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A guide to reducing or stopping mental health medication

Notes for prescribers

Prescribers notes for reducing or stopping mental health medication

These notes are written to augment the information for consumers in *A guide to reducing or stopping mental health medication*. They are intended for any prescribers helping someone stop their mental health medication, but it is anticipated they will be most useful for general practitioners.

In general, medication discontinuation symptoms (MDS) occur for:

- around half of all people stopping serotonin specific reuptake inhibitors (SSRIs)
- between a third and a half of people taking other medications such as antipsychotics, benzodiazepines/zopiclone and mood stabilisers.[1]

They are more likely with paroxetine, venlafaxine, clozapine and lamotrigine but less likely with sodium valproate.[1,2,3]

Of those people who do get MDS, about half will get significant symptoms that impair their day-to-day functioning.[2]

The nature and frequency of MDS is quite variable from person to person and drug to drug.

The best approach for most medication is to gradually reduce or taper the dose. For those who still get significant MDS, it may be possible to switch from a shorter acting to a longer acting similar medication.

For a list of common withdrawal symptoms and coping strategies see *A guide to reducing or stopping mental health medication*.

Notes on specific medications

Information in this section is drawn from the Medsafe website[4] for preparation doses, and the *Australian Don't Rush to Crush Handbook*[5] for details on whether tablets may be dissolved in water.

The information assumes people will be taking the medication as prescribed. Some of the medications below, such as methylphenidate, dexamphetamine, the benzodiazepines and zopiclone, may be used in doses well above those usually prescribed and taken by routes other than orally, e.g. intravenously. In these circumstances referral to a specialist alcohol and drug service is advised. Others such as quetiapine may be misused for recreational reasons but not usually in an addictive pattern.

Antidepressants

Converting a shorter acting to a longer acting SSRI

Converting from a shorter acting SSRI antidepressant (sertraline, paroxetine, citalopram, escitalopram) to fluoxetine is often recommended to minimise MDS.[6,7] This is especially worth trying if the initial discontinuation of paroxetine or venlafaxine is troublesome.

This is a proven approach for benzodiazepine/zopiclone discontinuation,[8,9] e.g. converting from midazolam to diazepam, and makes sense for antidepressants. Clinical experience suggests this approach is helpful sometimes and not at other times, especially for venlafaxine.

Fluoxetine

Fluoxetine is metabolised more slowly than other antidepressants and therefore MDS tend to be mild or absent.

Fluoxetine is also available as a dispersible tablet which dissolves in water for people who need doses not easily divisible by 10 or 20mg

(the standard tablet or half tablet dose). The prescription needs to be endorsed to mention this. This allows very small reductions to be made. For example, if 20mg is dissolved in 100ml of water, and 10ml is consumed, that is a dose of only 2mg.

Paroxetine

Paroxetine is cleared quickly from the body so MDS are more common and severe than with most other antidepressants.

It is also difficult to reduce paroxetine. While it is possible for a pharmacist to produce a liquid version, this only lasts about a day, making it impractical for all but the most severe discontinuation reactions. If you observe troublesome MDS the best option is to convert to fluoxetine and reduce the dose slowly.[7]

Venlafaxine

Along with paroxetine, venlafaxine is associated with more frequent and more severe MDS than most other antidepressants.

The current funded version (Enlafax) is available in 37.5mg, 75mg and 150mg extended release capsules. Many people taking venlafaxine are on more than 200mg a day, so it is possible to support people discontinuing venlafaxine with relatively small reductions in dose.

As mentioned above, conversion to fluoxetine is reported to be helpful for some but not all people coming off venlafaxine.

More information on switching antidepressants can be found at the following website:

http://www.gpnotebook.co.uk/simplepage.cfm?ID=1630863432

Antipsychotics

There is much less information on antipsychotic discontinuation than on benzodiazepine or antidepressant discontinuation, but case reports leave little doubt this can occur and can be quite troublesome for some individuals.

Most antipsychotics are available in a range of tablet dosages. This means gradually tapering the medication being stopped is usually a

reasonable approach.

There is little information available on whether or not switching to a longer acting antipsychotic can make medication discontinuation easier.

Switching from one to another is common in clinical practice and reasonably straightforward, but whether this helps ease MDS is unclear and there are very few reports of this approach being used.

Currently the best advice is to stop antipsychotics by a slow taper as described in the stopping medication section of *A guide to reducing or stopping mental health medication*.

As an alternative to converting to another antipsychotic medication, there are other medications that may help ease MDS if they are troublesome. Which medication offered will depend on the medication people are coming off and the symptoms they are experiencing.

Quetiapine

Quetiapine has a shorter half-life than most other antipsychotics and reports from people who are prescribed it indicate that it can sometimes by very difficult to stop due to the intensity of MDS.

