



Consensus Statement | Psychiatry

Recommendations for the Deprescribing of Psychotropic Medications

A Consensus Statement From the American Society of Clinical Psychopharmacology Task Force

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Abstract

IMPORTANCE There is a need for greater recognition of clinical psychopharmacology endpoints, including instances where specific psychotropic medications may become unnecessary, redundant, contradictory, or otherwise inappropriate and therefore merit deprescribing.

OBJECTIVE To address circumstances warranting psychotropic medication deprescribing.

EVIDENCE REVIEW The American Society of Clinical Psychopharmacology convened a panel of 45 international psychopharmacology experts who developed and completed a multiround Delphi survey and conducted a focused literature review between January and May of 2025, in order to identify areas of consensus or disagreement on key aspects of the deprescribing of psychotropic medications. These included collaborative risk-benefit assessments with patients; pharmacokinetic and pharmacodynamic factors; pharmacogenomics; distinguishing redundant or conflictual from complementary mechanisms of action; managing adverse effects; assuring medication adherence; drug tolerance or tachyphylaxis; medication misuse; and the psychological context and ramifications of deprescribing.

FINDINGS Consensus was achieved on 44 of 50 final Delphi statements (88%). Panelists unanimously agreed that components of a pharmacotherapy regimen should undergo periodic review to ensure that treatments target relevant symptoms and have favorable risk-benefit ratios. Key points of consensus were that deprescribing: (1) should not occur without first assessing medication adherence; (2) merits consideration if less than partial therapeutic response is apparent, or if treatment goals have been reached and relapse prevention is not a long-term objective; (3) involves psychological ramifications that warrant attention; (4) should be followed by close clinical monitoring; and (5) risk-benefit decisions should ideally involve active patient participation within a shared decision-making model.

CONCLUSIONS AND RELEVANCE Through this Consensus Statement, the Task Force identified circumstances in which the selective elimination of certain psychotropic medications may be clinically indicated. Empirical trials are needed to assess the implementation of deprescribing protocols and gauge their safe, effective, and acceptable outcomes.

Key Points

Question When should mental health clinicians consider deprescribing psychotropic medications?

Findings The American Society of Clinical Psychopharmacology convened a 45-member international task force that undertook a Delphi survey and selective literature review to identify clinical situations favoring psychotropic drug deprescribing. Deprescribing should be considered when benefits are absent or risks outweigh benefits; after assuring adequate adherence and trials; and psychosocial ramifications of medication cessation are considered.

Meaning Clinicians should regularly and systematically evaluate the relevance and appropriateness of all components within a psychopharmacology regimen to determine when monitored deprescribing appears indicated.

+ Invited Commentary

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Introduction

The term *deprescribing* has been adopted throughout most areas of medicine to describe the purposeful, supervised discontinuation of medications deemed inappropriate for a given patient.^{1,2} The pharmacotherapy of complex and often difficult-to-treat psychiatric disorders frequently requires the nuanced use of psychotropic medications to achieve remission or stability. However, this may increase the risk for unnecessarily complicated medication regimens, unintended drug-drug interactions, and cumulative adverse drug effects. Deprescribing might be indicated for various reasons, including successful completion of a time-limited treatment, lack of efficacy, duplicative or contradictory drug mechanisms, irrational combinations or mismatches between treatment targets and pharmacodynamic effects, drug misuse, diagnostic revisions, refocusing toward nonpharmacological (eg, psychotherapeutic) interventions, and risks that outweigh benefits. As many psychiatric disorders are chronic, recurrent, frequently comorbid, and often incompletely responsive to appropriate pharmacotherapy, little guidance exists to help clinicians navigate decisions about eliminating medications that warrant discontinuation.

Recognizing this knowledge gap and need for greater decision support to practitioners, the American Society of Clinical Psychopharmacology (ASCP) convened an international task force to address circumstances warranting psychotropic medication deprescribing. Prior literature has extensively addressed the mechanics and logistics of tapering regimens and managing drug discontinuation effects.³⁻⁷ We instead sought to establish principles to help guide decisions about whether and when to stop a medication safely and appropriately.

Methods

The survey followed a Delphi model,^{8,9} mandating anonymity (to minimize undue influence from identifiable participants), iterative data collection, panelist feedback (provided as quantitative and qualitative summaries), and a statistical summary of findings for identifying consensus ratings. Survey questions were rated on a scale of 1 ("strongly agree"), 2 ("moderately agree"), 3 ("neither agree nor disagree"), 4 ("moderately disagree"), or 5 ("strongly disagree"), with an additional option of "I do not have the expertise to answer this question." Respondents who endorsed the latter item, or those who did not otherwise complete the question, were removed from the denominator when ascertaining consensus for each item. Panelists assigned confidence ratings of "low," "medium," or "high" to each response, alongside narrative commentary.

