1. Goal of the Guidelines
Persistent gaps exist in the quality of mental health care delivered to the Florida Medicaid population. In view of this reality the overall purpose of the guidelines presented in this document is to inform clinicians, specifically primary care clinicians on whom the care of patients with mental illnesses often falls, of the most current evidence-based (EBM) approaches to the pharmacological treatment of bipolar disorders, schizophrenia and depression. The guideline expert panel group included representatives from the scientific community at the national level, academia, state of Florida, specialists and primary care clinicians from Florida. In bringing together this wide group of stakeholders with diverse clinical experience and views we have endeavored to produce a document that is sensitive to the practice reality and at the same time provide care recommendations relevant to both clinicians and patients.

The guidelines underwent a thorough review of the most recent literature by the experts, are scientifically valid and incorporate a grading system for displaying the quality of the available evidence and strength of clinical recommendations. We readily recognize that the knowledge about mental disorders is evolving and expanding and so the need to regularly update the information in the guidelines. These guidelines will be regularly updated in both printed and electronic forms.

It is therefore our hope that the clinical decisions made by clinicians will be grounded on reliable evidence, account for individual variations and patient needs in treating these complex and challenging conditions.

2. Level Framework for Best Practice Guidelines
The panel decided to continue using the existing format of the Adult Florida Best Practice Guidelines, where instead of creating an algorithm where specific options were mandatory or had to be used first or diagrammatically looked like they had to be used first, the adult expert panel decided to categorize options in different levels, based upon strength of science and expert consensus regarding a particular agent or treatment option. The panel weighed both safety and efficacy issues when assigning particular treatment options to a Level. Level 1 options were considered to have stronger evidence and consensus than level 2 and below. The panel chose this approach with an understanding that using a particular option at any level would depend upon clinical judgment and patient or family needs or preferences. Level 0 refers to an assessment level prior to any decisions regarding treatment options.

Continued on page 2
3. Disclaimer
The Florida Best Practices Medication Guidelines for the use of psychotropic medication in adults reflect the state of knowledge, current at the time of publication, on effective and appropriate care, as well as clinical consensus judgments when research is lacking. The inevitable changes in the state of scientific information and technology mandate that periodic review, updating, and revisions will be needed. These guidelines do not apply to all patients and each must be adapted and tailored to each individual patient. Proper use, adaptation, modifications, or decisions to disregard these or other guidelines, in whole or in part, are entirely the responsibility of the clinician who uses the guidelines. The authors bear no responsibility for the use of these guidelines by third parties.

4. Careful Diagnostic Evaluation
- Bipolarity must be assessed in patients presenting with depression
- Suicidality must be carefully assessed
- Psychiatric and physical comorbidities must be carefully assessed
- Substance abuse must be evaluated and addressed

5. Measurement-Based Care
- Treatment targets need to be precisely defined
- Effectiveness and safety/tolerability of medication treatment must be systematically assessed by methodical use of appropriate rating scales and side-effect assessment protocols

For schizophrenia:
- Clinical Global Impression Scale (CGI) and
- Brief Psychiatric Rating Scale (BPRS)

For Major Depressive Disorder:
- Hamilton Rating Scale for Depression (HRSD) and
- Patient Health Questionnaire (PHQ)
- Montgomery-Asberg Depression Rating Scale (MADRS) as an acceptable alternative to HRSD
- Quick Inventory of Depressive Symptoms (QIDS)

For Bipolar Disorder:
- Young Mania Rating Scale for Bipolar Disorder (YMRS)
- Hamilton Rating Scale for Depression (HRSD)
- Encourage self-rating scale for depression such as:
  - 16-Item Quick Inventory of Depression Symptomatology (QIDS-SR16)
  - Clinical Global Impression Scale
  - Montgomery Asberg Depression Scale
  - Mood Diary

6. Collaborative Treatment Decision-Making
- Ongoing calibration of expected outcomes and progression towards goals
Florida Best Practice Medication Guidelines for Treatment of Acute Bipolar Depression

Adjunctive Psychosocial Treatments (as indicated)

- Cognitive Behavior Therapy
- Family-focused therapy
- Interpersonal and Social Rhythm Therapy

