The Maudsley®

Deprescribing Guidelines

Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs

Mark Horowitz
David Taylor

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Preface

'It is an art of no little importance to administer medicines properly; but it is an art of much greater and more difficult acquisition to know when to suspend or altogether omit them.'

Philippe Pinel 1745–1826

This is not a book that questions the validity or effectiveness of medicines used for mental health conditions. It is a guide to the deprescribing of psychotropic medication in situations where deprescribing is, on balance, agreed to be a better option than continued prescribing. The agreement here is between prescriber and patient. The core tenet of this text is that decisions are made jointly in the patient's best interest.

Patients have expressed dissatisfaction – and sometimes outrage – with available medical assistance for stopping psychiatric medications. This has led to many tens of thousands of patients seeking advice from online peer-support forums. When surveyed, these patients report that their doctors were often unhelpful either because they recommended tapering too quickly or because they were not familiar enough with withdrawal effects to provide helpful advice.[1] Some doctors are apparently still suggesting that antidepressants do not cause withdrawal symptoms. The main requests from these patients are that health professionals are sufficiently well informed to provide personalised, flexible reduction plans and that access is provided to smaller doses to facilitate tapering (either liquid versions of medication, or specially compounded smaller dose tablets or capsules).[1] We hope this textbook will contribute to a broader understanding of these issues, a greater expertise in helping patients and a better outcome for all.

In writing this textbook we took on what some might consider an impossible task. Safely stopping psychiatric medications is not simply a matter of outlining a regimen of reducing doses for patients to follow. There are too many aspects of the drug, the individual and their lives that come into play such that adjustments inevitably need to be made, often involving a certain amount of trial and error. Yet the most common request we receive from patients and clinicians is to provide tapering schedules to guide reductions. It can be daunting to begin a journey without a map to follow. So in this book we have tried to balance specific guidance with flexibility, offering different routes to reducing doses, whilst trying to accommodate the complexity required for adjusting the course for an individual. We have also tried to acknowledge the tenets of other guidance

in this field. The advice given here is, for example, largely consistent with the UK NICE guidelines on this topic, but we aimed to provide greater detail on how to implement the broad principles outlined.

Balancing competing priorities has proved difficult. On the one hand, patients often report that they are tapered off psychiatric drugs too quickly, and on the other, patients should not be exposed for an unnecessarily long time to a drug that could be stopped more quickly. Added to this is the awareness that there is great variation from one person to another – and that we have little to guide us in predicting how an individual will react. We have therefore attempted to accommodate a wide variety of circumstances with further instructions on how to make changes from the suggested regimens.

We wrote this book partly because of our own difficulties in coming off various psychiatric drugs. Our main motivation has been that, by clarifying what is known about safe deprescribing and applying that to practice, we will spare others some of the difficult experiences we have endured. It is perhaps the book that we wished our prescribers had possessed.

It is sobering to consider that had we not experienced stopping medication first-hand we would have found it hard to believe the accounts of patients, which can seem almost fantastical in the variety and severity of symptoms (what one experienced practitioner in this field has called 'the unbelievability factor'[2]). We hope this book will help clinicians develop a greater appreciation for the difficulties some patients experience when trying to stop psychotropic medication.

We recognise that much of the guidance included in this book requires confirmation and clarification from further research but we also appreciate that people are already reducing and stopping their medication and that we should not let the perfect be the enemy of the good. The main messages of the textbook could be summed up in a few words: go slowly, at a rate the patient can tolerate and proceed even more cautiously for the last few milligrams, which are often the hardest to stop.

One major barrier for prescribers we have observed is a reluctance to prescribe liquid versions of drugs, compounded medication or other unlicensed (but widely used) methods to make up the smaller doses of medication necessary for optimal tapering. Often this is for good reasons like cost and complexity. However, minute doses are likely to be required for a substantial proportion of long-term users if they are to stop their medication safely. Many patients report that once a clinician has traversed this psychological moat the process of tapering off their medication becomes substantially easier.

We have also sought to empower patients in the process of coming off their drugs. Patient autonomy is increasingly highlighted in medicine (and psychiatry more widely), but in the area of deprescribing where relatively little is known and where patient experience is so central, it is even more important. We have observed that patients soon become the experts in understanding what rate they can tolerate in reducing their medications and we hope that clinicians will support patients in this process. An old adage from another area of medicine – 'Pain is what the patient says it is' – might be borrowed here. Withdrawal is what the patient says it is.