Survey items were developed by Task Force members through multiple rounds of review, revision, and input from all panelists between January and May 2025, before making final ratings. Consensus agreement or disagreement with each statement was defined as 75% or more concordance among panelists (ie, strongly or moderately agreed or disagreed). Proportions of agreement for items achieving consensus are reported with 95% CIs. Following the first round, a core workgroup identified questions achieving less than 75% consensus and developed follow-up questions, based on narrative content from the first round, in further efforts to achieve consensus. Items for which consensus could not be achieved after 2 rounds alongside narrative discussions among panelists were deemed to reflect dissensus, and reasons for disagreement were summarized. The reporting of results adhered to [ACCORD](#) guidelines.¹⁰

The Task Force comprised 45 members chosen based on recognized expertise as practitioners and investigators in clinical psychopharmacology, as reflected by publications, educational activities, academic and clinical reputation, and expressed interest in clinical psychopharmacology. Delphi panelists consisted of all listed coauthors plus 2 additional survey respondents.

A first survey round was sent by email to task force panelists with 91 items in 2 main sections: the first had 39 statements addressing general deprescribing principles; pharmacokinetics, pharmacodynamics, and pharmacogenomics; adverse effect management; treatment adherence; special populations; and the psychological context of deprescribing. The second focused on specific

medication classes or disease states. This publication reports findings from the first survey section and presents descriptive statistical data. Institutional review board approval and informed consent were not obtained as this consensus statement involved no research subjects.

Results

The survey first queried panelists' views about retaining vs replacing the term "deprescribing," given its sociolinguistic controversies as expounded by the antipsychiatry community.² The most frequently endorsed opinion (10 of 22 [45%]) was affirmative. Subgroups favored alternative phrases (eg, "rational medication discontinuation" [6 of 22 {27%}] or "medication discontinuation and tapering" [5 of 22 {23%}]). Ultimately, we retained the term since no alternative preferred descriptor emerged, alongside the desire to preserve consistency within the broader medical literature.

Consensus was reached on 34 of 39 (87%) round 1 statements focusing on general deprescribing principles. A second round involved reworded items that failed to gain consensus in round 1, plus 12 new items prompted by round 1. From a final (round 1 plus round 2) total of 50 questions, consensus was reached on 44 (88%).

Initiating the Deprescribing Process

Table 1 summarizes general concepts about deprescribing that achieved consensus across both rounds. Panelists' strong endorsements reflected (1) individualization of care rather than all-or-none declarations about deprescribing; (2) advocating regular, periodic formal reviews of medication regimens; and (3) unanimous agreement that patients' preferences be considered using a patient-centered, culturally-sensitive approach.

Table 1. General Concepts About the Deprescribing Process

Delphi statement	Agreement, % (95% CI)	Rated with high confidence, total/total No. (%)
The utility of continuing any particular psychotropic medication should be periodically reassessed, at the very least, on an annual basis	100 (93-100)	43/45 (96)
A risk-benefit analysis should be conducted before deprescribing any drug to gauge benefits vs lack of efficacy, or benefits vs adverse effects and their manageability	100 (93-100)	43/45 (96)
It is important to take into consideration patients' cultural attitudes and values when deciding when and how to deprescribe, for instance understanding culturally-driven beliefs about medications and their role in the management of mental health conditions	100 (93-100)	37/45 (82)
In patients who are taking multiple psychiatric medications, whenever feasible, only one deprescribing change should be made at a time	100 (93-100)	32/45 (71)
Patients who request to stop a medication that seems to be effective for previously poorly controlled symptoms should be guided through a risk-benefit discussion of continuation, discontinuation, or other modification to their regimen (eg, dosage or formulation changes, potential alteration of medications other than ones they identify as being problematic)	98 (91-102)	37/44 (84)
If a decision to taper a previously efficacious psychotropic medication is agreed upon, follow-up visits should occur with potentially greater frequency and utilize measurement-based care due to a greater risk of relapse or clinical decompensation	96 (89-103)	32/43 (74)
The impact of medication changes on functioning (relationships, occupational roles, self-care, etc) should be discussed	93 (88-104)	33/42 (79)
At the time of an initial consultation with a new patient, in the absence of obvious toxicity states, decisions about deprescribing an existing longstanding medication should generally not be made until there has been a careful assessment of its utility, which often may require several appointments and/or corroborating input to determine	91 (87-105)	21/41 (51)
To reduce the risk of relapse, whenever possible, a medication that has been effective should be deprescribed only after an extended period (eg, several months or longer) of sustained symptom remission	89 (86-106)	28/40 (70)
Discontinue a medication if it has failed to produce at least a partial response (≥25% reduction in overall symptomatology), or clinically meaningful significant improvement in at least one core target symptom (eg, suicidal ideation, insomnia, anxiety) after a conventionally defined adequate trial	87 (86-107)	18/39 (46)
Patients prescribed nonempirically supported polypharmacy for conditions for which pharmacotherapy is not indicated as a first-line treatment (eg, borderline personality disorder, PTSD) should be routinely evaluated for systematic deprescribing of non-evidence-based medications	83 (84-108)	17/37 (46)
Patients should be invited to bring a partner, family member, friend, or other trusted person into discussions about medication continuation or discontinuation	83 (84-108)	16/37 (43)

