

| Questions to ask about each individual medication: |
|---|
| 1. Is there an indication for the medication? |
| 2. Is the medication effective for the condition? |
| 3. Is the dosage correct? |
| 4. Are the directions correct? |
| 5. Are the directions practical? |
| 6. Are there clinically significant drug–drug interactions? |
| 7. Are there clinically significant drug–disease/condition interactions? |
| 8. Is there unnecessary duplication with other medication(s)? |
| 9. Is the duration of therapy acceptable? |
| 10. Is this medication the least expensive alternative compared to others of equal utility? |

# Gradual Dose Reduction Strategies

- Gradual Dose Reduction (GDR) is a strategy for slowly but methodically lowering medication doses to optimize medication use

- Goals
  - Remove a medication completely
  - Find a dose that optimizes efficacy and minimizes side effects

- Individualized to patient and medication




Tjia J, Reidenberg MM, Hunnicutt JN, et al. *Consult Pharm*. 2015;30(10):599-611.
Graff-Guerrero A, Rajji TK, Mulsant BH, et al. *JAMA Psychiatry*. 2015;72(9):927-934.
Takeuchi H, Kantor N, Uchida H, et al. *Schizophenia Bulletin*. 2017;43(4):862-871.

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# Gradual Dose Reduction Strategies

- Tjia et al. provided a literature search and identified that while discontinuation strategies are important, they are 'unstandardized' and 'not validated'
- They recommend a pharmacology-based gradual reduction strategy

| Generic/Brand | $t_{½}$ | Adjusted $t_{½}$ for Increased Age (65–89 Yr: 1.5 × $t_{½}$) | Calculated Time to Steady-State (5–7 Half-Lives to Reach Steady State) | Time to Next Gradual Dose Reduction (Leave at Steady State for ~7 Days) | Clinically Recommended Time Between Gradual Dose Reduction | Estimated Time to Discontinuation |
|---|---|---|---|---|---|---|
| Aripiprazole/ Abilify | Parent: 75 hrs<br>Active metabolite: 94 hrs | Parent: 83 hrs<br>Active metabolite: 141 hrs | 41 days (based on active metabolite) | 48 days | 2 months | 4 months |
| Olanzapine/ Zyprexa | Parent: 21–54 hrs | Parent: 32–81 hrs | 9–24 days | 16–31 days | 2–4 weeks | 4–8 weeks |
| Quetiapine/ Seroquel | Parent:<br>IR: 6 hrs<br>ER: 7 hrs | Parent:<br>IR: 9 hrs<br>ER: 11 hrs | Parent:<br>IR: 2.5 days<br>ER: 3 days | Parent:<br>IR: 9.5 days<br>ER: 10 days | 2 weeks | 4 weeks |
| Risperidone/ Risperdal | Parent: 3–20 hrs<br>Active metabolite: 21–30 hrs | Parent: 4–30 hrs<br>Active metabolite: 32–45 hrs | Parent: 1–9 days<br>Active metabolite: 9–13 days | Parent:<br>8–16 days<br>Active metabolite: 16–20 days | 2–3 weeks | 4–6 weeks |



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Graff-Guerrero A, Rajji TK, Mulsant BH, et al. *JAMA Psychiatry*. 2015;72(9):927-934.
Takeuchi H, Kantor N, Uchida H, et al. *Schizophenia Bulletin*. 2017;43(4):862-871.

# Gradual Dose Reduction Strategies

- Takeuchi et al. conducted a systematic review and meta-analysis on immediate vs. gradual dose reduction.
- No major differences in outcome measures
- Researchers found advantages to individualizing the strategy based on patients risk/benefit and medication list.

- Graff-Guerrero et al. conducted an evaluation of gradual dose reduction in stable late-life schizophrenia patients
- Showed dose-reductions were feasible and safe.
- Results showed improvements in illness severity and reduction in adverse reactions.
- Even when discontinuation is not the goal, dose reductions can be beneficial



Tjia J, Reidenberg MM, Hunnicutt JN, et al. *Consult Pharm*. 2015;30(10):599-611.
Graff-Guerrero A, Rajji TK, Mulsant BH, et al. *JAMA Psychiatry*. 2015;72(9):927-934.
Takeuchi H, Kantor N, Uchida H, et al. *Schizophenia Bulletin*. 2017;43(4):862-871.

Qsource

# Gradual Dose Reduction Strategies

- Dose reduction strategies should be individualized to patients
- Focus on:
  - Maintaining disease management
  - Minimizing side effects
  - Reaching an attainable goal → discontinuation or lowered dose
- Gradual dose reduction strategies have been shown to be beneficial in the literature and in practice



Tjia J, Reidenberg MM, Hunnicutt JN, et al. *Consult Pharm*. 2015;30(10):599-611.
Graff-Guerrero A, Rajji TK, Mulsant BH, et al. *JAMA Psychiatry*. 2015;72(9):927-934.
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# Case Discussion 1

- WM, 79 y/o female
- Diagnoses – Bipolar disorder, Major Depressive Disorder (MDD)
- Background
  - Long-term mental health patient
  - Assisted living patient
  - Poor family resources/support

# Case Discussion 1

- Medication
  - risperidone 0.5mg BID
  - lorazepam 0.5mg BID as needed

- Baseline Function
  - Patient ambulatory with walker
  - Talks to herself
  - Inserts herself into conversations
  - Otherwise pleasant and cooperative

