THERAPEUTIC ADVANCES in
Psychopharmacology

Original Research

The missing link? Pharmacists' perspectives on discontinuation of long-term antidepressants: a qualitative study

Ther Adv Psychopharmacol

2025, Vol. 15: 1–14

DOI: 10.1177/20451253251333977

Ellen Van Leeuwen, Els Mehuys, Chris F. Johnson, An-Sofie De Keyzer, Koen Boussery and Thierry Christiaens

Abstract

Background: Long-term use of antidepressant drugs is widespread despite guidelines recommending limited duration. General practitioners (GPs) play a central role in reviewing and discontinuing antidepressants, although they hesitate to initiate a discussion about the long-term use. The potential role of pharmacists in this process is underexplored, despite their pharmaceutical expertise and accessibility.

Objectives: To explore community pharmacists' perspectives on the discontinuation of long-term use of antidepressants, and the barriers and facilitators to their involvement in this process.

Design: Qualitative study.

Methods: Semi-structured interviews were conducted with 14 Belgian community pharmacists until data saturation. Interviews were recorded, transcribed, and thematically analyzed.

Results: Four themes emerged. (1) "Antidepressants at the pharmacy: a persistent taboo" showed pharmacists' hesitancy to initiate discontinuation discussions due to societal stigma and fear of being perceived as nosy. (2) "Balancing risks vs benefits" highlights that pharmacists were primarily concerned about relapse in stable patients but recognized that a patient request from a patient experiencing side effects may facilitate discontinuation. (3) "Is this my role?," pharmacists viewed GPs as the primary decision-makers in discontinuation, limiting their role to supporting GP treatment decisions. Key facilitators for discontinuation included a GP's decision to stop and a motivated patient. Regular reviews by the pharmacist could also facilitate the discontinuation process. (4) Optimizing pharmacists' role' with a strong need for GP collaboration, and acknowledging a need to optimize knowledge and skills to support antidepressant discontinuation.

Conclusion: Our study reveals that pharmacists viewed GPs as pivotal in the discontinuation process, as they make the decisions, while they see their role as supportive, following the doctor's decision. However, they faced significant barriers to discontinuing long-term antidepressants, including fear of relapse, societal taboo, and unclear responsibilities. More education, confidence building, and better collaboration with GPs could empower pharmacists to play a proactive role, improving the antidepressant discontinuation process.

Keywords: antidepressants, depressive disorder, discontinuation, pharmacists, primary care

Received: 7 October 2024; revised manuscript accepted: 17 March 2025.

Correspondence to:
Ellen Van Leeuwen
Clinical Pharmacology Unit, Department of Basic and Applied Medical Sciences & Department of Public Health and Primary Care, Ghent University, Ghent, Belgium
Ellen.vanleeuwen@ugent.be

Els Mehuys
Department of Bioanalysis, Pharmaceutical Care Unit, Ghent University, Ghent, Belgium

Chris F. Johnson
Specialist Mental Health and Advanced General Practice Pharmacist, Primary Care, Pharmacy Services, NHS Greater Glasgow and Clyde, Glasgow, UK

An-Sofie De Keyzer
Clinical Pharmacology Unit, Department of Basic and Applied Medical Sciences, Ghent University, Ghent, Belgium

Koen Boussery
Department of Bioanalysis, Pharmaceutical Care Unit, Ghent University, Ghent, Belgium

Thierry Christiaens
Clinical Pharmacology Unit, Department of Basic and Applied Medical Sciences, Ghent University, Ghent, Belgium

Chris F. Johnson Is currently affiliated to Career Researcher Fellow, NHS Research Scotland and Honorary Research Fellow, School of Health & Wellbeing, University of Glasgow

Introduction

Antidepressant prescribing continues to increase across the globe,[1] with concerns about the long-term use.[2] In Belgium, about 40% of the people who take an antidepressant take them for 3 years or longer.[3] Similar trends are observed in other countries for example, within Scotland and the England, up to 50% of individuals prescribed

antidepressants have treatment for over 2 years,[4,5] and more than 5 years in the United States.[6]