Abbreviation: PTSD, posttraumatic stress disorder.

Managing Adverse Effects and Safety Monitoring

Panelists advocated for comprehensive risk-benefit assessments before deprescribing an existing medication for a given patient. Factors such as patients' fear of (rather than actual) adverse effects,¹¹ risk of placebo effects,¹² and unawareness of strategies to mitigate true adverse effects that might occur are critical to frank discussions about deprescribing. **Table 2** presents statements regarding adverse drug effects where consensus was reached.

Additional statements addressed potential cognitive and other adverse consequences of anticholinergic medications used to manage antipsychotic-induced movement disorders, given the potential hazards of anticholinergic load.¹³ Panelists were asked about replacing anticholinergics (eg, benztropine or trihexyphenidyl) with amantadine or switching to antipsychotics less prone to cause parkinsonism, but responses fell short of consensus (68%; 95% CI, 54%-82%; 9 of 22 [41%] with high confidence).

The majority did not agree with the common clinical practice of not restarting (ie, deprescribing) a medication that a patient intentionally overdosed on, even if it was previously effective (only 46% agreement [10 of 22] after 2 rounds of statement rephrasing). Respondents acknowledged the conundrum such scenarios pose but emphasized the need to contextualize individual circumstances (eg, how useful the medication had been, whether viable alternatives exist, and what measures could be taken to reduce the risk of future overdose).

Table 2. Managing Adverse Effects and Safety Monitoring

Statement	Agreement, % (95% CI)	Rated with high confidence, total/total No. (%)
In a patient prescribed a psychopharmacologic antidote for antidepressant-induced sexual dysfunction (eg, bupropion), the antidote should be discontinued, rather than passively retained, after an adequate trial if it is not meaningfully beneficial for its intended purpose	100 (93-100)	32/45 (72)
Patient complaints about bothersome adverse effects should prompt a risk-benefit assessment that includes strategies to manage potential adverse effects, appraise the magnitude of benefit of an existing medication/drug regimen, and assess viable alternative treatment strategies if needed	98 (91-102)	36/44 (82)
When efficacy is apparent, efforts should be made when feasible to manage bothersome but medically nonacute, nonserious adverse effects (such as weight gain or sexual dysfunction) before deprescribing a suspected offending agent—unless the burden of adverse effects unequivocally outweighs benefits	98 (91-102)	32/44 (73)
Patients who express interest in stopping a medication should be provided with a risk-benefit assessment candid appraisal by the prescriber about the likely impact of deprescribing on their perceived adverse drug effects and risk for relapse	98 (91-102)	34/44 (77)
Nonserious adverse drug effects that are commonly transient (eg, nausea) or dose-related (eg, sexual dysfunction) should, in general, not prompt deprescribing before efficacy from an adequate trial has been discerned, unless patients express an overriding preference for discontinuation before an adequate trial has occurred	94 (88-104)	28/42 (67)
Anticholinergic drugs should be deprescribed if they have been initiated with the intention to prevent (rather than treat) extrapyramidal adverse effects (EPS) from antipsychotic medications, and extrapyramidal adverse effects have not occurred.	86 (85-107)	18/39 (46)
In patients who take a medication for which laboratory test monitoring is essential (for example, monitoring of kidney function in a patient on lithium) but either refuse or repeatedly fail to obtain the required laboratory test(s), that medication should be deprescribed and replaced with an alternative medication for which laboratory test monitoring is not essential, even if the medication is clinically efficacious	84 (85-108)	15/38 (39)
Cross-tapering is advisable when switching within-class from a drug with anticholinergic properties (eg, olanzapine, quetiapine) to one without anticholinergic properties (eg, aripiprazole, risperidone) to avoid cholinergic rebound	84 (85-108)	8/38 (21)
Anticholinergic drugs should be tapered rather than abruptly discontinued to minimize cholinergic rebound, except when abrupt cessation is necessary in urgent settings such as anticholinergic delirium or toxicity	83 (84-108)	16/37 (43)
In a patient who has experienced efficacy but clinically significant weight gain from a psychotropic medication, additional interventions should be undertaken to counteract weight gain (such as augmentation with metformin or a GLP-1 agonist, as well as lifestyle modification) before deciding to deprescribe that medication	81 (84-108)	13/36 (36)

