6 Steps to deprescribing: A practical approach

Amber Frank, MD, and Madhuri Shors, MD, MPH

Dr. Frank is an Instructor in Psychiatry, Harvard Medical School, Boston, Massachusetts, and Staff Psychiatrist and Associate Program Director of the Adult Psychiatry Residency, Cambridge Health Alliance, Cambridge, Massachusetts. Dr. Shors is an Assistant Professor of Psychiatry, University of Minnesota, and Staff Psychiatrist and Interim Psychiatry Director, Community-University Health Care Center, Minneapolis, Minnesota.

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Taking over the care of a patient with a complex medication regimen consisting of multiple psychotropics is a common experience for many practicing psychiatrists. Increasing attention has been paid to the risks of polypharmacy and the importance of "deprescribing"—reducing or stopping medication—when the risks of a drug outweigh the benefits.[1,2] However, successfully reducing medication burden can be a challenge, particularly when there is fear of decompensation or if the patient is psychologically attached to the complex medication regimen.

We describe a pragmatic approach to deprescribing, outlining 6 steps that we have used successfully in several treatment settings, which can assist prescribers facing similar challenges in their own practices.

1. Obtain a detailed history. First compile a comprehensive list of the patient's medications, including psychotropics, other drugs, and supplements. If necessary, coordinate with your patient's primary care provider. Then reassess the patient's history of illness and efficacy of pharmacologic and nonpharmacologic treatments and how the current regimen has evolved. Understand the patient's course of illness, coping styles, strengths, and vulnerabilities with an eye toward deprescribing.

2. Investigate underlying meaning. Even the most biologically oriented prescribers can benefit from exploring the underlying meaning the patient ascribes to the medication regimen. Common themes include:

- hesitation to relinquish a complex medication regimen because the patient fears decompensation (which could be either realistic or unrealistic)
- attachment to the "sick role"
- interpreting the complex regimen as evidence of the provider's care and concern.

A series of sensitive conversations exploring these factors and addressing their underlying meaning can help increase a patient's trust in the process of deprescribing.

3. Assess risk vs benefit. Weigh and educate the patient on the potential risks and benefits of each medication, as well as drug interactions and additive side effects.

4. Start with:

The most risky. Medications with significant risk for serious adverse effects (eg, high doses of a QTc-prolonging medication in a patient with elevated QTc) should be targeted early.

The least likely to be missed. If there are no high-risk medications that need to

take priority, discontinuation of a "redundant" medication, such as a low-dose antihistamine prescribed with multiple other sedating medications, can be an achievable first step. By starting with a medication that the patient is unlikely to miss, the provider can make efficient initial progress while building patient confidence in the deprescribing process.

Medication the patient is most motivated to discontinue. This strategy can enhance the therapeutic alliance and increase the likelihood of successful patient engagement for patients hesitant to decrease medications, so long as there are no significant contraindications to discontinuing the medication.

5. Go slowly. As long as there are no medications that put the patient at risk and require rapid discontinuation, going slowly increases the likelihood of long-term success by:

- permitting careful monitoring for any worsening symptoms
- allowing more time for physiologic readjustment
- enabling the patient and provider to build confidence in the process over time.

With slow discontinuation, normal emotions, such as transient, situationally appropriate anxiety about a life stressor, are less likely to be misinterpreted by the patient or provider as an inability to tolerate medication reduction because there is more opportunity to observe overall trends in symptoms.

6. Replace medications with alternatives. Offering non-pharmacological treatment when possible can greatly facilitate reducing the number of medications. Examples include:

- teaching a patient breathing exercises or mindfulness while preparing to decrease an as needed anxiolytic
- engaging the patient in cognitive-behavioral therapy for insomnia before reducing sleep medications
- working together to identify opportunities for behavioral activation and exercises that are the most achievable for the patient.

This replacement strategy can work in a physiologic sense and address a patient's fear that medications are "taken away" without alternatives in place.

Although these strategies might not work for every patient and are not recommended for reducing medications that are medically necessary, using this approach will increase the likelihood of long-term success and maintain the patient–provider alliance when reducing unnecessary and potentially risky polypharmacy. An article by Gupta and Cahill[1] describes some similar approaches with additional discussion and considerations.

Target medications with significant risk for serious adverse effects first for deprescribing

References

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