On this topic, we have also included in this textbook the voices of patient experts and advocates who have been instrumental in drawing attention to the problems many patients face in withdrawal, and in working out innovative approaches to minimise risks. Some of these patient experts have medical training, and some have published

research in academic journals. Their experience of being both patients and, in some cases, clinicians brings unique insight into the process.

When discussing withdrawal syndromes from psychiatric drugs, the concepts of addiction or misuse and abuse often arise. However, we have emphasised throughout this textbook that physical dependence is a predictable physiological response to chronic use of psychotropic medication. This inevitably and predictably leads to a withdrawal syndrome on stopping or reducing the dose and does not indicate addiction, misuse or abuse.

This book has been written so that it may be read from cover to cover but it is also designed to be sampled as needed by the busy clinician. To this end, there are 'quick start' guides for tapering specific drugs that are designed to be intelligible largely independent of the rest of the book. The chapters on individual drug classes outline the issues specific to each class but also to tapering in general, given some commonalities. This deliberate design has necessitated some degree of repetition, the reasons for which we hope the reader will understand.

We would like to pay special tribute to Adele Framer for sharing the wisdom gained from years of supporting patients to safely stop antidepressants and other psychiatric drugs in peer-led forums, combining lived experience with academic knowledge. Also, Nicole Lamberson and Christy Huff, medical professionals with lived experience, for contributing their long experience in helping people to safely stop benzodiazepines via peer-led forums. We would also like to thank Bryan Shapiro for his help putting together the section on gabapentinoids, and Andrea Atri Mizrahi and Ivana Clark for their tireless efforts in assembling and checking for accuracy substantial parts of the drug-specific guidance. Lastly we would like to record our appreciation for the support of Robin Murray in our work in the field of deprescribing.

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Notes on using The Maudsley® Deprescribing Guidelines

The main aim of *The Guidelines* is to provide clinicians with practically useful advice on the deprescribing of psychotropic agents in commonly encountered clinical situations. The advice contained in this handbook is based on a combination of literature review, clinical experience and expert contribution, including from patient experts and advocates. We do not claim that this advice is necessarily 'correct' or that it deserves greater prominence than the guidance provided by other professional bodies or special interest groups. We hope, however, to have provided guidance that helps to assure the safe, effective and economical use of medicines in psychiatry, including when they are no longer required.

We hope also to have made clear precisely the sources of information used to inform the guidance given. Please note that some of the recommendations provided here involve the use of unlicensed formulations of some drugs in order to facilitate tapering. Note also that, while we have endeavoured to make sure all quoted doses are correct, clinicians should always consult statutory texts before prescribing. Users of *The Deprescribing Guidelines* should also bear in mind that the contents of this handbook are based on information available to us in November 2023. Much of the advice contained here will become out-dated as more research is conducted and published.

No liability is accepted for any injury, loss or damage, however caused.

Notes on inclusion of drugs

The Deprescribing Guidelines originate in the UK but are intended for use in other countries outside the UK. With this in mind, we have included in this edition those drugs in widespread use throughout the Western world in November 2023. These include drugs not marketed in the UK, such as desvenlafaxine, vilazodone, amongst several others. Many older drugs or those not widely available are either only briefly mentioned or not included on the basis that these drugs were not in widespread use at the time of writing. This book was written to have worldwide utility, although it retains a mild emphasis on UK practice and drugs.

Contributors' Conflict of Interest

Most of the contributors to *The Deprescribing Guidelines* have not received funding from pharmaceutical manufacturers for research, consultancy or lectures, although some have. Readers should be aware that these relationships inevitably colour opinions on such matters as drug selection or preference. However, in the case of a textbook that advises on stopping psychiatric drugs, and that generally recommends not using medications to treat withdrawal from another, such conflicts may be less pertinent than in other circumstances. As regards direct influence, no pharmaceutical company has been allowed to view or comment on any drafts or proofs of *The Deprescribing Guidelines*, and none has made any request for the inclusion or omission of any topic, advice or guidance. To this extent, *The Deprescribing Guidelines* have been written independent of the pharmaceutical industry.