Abbreviation: GLP-1, glucagon-like peptide-1.

Pharmacokinetic, Pharmacodynamic, and Pharmacogenomic Considerations

A central focus of deprescribing involves recognizing drug-drug interactions, mechanistic redundancies or conflicts, and the impact of stopping 1 medication on coprescribed agents. Panelists strongly endorsed the need for prescribers to appreciate such pharmacokinetic and pharmacodynamic considerations before and during any deprescribing effort. Four statements achieved consensus:

- "When a moderate or strong inhibitor or inducer of cytochrome P450 isoenzymes is deprescribed, the patient should be specifically monitored for possible increased or decreased effects of medications that are substrates of those enzymes." (100% agreement; 95% CI, 93%-100%; 18 of 21 [86%] with high confidence).
- "If pharmacogenomic testing has been obtained, the identification of a medication as falling within a 'cautionary use' category is not in itself reason to deprescribe it." (94% agreement; 95% CI, 88%-104%; 30 of 45 [67%] with high confidence).
- "Medications with a long terminal elimination half-life (eg, fluoxetine, vortioxetine, cariprazine, aripiprazole) or long-acting injectable antipsychotics generally can be abruptly stopped without the need for a downward dose titration because they will auto-taper." (81% agreement; 95% CI, 84%-108%; 17 of 45 [38%] with high confidence).
- "Decisions to deprescribe a medication due to a possible drug-drug interaction should be evaluated, via literature search and/or consultation with a pharmacist, as to the nature and clinical significance of the purported drug-drug interaction." (89% agreement; 95% CI, 86%-106%; 26 of 45 [58%] with high confidence).

When asked whether "discontinuation phenomena" from stopping short half-life serotonergic drugs (eg, vertigo, "brain zaps")¹⁴ could be effectively managed via substitution of longer half-life serotonergic compounds, responses nearly reached consensus (74% agreement; 95% CI, 61%-87%) but few expressed high confidence (9 of 42 [21%]). Indeed, no clinical trial has evaluated fluoxetine substitution to mitigate antidepressant withdrawal, even though that strategy is often recommended.¹⁵ Although most respondents believed slow tapers were unnecessary for outgoing medications with long half-lives, only 17 of 45 (38%) expressed that view with high confidence.

Two additional first round questions nearly achieved consensus. First, panelists were asked if cross-tapers are generally unnecessary in the case of switching between drugs that inhibit serotonin reuptake (61% agreement; 95% CI, 46%-76%; 17 of 43 [39%] with high confidence). Full agreement (100%; 100% high confidence) was achieved when this query was changed in round 2 to, "Abrupt switching (vs tapering-off) from one serotonin reuptake inhibitor to another should not be undertaken without first considering the half-life and any other effects of the medication being discontinued." Second, the survey question, "In patients who are being prescribed 2 medicines that bind to the serotonin transporter (eg, 2 selective serotonin reuptake inhibitors [SSRIs], or an SSRI plus a serotonin-norepinephrine reuptake inhibitor [SNRI]), 1 of the 2 agents should be deprescribed due to mechanistic redundancy and the risk for serotonin syndrome" achieved 69% agreement (95% CI, 55%-83%; 13 of 41 [31%] with high confidence). Although clinicians may worry about this possibility, panelists noted that serotonin syndrome due to the use of 2 mechanistically redundant serotonergic medications is very uncommon.