Level 0: Comprehensive Assessment

- Careful differential diagnostic evaluation
- Suicidality and aggression
- Psychiatric, substance abuse and physical co-morbidities
- Measurement-based care
- Collaborative treatment decision-making
- Psychosocial assessment

Level 1: Established efficacy, but limited tolerability*

- Quetiapine monotherapy
- Olanzapine + fluoxetine

Level 2: Established tolerability, but limited efficacy**

- Lamotrigine monotherapy
- (Lithium or valproate) + (lamotrigine, SSRI or Bupropion)

* Tolerability limitations include sedation and weight gain
** Efficacy limitations include negative randomized controlled trials and meta-analyses

Level 3: If Levels 1 and 2 ineffective or not tolerated*

- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- SGA + (lithium, valproate, lamotrigine, SSRI or Bupropion)
- Antimanic therapy + (SNRI, modafanil, pramipexole, MAOI, TCA, thyroid, stimulant)
- Carbamazepine
- Adjunctive inositol, eicosapentaenoic acid (EPA)

* Consideration merited due to clinical need, despite even greater efficacy/tolerability limitations than level 1 and 2 treatments

Number of iterations at each level and adjunctive treatment(s) to be determined by clinician judgment/patient needs
Measurement-based care:

- Treatment targets need to be precisely defined
- Use of rating scales recommended
- Effectiveness and safety/tolerability of medication treatment must be systematically assessed

Recommended rating scales:

- 16-item Quick Inventory of Depression Symptoms (public domain) www.ids-qids.org/translations/english/QIDS-SREnglish2page.pdf
- Montgomery Asberg Depression Rating Scale (public domain) www.opapc.com/images/pdfs/MADRS.pdf
- Patient Health Questionnaire-9 (public domain) http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf

References:


Florida Best Practice Medication Guidelines for the Treatment of Bipolar Disorder Acute Mania

**Level 0**
**Comprehensive Assessment**
- Careful differential diagnostic evaluation
- Suicidality and aggression
- Psychiatric, substance abuse and physical co-morbidities
- Measurement-based care
- Collaborative treatment decision-making
- Integration with primary care providers

**Level 1A**
*If not treatment resistant and not very severe:*
- Monotherapy with aripiprazole, lithium, olanzapine, quetiapine, risperidone, valproate, or ziprasidone.

**Level 1B**
*If severe and/or treatment resistant:*
- Lithium, valproate plus a second generation antipsychotic (SGA) except asenapine, clozapine, haloperidol, paliperidone or ziprasidone

**Level 2**
*If Level 1 is not effective*
- Two-drug combination of lithium + valproate
- Lithium or valproate plus non-clozapine second generation antipsychotic (SGA)
- Carbamazepine monotherapy
- Lithium plus carbamazepine

**Level 3**
*If Levels 1 and 2 ineffective or not tolerated* *
- Clozapine monotherapy
- Clozapine plus lithium or valproate
- Valproate + carbamazepine
- Electroconvulsive Therapy (ECT)

**Level 4**
*If levels 1, 2,3, ineffective or not tolerated* *
- A three-drug combination of level 1, 2, and 3. Drugs may include first generation antipsychotic (FSA) BUT NOT 2 antipsychotics
  Example: lithium + (valproate, carbamazepine or oxcarbamazepine) + antipsychotic

*Continued on page 6*
Florida Best Practice Medication Guidelines for the Treatment of Bipolar Disorder Acute Mania

Continued from page 5

Measurement-based care
- Treatment targets need to be precisely defined
- Use of rating scales recommended
- Effectiveness and safety/tolerability of medication treatment must be systematically assessed

Recommended scales for bipolar disorder Acute Mania:
- Young Mania Rating Scale for Bipolar Disorder (YMRS)
- Hamilton Rating Scale for Depression (HRSD)

Reference
2. Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the management of patients with bipolar disorder: consensus and controversies. Bipolar Disorders 2005:7(Suppl.3):5-69

*Number of iterations at each level and adjunctive treatment(s) to be determined by clinician judgment/patient needs
Florida Best Practice Medication Guidelines for Bipolar Continuation / Maintenance Therapy

Adjunctive psychosocial treatments (as indicated)

- Psychoeducation
- Cognitive Behavior Therapy
- Family therapy
- Interpersonal and Social Rhythm Therapy