Abbreviations List

% CI	percentage confidence interval
ADHD	attention deficit hyperactivity disorder
AMPA	α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid
APA	American Psychiatric Association
BDD	body dysmorphic disorder
BIND	benzodiazepine-induced neurological dysfunction
BNF	British National Formulary
BZD	benzodiazepine
BzRAs	benzodiazepine receptor agonists
CABG	coronary artery bypass graft
CANMAT	Canadian Network for Mood and Anxiety Treatments
CBT	cognitive behavioural therapy
CBT-I	cognitive behavioural therapy for insomnia
CFS	chronic fatigue syndrome
CNS	central nervous system
COPD	chronic obstructive pulmonary disease
CR	controlled release
CSM	Committee on the Safety of Medicines
DAT	dopamine transporter
DAWSS	Discriminatory Antidepressant Withdrawal Symptom Scale
DESS	discontinuation-emergent signs and symptoms
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders 3rd revised edition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders 5th revised edition
EMA	European Medicines Agency
EMPOWER	Eliminating Medications Through Patient Ownership of End Results
ER	extended release
FDA	US Food and Drugs Administration
FND	functional neurological disorder
GABA	gamma-aminobutyric acid
$GABA_A$	gamma-aminobutyric acid type A receptor
GAD	generalised anxiety disorder
GMC	General Medical Council
GP	general practitioner
HAM-A	Hamilton Anxiety Rating Scale
HAM-D	Hamilton Depression Rating Scale
HPA	hypothalamic-pituitary-adrenal
IBS	irritable bowel syndrome
ICD-10-CM	The International Classification of Diseases, 10th Revision, Clinical Modification

IR	immediate-release
LGIB	lower gastrointestinal bleeds
MADRS	Montgomery-Åsberg Depression Rating Scale
MAO	monoamine oxidase
MAOI	monoamine oxidase inhibitor
MB-CT	mindfulness based cognitive therapy
MDD	major depressive disorder
MDMA	3,4-methylenedioxymetham phetamine
MHRA	Medicines and Healthcare Products Regulatory Agency
MMSE	Mini Mental State Examination
MUS	medically unexplained symptoms
NaSSAs	noradrenaline and specific serotonergic antidepressants
NET	noradrenaline transporter
NEWT	North East Wales NHS Trust
NGO	non-governmental organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIDA	National Institute on Drug Abuse
NMDA	N-methyl-D-aspartate
NNT	number needed to treat
NPS	National Prescribing Service
OCD	obsessive compulsive disorder
ODV	O-desmethylvenlafaxine
ONS	Office of National Statistics
OR	odds ratio
PAWS	post-acute withdrawal syndrome
PD	panic disorder
PET	positron-emission tomography
PIL	patient information leaflet
PPWS	persistent post-withdrawal syndrome
PSSD	post-SSRI sexual dysfunction
PTSD	post-traumatic stress disorder
PWS	persistent withdrawal symptoms
RCPsych	Royal College of Psychiatrists
RCT	randomised controlled trial
RIMA	reversible inhibitor of monoamine oxidase A
RLS	restless leg syndrome
RO	receptor occupancy
RPS	Royal Pharmaceutical Society
SAD	social anxiety disorder
SARI	serotonin antagonist and reuptake inhibitors
SERT	serotonin transporter
SIADH	syndrome of inappropriate secretion of antidiuretic hormone
SMD	standardised mean difference
SmPC	summary of product characteristics
SNRI	serotonin and norepinephrine reuptake inhibitor
SR	sustained-release
SSRI	selective serotonin reuptake inhibitor
STOPP	Screening Tool of Older Persons' Prescriptions
TCAs	tricyclic antidepressants
TI	The Therapeutics Initiative
TIA	transient ischaemic attack
UGIB	upper gastrointestinal bleeds
WHO	World Health Organization
XR or XL	extended-release
Z-drugs	nonbenzodiazepine sedative-hypnotics