Additional comments focused on the need for careful monitoring and support, especially when patients may have limited insight. These included the importance of having a trusted caregiver comonitor changes over time; education around and alertness to signs of relapse; and uncertainty about undue burden on the patient alone to recognize and report signs of relapse.

Treatment Adherence Considerations

Panelists acknowledged that poor medication adherence is common (only approximately 50% of patients with chronic mental health conditions are considered to have adequate treatment adherence¹⁶) and highly underappreciated in deprescribing decisions; its assessment should be routine. Understanding reasons for nonadherence is central to shared decision-making. Negative

effects of poor adherence are well-established, including illness relapse, poor quality of life, increased use of health care services, worse trajectory of outcome and premature mortality due to exacerbation of medical conditions or suicide.¹⁷⁻¹⁹ Panelists noted that clinician assessment of adherence is often unreliable.²⁰

The following 3 statements achieved consensus:

- "When considering whether to deprescribe an existing medication based on lack of efficacy, conclusions about perceived poor efficacy should not be made until the prescriber has made a careful assessment of adherence or adequacy of a trial." (100% agreement; 95% CI, 93%-100%; 36 of 45 [79%] with high confidence).
- "Discussions about deprescribing a medication should routinely involve prescribers actively exploring a patient's possible current or past medication nonadherence and reasons for nonadherence." (96% agreement; 95% CI, 89%-103%; 34 of 45 [74%] with high confidence).
- "When considering whether to deprescribe a medication for suspected lack of efficacy, collateral information about adherence and benefits should first be obtained whenever possible from relevant sources (eg, previous prescribers, caregivers, or close family members)." (85% agreement; 95% CI, 85%-107%; 21 of 45 [47%] with high confidence).

The Psychological Context of Deprescribing and the Role of Psychotherapy

Panelists recognized the psychological implications and ramifications of discussing or implementing medication deprescribing. Numerous psychosocial factors bear on such interactions, including patient insight, health literacy and expectations, therapeutic alliance, perceived cultural and family values related to mental health, influence of social media on patient understanding of illness, and prior treatment experiences.²¹⁻²³ Similarly, patient reactions to deprescribing recommendations are strongly influenced by conscious and unconscious beliefs about medication.²⁴ For example, individuals with secure attachment styles may be inclined to experience health care professionals and medications as positive forces that facilitate their well-being making them less likely to unilaterally discontinue medications. Those with insecure attachment styles may be more inclined to perceive their clinicians and medications negatively, experiencing dependence on them as indicators of weakness or loss of control over their mental health,²⁵ leading to premature discontinuation of medications. Early life adversity can foster a sense of basic mistrust, leading to perceptions of medication as extensions of unreliable or exploitative caregivers, thereby making nonadherence more probable. Anxious attachment styles have been associated with the prescribing of more psychiatric medications, while attachment avoidance correlates with fewer.²⁶

Psychologically, medication may serve as a transitional object, the internalized representation of a caregiver that helps patients feel connected to their prescriber.²⁷ Medication may also validate the legitimacy of someone's distress and psychiatric illness, affirming that their struggles are neither imaginary nor intangible. Patients may unconsciously fear the loss of medication as a valued object, or expect negative outcomes from deprescribing. Even among those reporting no benefit from a medication, some may nevertheless fear they will worsen without it. Patients may doubt their ability to manage stressors without medication, especially if they lack access to adequate therapeutic support or alternative coping mechanisms.

An underappreciated psychological context about deprescribing involves patients assuming an active role in shared decision-making.²⁸ Collaborative decision-making, where patients are educated about risks, benefits, and treatment options, are crucial for patient autonomy and respect. Shared decisions help manage uncertainties about outcomes and relapse risks, fostering a greater sense of agency and shared accountability.

It is essential for clinicians to query and appreciate patients' anticipated outcomes after deprescribing. With some medications (eg, benzodiazepines), the sheer prospect of discontinuation can prompt emotional discomfort and expectations of intensified suffering. Thus, psychoeducation, collaborative tapering plans, adjunctive coping skills, and regular supportive monitoring are imperative.

Survey items regarding the psychology of deprescribing that achieved consensus are summarized in **Table 3**. In some instances, respondents expressed concerns that a recommendation might be logical, but not evaluated through empirical trials (eg, whether it is advisable to provide or offer formal cognitive therapy when deprescribing a medication).