# Case Discussion 1

- GDR was done on WM's risperidone and stopped for 60 days

- Changes in behavior:
  - Pleasant but increasingly suspicious, especially other residents she doesn't get along with
  - Slow development of visual hallucinations (worsening her suspicion of others)
  - Increasingly fearful and guarded
  - Overall the patient became more erratic, labile and accusatory

# Case Discussion 1

- Change in behavior identified
- Provider restarted risperidone
  - 0.25mg daily for 1 week then slowly back to 0.5mg BID
- Patient gradually returned to a calm and cooperative state
  - Free of psychosis, hallucinations, and paranoia

# Case Discussion 1 Pearls

- Important to consider patient's quality of life when attempting GDR
  - Patient had some social issues on medication but off medication her psychosis was much worse
- Reasonable and prudent to use medications to maintain patient and staff safety
- Document specific psychosis-related events to justify antipsychotic use
- Use lowest dose possible and monitor for side effects
  - AIMS testing for tardive dyskinesia and drug-induced Parkinsonism

# Case Discussion 1 Pearls

- Medication considerations
  - Don’t try to re-invent the wheel
  - Start with the patient, their comorbidities and psychiatric-related conditions before choosing a medication
  - Use low doses
  - Titrate to quality of life or functional effect
- In this case risperidone was chosen
  - Patient had positive experience/tolerability
  - Lower falls risk in a mobile patient
  - Less sedating relatively

# Case Discussion 2

- GS, 61 y/o female
- Diagnoses
  - Cognitive Communication Deficit
  - Schizoaffective disorder, depressive type
  - Anxiety
  - Major Depressive Disorder
  - Insomnia
- Home Medication List
  - escitalopram 20mg PO QAM
  - lorazepam 0.5mg PO Q8hr prn anxiety
  - quetiapine 300mg PO QHS
- Good baseline medication compliance and family resources/support
- Stable connection to outpatient psychiatrist

# Case Discussion 2

- Background
  - Admitted to hospital then SNF seconda to a fall and femur fracture
  - Poor historian
  - Medication list in the hospital and transition to SNK did not include quetiapine
  - Patient withdrew from high-dose quetiapine in the hospital and SNF

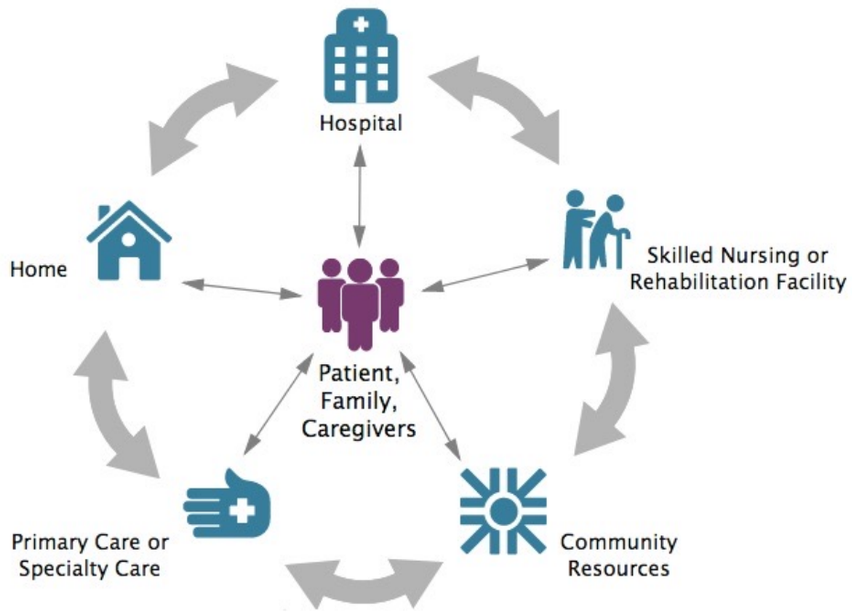




Image at: https://www.pcori.org/topics/transitional-care/about-transitional-care

# Case Discussion 2

- Resolution
  - Psychiatric care provider assumed care 3 days into SNF stay
  - Patient had become increasing anxious, tearful, guarded, and paranoid
  - Provider contacted outpatient psychiatrist who provided medication and history information
  - Patient was restarted on quetiapine 100mg PO QHS
  - After 3 days, symptoms resolved and patient stabilized, completed recovery from her fracture and was discharged home on a lower dose

# Case Discussion 2 Pearls

- Always ensure you have a complete picture of the patient's history and medication list
- Be cautious with information flow at transitions of care
  - There are places where information can be lost
- Use these situations as opportunities to ensure patient is optimally treated
  - Did she need to be on 300mg in the first place?

# Case Discussion 2 Pearls

- Medication Considerations
  - Quetiapine is commonly used in practice for numerous mental health disorders
  - Can be prescribed for insomnia, especially if poorly controlled
  - In this case, quetiapine was likely chosen for its effect on schizoaffective disorder, psychosis, insomnia, and anxiety
  - Use the lowest dose possible and avoid abrupt discontinuation

# Conclusion

- Antipsychotic medications are common in practice and have variable efficacy and safety considerations
- Risks and benefits to starting, continuing and discontinuing agents should be evaluated, especially in the long-term care population
- Off-label use of antipsychotic agents is common however benefits may be setting and situation-specific
- Gradual dose reduction strategies have shown benefit in patient care and should be implemented when deemed necessary
- Patient's quality of life should be a main factor in determining goals of care

# Connect With Us

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