The majority of antidepressants are prescribed for the treatment of depression. Antidepressant treatment for depression is only recommended for 6 months after improvement and up to 2 years for patients with high risk of relapse.[7,8]

As with all medicines, continuing treatment longer than necessary exposes patients to avoidable drug-related harms such as bleedings, weight gain, emotional numbness, a sense of psychological dependence on the antidepressant and difficulty coping without it, and physical dependence (resulting in withdrawal symptoms when stopping), and unnecessary costs.[9–14] Older and more frail individuals are at greater risk of harms such as falls, fractures, and gastric bleeds.[9–11]

Both patient-related and doctor-related factors influence the success of discontinuing antidepressants.[15] Patient barriers were numerous and included fear of relapse and withdrawal symptoms, a positive perception effect of antidepressants, a perception that depression was a long-term condition, and also their self-identity could influence the decision to discontinue. Other reasons were inadequate information about stopping and the lack of support of significant others. Moreover, patients view their general practitioners (GPs) as primarily responsible for starting conversations about discontinuing long-term antidepressant use, but other health professionals besides their own doctor could also facilitate discontinuation.[15–17] However, a recent systematic review of healthcare professionals' perspectives, particularly GPs, found that the idea of discontinuing long-term antidepressants presents significant challenges for them.[18] Many GPs do not routinely start discussions about reducing and/or stopping antidepressant treatment but opt for the "status quo" and continuing treatment. As a result, this lack of professional support leaves patients uninformed and may lead them in a cyclic process of stopping, and restarting the antidepressant on their own, without adequate medical guidance, and/or leading to help-seeking outside mainstream health care (such as online fora).[19–22] This suggests that GPs should take the lead to frequently review the treatment, and a need to warn patients about possible withdrawal effects, and for slow tapering.[23]

Qualitative research suggests that GPs recognize community pharmacists as potential allies in the antidepressant discontinuation process,[24–26] similar to their role with other medicines.[27,28] While GPs initiate and prescribe antidepressants, pharmacists are also involved in the care of patients receiving antidepressants and can contribute to the discontinuation process, potentially serving as a missing link. Our hypothesis is that community pharmacists, given their expertise in medicines, can play a role in the discontinuation process by collaborating with the GP to support patients during antidepressant discontinuation. This approach has already been piloted in the Netherlands.[29]

However, a systematic review of healthcare professionals' perspectives identified a knowledge gap, with no primary studies exploring pharmacists' views.[18] Given their unique position, combining pharmaceutical expertise and accessibility, understanding pharmacists' perspectives on long-term antidepressant discontinuation is essential. This study aims to bridge this gap by exploring community pharmacists' perspectives, identifying barriers and opportunities for their involvement, and providing insights that can inform the development of guidance for GP–pharmacist collaboration in supporting patients during discontinuation.

Methods

Study design and participant recruitment

We conducted a qualitative study using semi-structured interviews with community pharmacists from the five provinces in Flanders (the Dutch-speaking part of Belgium), recruited from the national register by two researchers (E.V.L. and A.D.K.). To ensure a diverse and representative sample, purposive sampling was employed based on specific criteria: age, gender, years of professional experience (to ensure variation across these characteristics), and pharmacy environment (urban, suburban, or rural) to include pharmacists from different geographical settings. These criteria were chosen because they may influence pharmacists' perspectives on antidepressant discontinuation, helping to capture a broad range of experiences and viewpoints related to dispensing antidepressants. A researcher (A.D.K.) contacted the participants via phone to discuss the study. The inclusion criteria were that they needed to be dispensing antidepressants. When they met the inclusion criteria and agreed to participate, all pharmacists signed a written informed consent form.

