

34 - How and when to stop⁵⁵

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30 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 A large meta-analysis concluded that the risk of relapse with newer SGAs is similar to that associated with older drugs.³ (Note that lack of relapse is not the same as good functioning.³⁷) The proportion of patients with multi-episode schizophrenia who achieve remission is small and may differ between antipsychotic drugs. The CATIE study³⁸ reported that only 12% of patients treated with olanzapine achieved remission for at least 6 months, compared with 8% treated with quetiapine and 6% with risperidone. The advantage seen here for olanzapine is consistent with that seen in an acute efficacy network meta-analysis,³⁹ and in two recent meta-analyses of long-term efficacy.^{40,41}

Adherence to antipsychotic treatment Among people with schizophrenia, non-adherence to antipsychotic treatment is high. Only 10 days after discharge from hospital, up to 25% are partially or non-adherent, rising to 50% at 1 year and 75% at 2 years.⁴² Not only does non-adherence increase the risk of relapse, it may also increase the severity of relapse and the duration of hospitalisation.⁴² The risk of suicide attempts also increases four-fold⁴² (see section on working towards adherence in Chapter 14). Given these low rates of adherence and the near certainty of relapse if antipsychotics are not taken, the use of oral antipsychotics is difficult to justify.

Dose for prophylaxis Many patients probably receive higher doses than necessary (particularly of the older drugs) when acutely psychotic.^{43,44} In the longer term, a balance needs to be made between effectiveness and adverse effects. Lower doses of the older drugs (8mg haloperidol/day or equivalent) are, when compared with higher doses, associated with less severe adverse effects,⁴⁵ better subjective state and better community adjustment.⁴⁶ Very low doses increase the risk of psychotic relapse.^{43,47,48} The largest meta-analysis showed very clearly that prophylactic efficacy begins to be lost at doses below around 5mg/day risperidone equivalents.³⁵ Doses that are acutely effective should generally be continued as prophylaxis,^{49,50} although an exception to this is prophylaxis after a first episode, where very careful dose reduction is probably supportable. There is some recent support for dose reduction in multi-episode schizophrenia.⁵¹ The concept of guided antipsychotic dose reduction has gained attention in the past few years, following the apparent success of the famous Wunderink study.¹⁴ Later studies have suggested that guided dose reduction is associated with a substantially greater risk of relapse compared with continuation.^{52,53} However (and perhaps most importantly), guided dose reduction or stopping treatment does not result in relapse in everyone, at least over the time periods examined.⁵⁴ So some people (probably a small minority) appear to be able to stop antipsychotic treatment without relapsing.

How and when to stop⁵⁵ The decision to stop antipsychotic drugs requires a thorough

risk-benefit analysis for each patient. Withdrawal of antipsychotic drugs after long-term treatment should be gradual and closely monitored. The relapse rate in the first 6 months after abrupt withdrawal is double that seen after gradual withdrawal (defined as slow taper down over

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