Level 1A: If full remission:
- Continue effective and well-tolerated acute treatment(s)*

Level 1B: If partial remission:

With residual manic symptoms
- Lithium, valproate, aripiprazole, olanzapine, quetiapine, risperidone
- Adjunctive aripiprazole, quetiapine, risperidone, or ziprasidone (added to lithium or valproate)

With residual depressive symptoms
- Lamotrigine, lithium, valproate, quetiapine
- Adjunctive quetiapine (added to lithium, valproate, or lamotrigine)

Level 2: If Level 1 ineffective or not tolerated:
- Follow acute mania/bipolar depression guidelines to achieve remission or partial remission

*Longer-term use limited for carbamazepine (drug interaction risk, limited longer-term efficacy data), antipsychotics (side effect risk), antidepressants (mania risk, limited longer-term efficacy data), electroconvulsive therapy (inconvenience/expense, limited longer-term efficacy data)

Number of iterations at each level and adjunctive treatment(s) to be determined by clinician judgment/patient needs
Measurement-based care:

- Treatment targets need to be precisely defined
- Use of rating scales recommended
- Effectiveness and safety/tolerability of medication treatment must be systematically assessed
- Collaborative treatment decision-making
- Integration with primary care providers

Recommended rating scales:

- 16-item Quick Inventory of Depression Symptoms (public domain) www.ids-qids.org/translations/english/QIDS-SREnglish2page.pdf
- Montgomery Asberg Depression Rating Scale (public domain) www.opapc.com/images/pdfs/MADRS.pdf
- Patient Health Questionnaire-9 (public domain) http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf

References:


## Mood Stabilizers – Recommendations for Bipolar Disorders

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lithium</strong></td>
<td>In acute mania: 0.8 – 1.2 mEq/L (1200-2400 mg/d)</td>
<td>Initial titration for tolerability – start 600-900 mg/d, increase 300 mg/day every 5 days. Check levels 5 days after initiation/dose change. Check levels frequently if clinical toxicity. Monitor renal and thyroid functions. Lower doses/levels may be necessary in non-manic compared to manic patients. For maintenance, some patients require 0.8 to 1.2 mEq/L, others can be maintained with lower levels, but not below 0.6 mEq/L in elderly, start with lower lithium dose, titrate more slowly, and require lower serum lithium levels.</td>
</tr>
<tr>
<td><strong>Valproate</strong></td>
<td>In acute mania: 85 -125 µg/mL (5-60 mg/kg/d; 1000-2500 mg/d)</td>
<td>Initial loading may be tolerated, but some patients need initial titration for tolerability. Check levels 48 hrs after initiation and adjust dose accordingly. Side effects (esp. gastrointestinal) more evident above 100µg/mL. More etarogenetic than other mood stabilizers. Lower doses/levels may be necessary in non-manic compared to manic patients.</td>
</tr>
<tr>
<td><strong>Carbamazepine</strong></td>
<td>In acute mania: 200 – 1600 mg/d (6-12 µg/mL)</td>
<td>Initial titration for tolerability due to hepatic auto-induction – start 200-400 mg/d, increase 200 mg/d every 3 days. Lower doses/levels may be necessary in non-manic compared to manic patients. Monitor for blood dsycrasias and serious rash. Screen Asians for HLA-B*1502 (serious rash risk indicator). Decreases serum levels of multiple other drugs.</td>
</tr>
<tr>
<td><strong>Lamotrigine</strong></td>
<td>In bipolar maintenance 100 – 400 mg/d</td>
<td>Initial titration to reduce risk of serious rash (Stevens-Johnson syndrome), start 25 (12.5 with valproate) mg/d after 2 and 4 weeks and weekly thereafter. Initial target dose 200 mg/d, but final doses may be 100-400 mg/d. May be used in some patients with acute bipolar depression (despite acute efficacy limitation) due to good tolerability and depression prevention efficacy.</td>
</tr>
</tbody>
</table>
### Mood Stabilizers – Recommendations for Bipolar Disorders