Study setting

Belgium has a dense network of community pharmacies staffed by a least one pharmacist (1 pharmacist per 2381 habitants), which can be visited without appointment.[30] Patients can visit any pharmacy, but most patients with long-term medication use the same pharmacy. In the last years, patients with chronic conditions have been urged to register with one pharmacy, which ensures their medication scheme is up-to-date and shared with other healthcare professionals. Pharmacists' renumeration is mainly based on sales volumes, with only a smaller portion for professional pharmaceutical services such as medicines services for asthma, and polypharmacy medication reviews. Pharmacists are not integrated into the general practice. Collaboration and discussion between GPs and pharmacists are encouraged through reimbursing locally organized medico-pharmaceutical concertations (MFO/CMP), participation is voluntary. Consequently, the level of collaboration between GPs and community pharmacists in practice largely depends on the individual HCPs and pharmacists.

Data collection

A female pharmacy student (A.D.K.) who received training in performing in-depth interviews conducted semi-structured interviews with 14 community pharmacists, between February 2021 and May 2021 using an interview guide (see Supplemental Box 1). The student was independent and not known to the interviewees, and the interviewees were aware that the interviewer was a pharmacy student. The interview guide was informed by the literature[31–33] and the research group's clinical expertise. The interviews were video-recorded, transcribed verbatim, checked, and anonymized. Depending on the preferences of the interviewees, the interviews took place either online or in-person at the pharmacy with no one else present. No repeat interviews were conducted, and transcripts were not returned to participants for comments.

Data analysis

All transcripts were uploaded in NVivo v12 (QRS International, Doncaster, VIC, Australia) and thematically analyzed by two researchers, for example, AKS (pharmacy student) and a qualitative researcher (E.V.L., MD, PhD).[34] The two principal coders (E.V.L., A.D.K.) independently reviewed five interviews creating codes and adding notes as they familiarized with the data. They then collaborated to create initial codes, and through repeated reading and analysis, combined, clustered, and collapsed the codes, while noting significant topics and potential themes creating a first framework. To enhance the credibility of the findings, the analysis process (including coding, category development, and theme identification) was reviewed with the broader research team, and team agreement was sought as the themes were reviewed, refined, and reordered ensuring a concise and meaningful representation of the data.

To ensure consistency, intercoder reliability checks were conducted. The two primary coders continued to analyze the data by reading and reviewing the transcripts, with further revisions and adjustments, iteratively. Any discrepancies or differences in interpretation were resolved through discussion, and the final agreement on the codes and themes was reached within the wider team. The initial framework underwent further revisions and adjustments, and the primary themes were discussed, and finalized by the entire research team. Data collection continued until saturation was achieved, which was determined when no new concepts emerged in two subsequent interviews, and when each category was comprehensively described. The consolidated criteria for reporting qualitative research (COREQ) were used to structure our reporting.[35]

Results

Of the 26 contacted community pharmacists, 14 agreed to participate. The mean age was 40 (range 26–57) years old, the majority identified as female (11/14), with at least 2 participants from each of the 5 provinces (see Table 1). Interviews lasted between 30 and 60 min.

Four main themes were identified from the data analysis. Table 2 includes quotes that illustrate each subtheme within these main themes.

Antidepressants at the pharmacy: A persistent taboo

Pharmacists acknowledged hesitating to initiate discussion with patients about antidepressant discontinuation due to fear of being perceived as nosy or intrusive. Pharmacists reported that while some patients are open about their antidepressant use and well-being, many are reserved and shared minimal information. There was an assumption

Table 1. Sample demographics.

Participants	*n*
Age (years)	
25–34	4
35–45	5
45–55	3
55–65	2
Sex	
Female	11
Male	3
Pharmacy location	
Rural	7
Urban	7
Years of practical experience	
⩽5	3
6–15	2
16–30	7
>30	2

GP, general practitioner.

that patients may feel ashamed about their antidepressant use and well-being due to the societal taboos, which contributed to their reluctance to openly discuss it. Moreover, pharmacists noticed that GPs in their communication with patients often avoid direct terms like "antidepressants" and "depression," potentially reinforcing the taboos around antidepressant use and leaving patients unaware of why they were taking the medication. This also led pharmacists to avoid these terms to improve patient acceptance, but this hindered discussions about discontinuation.