Chapter 1

Introduction to Deprescribing Psychiatric Medications

Deprescribing as an Intervention

Deprescribing is the planned and supervised process of reducing or stopping medication for which existing or potential harms outweigh existing or potential benefits.[1] The term 'deprescribing' originates from geriatric medicine where polypharmacy in frail patients can cause more harm than benefit.[1] Deprescribing is increasingly recognised to be a key component of good prescribing – reducing doses when they are too high, and stopping medications when they are no longer needed.[2] This process cannot occur in a vacuum of theoretical concerns but should take into account the patient's health, current level of functioning and, importantly, their values and preferences.[1] Deprescribing seeks to apply best practice in prescribing to the process of stopping a medication. It requires the same skill and experience as for the process of prescribing from prescribers, as well as support from pharmacists and other healthcare staff to obtain the best results. Importantly, it should place patients at the centre of the process to ensure medicines optimisation.[3]

There has historically been little attention paid to deprescribing in psychiatry. There is a dearth of research into a structured approach to stopping psychiatric medication, with the exception of some early studies examining stopping benzodiazepines[1] and in some specific populations, like people with learning disabilities. The focus of research efforts has been predominantly the prescribing of psychiatric medications – for example, there are estimated to be about 1,000 (published and unpublished) studies on starting antidepressants and only 20 on stopping them.[4] Concern about this imbalance is not specific to psychiatry with other medical specialties, such as cardiology, also engaging in a re-appraisal of long-term medication continuation, with support for developing strategies for repeated risk–benefit analyses over time.[5]

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The context for deprescribing

Over-prescription in psychiatry

Despite evidence of benefit for psychiatric drug treatment, there have been concerns raised regarding over-prescription. 1 in 6 people in western countries are prescribed an antidepressant in any given year, with rates rising a few per cent each year.[4,6] These increasing prescription numbers are mostly caused by longer periods of prescribing – the median duration of use of antidepressants is now more than 2 years in the UK and more than 5 years in the USA.[6] Some commentators have suggested that the increasing duration of prescriptions in part reflect the difficulty people have in stopping these medications due to withdrawal effects.[7] In practice, 30–50% of patients do not have evidence-based reasons for the continued prescription of antidepressants,[8–10] prompting calls to action to reduce associated risks.[6,11] There have been similar concerns about the high rates of antipsychotic use in conditions other than serious mental illness,[12] as well as a reconsideration of their open-ended use in psychotic conditions for all patients.[13,14] There are long-standing worries about levels of benzodiazepine and z-drug prescribing,[15,16] and more recent concerns about gabapentinoid prescribing.[17]

High rates of medication prescribing has also gained governmental attention in the UK,[17] with a particular focus on psychiatric drugs. A government report has noted that 1 in 4 adults in the UK are prescribed at least one dependence forming medication each year, with some patients having difficulties stopping these medications.[18] One central concern is that short-term symptom control might be prioritised over long-term functional outcomes, especially as most studies guiding treatment protocols measure symptomatic outcomes over short time periods rather than functional outcomes (or other outcomes often valued by patients) over longer time periods.[13,19,20]

Alongside this disquiet regarding over-prescription there has been renewed scrutiny of the effectiveness of some psychiatric medications. There is some consensus in the UK and Europe that benzodiazepines and z-drugs have limited effectiveness in the long term, with guidance recommending against long-term treatment for anxiety and insomnia,[21] matched by guidance in the USA from some health management organisations.[15] Preliminary studies have recently found similar outcomes in the treatment of selected patients with first-episode psychosis with or without antipsychotics in the context of comprehensive psychosocial support,[22,23] and non-drug treatment for serious mental illness has attracted increasing interest, including a large randomised controlled trial (RCT).[24] There have been calls from clinicians and patients for 'minimal medication' options for the treatment of psychotic conditions, such as have been established in Norway and parts of the USA.[25] There has continued to be debate regarding the efficacy of antidepressants[26,27] with arguments being made for their use in selected populations.[28] Concerns have emerged regarding the efficacy and safety of gabapentinoids.[17] In some countries there has been a shift away from a drug-centric approach in some patient groups – for example, in England and Wales the National Institute for Health and Care Excellence (NICE) now recommends that mild depression should not be treated with antidepressants as a first-line treatment, and suggests eight equally effective (and cost-effective) non-pharmacological treatment options for severe depression, alongside medication options.[29]

In addition to the above, there has also been significant critical attention directed towards the relapse prevention properties of psychiatric drugs.[30,31] All psychiatric drug classes are recognised to cause withdrawal effects when stopped that may be misinterpreted as relapse of the initial condition necessitating treatment.[32] These withdrawal symptoms are often ignored in discontinuation studies examining relapse prevention properties.[30,33,34] As a result there have been questions raised as to whether the relapse prevention properties of psychiatric drugs have been over-stated by misclassification of withdrawal effects as relapse,[30,33,34] indicating we should be cautious in our interpretation of these studies.

