



Evidence Search results

Search topic:	Find evidence regarding STOMP pathway for complex emotional needs. How this is managed through the STOMP pathway in other Trusts. Is there any evidence of success? Looking for adults with borderline personality disorders, depression, emotionally unstable personality disorder. Not bipolar, or schizophrenia.
Date requested:	3 rd October 2025
Date completed:	2025
Search completed by:	Laetitia Delaleuf
Number of results selected:	26
Time taken:	17 h

Citing this evidence search

If you reference this search in any paper, publication or presentation, please let us know and use the following format:

Delaleuf, L. (2025). *Evidence summary: STOMP pathway and complex emotional needs*. Taunton, UK: Somerset NHS Foundation Trust Knowledge & Library Service.

Content

[GUIDELINES / RECOMMENDATIONS](#)

[GENERAL - DEPRESCRIBING IN MENTAL HEALTH](#)

[PROJECT](#)

[BORDERLINE PERSONALITY DISORDER](#)

[DEPRESSION](#)

[SPECIFIC DRUGS](#)

- [Antidepressants](#)
- [Antipsychotics](#)
- [Benzodiazepines](#)

[PROFESSIONAL PERSPECTIVES](#)

[DEMENTIA / OLDER PERSONS](#)

[CHILDREN AND ADOLESCENTS](#)



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Summary of results

Copilot AI may have been used in part or in full to create this summary.

Deprescribing originated in geriatric and palliative care medicine. It was later expanded into mental health, as individuals receiving mental health treatment frequently experience polypharmacy.

Gupta, S. and Cahill, J.D. (2016) expand from the model developed for older persons and suggest adaptation in psychiatry. The main factors to consider when deprescribing are

- “intervention timing
- medical and psychiatric history,
- psychosocial supports,
- the development of a plan for tapering, with ongoing monitoring and support”

From these considerations, Fineberg, S.K., Gupta, S. and Leavitt, J. (2019) have developed a model adapted to borderline personality disorder:

Table 1		
Continued		
Steps	Components of each step	Suggested modifications in BPD treatment ^b
	Agree on monitoring/follow-up schedule and crisis plan	Being specific about how and when reevaluation of the deprescribing effort will occur may be especially important Consider using both subjective reports and quantitative scales
7. Monitor and, if necessary, adapt	Repeat each of the points in step 6, and also potentially the following: adjust rate of taper; treat discontinuation syndrome or relapse; abort/defer deprescribing	Keep in mind: It is helpful to discuss and try to understand symptoms/problems/benefits that arise during this process Collaborative and flexible responses are likely to be helpful Periods of acuity can be transient in BPD, and discussion of context may help prescriber and patient to understand the role of deprescribing in clinical change; not every clinical change requires immediate change in medication plan Ongoing discussion with other caregivers is likely to help Deprescribing is a process, not an endpoint; needs may change over time with age, clinical status, social environment, etc.

^a Adapted from Gupta and Cahill (2016).¹¹
^b Note opportunities for therapeutic process in each step.



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Table 1		
How to Deprescribe in BPD Treatment ^a		
Steps	Components of each step	Suggested modifications in BPD treatment ^b
1. Choose the right time	Avoid times of acuity Well-established treatment alliance Caution with active substance abuse	Attend closely to short- and long-term fluctuations in symptoms and in alliance Encourage patients' agency by introducing the idea of deprescribing and then returning to this step to ask them to suggest a good time
2. Compile a list of all medications	Document: dose, route, expected duration, and original indication; current therapeutic + adverse effects Estimate: potential drug-drug interactions; future risk-benefit ratio	Given potential for multiple comorbidities and therefore multiple providers, extra care may be needed to develop a comprehensive list Periodic review will be especially important, given potential for new/different providers Carefully clarify which are prescribed versus which are taken Consider risks from any overused medications or substances of abuse
3. Initiate the discussion with the patient	Discuss with the patient: knowledge and attitudes about their medications; perceptions of risks/benefits; meaning of medication(s)	Meaning of medication may be especially important in BPD
4. Introduce the idea of deprescribing (include friends and family if possible)	Inform about the process of deprescribing and its indications Solicit ideas/concerns/expectations Address emotions (anxieties, also hopes!) of the patient, family, and clinical care team Collaborate with family, caregivers	Work with patient to offer best understanding of what really helps (therapy, which medications, etc.) for specific symptoms Patients, families, caregivers (and prescribers ourselves) may feel intense wish to "fix the problem" with medications, and deprescribing may induce anxiety; collaboration and open discussion of these concerns can be very helpful Be on the lookout for unrealistic hopes about both medications and deprescribing Be aware of "countertransference" prescribing, which can lead to over- or underuse of medications; it can be helpful to keep in mind usual treatment practices in your own care of patients, to consult with colleagues, and to use note writing as an opportunity to engage patients' perspectives and to consider your own emotions
5. Identify which medication would be most appropriate for a taper	Collaboratively weigh pros and cons of deprescribing each medication Solicit preferences	For a variety of reasons, the medication that a patient identifies for tapering may not correspond with that identified by the prescriber, based on the risk-benefit ratio; this step may itself be an opportunity to return to step 3 and to further explore patient's experience of medication, including which symptoms are important Consider safety of the current medications, including risk in overdose; dispensing smaller pill counts or having someone hold high-risk medications may decrease risk Consider long-term effects of medications
6. Develop a plan	Start date and rate of taper Is another medication/formulation indicated during the taper? Reinforce biopsychosocial strategies Inform about expected and possible discontinuation effects	Emphasizing the collaboration between patient and provider may engage the patient in feeling cared for Emphasizing the importance of patient feedback about effects may engage the patient in taking charge and growing agency

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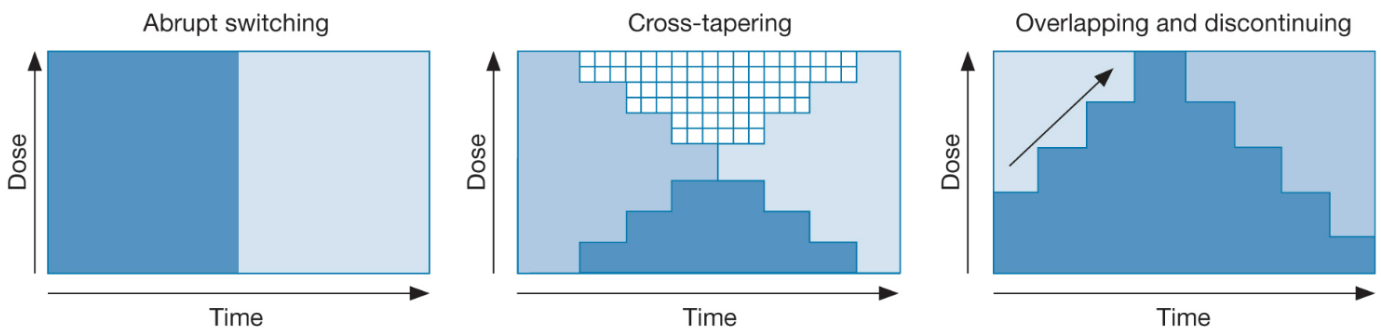
^a Adapted from Gupta and Cahill (2016).¹¹

^b Note opportunities for therapeutic process in each step.