> I still feel a bit inhibited in that regard sometimes, to not come across as the curious pharmacist. (Pharm 4)

Balancing risks versus benefits

Risk of relapse. There was uncertainty about whether a patient who is currently feeling well, with no concerns from either the patient or their GP regarding antidepressant use, should consider stopping treatment.

> If the patient is feeling fine and doctor is ok with it, it is sometimes difficult to know if it is appropriate to stop. (Pharm 3)

Pharmacists' main concerns were the risk of destabilizing and/or causing relapse in stable patients. They reported that patients do not want to take the risk of relapse when they were feeling well and assumed this also applies for GPs. Challenging the GP's decision was seen as increasing the risk of relapse.

On the other hand, there was an awareness that antidepressants are not meant to be taken lifelong, particularly when initiated during challenging life events. While some pharmacists perceived natural remedies such as saffron, rhodiola, and magnesium as potential safe alternatives to the antidepressant, others were skeptical.

Perceived safety. Pharmacists noticed many side effects from long-term use, with patients often reporting issues such as weight gain, emotional blunting, or sexual problems, even after many years of use. In these cases, pharmacists feel responsible for educating patients about these side effects and providing guidance on how to deal with them to optimize medication adherence. It was assumed that side effects were acceptable for patients because they would have stopped the antidepressant at the beginning if side effects were intolerable. Safety concerns about potential antidepressant drug–drug interactions were also prevalent and flagged by the pharmacy software programs. However, not all doctors changed the antidepressant, leaving pharmacists uneasy about its safety profile.

Side effects as facilitator to discontinue. Experiencing side effects when feeling stabilized could trigger patients to discuss their antidepressant with their pharmacist and request discontinuation. In such cases, patients' strong desire to discontinue often outweighs their concerns about a possible relapse and acts as a strong facilitator for pharmacists to support patients in their wish to stop. They then provided information about tapering and advised to consult their doctor for a final decision.

> She asked me if she could stop; she was already much happier and wanted to quit because it was making her feel sleepy. I listen, and told her that she shouldn't stop suddenly and that it's better to ask the doctor how to do it. She then discussed it with the doctor, and after tapering she successfully managed to stop. (Pharm 4)

Table 2. Quotes.

Themes and subthemes		The Number of pharmacists that contribute to subtheme (n)
Antidepressants at the pharmacy: a persistent taboo		
	It's not because we are curious, but I would like to know it to be able to see it in the bigger picture and understand the person better. However, often the patient doesn't allow that. (Pharm 1)	*14*
Balancing risks versus benefits		
Risk of relapse	*That is actually very challenging for us. If a patient asks us to stop and tells us that they asked the doctor and the doctor said they should continue taking it, then it's very difficult to go against the doctor's recommendation and say; I would also stop if I were you*. (Pharm 10)	*14*
Perceived safety	*People often take antidepressants for years and then they come asking for vitamins because they feel tired and have trouble getting through the day. However, this fatigue and reduced energy can also be a side effect of the antidepressants. I try to explain that feeling fatigued or less active can be a side effect of the medication and that vitamins might help address these effects*. (Pharm 1)	*13*
Side effects as facilitator to discontinue	*The fact that they continue to experience certain side effects even when they're feeling good is a motivation to stop. For men, sometimes it's impotence or weight gain for women, it could be that their emotions are dulled. These factors can be reasons for wanting to discontinue the medication*. (Pharm 9)	*9*
Is this my role?		
The real discussion happens at the GP consultation	*In itself, it's not that difficult as we have to follow. We can make a suggestion, but we won't say, "Okay, now we're going to stop." We basically follow what the patient indicates and what the doctor suggests, and then we try to convey the same message as the doctor in the best possible way*. (Pharm 7)	*14*
An antidepressant review as a facilitator?	*Using the GheOP^{3}S tool[1] ([a screening tool developed for the Belgian community pharmacist to detect drug-related problems) and the STOPP[2]criteria that clearly state that it should be reconsidered after six months, I feel more confident in including it as part of a medication review. I can more easily inquire whether it has been discussed with the doctor and ask about the duration of the therapy*. (Pharm 1)	*10*
Pharmacists' various roles in the discontinuation process	Easy access for medicine information *She asked me if she could stop; she was already much happier and wanted to quit because it was making her feel sleepy, and she works in the hospitality industry. I tried to listen and told her that she shouldn't stop suddenly and that it's better to ask the doctor how to do it. She then discussed it with the doctor, and after tapering with a lower dose, she successfully managed to stop*. (Pharm 3)	14