#### Second Generation Antipsychotics & Antidepressants – Recommendations for Bipolar Disorder

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second Generation Antipsychotics</strong>&lt;br&gt;(SGA)</td>
<td>In acute mania:&lt;br&gt;- Aripiprazole: 15-30 mg/d&lt;br&gt;- Asenapine: 10-20 mg/d&lt;br&gt;- Olanzapine: 6-20 mg/d&lt;br&gt;- Quetiapine: 400-800 mg/d&lt;br&gt;- Risperidone: 2-6 mg/d&lt;br&gt;- Ziprasidone: 80-160 mg/d&lt;br&gt;- Clozapine: 60-400 mg/d (if treatment resistant)</td>
<td>Initial titration may be necessary for tolerability. Lower doses may be necessary in non-manic patients (e.g. quetiapine 300 mg/day or lower to attenuate sedation). Ziprasidone should be taken with food. Asenapine is sublingual. Monitor for side effects, including sedation (esp. with quetiapine and clozapine), weight gain (esp. with olanzapine and clozapine), akathisia (esp. with aripiprazole and ziprasidone), and EPS (esp. with risperidone). Monitor weight and BMI at each visit and laboratory metabolic indices at baseline, 3 months and yearly thereafter.</td>
</tr>
<tr>
<td><strong>Antidepressants</strong></td>
<td>In acute bipolar depression:&lt;br&gt;- Bupropion: 300-450 mg/d&lt;br&gt;- Citalopram: 20-40 mg/d&lt;br&gt;- Escitalopram: 10-20 mg/d&lt;br&gt;- Fluoxetine: 20-80 mg/d&lt;br&gt;- Paroxetine: 20-50 mg/d&lt;br&gt;- Sertraline: 50-200 mg/d</td>
<td>May be used in combination with antimanic drugs in some patients with acute bipolar depression, but should not be prescribed as monotherapy in patients with bipolar I disorder due to manic switch risk. SNRIs and TCAs have greater manic switch risk. Increased suicidality risk in pediatric and young adult patients. Utility in bipolar depression prevention is controversial.</td>
</tr>
</tbody>
</table>

November 2011
Level 0: Comprehensive assessment
- Assess comorbidities (e.g., substance abuse, anxiety disorders), and clinical features (psychosis, suicidality)
- Assess for bipolarity

Level 1: Initial Treatment
- Discuss treatment options, including evidence-based psychotherapy (CBT, IPT)*
- Monotherapy 6-12 weeks adequate trial of:
  - SSRI (esp. sertraline, escitalopram) or venlafaxine
  - Bupropion (if tolerability concerns), mirtazapine (if insomnia)

Level 2A: If level 1 no response or not tolerated
- Switch to different monotherapy
  - Agent from different or same class (SSRI, SNRI, mirtazapine, bupropion)
- Evidence-based psychotherapy (CBT, IPT)

Level 2B
- Augment prior monotherapy with:
  - Agent from different class (SSRI, SNRI, T3, Lithium, mirtazapine, bupropion BUT NOT SSRI + SNRI
- Evidence-based psychotherapy

Level 3 If Levels 1 and 2 ineffective or not tolerated
- Consider psychiatric consultation
- Electroconvulsive therapy (ECT)
- TCA, MAOI
- SSRI or SNRI + Bupropion or Mirtazapine
- SSRI or SNRI + Aripiprazole or Quetiapine
- Fluoxetine + Olanzapine (tolerability concerns)
- Augmentation after partial response with agent from different class (SSRI, SNRI, mirtazapine, bupropion, TCA), or lamotrigine
- Transcranial magnetic stimulation

* Evidence-based psychotherapy: Cognitive behavior therapy (CBT) Interpersonal therapy (IPT)
Treatment of Adult Major Depressive Disorder
Nonpsychotic

**Level 4**  *If Levels 1-3 ineffective or not tolerated*

- Re-evaluate diagnosis if patient has failed to respond to two or more treatments
- Augment antidepressant with Vagal Nerve Stimulation (VNS)
- MAOI augmentation (AVOID CONTRAINDICATED COMBINATIONS)
- Triple drug combination (little evidence exists supporting or refuting this strategy):
  - SSRI or SNRI + Mirtazapine + Bupropion
  - SSRI or SNRI + Mirtazapine + Lithium
  - SSRI or SNRI + Bupropion + second generation antipsychotic
- If no response, try different two or three drug combination
Measurement-based Care

Effective and safety tolerability of medication treatment must be systematically assessed by use of appropriate rating scales and side-effect assessment protocols.