Branford, D. and Parker, C. (2020) listed further tools to support deprescribing:

Tool	Description
Beers (2012) criteria for potentially inappropriate medication use in older adults	The original prescribing indicator reference. In some respects the 66 indicators are US specific. There are regular updates of the 1991 indicators; the indicators have been tested in a variety of situations worldwide (Beers, 2012)
A pharmacist-led information technology intervention for medication errors (PINCER) Indicators	10 UK indicators validated in general practice. The PINCER trial demonstrated the effectiveness of a pharmacist-led IT-based intervention to reduce hazardous prescribing. Odds ratios for error were significantly lower in intervention grp (0.51 to 0.73) (Avery AJ et al, 2012)
Royal College of General Practice (RCGP) indicators	34 prescribing safety indicators developed and designed for use in UK general practice. Using a similar process, an updated list of 56 indicators has recently been identified (Avery AJ et al, 2011)
Scottish – inappropriate prescribing to vulnerable patients	15 RAND UCLA-derived indicators that were developed in Scotland and tested on general practice data from 1.7 million patients. A composite indicator was found to be the most reliable measure of a practice's performance (Guthria B et al, 2011)
STOPP/START criteria STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment)	87 indicators developed by consensus methods in Ireland. They have been validated extensively in the UK setting. Many of the STOPP criteria were included in the RCGP indicator set (Gallagher P et al, 2008)

As well as 3 models of deprescribing:



In terms of guidelines, [The Maudsley](#) published in 2024 a deprescribing guidelines with a safe deprescribing chapter on antidepressants, benzodiazepines, z-drugs and gabapentinoids.

Beyond the medication approach, common reactions from patients are ([Fineberg, S. K., Gupta, S. and Leavitt, J. 2019](#)):



Table 2

Overcoming Hurdles: Common Patient Responses to Deprescribing

Common reactions	Possible factors	Possible responses
“I know you’re doing this because you don’t want to see me. I should’ve known, I’m a horrible person and nobody cares for me or understands my suffering.”	Anxiety about abandonment; medication symbolizes care	Assurance that medication reduction ≠ reduction in individual care Schedule frequent check-in visits, at least at first
“Dr. Jones was the best doctor ever. He prescribed the lithium that saved my life and now you want to take it away.”	Splitting—idealization of previous provider and devaluation of new one Medication as a transitional object	Explore feelings about Dr. Jones’s departure Alternative strategies to make treatment be/feel more continuous and less abruptly changed
“You are not good enough. I don’t want to see you anymore. I want to see someone who will give me what I really need.”	Splitting, perhaps triggered by feeling unheard or devalued	Value the patient’s experience: ask about this medication, past/current symptoms Collaborate with patient by offering a range of possible options for medication, dosing amount and timing; encourage patient to lead decision making
“I am feeling really anxious/I cannot sleep since we cut back on the Klonopin.”	Benzodiazepine withdrawal Medication as a transitional object	Slow the rate of taper Reassurance Teach sleep hygiene Medications, such as antihistamines, to allay withdrawal symptoms
“What if I lose my benefits if I am not on medication?”	Systemic issue in disability assessment	Validate the concern Clarity and transparency in communication with social services and patient
“The meds are working fine. Why do you want to change them?”	To some extent, this concern is legitimate, and a maxim Abandonment fears may also be present	Validate the logic of the argument Discuss that what counts as effective and useful can change over time

Another aspect to consider is the adherence of other health professionals, such as GPs in deprescribing, ([Kelly, D. et al. 2021](#) and [Van Leeuwen, E. et al. 2024](#)) both highlighted the importance of education, confidence-building and a multi-disciplinary approach to this.

A London project ([Jerjes, W. et al. 2024](#)) in a large primary care centre took place using non-coded patients (patients without regular or annual check) with a polypharmacy regimen. The project followed a quality improvement process (Plan-Do-Study-Act cycle). Patients were thoroughly reviewed, medication dose reduced, and an evaluation was done, followed by non-pharmaceutical support and an annual check was put in place. The project achieved a reduction in multiple psychotic medications with positive outcomes in health and mental health scores. The factors of success were the person-centred and holistic approach that went beyond medication reduction and integrated lifestyle modifications and patient education. Another factor of success was the educational approach for both patients and clinicians embedded into clinical practice.

However, the project highlighted the difficulty achieving a balance between medication reduction and maintaining mental health stability. It also highlights the necessity in specific cases to maintain or introduce polypharmacy, specifically for multiple comorbidities or treatment-resistant cases.

Complementary to this, research is done on Mindfulness and CBT as a support to deprescribing: [Huijbers, M.J. et al. 2020](#) and [Maund, E. et al. 2019](#))

Finally, I have also added research done [in older persons](#), [children and adolescents](#) that emphasises the importance of a holistic multidisciplinary approach. Additionally, the implementation of a trauma-informed perspective can further facilitate the process of deprescribing.

I hope this is helpful. Please contact the Library if you would like any further information or would like to revise your search: library@somersetft.nhs.uk.



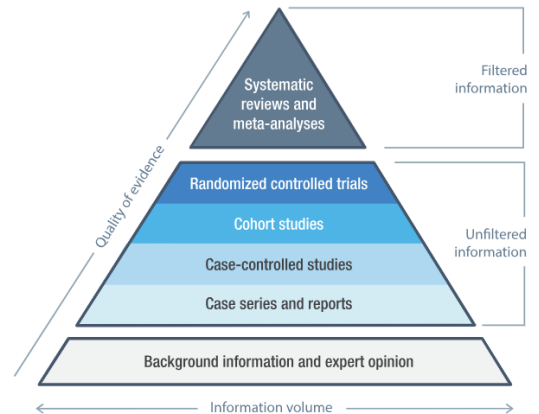
We would like to capture information about the impact this evidence search has had on your practice or decision—making. We can use this to promote this service to others within the Trust and it also ensures this service continues to develop and meet the needs of everyone who uses it. Please take a few moments to complete our short [impact survey](#).

Search results

Full-text access:

Abstracts are provided where available. To check if the full-text of an article is available, click on the links provided and log in with your NHS OpenAthens username and password, if prompted. You can register for an NHS OpenAthens username and password at: <https://openathens.nice.org.uk>. If there is no link, or the full-text is not available to you, please send the details of the article to library@somersetft.nhs.uk or and we will try and find it for you.

For your information, and to help you assess the quality of the research, here is a [hierarchy of the quality of evidence](#) that you may find useful:





GUIDELINES / RECOMMENDATIONS

Book: The Maudsley deprescribing guidelines : antidepressants, benzodiazepines, gabapentinoids and z-drugs / Mark Horowitz, David Taylor

Author: Horowitz, M. and Taylor, D.

Publication Date: 2024

John Wiley and Sons.