Research and guideline establishment in deprescribing

In recent years interest in psychiatric deprescribing has increased exponentially. Numerous studies have been conducted or are ongoing exploring reducing and stopping antipsychotics in first and multi-episode psychotic conditions, in Taiwan, France, Denmark, the Netherlands, England, Australia and Germany, including the establishment of an international research consortium.[14] Some of these studies are examining gradual reductions, or hyperbolic dose reductions specifically.[14,35] Alongside this there are studies looking at how to help patients stop antidepressants – in the UK,[36] the Netherlands[37] and in Australia[38] – as well as several published studies looking at substitutions for antidepressant treatment like preventative cognitive therapy or mindfulness-based cognitive therapy.[39–41]

There has been increasing interest in the process of stopping medication based on the pharmacological properties of the drugs,[42–45] as well as in the practical means for making gradual dose reduction (for example, using compounded tablets in very small doses).[46–48] There has also been increased focus on the non-pharmacological aspects of reducing and stopping medication – the positive and negative impact on people's lives, as well as the barriers and the facilitators.[1,49–52]

In parallel, there has been increasing institutional interest in deprescribing in some countries. In the UK, in recent years, there has been guidance issued by the Royal College of Psychiatrists on how to safely stop antidepressants,[53] as well as guidance from NICE on how to stop antidepressants, benzodiazepines, z-drugs, opioids and gabapentinoids.[54] Similar guidance on how to stop antipsychotics has been called for.[55] In England, the National Health Service (NHS) has introduced structured medication reviews to reduce the use of unnecessary medication, including some psychiatric drugs,[56] and the Department of Health and Social Care has been tasked with upscaling deprescribing capacity in the NHS.[18]

Many clinicians report an interest in deprescribing and in receiving training for its practice. In total, 75% of UK clinicians working in first-episode psychosis services thought that early discontinuation of antipsychotic medication was beneficial for most patients.[57] In patients with multiple psychotic episodes English psychiatrists reported that they would feel comfortable supporting about 20% of their patients to discontinue their antipsychotics, with a minority of psychiatrists comfortable to support greater proportions.[58] In a survey 68% of GPs expressed a desire for more training on the withdrawal effects of antidepressants.[59] As mentioned, in Norway, government directives have led to the establishment of 'drug-free' wards, in which deprescribing is a central activity.[25] There are several dedicated psychiatric drug deprescribing services established around the world situated either in public or private healthcare settings or run by

NGOs partnered with health systems.[60] Indeed, several academics and psychiatrists have written about their own experience stopping psychiatric medication, often with the theme that this process was far more difficult than the published literature or their training had intimated.[61–63]

Patient knowledge and advocacy

This rise in academic, professional and institutional interest in psychiatric drug deprescribing has lagged behind decades of interest in the topic by patient groups who have sought ways to rationalise (and generally reduce) their medication in the relative absence of professional help. This movement seems driven by the subjectively unpleasant effects and physical health consequences from being on such medications.[64–67] It is noteworthy that much of the academic work now being conducted in deprescribing borrows from the expertise developed by patient groups.[44,48,62,66] Groups of patients (often supported by clinicians) have created guidance and advice on the topic of deprescribing in various guides and websites.[64,66,68] Manuals like *The Ashton Manual* (written by the clinical pharmacologist Professor Heather Ashton) are widely used in peer-led withdrawal communities,[69] and this manual has influenced NICE guidance on withdrawing from benzodiazepines.[70] Alongside this there has been substantial patient advocacy for more clinical services for deprescribing, which has been part of the driving force in the shift of interest to this topic,[64,71–73] as well as increasing media attention to the issue of how to safely stop psychiatric medications and the adverse consequences of stopping too rapidly.[74–78]

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Why deprescribe?

A variety of clinical scenarios may warrant deprescribing. These include:

- high-dose prescribing,
- polypharmacy (drug-drug interactions, effects on adherence, and medical risk in vulnerable populations).
- inappropriate prescribing (wrong drug, dose or duration),
- patient preference,
- harms outweighing benefits,
- condition improved, resolution of stressors or alternative coping strategies developed.