Deprescribing Decisions During Pregnancy and Lactation

Individuals who are pregnant or planning to become pregnant may have a particular desire to stop medications. Patients' motivations to stop an efficacious medication due to fear of risks from fetal exposure may not necessarily be evidence-based or sufficiently consider relapse risk. In mild illness, careful decisions can be made to taper and discontinue medications. Well-meaning but ill-informed clinicians may urge patients who are pregnant to discontinue medications without accurate knowledge about a medication's comprehensive human pregnancy data, or a full understanding of patient-specific risks. Importantly, the benefits of a given medication need to be considered strongly, as the risk of relapse after medication discontinuation for many psychiatric disorders is high. The quality of human pregnancy safety studies varies, and unaccounted-for factors such as poor nutrition, obesity, and smoking impose confounding by indication, obscuring causal inferences about adverse drug effects. Psychiatric disorders themselves also contribute to neonatal and obstetrical risks.

Some psychotropics are better known than others regarding reproductive safety data, and many have extensive safety data supporting use in pregnancy when warranted by the risks of untreated illness. Nevertheless, apprehension among both patients and prescribers speaks for greater education across multidisciplinary health care professionals, patients, and families about accurate safety data. A particularly complex class of medications includes mood stabilizers. For example, the use of lithium is nuanced, due to a small risk of cardiovascular malformations that were historically overestimated,²⁹ balanced against the robustness of an individual's response to lithium, relapse rates in bipolar disorder, and risk of severe postpartum illness. Conversely, valproate poses substantial risks during pregnancy for major malformations and poor neurodevelopmental outcomes.³⁰⁻³²

Four Delphi statements regarding deprescribing during pregnancy or lactation achieved consensus, presented in **Table 4**. Agreement was not universal regarding valproate deprescribing in women of reproductive age. When panelists were asked whether "valproate should be routinely deprescribed in women of childbearing potential, whether or not a pregnancy is planned," agreement was 67% (95% CI, 44%-84%; 64% expressed high confidence), with 27% moderately or strongly disagreeing with this.

Deprescribing Decisions in Older Adults and the Medically Ill

The literature on deprescribing has historically focused on older adults, where multiple health conditions and often complex combination nonpsychotropic drug regimens pose concerns about

Table 3. Psychosocial Context of Deprescribing Psychotropic Medications

Statement	Agreement, % (95% CI)	Rated with high confidence, total/total No. (%)
Clear communication with patients about the rationale for deprescribing may help allay patient fears about the process (eg, belief that prescriber no longer cares for them, doubts about their ability to function without a specific medication, worries about medical sequelae of tapering)	98 (91-102)	34/44 (77)
To reduce the risk of relapse, whenever possible, deprescribing a medication that has been effective and the patient has been on for a long time should be deferred if there are impending major life changes or stresses	96 (89-103)	21/43 (49)
Understanding patients' psychological relationship to medication will aid prescribers to deprescribe more effectively, for instance providing accurate psychoeducation about the limitations of pharmacotherapy to those who overvalue somatic treatments or outlining a collaborative taper schedule for those with psychological or physical sensitivity to changes in medication dosing	94 (88-104)	25/42 (59)
Providing patients with psychological supports, such as cognitive behavioral therapy, to augment functioning in advance of deprescribing may reduce patient fears about negative sequelae of deprescribing	87 (86-107)	15/39 (38)
Patients' psychological barriers to deprescribing may include unconsciously fearing the loss of medication as a valued object, experiencing loss of medication as a rejection by the prescriber, and a threat to the medical legitimacy of their suffering	81 (84-108)	15/36 (42)

redundant or conflictual drug-drug interactions.³³ Survey items focused on key issues outlined in

Table 5.

Consensus agreement was reached on all but 1 question: "In older adults starting on a serotonin reuptake inhibitor who are on a thiazide diuretic, to reduce the risk of hyponatremia, emphasis should be given to switching the patient to an alternative medication," where 58% of panelists agreed (95% CI, 37%-79%; 32% had high confidence). Prescribers should consider the broad differential diagnosis of hyponatremia before reflexively assuming the need to deprescribe a serotonergic antidepressant as a presumed culprit, and consider the feasibility of deprescribing nonpsychiatric medications associated with hyponatremia³⁴ (91% agreement; 95% CI, 79%-103%; 38% expressed high confidence).