ISBN: 9781119822981

URL: <https://research.ebsco.com/linkprocessor/plink?id=9c3d3fb9-da20-33e5-acda-670fd83e9185>

Table of content:

[Introduction to Deprescribing Psychiatric Medications](#)

[Safe Deprescribing of Antidepressants](#)

[Safe Deprescribing of Benzodiazepines and Z-drugs](#)

[Safe Deprescribing of Gabapentinoids](#)

[Clinical practice guideline recommendations on tapering and discontinuing antidepressants for depression: a systematic review](#)

Authors: Sørensen, Anders;Juhl Jørgensen, Karsten and Munkholm, Klaus

Publication Date: -01st ,2022

Journal: Therapeutic Advances in Psychopharmacology 12, pp. 20451253211067656

Abstract: Background: Tapering and discontinuing antidepressants are important aspects of the management of patients with depression and should therefore be considered in clinical practice guidelines. Objectives: We aimed to assess the extent and content, and appraise the quality, of guidance on tapering and discontinuing antidepressants in major clinical practice guidelines on depression. Methods: Systematic review of clinical practice guidelines on depression issued by national health authorities and major national or international professional organisations in the United Kingdom, the United States, Canada, Australia, Singapore, Ireland and New Zealand (PROSPERO CRD42020220682). We searched PubMed, 14 guideline registries and the websites of relevant organisations (last search 25 May 2021). The clinical practice guidelines were assessed for recommendations and information relevant to tapering and discontinuing antidepressants. The quality of the clinical practice guidelines as they pertained to tapering and discontinuation was assessed using the AGREE II tool. Results: Of the 21 included clinical practice guidelines, 15 (71%) recommended that antidepressants are tapered gradually or slowly, but none provided guidance on dose reductions, how to distinguish withdrawal symptoms from relapse or how to manage withdrawal symptoms. Psychological challenges were not addressed in any clinical practice guideline, and the treatment algorithms and flow charts did not include discontinuation. The quality of the clinical practice guidelines was overall low. Conclusion: Current major clinical practice guidelines provide little support for clinicians wishing to help patients discontinue or taper antidepressants in terms of mitigating and managing withdrawal symptoms. Patients who have deteriorated upon following current guidance on tapering and discontinuing antidepressants thus cannot be concluded to have experienced a relapse. Better guidance requires better randomised trials investigating interventions for discontinuing or tapering antidepressants.

[Deprescribing benzodiazepine receptor agonists: Evidence-based clinical practice guideline](#)

Authors: Pottie K.;Thompson W.;Davies S.;Grenier J.;Sadowski C.A.;Welch V.;Holbrook A.;Boyd C.;Swenson R. and Barbara Farrell A.Ma.

Publication Date: 2018

Journal: Canadian Family Physician 64(5), pp. 339 EP



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Abstract: Objective To develop an evidence-based guideline to help clinicians make decisions about when and how to safely taper and stop benzodiazepine receptor agonists (BZRAs); to focus on the highest level of evidence available and seek input from primary care professionals in the guideline development, review, and endorsement processes. Methods The overall team comprised 8 clinicians (1 family physician, 2 psychiatrists, 1 clinical psychologist, 1 clinical pharmacologist, 2 clinical pharmacists, and 1 geriatrician) and a methodologist; members disclosed conflicts of interest. For guideline development, a systematic process was used, including the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach. Evidence was generated by conducting a systematic review of BZRA deprescribing trials for insomnia, as well as performing a review of reviews of the harms of continued BZRA use and narrative syntheses of patient preferences and resource implications. This evidence and GRADE quality of evidence ratings were used to generate recommendations. The team refined guideline content and recommendations through consensus and synthesized clinical considerations to address front-line clinician questions. The draft guideline was reviewed by clinicians and stakeholders. Recommendations We recommend that deprescribing (tapering slowly) of BZRAs be offered to elderly adults (≥ 65 years) who take BZRAs, regardless of duration of use, and suggest that deprescribing (tapering slowly) be offered to adults aged 18 to 64 who have used BZRAs for more than 4 weeks. These recommendations apply to patients who use BZRAs to treat insomnia on its own (primary insomnia) or comorbid insomnia where potential underlying comorbidities are effectively managed. This guideline does not apply to those with other sleep disorders or untreated anxiety, depression, or other physical or mental health conditions that might be causing or aggravating insomnia. Conclusion Benzodiazepine receptor agonists are associated with harms, and therapeutic effects might be short term. Tapering BZRAs improves cessation rates compared with usual care without serious harms. Patients might be more amenable to deprescribing conversations if they understand the rationale (potential for harm), are involved in developing the tapering plan, and are offered behavioural advice. This guideline provides recommendations for making decisions about when and how to reduce and stop BZRAs. Recommendations are meant to assist with, not dictate, decision making in conjunction with patients.

[BACK TO TOP](#)

GENERAL - DEPRESCRIBING IN MENTAL HEALTH

[Psychiatric Deprescribing: A Narrative Review](#)

Authors: Harding, Shari L.; Ellis, Kerri A.; Boisseau, John and Petreca, Victor

Publication Date: 2024

Journal: Journal of the American Psychiatric Nurses Association 30(4), pp. 810–818

Abstract: Objective: Psychiatric deprescribing is an intervention where psychiatric medications are reduced or discontinued with the goal to improve health and reduce unnecessary risks. The purpose of this study was to synthesize the literature related to psychiatric deprescribing to discuss practice and research implications.

Methods: A structured search of the literature was conducted from May to September 2022, yielding 29 articles meeting inclusion criteria. Articles were reviewed and synthesized.

Results: Psychiatric deprescribing is a complex process with many potential facilitators and barriers. The extant literature provides insight into current gaps in knowledge and implications for clinical practice and research.

Conclusions: In current clinical practice, psychiatric deprescribing is a priority but there are significant barriers. Several areas of future research could be pursued to better support evidence-based practice in this area.

[Deprescribing in mental health: pragmatic steps for a better quality of life](#)

Authors: Tomova, Nana; Hale, Ami and Kruschandl, Michelle

Publication Date: 2021

Journal: Journal of Prescribing Practice 3(2), pp. 60–66

Abstract: Half of the UK population take at least one prescribed medicine, while a quarter take three



or more. Polypharmacy has become increasingly common, with the average number of items prescribed per person per year in England having increased by 53.8% in the last decade. Patients are prescribed, and may continue taking, medicines that cause adverse effects and where the harm of the medicine outweighs the benefit. Adverse reactions to medicines are connected to 6.5% of hospital admissions. Patients admitted with one drug side effect are more than twice as likely to be admitted with another. Deprescribing is the optimisation of medication and is a vital part of improving outcomes, managing chronic conditions, and avoiding adverse effects. The goal of deprescribing is to lessen medication burden and enhance quality of life. This article presents case studies from clinical practice in a mental health service, and highlights the merits of specialist pharmacist-led interventions with respects to medication reviews and deprescribing.

[Deprescribing in mental health care](#)

Authors: Branford, David and Parker, Caroline

Publication Date: 2020

Journal: Journal of Prescribing Practice 2(8), pp. 460–465

Abstract: Deprescribing has mostly developed in older adult care as a strategy to reverse the potential harm to older adults of receiving too many inappropriate medicines. There are many studies in older adult care that show that by deprescribing medicines, prescribers are able to improve patient function, generate a higher quality of life, and reduce bothersome signs and symptoms. However, there have been few comparable studies in mental health. Overprescribing or inappropriate prescribing has also become an issue for mental health care. However, it commonly relates to psychotropic medicines and, in particular, to antidepressants, benzodiazepines, z hypnotics, antiepileptics, such as pregabalin, and to multiple psychotropic prescribing. In other areas of therapy associated with physical health, the concerns have generally been those of under prescribing. This paper discusses how relevant deprescribing is to mental health care and some of the issues to consider.; Deprescribing has mostly developed in older adult care as a strategy to reverse the potential harm to older adults of receiving too many inappropriate medicines. There are many studies in older adult care that show that by deprescribing medicines, prescribers are able to improve patient function, generate a higher quality of life, and reduce bothersome signs and symptoms. However, there have been few comparable studies in mental health. Overprescribing or inappropriate prescribing has also become an issue for mental health care. However, it commonly relates to psychotropic medicines and, in particular, to antidepressants, benzodiazepines, z hypnotics, antiepileptics, such as pregabalin, and to multiple psychotropic prescribing. In other areas of therapy associated with physical health, the concerns have generally been those of under prescribing. This paper discusses how relevant deprescribing is to mental health care and some of the issues to consider.