Recommended scales for major depressive disorder – psychotic

- Hamilton Rating Scale for Depression (HRSD)
- Patient Health Questionnaire (PHQ)
- Montgomery-Asberg Depression Rating Scale (MADRS) as an acceptable alternative to HRSD
- Brief Psychiatric Rating Scale (BPRS) or
- Positive and Negative Symptom Subscale (PANSS) – not in the public domain

Level 0 Comprehensive Assessment

- Assess comorbidities (e.g. substance abuse, anxiety disorders), and clinical features (psychosis, suicidality)
- Assess for bipolarity

Level 1 Initial Treatment

- Discuss treatment options, including evidence-based psychotherapy (CBT, IPT)*
- Antidepressant + antipsychotic

Level 1A

- The addition of Lithium may augment response in MDD

Level 2 If Level 1 is ineffective or not well tolerated

- Antipsychotic + SSRI or SNRI
- Electroconvulsive Therapy (ECT) with patient consent, if severe

Level 3 If levels 1-2 ineffective or not tolerated

- Other drug combinations including Lithium
- Electroconvulsive therapy with patient consent if not attempted earlier
- Antidepressant (any including tricyclic) + antipsychotic (including perphenazine)
- Re-evaluate diagnosis if the patient has failed to respond to two or more treatments

*Evidence-based psychotherapy: Cognitive behavior therapy (CBT) Interpersonal therapy (IPT)
Treatment of Adult Major Depressive Disorder
Psychotic

References:


Florida Best Practice Medication Guidelines for Schizophrenia

Level 0: Comprehensive Assessment

- Careful differential diagnostic evaluation
- Suicidality and aggression
- Psychiatric, substance abuse and physical co-morbidities
- Measurement-based care
- Collaborative treatment decision-making
- Integration with primary care providers
- Assess social support system (housing, family, other caregivers)
- Evaluate threats to continuity of care (access to medication, etc.)

Level 1: Monotherapy with an oral antipsychotic other than clozapine

Level 1A: Any oral antipsychotic other than olanzapine and clozapine

Level 1B: Any oral antipsychotic, excluding clozapine

Balance efficacy, side-effects, individual vulnerabilities and preferences

Footnotes

1. Relatively equivalent efficacy of different antipsychotic agents
2. Significant differences in side-effect profiles across agents
3. Individual differences in sensitivity to different side-effects
4. Dosing strategies optimal for each agent
5. Olanzapine on Level 1B because of significantly greater risk of metabolic side-effects

Level 2: If Level 1 ineffective or not tolerated*

- Consider long-acting injectable for non-adherence
- Highly recommended to consider clozapine when lack of efficacy
  (Consider Clozapine after 2-3 failed antipsychotic trials)

*Number of iterations at each level and adjunctive treatment(s) to be determined by clinician judgment/patient needs
Florida Best Practice Medication Guidelines for Schizophrenia

Level 3: *If levels 1, 2 are ineffective or not tolerated*
- Diagnostic review and/or consultation
- Clozapine if not tried earlier
- Antipsychotic + ECT
- Augmentation of clozapine with 2nd. antipsychotic
  - suggestive evidence to support the use of high-potency agents
- Augmentation of antipsychotic with anticonvulsant
  - little evidence to support this approach
- Other antipsychotic combinations (if partial response with one agent)
  - little evidence to support this approach for enhanced efficacy
  - may be useful for the treatment of side effects

Measurement-based Care
- Treatment targets need to be precisely defined
- Use of rating scales recommended
- Effectiveness and safety/tolerability of medication treatment must be systematically assessed

Collaborative Treatment Decision-making
- Selection of antipsychotic medication with well-informed patients made on the basis of prior individual treatment response, side-effect experience, medication side-effect profile, and long-term treatment planning

Psychosocial Treatment
- Family psychoeducation
- Cognitive behavior therapy
- Social skills training

Recommended Scales for Schizophrenia
- Clinical Global Impression Scale (CGI) www.depression-webworld.com
- Brief Psychiatric Rating Scale (BPRS) www.priory.com/psych/bprs.htm or www.cnsforum.com/clinicalresources/ratingscales/ratingpsychiatry/schizophrenia/
References:
# Florida Best Practice Medication Guidelines for Schizophrenia