Discussion

Panelists unanimously called for systematic, periodic reviews of psychopharmacology regimens to assure that prescribed medications remain relevant, benefits outweigh risks, and patients assume an active collaborative role in shared decision-making. The most common caveats raised by panelists were (1) substantial challenges to developing generalizable statements for diverse patient-specific clinical situations, and (2) concerns that some recommendations may more often reflect intuitive knowledge rather than findings supported by evidence-based clinical trials. However, few empirical studies have focused on optimal strategies to discontinue medication. This supports the third-most

Table 4. Considerations in Pregnancy and Lactation

Statement	Agreement, % (95% CI)	Rated with high confidence, total/total No. (%)
In a woman taking psychotropic medications who plans to breastfeed, given limited knowledge about drug safety in breastfeeding, decisions about whether to continue or deprescribe an existing medication during breastfeeding should involve a shared discussion of risks and benefits, including relapse risk, rather than issuing absolute declarations about continuing vs stopping a medication	100 (93-100)	41/45 (91)
When individuals of reproductive potential are planning pregnancy or are pregnant, the risks of relapse of the psychiatric disorder must be strongly considered in the risk-benefit analyses of deprescribing medications	100 (93-100)	40/45 (89)
In patients with bipolar disorder who are of childbearing age and potential (or females younger than reproductive age), valproate should be routinely deprescribed in favor of a different mood stabilizing medication due to the highly teratogenic effects of valproate and neurotoxic effects for the fetus	95 (89-103)	28/43 (65)
Lithium should not automatically or routinely be discontinued in patients with bipolar I disorder who wish to become pregnant or are pregnant	77 (65-89)	17/35 (49)

Table 5. Deprescribing in the Elderly and Medically Ill

Statement	Agreement, % (95% CI)	Rated with high confidence, total/total No. (%)
As patients who are on a benzodiazepine become older adults, risk-benefit considerations should be carefully reviewed again to determine whether or not the benzodiazepine should be deprescribed	100 (93-100)	41/45 (91)
The medication list of older adults should be routinely evaluated for the cumulative (total) anticholinergic burden. If the anticholinergic burden is found to be significant, collaborative efforts should be made to discontinue or reduce medications with substantial anticholinergic activity. If needed, these patients may be switched to alternative medications with lower anticholinergic activity	100 (93-100)	39/45 (87)
The medication list of patients (especially older adults) who either have or are at significant risk for orthostatic hypotension should be evaluated to identify medications that may contribute to orthostatic hypotension. A systematic effort should be made in these patients to discontinue these medications or, at least, minimize their doses	100 (93-100)	33/45 (73)
In patients (especially older adults and those with respiratory disease) who need to be on an opioid medication, if clinically feasible, attempts should usually be made to discontinue benzodiazepines or, at least, minimize their doses	100 (93-100)	25/45 (56)
In older adults who have had a fall (or are at an increased risk of falling), we should routinely check orthostatic vital signs and conduct a thorough clinical evaluation that may include use of a standardized assessment such as the STOPPFall tool to identify fall-risk-increasing drugs (FRIDs) and deprescribe them where possible, using its guidelines	100 (93-100)	22/45 (49)
Before deprescribing a psychotropic medication—particularly in older adults or the medically ill, who may be especially likely also to be taking nonpsychiatric medications—clinicians should comprehensively check for drug-drug interactions (such as relevant cytochrome p450 substrates) that might be affected by the elimination of a particular psychotropic drug	95 (89-103)	33/43 (77)

common concern of panelists: because most serious psychiatric conditions are highly recurrent or chronic, true pharmacological endpoints are often elusive.

In patients with complex treatment histories who have undergone numerous medication trials, the decision to deprescribe a pharmacotherapy having only modest efficacy must be weighed against a frequent dearth of appropriate (and not necessarily better) alternatives. Complex polypharmacy regimens often derive from such circumstances, where multiple retained drugs may reflect skepticism that simpler strategies would yield better results. Consequently, practice guidelines favor retaining and augmenting (rather than discontinuing) partially effective medications when many other options have been tried.³⁵ All parties may perceive lower stakes when opting to deprescribe a single medication following an uncomplicated history and course in nonchronic, nonrecurrent disorders. In the case of deconstructing a multidrug regimen, findings from this Task Force would argue for systematically changing 1 variable at a time, evaluating perceived benefits of individual components, pruning redundant or contradictory agents, and assessing adverse effect burden and manageability.