[Deprescribing for psychiatry: The right prescription?](#)

Authors: Cahill J.D. and Gupta S.

Publication Date: 2018

Journal: Current Psychiatry Reviews 14(1), pp. 4 EP

Abstract: Background: The term "deprescribing" has been coined to describe a specific intervention designed to optimize the reduction or cessation of medications for which benefits no longer outweigh the risks. As a wider concept, it may also come to embody a shifting perspective in the management of chronic illnesses where multiple, changing factors add complexity and nuance to the risk/benefit calculations that underlie prescription. Despite a burgeoning literature in geriatric medicine and palliative and primary care, the term is only recently being introduced to psychiatry. Objective(s): This article seeks to raise the question of whether deprescribing may be useful as a construct, clinical intervention and novel field of research in the field of psychiatry. Method(s): A focused review of the literature is used to provide context and frame some arguments for and against the adoption of deprescribing concepts and practice in psychiatry at this time. Result(s): With both potential risks as well as benefits, the relative expertise in complex shared decision-making and psychosocial aspects of prescribing, mean the specialty of psychiatry has much to gain from and contribute to the field of deprescribing. Conclusion(s): Existing deprescribing guidelines may be adapted to guide initial



implementation strategies in psychiatry. These should then undergo rigorous clinical trials to establish effectiveness and/or identify populations of most benefit. Further research is warranted to help guide decision-making around long-term psychotropic use.

[A Prescription for "Deprescribing" in Psychiatry](#)

Authors: Gupta, Swapnil and Cahill, John Daniel

Publication Date: -08-01 ,2016

Journal: Psychiatric Services (Washington, D.C.) 67(8), pp. 904–907

Abstract: The term "deprescribing," initially coined in geriatric medicine, describes a process of pharmacologic regimen optimization through reduction or cessation of medications for which benefits no longer outweigh risks. Burgeoning rates of polypharmacy, growing appreciation of long-term adverse effects, and a focus on patient-centered practice present specific indications for deprescribing in psychiatry. A strong therapeutic alliance, appropriate timing, and consideration of the meaning of medication for the patient must accompany the following established elements: review of all medications, identification of medications that could be ceased or reduced, collaborative planning of the deprescribing regimen, and provision of review and support to the patient and caregivers. The authors discuss how deprescribing might be adapted for and implemented in psychiatry, identify potential barriers, and make recommendations for future directions.

[BACK TO TOP](#)

PROJECT

[Mental Health Polypharmacy in "Non-Coded" Primary Care Patients: The Effect of Deprescribing](#)

Authors: Jerjes W.;Ramsay D.;Stevenson H. and Lalji K.

Publication Date: 2024

Journal: Journal of Clinical Medicine 13(4), pp. 958

Abstract: Background: Mental health (MH) polypharmacy, defined as prescribing multiple mental health medications for the same condition, presents significant challenges in clinical practice. With varying prevalence rates and an increasing trend, particularly in the UK, this deprescribing prospective quality improvement project aimed to address the complexities and risks associated with MH polypharmacy. Patients and Methods: A large primary care centre in London was selected for this project. Electronic records of 667 patients (non-coded in mental health lists) were analysed as a result of the absence of a Systematised Nomenclature of Medicine Clinical Terms (SNOMED CT) for mental health. Seventy-two non-coded patients exhibiting "same-class" as well as "adjunctive" and "augmentation" polypharmacy were identified. Their demographic and health data, including MH diagnoses, physical status, and lifestyle habits, were evaluated. This deprescribing prospective project included 68 patients and employed a model inspired by the Plan-Do-Study-Act (PDSA) cycle, focusing on reducing psychotropic, adjunctive, and augmentative medications while monitoring mental health control through face-to-face consultations using the Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder Assessment-7 (GAD-7) scores, alongside physical health parameters. Result(s): The project revealed a significant decrease in the average number of psychotropic and adjunct medications from initial consultations to the end of the 18-month period. Additionally, a marked reduction in reported side effects and drug interactions was observed. Improvements in mental health control, as evidenced by PHQ-9 and GAD-7 scores, were noted. Physical health parameters, including BMI, blood pressure, heart rate, HbA1c, and cholesterol levels, also showed significant improvements. Educational initiatives for patients and clinicians were successfully implemented, contributing to these positive outcomes. Discussion(s): The project faced challenges like balancing medication reduction with mental health stability, patient apprehension, and the absence of standardised protocols. However, the successful reduction in medication numbers and the improvement in health outcomes highlight the effectiveness of the model. This project underscores the necessity of a tailored approach to MH polypharmacy, emphasising continuous education, clinical titration, and adherence to guidelines. Future research is needed to develop clear guidelines for medication combination in mental health care and to understand the long-term effects



of polypharmacy in mental health populations. Conclusion(s): This project demonstrates the potential for significant improvements in the management of MH polypharmacy. By carefully managing medication reductions and employing a comprehensive care approach, including patient education and clinician training, the project achieved improvements in both mental and physical health outcomes. These findings suggest a promising direction for future practices in MH polypharmacy management.

[BACK TO TOP](#)

BORDERLINE PERSONALITY DISORDER

[Collaborative deprescribing in borderline personality disorder: A narrative review.](#)

Authors: Fineberg S.K.;Gupta S. and Leavitt, J.

Publication Date: 2019

Journal: Harvard Review of Psychiatry 27(2), pp. 75–86

Abstract: Psychopharmacology in borderline personality disorder (BPD) is complicated by comorbid disorders, substance use, sensitivity to side effects, risk of self-harm through medication misuse, and intense but transient symptoms. Patients' relationships with medications may range from tenuous to highly enmeshed, and may profoundly influence the response to treatment. For these reasons, awareness of current evidence and flexible approaches are particularly relevant to prescribing in BPD. In this narrative review, we illustrate the current status of medication management in BPD by focusing on polypharmacy. We use a single vignette to explore the limitations of prescribing multiple medications and the factors contributing to polypharmacy. With the same vignette, and using the framework of deprescribing, we describe how medication regimens can be reduced to a necessary minimum. Deprescribing, originally developed in geriatric medicine, is an active intervention that involves a risk-benefit analysis for each medication, keeping in mind the patient's medical and psychiatric status and his or her preferences and values. Deprescribing lends itself well to use in psychiatry and especially in BPD because of its emphasis on the patient's preferences and on repeated conversations to revisit and update decisions. In addition to elaborating on the deprescribing framework, we provide recommendations for conducting these critical discussions about medications in BPD, with particular attention to the patient's relationship to the medication. Finally, we summarize our recommendations and strategies for implementing flexible and responsive medication management for patients with BPD. We suggest areas of future research, including testing the efficacy of targeted intermittent medication treatments.

