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Schizophrenia and related psychoses CHAPTER 1 When to attempt discontinuation Longstanding or lifelong antipsychotic treatment is something of a modern-day phenomenon. In the 1960s, discontinuation of antipsychotics was usually attempted after acute response. There are currently no evidence-based recommendations for antipsychotic withdrawal but we suggest that it only be considered in patients who have been in remission for 6 months (first episode) or 1 year (multi-episode). Relapse rates using fast linear tapers generally exceed 90% for both groups of patients. This might suggest that abrupt tapering always precipitates relapse or that relapse is inevitable when anti psychotics are withdrawn. Certainly, some people (probably the majority with a schizophrenia diagnosis) will relapse no matter how the antipsychotic is stopped. A cautious approach to antipsychotic reduction is recommended, especially in long- term users, where a test reduction of 5–10% of dose might be a sensible starting point. In people who have been on medication for shorter periods (e.g. <1 year) a reduction as large as 25% might be feasible. The patient should then be monitored for several weeks following this reduction for any withdrawal symptoms or worsening of psychotic symptoms. These symptoms may be transitory withdrawal effects rather than signs of inevitable relapse necessitating reinstatement of the regular dose of medication.²⁰ If a patient tolerates this reduction with no significant effect on their overall mental state (or perhaps only mild symptoms) then further reductions could be made at the same rate (for example, a reduction of 10–25% of the dose every 2–3 months). Patients may require increased psychosocial support during this period of withdrawal. If a patient experiences significant withdrawal symptoms or worsening of psychotic symptoms then an increase in dose back one or two steps or back to the original dose may be necessary.²⁰ This does not preclude further attempts at reduction, but these attempts should be delayed until stability is established and should be performed more gradually than previously attempted (some long-term users can only tolerate <5% dose reductions per month). Final doses before complete cessation may need to be very small to prevent a large decrease in D2 blockade. This may need to be as small as 1/80th the original therapeutic dose (for example, 0.25mg of olanzapine) or smaller. Delivery of these small doses will require splitting tablets or using liquid formulations of the medications. Use of adjunctive medication to manage withdrawal symptoms may lead to accumulation of further medications and so pausing or slowing the taper is generally more advisable.²⁰ Every- other-day dosing of

antipsychotics with half-lives of less than 24 hours leads to fluctuating plasma levels, which can precipitate withdrawal effects and so should generally be avoided. Reducing depot medication may facilitate gradual tapering because of the longer half-lives of elimination. However, depots cannot be said to be 'self-tapering' for long-term users because the time taken for elimination may be shorter than the time required for many patients to adapt to lower blood levels of medication, and will require switching from the lowest depot dose to oral medication in order to continue a gradual taper.^{37,38} Example reducing regimens are presented in Table 1.27 and Box 1.1.

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