Most panelists (15 of 22 [67%]) favored deprescribing valproate in women of childbearing potential, but the failure to reach consensus was surprising, given the substantial literature regarding valproate's significant anatomical and neurodevelopmental teratogenicity.^{30-33,36} Valproate's teratogenic risks occur before pregnancy is usually recognized,³⁰ and nearly 50% of pregnancies worldwide are unplanned,³⁷ prompting the World Health Organization to declare that valproate should not be prescribed to women and girls of childbearing potential.³¹ Dissenting panelists objected to routine deprescribing, adding comments such as, "Decisions depend on prior failed trials and broader clinical contexts." Many reproductive psychiatry experts consider valproate an inappropriate pharmacotherapy at any point during pregnancy.^{30,32,33}

A central theme from the Task Force findings was the need to make collaborative risk-benefit analyses a proactive, deliberative act that serves as a core tenet of psychopharmacology management. Panelists often eschewed all-or-nothing generalizations about deprescribing in the absence of more nuanced information about a given patient's circumstances, clinical status, and preferences, instead advocating for a dialogue with patients as stakeholders in their own outcomes. Panelists also strongly favored deprescribing non-evidence-based treatments (eg, complex combination therapies for conditions that may be poorly responsive to pharmacotherapy, such as borderline personality disorder³⁸). In such instances, decisions to deprescribe pharmacotherapy may be linked to reorienting patients to nonpharmacological (and potentially more efficacious) interventions, such as structured psychotherapies.

Panelists called for prescribers to recognize clinically meaningful drug-drug interactions and the ramifications of stopping 1 medication relative to those remaining. There was a general preference for cross-tapering approaches rather than direct switches when changing medications, especially for agents with potential rebound effects or adverse cognitive consequences such as anticholinergic drugs.³⁹

Increased awareness of intentional deprescribing has pragmatic implications. First, residency (and nonphysician prescriber⁴⁰) training programs provide little education on timing, planning, context, and logistics of ending a psychotropic treatment. Helping prescribers-in-training match target symptoms with evidence- or rationale-based pharmacotherapies should include the skill set of identifying treatment endpoints and continually assessing efficacy, relevance, and tolerability. Actively educating and involving patients in the process fosters collaboration and may help mitigate concerns about deprescribing. Finally, from the standpoint of regulatory agency oversight of psychotropic medications, particularly with new molecules or medication classes, it is worth noting the value of demonstrating the safety and efficacy not only of upward- but also downward-dosing titrations and discontinuation effects. Notable examples would be lithium (abrupt vs gradual cessation substantially hastens time until relapse in bipolar disorder⁴¹) or abrupt antipsychotic cessation leading to withdrawal dyskinesias.⁴²

Scott and colleagues¹ proposed a 5-step deprescribing process: (1) ascertain all drugs the patient is currently taking and reasons for each; (2) consider overall risk of drug-induced harm in individual patients; (3) assess each drug in regard to its current or future benefit potential compared with current or future harm or burden potential; (4) prioritize drugs for discontinuation that have the lowest benefit-harm ratio and lowest likelihood of adverse withdrawal reactions or disease rebound syndromes; and (5) implement a discontinuation regimen and monitor patients closely for improvement or worsening. These basic principles are consistent with the statements endorsed within the present survey.

Finally, these Task Force recommendations should not be misconstrued as a standard of care, because individual circumstances must contextualize decisions to continuing or stop a medication. Nevertheless, the findings underscore the importance of viewing prescribing and deprescribing as successive, dynamic phases of treatment. The process should be deliberative, thoughtful, and proactive with continual reassessment of treatment aims and goals, awareness of alternatives, degrees of success or failure, and prespecified endpoints that may evolve over time in the longitudinal care of any given patient.

Conclusions

A conceptual framework can be established and implemented to identify clinical circumstances where selectively discontinuing certain psychotropic medications is indicated. The process of initial prescribing, renewing, and deprescribing should be viewed as a fluid, longitudinal endeavor pursued with active oversight and collaboration with patients across their illness course over time.

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Dr Aaronson reported receiving consulting fees from LivaNova, Neuronetics, Genomind, and Sage Therapeutics; he reported receiving grants from Compass Pathways; and he reported receiving personal fees from Boehringer Ingelheim outside the submitted work. Dr Jha reported receiving grants from Neurocrine Biosciences, Supernus, and Janssen Research & Development; he reported receiving consulting fees from Boehringer Ingelheim and Janssen Scientific Affairs; he reported receiving personal fees from Sanofi, Psych Congress, and AbbVie; he reported fees for service on data safety and monitoring boards from Worldwide Clinical Trials, IQVIA, and Vicore Pharma; he reported honoraria for educational presentations from Medscape, Clinical Care Options, Physicians' Education Resource, Efficient CME, and HC Wainwright & Co outside the submitted work. 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