[BACK TO TOP](#)

DEPRESSION

[Deprescribing antidepressants for depression - what is the evidence for and against?](#)

Authors: Looi J.C.L.;Allison S.;Bastiampillai T.;Kisely S.;Maguire P.A.;Woon L.S.C.;Anderson K. and Malhi G.S.

Publication Date: 2025

Journal: Australasian Psychiatry 33(1), pp. 12 EP

Abstract: Objective: Recent guidelines suggest that the overall quantity and duration of antidepressant prescriptions should be reduced. In this paper, we comment on the evidence both for and against this view. Method(s): We critically review the arguments proposed by proponents of antidepressant deprescribing in the context of the evidence-base for the treatment of depression. Result(s): Proponents of deprescribing do not address the substantive issues of whether inappropriate prescribing has been demonstrated, and when prescribing is needed. Their arguments for deprescribing are rebutted in this context. Conclusion(s): Whether or not to deprescribe antidepressant medication needs to take into consideration the risk-benefit profile of the decision, the responsibility for which needs to be shared and based on the context of the patient's depression, their preferences, experiences and perspectives.



[Barriers and facilitators to antidepressant deprescribing-A qualitative interview study with general practitioners in Germany](#)

Authors: Vukas J.;Brisnik V.;Sanftenberg L.;Henningsen P.;Gensichen J. and Dreischulte T.

Publication Date: 2025

Journal: European Journal of General Practice 31(1), pp. 2531879

Abstract: Background: Long-term use of antidepressants frequently extends beyond clinical guidelines, with limited structured support for deprescribing in primary care. Little is known about the factors that influence general practitioners (GPs) in Germany regarding deprescribing of antidepressants. Objective(s): To identify barriers and facilitators that influence GPs in Germany regarding antidepressant deprescribing. To provide points of departure for developing a targeted intervention to address these challenges. Method(s): We conducted semi-structured interviews with 20 GPs in Bavaria and purposively sampled for diversity in gender and professional experience. The interview topic guide was informed by the Capability-Opportunity-Motivation-Behaviour (COM-B) model and the Theoretical Domains Framework (TDF). Interviews were transcribed verbatim. Thematic analysis was conducted using a structured coding approach. Result(s): Key barriers to deprescribing included time constraints, limited practical tools, and inadequate collaboration with specialists, as well as uncertainty about when to deprescribe. Social and psychological factors, such as patient fears, were also significant. Facilitators included strong GP-patient communication, the use of digital tools, pharmacist support, and positive attitudes towards deprescribing. Conclusion(s): Antidepressant deprescribing in German primary care is shaped by systemic, social, and behavioural factors. Addressing time constraints, enhancing interdisciplinary collaboration, and integrating decision-support tools into clinical practice could facilitate deprescribing. These insights inform targeted interventions to promote safe and evidence-based antidepressant use. Further research is recommended to develop an intervention suitable for real-world usage.

[BACK TO TOP](#)

SPECIFIC DRUGS

- [Antidepressants](#)

[Deprescribing of antidepressants: development of indicators of high-risk and overprescribing using the RAND/UCLA Appropriateness Method](#)

Authors: Brisnik V.;Vukas J.;Jung-Sievers C.;Lukaschek K.;Alexander G.C.;Thiem U.;Thurmann P.;Schule C.;Fischer S.;Baum E.;Drey M.;Harder S.;Niebling W.;Janka U.;Krause O.;Gensichen J. and Dreischulte T.

Publication Date: 2024

Journal: BMC Medicine 22(1), pp. 193

Abstract: Background: Antidepressants are first-line medications for many psychiatric disorders. However, their widespread long-term use in some indications (e.g., mild depression and insomnia) is concerning. Particularly in older adults with comorbidities and polypharmacy, who are more susceptible to adverse drug reactions, the risks and benefits of treatment should be regularly reviewed. The aim of this consensus process was to identify explicit criteria of potentially inappropriate antidepressant use (indicators) in order to support primary care clinicians in identifying situations, where deprescribing of antidepressants should be considered. Method(s): We used the RAND/UCLA Appropriateness Method to identify the indicators of high-risk and overprescribing of antidepressants. We combined a structured literature review with a 3-round expert panel, with results discussed in moderated meetings in between rounds. Each of the 282 candidate indicators was scored on a 9-point Likert scale representing the necessity of a critical review of antidepressant continuation (1-3 = not necessary; 4-6 = uncertain; 7-9 = clearly necessary). Experts rated the indicators for the necessity of review, since decisions to deprescribe require considerations of patient risk/benefit balance and preferences. Indicators with a median necessity rating of ≥ 7 without disagreement after 3 rating rounds were accepted. Result(s): The expert panel comprised 2 general practitioners, 2 clinical pharmacologists, 1 gerontopsychiatrist, 2 psychiatrists, and 3 internists/geriatricians (total N = 10). After 3 assessment rounds, there was consensus for 37 indicators of high-risk and 25



indicators of overprescribing, where critical reviews were felt to be necessary. High-risk prescribing indicators included settings posing risks of drug-drug, drug-disease, and drug-age interactions or the occurrence of adverse drug reactions. Indicators with the highest ratings included those suggesting the possibility of cardiovascular risks (QTc prolongation), delirium, gastrointestinal bleeding, and liver injury in specific patient subgroups with additional risk factors. Overprescribing indicators target patients with long treatment durations for depression, anxiety, and insomnia as well as high doses for pain and insomnia. Conclusion(s): Explicit indicators of antidepressant high-risk and overprescribing may be used directly by patients and health care providers, and integrated within clinical decision support tools, in order to improve the overall risk/benefit balance of this commonly prescribed class of prescription drugs.

[Understanding Australian general practice patients' decisions to deprescribe antidepressants in the WiserAD trial: A realist informed approach](#)

Authors: Coe A.;Gunn J.;Allnut Z. and Kaylor-Hughes C.

Publication Date: 2024

Journal: BMJ Open 14(2), pp. e078179

Abstract: Objectives To evaluate how an approach to antidepressant deprescribing works, for whom, and in what contexts by (1) examining the experiences and perceptions of the approach for antidepressant users, (2) identifying the mechanisms of the approach and (3) describing what contexts are associated with antidepressant tapering. Design This mixed methods study was informed by the principles of realist evaluation and was conducted in the first 3 months of participation in the WiserAD randomised control trial. Setting General practice, Victoria, Australia. Participants 13 antidepressant users from general practice participating in the WiserAD trial for antidepressant deprescribing. Intervention A patient-facing, web-based structured support tool that consists of a personalised tapering schedule, an action plan for managing withdrawal symptoms, a daily mood, sleep and activity tracker and mental health nurse support. Primary/secondary outcome measures The outcomes of the study were revealed on data analysis as per a realist evaluation approach which tests and refines an initial programme theory. Results The contexts of learnt coping skills, knowledge and perceptions of antidepressants and feeling well were evident. Outcomes were intention to commence, initiation of deprescribing and successful completion of deprescribing. Key mechanisms for antidepressant deprescribing were (1) initiation of the deprescribing discussion; (2) patient self-efficacy; (3) provision of structured guidance; (4) coaching; (5) mood, sleep and activity tracking and (6) feelings of safety during the tapering period. Conclusions The WiserAD approach to antidepressant deprescribing supported participants to commence and/or complete tapering. The refined programme theory presents the WiserAD pragmatic framework for the application of antidepressant deprescribing in clinical practice. Trial registration number ClinicalTrials.gov NCT05355025; ACTRN12622000567729; ISRCTN11562922; Pre-results.