High-dose prescribing, polypharmacy, inappropriate prescribing

It is widely agreed that high-dose prescribing and polypharmacy can, in many instances, produce more harm than benefit.[1] For many psychiatric conditions, including major depressive disorder, there is no clear advantage to high-dose pharmacotherapy, although the risks of adverse effects can increase as a function of dose.[2] The lower range of licensed doses is thought to achieve an optimal balance between efficacy, tolerability and acceptability in acute treatment.[2] The potential harms of high-dose antipsychotic prescribing and psychiatric drug polypharmacy are also well recognised.[1] Additionally, potentially inappropriate prescribing of psychiatric medication occurs commonly – including chronic polypharmacy for patients with personality disorders, in which guidance generally recommends avoiding pharmacological treatment or employing it for short-term use.[3] Deprescribing may be warranted for long-term benzodiazepine and z-drug use, which is generally officially frowned upon,[4] and in the substantial proportion of patients on antidepressants with no evidence-based reason for ongoing treatment (for example, the antidepressant may have had no beneficial effect or it might have been effective but has been continued for too long).[5]

Patient preference

In an era in which medical treatment in general is moving towards patient-centred treatment and away from paternalism, patient preference should be a central consideration, unless a patient is legally required to comply with treatment via a community treatment order.[6,7] Many patients report that their clinicians decline to help them reduce or stop their medication.[8] In some cases this can lead to patients following more risky options like stopping abruptly, the technique most likely to lead to aversive outcomes. Many people feel compelled to seek advice from online peer-support communities instead of their clinicians because of their clinicians' reluctance to support deprescribing, or lack of knowledge of how to do so.[8,9] Clinicians and patients may have different priorities with clinicians concerned with risk of relapse, symptom control and potential legal consequence for aversive outcomes, while patients may prioritise fulfilling social roles or quality of life, over being symptom free (although there is wide variation on this matter).[10] Negotiating a balance between differing priorities amongst patients and clinicians may be beneficial for outcomes, including treatment alliance and adherence to treatment recommendations in general.[7]

Harms outweigh benefits

For a portion of patients the benefits of medication will be outweighed by adverse effects.

Limited benefits

In some people the medication may never have been particularly effective but has continued because of inertia, a lack of attention to deprescribing or a desire not to 'rock the boat'.[11,12] Even in short-term trials the number needed to treat (NNT) for many forms of psychiatric medication is 6–10 or more meaning many patients are not helped by a specific effect of the medication to an appreciable degree. For some patients the medication may have been initially helpful, but through the development of tolerance to the drug this benefit has diminished.[13,14] This is well recognised for benzodiazepines and z-drugs, is also an issue for gabapentinoids,[15] and has also been somewhat controversially implicated in the long-term use of antidepressants,[16,17] and antipsychotics.[18,19]

Many medications are continued after initial symptoms have resolved with the intention of preventing future relapse. However, as above, there are significant concerns about the certainty of the evidence for the prophylactic properties for psychiatric drugs.[20–23] These discontinuation studies often stop psychiatric drugs abruptly or rapidly, do not take into account withdrawal effects, which are likely to be mis-classified as relapse in the discontinuation arms of these trials.[20–23] This phenomenon would provide an exaggerated estimation of the relapse prevention properties of psychiatric drugs,[20–23] and should lead us to be more cautious in interpreting the extent of the relapse prevention properties of some long-term psychiatric medications.

Adverse effects

The myriad adverse effects from psychiatric drugs range from weight gain and other metabolic consequences, particularly noted for atypical antipsychotics, to more subtle effects such as impaired capacity for feeling, memory or concentration caused by many psychiatric drug classes. Sexual side effects are very common, especially with selective serotonin reuptake inhibitors (SSRIs), where they occur in half or more of patients[24,25] and other adverse effects often thought to be short term have been found to persist.[26] There are also risks of long-term use such as possible cortical loss with antipsychotic treatment,[19,27] increased risk of dementia for some medications,[28,29] as well as falls and increased mortality, especially as people age.[30,31] Extra-pyramidal side effects from first-generation antipsychotics and tremor from lithium can be aversive.[1] When substantial benefits to a patient are provided by psychiatric drugs, these risks may be acceptable, but in other cases the balance of harms and benefits may not be favourable. As patients age the risks may increase owing to impaired metabolism of drugs and greater frailty, while the benefits may decrease, due to tolerance and perhaps the improvement of their condition over time.[7] Lastly, withdrawal effects are particularly associated with increased duration of medication use; one reason to stop medication earlier rather than later.[32,33]