It is available as 25mg, 100mg, 150mg, 200mg and 300mg tablets. The preparations available should not be halved so the smallest practical dose is 25mg.

The doses people take vary a lot depending on what it is being used for, from 25mg a day to help sleep and augment antidepressants in younger people, to over 800mg a day for psychotic disorders.

Gradually tapering off quetiapine is much easier if a person is on a high dose. It is important to note that MDS may still occur with relatively low doses.

Clozapine

Reports from people who are prescribed clozapine suggest it may be the most difficult antipsychotic to stop.

Clozaril is available as 25mg and 100mg tablets.

Standard doses of clozapine may be as high as 900mg, though many people are prescribed much lower doses. The 25mg tablet can be halved so dose reductions of 10 percent or smaller can be offered to people.

Some MDS may be due to cholinergic rebound and in severe cases anticholinergic medication may help ease these symptoms. Symptoms of cholinergic rebound include; agitation, headache, nausea, sweating and sudden reemergence of psychotic symptoms. Note that similar symptoms can also occur with other neurotransmitter systems.

Benzodiazepines and zopiclone

Benzodiazepines are all very similar in their actions, so they are easy to convert from one to another.

The best way to stop benzodiazepines is to convert a short acting benzodiazepine to a long acting one such as diazepam, given two or three times a day, and then reduce the dose in small steps. For some people this may need to happen over quite lengthy periods to reduce the discomfort of MDS.

Note: While not strictly a benzodiazepine, zopiclone acts in very much the same way and should therefore be considered as one to all intents and purposes, especially when considering discontinuation.[10]

Absorption rates, half-life and equivalent daily doses of common benzodiazepines					
Generic name	Trade name	Equivalent dose to 5mg diazapam	Time to peak concentration	Elimination half life	Duration of action
diazepam	Arrow-Diazepam	5mg	30-90 min	20-48 hours	Long
alprazolam	Xanax	0.5-1mg	60 min	6-25 hours	Short
clonazepam	Rivotril Paxam	0.5mg	2-3 hours	22-54 hours	Long
lorazepam	Ativan	1mg	2 hours	12-16 hours	Short
oxazepam	Ox-Pam	15-30mg	2-3 hours	4-15 hours	Short
nitrazepam	Nitrados	2.5-5mg	2 hours	16-48 hours	Long
temazepam	Normison	10-20mg	30-60 min/tablets 2 hours/capsules	5-15 hours	Short
flunitrazepam	Rohypnol	1-2mg	1-2 hours	20-30 hours	Intermediate
triazolam	Hypam	0.25mg	1-3 hours	2-5 hours	Very short
zopiclone	Imovane	7.5mg		5 hours	Very short

Note: Duration of action (approx.):

- Very short: <6 hours
- Short: <12 hours
- Intermediate: <24 hours
- Long: >24hours

Adapted from: *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (NSW Health, 2007).[11]

For a list of benzodiazepine dose equivalencies and further information on benzodiazepine discontinuation, see: http://www.benzo.org.uk/manual/ and/or http://online.lexi.com/action/home

Stimulants

Stopping methylphenidate and dexamphetamine can lead to severe MDS.

These are much more likely when the medications have been taken in doses above that which has been prescribed or have been used recreationally as part of an addictive pattern of use. In these circumstances referral to a specialist alcohol and drug service is advised.

For people using the medication as prescribed, a gradual taper is recommended.

Methylphenidate 10mg tablet is dispersible in water.

Dexamphetamine is available as a 5mg tablet.

Benzodiazepines may be prescribed for anxiety and agitation, antidepressants for low mood, low-dose antipsychotics for poor sleep and melatonin for sleep.[12]

If MDS are severe consider referral to a specialist alcohol and drug service.

Further reading

For further information on medication discontinuation:

Breggin, P. (2013). *Psychiatric Drug Withdrawal: a guide for prescribers, therapists, patients and their families*. Springer Publishing Company, New York.

Hall, W. (2012). *Harm Reduction Guide to Coming off Psychiatric Drugs. 2nd Edition*. The Icarus Project and Freedom Center. http://www.willhall.net/files/ComingOffPsychDrugsHarmReductGuide2Edonline.pdf

Matua Raki (2011). *Amphetamine-type stimulants (ATS), 21-26. In Substance withdrawal management: Guidelines for medical and nursing practitioners in primary health, specialist addiction, custodial and general hospital settings*. Wellington.

GP Notebook. http://www.gpnotebook.co.uk/simplepage.cfm?ID=1630863432

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3. Wilson, E. & Lader, M. (2015). A review of the management of antidepressant discontinuation symptoms. *Therapeutic Advances in Psychopharmacology, 5(6), 357–368*.

4. http://www.medsafe.govt.nz

5. Burridge, N., & Deidun. D. *Australian don't rush to crush handbook. Second Edition*. Collingwood 2016.

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