[Discontinuing antidepressant medication after mindfulness-based cognitive therapy: a mixed-methods study exploring predictors and outcomes of different discontinuation trajectories, and its facilitators and barriers](#)

Authors: Huijbers, Marloes J.;Wentink, Carolien;Simons, Esther;Spijker, Jan and Speckens, Anne

Publication Date: -11th ,2020

Journal: BMJ Open 10(11)

Abstract: Conclusions Discontinuing antidepressants appears to be difficult, stressing the need to support patients and physicians in this process. MBCT may offer one of these forms of support. Trial registration number ClinicalTrials.gov Registry (NCT00928980); post-results.

[Managing Antidepressant Discontinuation: A Systematic Review](#)

Authors: Maund, Emma;Stuart, Beth;Moore, Michael;Dowrick, Christopher;Geraghty, Adam W. A.;Dawson, Sarah and Kendrick, Tony

Publication Date: -1st ,2019

Journal: Annals of Family Medicine 17(1), pp. 52–60

Abstract: Purpose: We aimed to determine the effectiveness of interventions to manage antidepressant discontinuation, and the outcomes for patients. Methods: We conducted a



systematic review with narrative synthesis and meta-analysis of studies published to March 2017. Studies were eligible for inclusion if they were randomized controlled trials, quasi-experimental studies, or observational studies assessing interventions to facilitate discontinuation of antidepressants for depression in adults. Our primary outcomes were antidepressant discontinuation and discontinuation symptoms. Secondary outcomes were relapse/recurrence; quality of life; antidepressant reduction; and sexual, social, and occupational function. Results: Of 15 included studies, 12 studies (8 randomized controlled trials, 2 single-arm trials, 2 retrospective cohort studies) were included in the synthesis. None were rated as having high risk for selection or detection bias. Two studies prompting primary care clinician discontinuation with antidepressant tapering guidance found 6% and 7% of patients discontinued, vs 8% for usual care. Six studies of psychological or psychiatric treatment plus tapering reported cessation rates of 40% to 95%. Two studies reported a higher risk of discontinuation symptoms with abrupt termination. At 2 years, risk of relapse/recurrence was lower with cognitive behavioral therapy plus taper vs clinical management plus taper (15% to 25% vs 35% to 80%; risk ratio = 0.34; 95% CI, 0.18–0.67; 2 studies). Relapse/recurrence rates were similar for mindfulness-based cognitive therapy with tapering and maintenance antidepressants (44% to 48% vs 47% to 60%; 2 studies). Conclusions: Cognitive behavioral therapy or mindfulness-based cognitive therapy can help patients discontinue antidepressants without increasing the risk of relapse/recurrence, but are resource intensive. More scalable interventions incorporating psychological support are needed.

[BACK TO TOP](#)

- [Antipsychotics](#)

[Experiences of reduction and discontinuation of antipsychotics: a qualitative investigation within the RADAR trial](#)

Authors: Morant, Nicola; Long, Maria; Jayacodi, Sandra; Cooper, Ruth; Akther-Robertson, Johura; Stansfeld, Jacki; Horowitz, Mark; Priebe, Stefan and Moncrieff, Joanna

Publication Date: -9-28, 2023

Journal: eClinicalMedicine 64, pp. 102135

Abstract: Background: Antipsychotics are a core treatment for psychosis, but the evidence for gradual dose reductions guided by clinicians is under-developed. The RADAR randomised controlled trial (RCT) compared antipsychotic reduction and possible discontinuation with maintenance treatment for people with recurrent psychotic disorders. The current study explored participants' experiences of antipsychotic reduction or discontinuation within this trial. Methods: This qualitative study was embedded within the RADAR RCT (April 2017–March 2022) that recruited 253 participants from specialist community mental health services in 19 public healthcare localities in England. Participants were adults with recurrent non affective psychosis who were taking antipsychotic medication. Semi-structured interviews, lasting 30–90 min, were conducted after the trial final 24-month follow-up with 26 people who reduced and/or discontinued antipsychotics within the trial, sampled purposively for diversity in sociodemographic characteristics, trial variables, and pre-trial medication and clinical factors. Data were analysed using thematic analysis and findings are reported qualitatively. Findings: Most participants reported reduced adverse effects of antipsychotics with dose reductions, primarily in mental clouding, emotional blunting and sedation, and some positive impacts on social functioning and sense of self. Over half experienced deteriorations in mental health, including psychotic symptoms and intolerable levels of emotional intensity. Nine had a psychotic relapse. The trial context in which medication reduction was explicitly part of clinical care provided various learning opportunities. Some participants were highly engaged with reduction processes, and despite difficulties including relapses, developed novel perspectives on medication, dose optimisation, and how to manage their mental health. Others were more ambivalent about reduction or experienced less overall impact. Interpretation: Experiences of antipsychotic reductions over two years were dynamic and diverse, shaped by variations in dose reduction profiles, reduction effects, personal motivation and engagement levels, and relationships with prescribers. There are relapse risks and challenges, but some people experience medication reduction done with clinical guidance as empowering. Clinicians can use findings to inform and work flexibly with service users to establish optimal antipsychotic doses.



- Benzodiazepines

[**Implementation of an intervention aimed at deprescribing benzodiazepines in a large US healthcare system using patient education materials: a pre/postobservational study with a control group**](#)

Authors: Le T.M.;Campbell S.;Andraos A.;Ahlmarm P.;Hoang H.;Isserman S.;Goldzweig C.L.;Mays A.M.;Bradley K. and Keller M.S.

Publication Date: 2024

Journal: BMJ Open 14(4), pp. e080109

Abstract: Objectives Long-term benzodiazepine use is common despite known risks. In the original Eliminating Medications Through Patient Ownership of End Results (EMPOWER) Study set in Canada, patient education led to increased rates of benzodiazepine cessation. We aimed to determine the effectiveness of implementing an adapted EMPOWER quality improvement (QI) initiative in a US-based healthcare system. Design We used a pre-post design with a non-randomised control group. Setting A network of primary care clinics. Participants Patients with ≥ 60 days' supply of benzodiazepines in 6 months and ≥ 1 risk factor (≥ 65 years of age, a concurrent high-risk medication prescribed or a diazepam equivalent daily dose ≥ 10) were eligible. Intervention In March 2022, we engaged 22 primary care physicians (PCPs), and 308 of their patients were mailed an educational brochure, physician letter and flyer detailing benzodiazepine risks; the control group included 4 PCPs and 291 of their patients. Primary and secondary measures The primary measure was benzodiazepine cessation by 9 months. We used logistic regression and a generalised estimating equations approach to control for clustering by PCP, adjusting for demographics, frailty, number of risk factors, and diagnoses of arthritis, depression, diabetes, falls, and pain. Results Patients in the intervention and control groups were comparable across most covariates; however, a greater proportion of intervention patients had pain-related diagnoses and depression. By 9 months, 26% of intervention patients (81 of 308) had discontinued benzodiazepines, compared with 17% (49 of 291) of control patients. Intervention patients had 1.73 greater odds of benzodiazepine discontinuation compared with controls (95% CI: 1.09, 2.75, $p=0.02$). The unadjusted number needed to treat was 10.5 (95% CI: 6.30, 34.92) and the absolute risk reduction was 0.095 (95% CI: 0.03 to 0.16). Conclusions Results from this non-randomised QI initiative indicate that patient education programmes using the EMPOWER brochures have the potential to promote cessation of benzodiazepines in primary care.