Mental health condition improved or alternative coping

For some patients the original condition for which they were prescribed medication will have resolved or improved over time. The most obvious example is the circumstance in which a stressor that precipitated depression or anxiety has resolved, with a

corresponding improvement in the patient's condition. Even conditions often considered life-long such as psychotic conditions or affective disorders can improve with time – as reported in several cohorts of patients,[19,34,35] with up to 40% of people with psychotic conditions being well and on no or little medication years after first diagnosis.[19,36] The behaviours diagnosed as personality disorders generally improve over time;[37] patients may have found more stable personal or professional circumstances and maturity may limit emotional instability. For some patients, especially those who are stable, medication may have less benefit than during more active periods of their condition. Or patients may have developed or be interested in pursuing alternative approaches to managing their mental health conditions. As one example, NICE has identified a dozen treatments that are as effective (and cost-effective) as antidepressants in the treatment of depression.[38]

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Barriers and facilitators to deprescribing

There are numerous factors that can facilitate or hinder deprescribing. A narrative review outlined these factors with regard to stopping antidepressants, many of which are applicable to a variety of drug classes (Table 1.1).[1] Some of these factors can be addressed through education and support, as discussed in subsequent chapters. Additionally, there are many institutional factors that act as barriers to deprescribing: while deprescribing can produce benefits for patient health and well-being, as well as health services (e.g. reduced adverse effect burden) in the long term, in the short term it often involves greater resources (e.g. increased contact, monitoring and support), which can act as a deterrent.[2]

Importantly, previous experience of stopping medication – either planned or, more usually, spontaneously by the patient, often abruptly or rapidly – with negative consequences can deter patients and clinicians from wishing to trial this process again.[2] The sometimes alarming presentations with severe symptoms after drug cessation that have generally been interpreted as relapse can strongly re-enforce the impression of a need for medication. However, there is some evidence now that these presentations – even when they are delayed for some time after drug cessation – may in fact represent withdrawal effects or the consequence of withdrawal effects, sometimes called withdrawal-associated relapse (e.g. genuine relapse as a consequence of withdrawal effects such as insomnia).[3,4] There is further evidence, presented in subsequent chapters, that in at least some of these cases a more gradual, structured and pharmacologically informed approach to reduction may minimise or avoid some of the more negative aspects of this process.[2]

Table 1.1 Barriers and facilitators for patients to stop psychiatric medications. Adapted from [1] (2019).

Domain	Barriers	Facilitators
Psychological and physiological factors	■ Stressful life circumstances ■ Aversive experience of discontinuation in past leading to deterioration (withdrawal effects or relapse) ■ Lack of effective coping strategies ■ Physical dependence on psychiatric medications (leading to withdrawal effects)	■ Confidence in ability to discontinue ■ Life circumstances stable ■ Well-informed about approach to tapering
Perceived cause of mental health condition	■ Long-term (perhaps life-long) condition requiring long-term treatment ■ Primarily biochemical (or other biological) cause	■ Primarily life circumstances
Fears	■ Fear of relapse ■ Fear of withdrawal effects	■ Fear of 'addiction', physical dependence ■ Fear of adverse effects and long-term health complications
Personal goals/ motivations	■ Self-identity as 'disabled' ■ Stopping as threat to stability ■ Benefit of continuing to others around them ■ Cure is not possible, only management	■ Self-identity as 'healthy' ■ Desire to function without psychiatric medication ■ Feeling better ■ Dislike having to take a psychiatric medication

(*Continued*)

Table 1.1 (*Continued*)

Domain	Barriers	Facilitators
Perception of psychiatric medications	■ Positive effect ■ Natural or benign ■ Lack of concern over adverse/side effects	■ Ineffectual ■ Unacceptable adverse/side effects ■ Unnatural ■ Unhappy about long-term use
Information about the discontinuation process	■ Inadequate information about the discontinuation process, and risks and benefits of this	■ Information on how to safely discontinue and what to expect
Support network (friends, family, professionals)	■ Pressure to stay on medication	■ Support to come off medication

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