THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

ANTIDEPRESSANTS

Deprescribing in older people: A clinical practice guideline

dRx™

ANTIDEPRESSANTS

Tricyclic antidepressants:

Amitriptyline*, clomipramine, dosulepin, doxepin, imipramine, nortriptyline

Selective serotonin reuptake inhibitors, SSRIs:

Citalopram*, escitalopram*, fluoxetine, fluvoxamine, paroxetine, sertraline*

Serotonin and norepinephrine reuptake inhibitors, SNRIs:

Desvenlafaxine*, duloxetine*, venlafaxine*

Monoamine oxidase inhibitors, non-selective:

Phenelzine, tranylcypromine

Monoamine oxidase A inhibitors:

Moclobemide

Other antidepressants:

Agomelatine, mianserin, mirtazapine*, reboxetine, vortioxetine

*Common Pharmaceutical Benefits Scheme medicines

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking antidepressants for major depressive disorder: 1. Who have achieved symptomatic remission or clinical stability for 6 to 12 months with uninterrupted treatment after appropriate assessment; or 2. When the indication for continued use is unclear or unknown (e.g. no benefit has been derived).
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	If deprescribing is unsuccessful despite multiple attempts, taking into account the possibility of withdrawal effects rather than recurrence of symptoms, we suggest maintaining the lowest effective dose, but we suggest reassessing the need for long-term therapy periodically.

CBR, consensus-based recommendation; GPS, good practice statement

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks (taking into consideration the half-life of the antidepressant), ensuring the absence of physical or neuropsychiatric withdrawal symptoms before initiating further tapering. Once half the lowest standard dose formulation is reached for another one to four weeks, we suggest ceasing completely if no sign of recurrence of symptoms. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.

GPS Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. psychological interventions for psychiatric disorders such as cognitive-behavioural therapy) to individuals and their families or carers as appropriate (ungraded good practice statement).

MONITORING

CBR We suggest closely monitoring for worsening neuropsychiatric symptoms (e.g. increased anxiety, agitation, depressive symptoms) and cognition which could be short-lived or protracted, severe or mild, in addition to monitoring changes in psychological or physical health status, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical (recognising the possibility of withdrawal effects rather than recurrence of symptoms).

After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to report symptoms as needed.

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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