[**Deprescribing Strategies for Opioids and Benzodiazepines with Emphasis on Concurrent Use: A Scoping Review**](#)

Authors: Wang, Yanning;Wilson, Debbie L.;Fernandes, Deanna;Adkins, Lauren E.;Bantad, Ashley;Copacia, Clint;Dharma, Nilay;Huang, Pei-Lin;Joseph, Amanda;Park, Tae Woo;Budd, Jeffrey;Meenrajan, Senthil;Orlando, Frank A.;Pennington, John;Schmidt, Siegfried;Shorr, Ronald;Uphold, Constance R. and Lo-Ciganic, Wei-Hsuan

Publication Date: Feb 23 ,2023

Journal: Journal of Clinical Medicine 12(5), pp. 1788. doi: 10.3390/jcm12051788

Abstract: While the Food and Drug Administration's black-box warnings caution against concurrent opioid and benzodiazepine (OPI-BZD) use, there is little guidance on how to deprescribe these medications. This scoping review analyzes the available opioid and/or benzodiazepine deprescribing strategies from the PubMed, EMBASE, Web of Science, Scopus, and Cochrane Library databases (01/1995-08/2020) and the gray literature. We identified 39 original research studies (opioids: $n = 5$, benzodiazepines: $n = 31$, concurrent use: $n = 3$) and 26 guidelines (opioids: $n = 16$, benzodiazepines: $n = 11$, concurrent use: $n = 0$). Among the three studies deprescribing concurrent use (success rates of 21-100%), two evaluated a 3-week rehabilitation program, and one assessed a 24-week primary care intervention for veterans. Initial opioid dose deprescribing rates ranged from (1) 10-20%/weekday followed by 2.5-10%/weekday over three weeks to (2) 10-25%/1-4 weeks. Initial benzodiazepine dose deprescribing rates ranged from (1) patient-specific reductions over three weeks to (2) 50% dose reduction for 2-4 weeks, followed by 2-8 weeks of dose maintenance and then a 25% reduction biweekly. Among



the 26 guidelines identified, 22 highlighted the risks of co-prescribing OPI-BZD, and 4 provided conflicting recommendations on the OPI-BZD deprescribing sequence. Thirty-five states' websites provided resources for opioid deprescription and three states' websites had benzodiazepine deprescribing recommendations. Further studies are needed to better guide OPI-BZD deprescription.

[BACK TO TOP](#)

PROFESSIONAL PERSPECTIVES

[Health care professional barriers and facilitators to discontinuing antidepressant use: A systematic review and thematic synthesis](#)

Authors: Van Leeuwen E.;Maund E.;Woods C.;Bowers H.;Christiaens T. and Kendrick T.

Publication Date: 2024

Journal: Journal of Affective Disorders 356, pp. 616 EP

Abstract: Introduction: Long-term antidepressant (AD) use, much longer than recommended, is very common and can lead to potential harms. Objective(s): To investigate the existing literature on perspectives of health professionals (HPs) regarding long-term AD treatment, focusing on barriers and facilitators to discontinuation. Method(s): A systematic review with thematic synthesis. Eight electronic databases were searched until August 2023 including MEDLINE, PubMed, Embase, PsycINFO, CINAHL, AMED, Health Management Information Consortium, and the Networked Digital Library of Theses and Dissertation. Result(s): Thirteen studies were included in the review. Of these, nine focused on general practitioner perspectives, one on psychiatrist perspectives, and three on a mix of HPs perspectives. Barriers and facilitators to discontinuing long-term ADs emerged within eight themes, ordered chronologically based on HP considerations during an AD review: perception of AD use, fears, HP role and responsibility, HPs' perception of AD discontinuation, HPs' confidence regarding their ability to manage discontinuation, perceived patient readiness to stop, support from patient's trusted people, and support from other HPs. Limitation(s): Coding and development of subthemes and themes was performed by one researcher and further developed through discussion within the research team. Conclusion(s): Deprescribing long-term ADs is a challenging concept for HPs. The review found evidence that the barriers far outweigh the facilitators with fear of relapse as a main barrier. HP education, reassurance and confidence-building is essential to increase the initiation of the discontinuation process. Further research into the perspectives of pharmacists and mental health workers is needed as well as exploring the role of trusted people.

[Exploration of GP perspectives on deprescribing antidepressants: A qualitative study](#)

Authors: Kelly D.;Graffi J.;Noonan M.;Green P.;McFarland J.;Hayes P. and Glynn L.

Publication Date: 2021

Journal: BMJ Open 11(4), pp. e046054

Abstract: Objective Our aim was to explore general practitioners' (GPs) perceptions and experiences of discontinuing antidepressants. Study design A qualitative study using semistructured interviews was undertaken between July 2019 and March 2020. The interviews were transcribed and analysed using a thematic analysis framework. Setting GPs affiliated with a university education and research network for general practice in Ireland. Participants A purposive sample of GPs (n=10). Results Five themes emerged: shared decision-making; personalised therapy; medication-tapering toolkit; health service factors and concerns around tapering. GPs described being less likely to engage in deprescribing for patients with long-term and/or recurrent depression, older patients and those with comorbidities due to fear of relapse. Access to evidence-based psychological therapies, guidelines, information on rates of relapse, patient leaflets on discontinuing antidepressants and reminder prompts on GP-prescribing software were suggested to optimise appropriate antidepressant discontinuation. There was some suggestion that patients may use antidepressants for longer when talk therapy is not available or taken up. Conclusions GPs are largely confident in their role of managing mild-to-moderate depression and deprescribing antidepressants. This study provides an insight into factors that influence GPs' decisions to deprescribe antidepressants. More information on rates of relapse after discontinuation would be helpful to inform decision-making.



DEMENTIA / OLDER PERSONS

[Healthcare provider-related perceptions toward deprescribing inappropriate medications among older adult outpatients](#)

Authors: Rababa M.J. and Al Ghazo A.

Publication Date: 2024

Journal: PLoS ONE 19(11), pp. e0312762

Abstract: Objectives To examine healthcare provider-related perceptions toward deprescribing inappropriate medications among older adults. Methods A cross-sectional, correlational study used a convenience sample of outpatient older adults to measure their perception toward deprescribing using a Patient's Perceptions of Deprescribing (PPoD), which include 57 multiple-choice questions related to patients' sociodemographic data, health, medicines, healthcare providers, and experience of care provided by the clinic. Data were collected by a graduate nursing student from one pharmacy in a public hospital, five days per week, via in-person interviews. Conclusions The study found that older adults' trust in their PCP, collaboration with their PCP, involvement in the decision-making of deprescribing, and knowledge about medication are associated with clinical and medicine-related factors. Therefore, PCPs should discuss the benefits of deprescribing inappropriate medications to prevent long-term side effects. Future studies should focus on the effectiveness of evidence-based deprescribing protocols for older adults.

[Fall Outcomes in Older Adults Following Benzodiazepine/Z-Drug Discontinuation: A Retrospective Cohort Study in an Academic Health System](#)

Authors: Schindler N.J.;Zepel L.;Maciejewski M.L.;Hastings S.N.;Clark A.;Dublin S.;Albertson-Junkans L. and Pavon J.M.