<table>
<thead>
<tr>
<th>Medication</th>
<th>Chlorpromazine Equivalents¹</th>
<th>Acute Therapy</th>
<th>Maintenance Therapy</th>
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</thead>
<tbody>
<tr>
<td><strong>First Generation Antipsychotics</strong></td>
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<tr>
<td><strong>Phenothiazines</strong></td>
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<tr>
<td>Fluphenazine HCl</td>
<td>2</td>
<td>5-20 mg/day</td>
<td>5-15 mg/day</td>
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<tr>
<td>Fluphenazine² decanoate</td>
<td>NA</td>
<td>NA</td>
<td>6.25-50 mg/2wks</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>5</td>
<td>15-50 mg/day</td>
<td>15-30 mg/day</td>
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<tr>
<td>Perphenazine</td>
<td>8</td>
<td>16-80 mg/day</td>
<td>16-64 mg/day</td>
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<tr>
<td>Chlorpromazine</td>
<td>100</td>
<td>300-1,000 mg/day</td>
<td>300-600 mg/day</td>
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<td><strong>Butyrophenone</strong></td>
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<td>Haloperidol</td>
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<td>6-12 mg/day</td>
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<tr>
<td>Haloperidol decanoate</td>
<td>NA</td>
<td>NA</td>
<td>50-200 mg/4wks</td>
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<tr>
<td><strong>Second Generation Antipsychotics</strong></td>
<td></td>
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</tr>
<tr>
<td>Clozapine</td>
<td>NA</td>
<td>150-600 mg/day</td>
<td>150-600 mg/day</td>
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<td>Risperidone</td>
<td>NA</td>
<td>2-8 mg/day</td>
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<td>Olanzapine</td>
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<td>Quetiapine</td>
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<td>300-800 mg/day</td>
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<td>Ziprasidone</td>
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<td>120-240 mg/day</td>
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<td>Aripiprazole</td>
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<td>10-30 mg/day</td>
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<td><strong>Others</strong></td>
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<td>Thiothizene</td>
<td>5</td>
<td>15-50 mg/day</td>
<td>15-30 mg/day</td>
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<td>Molindone</td>
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<td>30-100 mg/day</td>
<td>30-60 mg/day</td>
</tr>
<tr>
<td>Loxapine</td>
<td>10</td>
<td>30-100 mg/day</td>
<td>30-60 mg/day</td>
</tr>
</tbody>
</table>

*Consider lower doses for 1st. episode due to higher sensitivity to medications in pharmaceutically naïve patients.*

1. Approximate dose equivalent to 100 mg of chlorpromazine (relative potency); it may not be the same at lower vs. higher doses. Chlorpromazine equivalent doses are not relevant to the second generation antipsychotics and therefore are not provided for these agents.

2. Fluphenazine decanoate dosage recommendations are based on an empirical rule suggested by Kane (1996) (25 mg every 3 wks of decanoate is equivalent to 665 chlorpromazine equivalents per day). These are theoretically determined values and should be interpreted as approximations only (Baldessarini et al. 1988).
3. Haloperidol decanoate dosage recommendations are based on the following rule: 5 mg oral haloperidol (250 chlorpromazine equivalents) per day is equivalent to 50 mg haloperidol decanoate every month. These are theoretically determined values and should be interpreted as approximations only. Olanzapine has been found to cause more weight gain and related metabolic side effects than other SGAs (Newcomer 2005).

4. Drug-drug interactions (DDIs) can impact dosing. Maintenance dose should generally be no less than half of the initial clinically effective dose, as that can result in reduced effectiveness of relapse prevention (Leucht et al. 2009).
In the context of dementia, anxiety disorders, and impulse control disorder:

- Antipsychotics have at best modest and variable benefits
  - Risks are not insignificant
  - No difference in efficacy between FGAs and SGAs
  - FGAs and SGAs are heterogeneous within class and differ in many properties:
    - efficacy
    - side effects
    - pharmacology
- Carry EPS (extrapyramidal symptoms) liability and metabolic effects
- Use in these conditions should be:
  - Targeted
  - After other alternative treatments have been tried
  - Generally short term
  - Monitored with periodic re-evaluation of benefits and risks
  - Prescribed at the minimal effective dose