Publication Date: 2024

Journal: Drugs and Aging 41(10), pp. 809 EP

Abstract: Background: Benzodiazepines and z-drugs increase the fall risk in older adults. There is a lack of real-world data examining the association between falls and deprescribing medications. Objective(s): In a retrospective cohort study of older adults with chronic benzodiazepine or z-drug use receiving care at an academic health system from January 2017 to December 2020, we explored the association between medication discontinuation and falls. Method(s): Chronic use was defined as ≥ 3 medication dispensing and cumulative days' supply ≥ 45 days within 100 days in 2018. Discontinuation was defined as a dispensing gap of ≥ 180 days within 1 year of chronic use eligibility, with a secondary definition requiring a gap of ≥ 90 days. Non-discontinuers ($n = 524$) were matched 4:1 to discontinuers ($n = 131$) if they had a fill in the same month as the matched discontinuation index date. The association between discontinuation and a fall during 2.25-year follow-up was assessed using Cox proportional hazards models. The analysis was repeated using a gap of ≥ 90 days ($n = 279$ discontinuers; 1116 matched non-discontinuers). Conclusion(s): Benzodiazepine/z-drug discontinuation was not associated with reduced risk of falls. However, the relationship between discontinuation and falls varies depending on the definitions used. It is essential to examine different discontinuation definitions in larger studies while considering other relevant clinical outcomes.

[An Approach to Deprescribe Antidepressants for Depression in Older Adults: Consensus, Multidisciplinary Practice Recommendations](#)

Authors: Lee E.A.;Wong C.-A.;Barrio L.;Godoy E.R.;Hackett D.;Thompson N.;Dreskin M.;Kumar S.;Khang P.;Steinberg S.G.;Distasio C.C.;Gibbs N.E.;Thai K.;Cheng S.C.;Yoshinaga M.;H Kanter, M. and Broder B.I.

Publication Date: 2023

Journal: The Permanente Journal 27(2), pp. 1 EP



CHILDREN AND ADOLESCENTS

[8.5 Trauma-Informed Prescribing and Deprescribing](#)

Authors: Keeshin B. and Morgan W.S.

Publication Date: 2025

Journal: Journal of the American Academy of Child and Adolescent Psychiatry 64(10), pp. S164

Abstract: Objectives: Child psychiatrists routinely care for children who have experienced maltreatment and other forms of trauma. Trauma is associated with a broad range of mental health problems, and symptoms of traumatic stress can mimic many of the most commonly treated childhood mental illnesses. Importantly, youth with a history of trauma, especially those with maltreatment and multisystem involvement, may end up on treatment regimens that, over time, prove ineffective or are no longer needed and warrant a thoughtful approach to deprescribing. Method(s): The AAP and AACAP have developed clinical guidance on evidence-informed, practical strategies for trauma-informed prescribing and deprescribing. These reports and the primary sources in the literature will be highlighted and contrasted with current, widely used clinical guidance for common mental health conditions such as depression, anxiety, ADHD, and aggression. Result(s): Guidelines highlight how trauma, and not simply a "PTSD" pathway, is a critical lens through which to understand and treat children who experience varying forms of distress. For both initiating and stopping treatment, specific assessment strategies, including trauma-informed principles and applications of measurement-based care, will highlight how clinicians can meaningfully incorporate trauma into their practice. Additionally, understanding the context and challenges of system-specific issues, including how current or past involvement of the child in the child welfare system will be discussed, is crucial. Conclusion(s): The trauma-informed use of psychotropic medication in youth with current or past mental health concerns can be challenging. Trauma reactions and system challenges can hinder the initiation or cessation of treatment when indicated. However, current clinical guidance that relies on trauma-informed assessments can help when considering the role of psychiatric treatment in the care of youth who have experienced significant trauma.

[Deprescribing Antidepressants in Children and Adolescents: A Systematic Review of Discontinuation Approaches, Cross-Titration, and Withdrawal Symptoms](#)

Authors: Stimpfl J.N.; Walkup J.T.; Robb A.S.; Alford A.E.; Stahl S.M.; McCracken J.T.; Stancil S.L.; Ramsey L.B.; Emslie G.J. and Strawn J.R.

Publication Date: 2025

Journal: Journal of Child and Adolescent Psychopharmacology 35(1), pp. 3 EP

Abstract: Background: Antidepressant medications, including selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), are commonly used to treat depressive, anxiety, and obsessive-compulsive disorders in youth. Yet, data on discontinuing these medications, withdrawal symptoms, and strategies to switch between them are limited. Method(s): We searched PubMed and ClinicalTrials.gov through June 1, 2024, to identify randomized controlled trials assessing antidepressant discontinuation in youth. We summarized pediatric pharmacokinetic data to inform tapering and cross-titration strategies for antidepressants and synthesized these data with reports of antidepressant withdrawal. Result(s): Our search identified 528 published articles, of which 28 were included. In addition, 19 records were obtained through other methods, with 14 included. The corpus of records included 13 randomized, double-blind, placebo-controlled trials (3026 patients), including SSRIs (K = 10), SNRIs (K = 4), and TCAs (K = 1), ranging from 4 to 35 weeks. Deprescribing antidepressants requires considering clinical status, treatment response, and, in cross-titration cases, the pharmacokinetics and pharmacodynamics of both medications. Antidepressant withdrawal symptoms are related to the pharmacokinetics of the medication, which vary across antidepressants and may include irritability, palpitations, anxiety, nausea, sweating, headaches, insomnia, paresthesia, and dizziness. These symptoms putatively involve changes in serotonin transporter expression and receptor sensitivity, impacting the serotonin, dopamine, and norepinephrine pathways. Conclusion(s): Although approaches to deprescribing antidepressants in pediatric patients are frequently empirically guided, accumulating data related to the course of relapse



and withdrawal symptoms, as well as the pharmacokinetic and pharmacodynamic properties of medications, should inform these approaches. Recommendations within this review support data-informed discussions of deprescribing-including when and how-that are critically important in the clinician-family-patient relationship.


[BACK TO TOP](#)



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Keywords/search strategy	Limits used
APA PsycInfo <2002 to November 2025 Week 1> 1 (power* adj emotion*).tw. 291 2 (complex adj3 emotion* adj5 need*).tw. 90 3 (dissocia* adj4 (disorder* or illnes*)).tw. 3045 4 (borderline* adj3 personalit* adj4 (disorder* or illnes*)).tw. 10633 5 (emotion* adj2 unstable*).tw. 278 6 exp Borderline Personality Disorder/ 8640 7 or/1-6 [CENS] 14624 8 ((medica* or pharmaceu* or drug*) adj (review* or assess* or eval* or reass* or checkup or "check-up" or optimi* or (re adj assess*))).tw. 2123 9 STOMP.tw. 64 10 deprescri*.tw. 401 11 (Comprehensive adj medica* adj manag*).tw. 20 12 (over adj medica*).tw. 243 13 or/8-12 [Deprescribing] 2796 14 7 and 13 8	

Databases/sources used		
<input type="checkbox"/> Pubmed	<input type="checkbox"/> HMIC	<input type="checkbox"/> BMJ Best Practice
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<input checked="" type="checkbox"/> Embase	<input checked="" type="checkbox"/> PsycINFO (2002-2025)	<input checked="" type="checkbox"/> Cochrane Library
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