(Continued)

Table 2. (Continued)

Themes and subthemes		The Number of pharmacists that contribute to subtheme (n)
	Magistral preparation expert *I recall a patient on Sipralexa® [escitalopram] who wanted to taper off the medication. The patient complained that the doctor said tapering wasn't possible due to the lack of available dosages. I informed the patient that we could prepare smaller, compounded doses at the pharmacy. I also reached out to the doctor, and that's how the tapering process began, following a reduction plan of the GP*. (Pharm 13)	14
	Discontinuation support with a safety net *An older lady of 65 who had been on antidepressants for over 20 years started tapering off with the doctor's guidance. At a certain point, she was on a low dose and things were not going well at all. She was even experiencing suicidal thoughts, it was also evident from her demeanour. That's when I began asking questions and contacted her doctor. I motivated her to go to the doctor and have her dosage reviewed. Eventually, the medication was restarted*. (Pharm 4)	9
	Advocating for patients *Usually, we feel that in cases where people ask to stop or taper off, doctors aren't really resistant, but rather a bit cautious about it. In such situations, we always reach out to the doctor ourselves to request the tapering and to collaboratively create a tapering plan.* (Pharm 8)	4
Optimizing pharmacists' role in antidepressant discontinuation		
Collaboration makes discontinuation easier	*Simply having good communication with the doctors. They could make it clear that a person is going to taper off, and include that information on a prescription or in accompanying documentation, so we can monitor it accordingly*. (Pharm 14)	*14*
Empowering pharmacists	*Despite being a pharmacist for a long time, I still find that challenging. I don't feel adequately trained for it, to be honest. We have received limited education on how to adjust tapering schedules*. (Pharm 4)	*11*
Change in pharmacists' practice	*What would really help is having counselling sessions similar to those for asthma and COPD. I do notice that it has its benefits. If we could sit down at a separate table for about fifteen minutes, go through a set of questions, and really listen to the patient, that could be effective*. (Pharm 7)	*14*

In general, despite some reservations, long-term use of antidepressants was considered potentially effective and relatively safe. Consequently, discontinuation was not seen as a priority unless patients requested it due to side effects.

Is this my role?

The real discussion happens at the GP consultation. Pharmacists emphasized the crucial role of the GP in the discontinuation process, viewing themselves as supporters who follow the GP's

treatment plan. They perceived GPs as responsible for initiating, reviewing, and adjusting pharmacological treatment, including discontinuation, due to their prescribers' role and their knowledge of the patients' depression, treatment experience, and psychosocial situation. In addition, they also experienced that patients may often perceive pharmacists primarily as commercial dispensers of medicines, rather than healthcare professionals involved in medicines optimization, which, in turn, reinforces GPs' key position. Patients' trust in GPs for their antidepressant guidance was illustrated by the fact that pharmacists noted that patients repeatedly expressed a willingness to discuss their treatment with their GP. Moreover, GPs have access to comprehensive health information that is not available to pharmacists. Despite occasional doubts about GPs' decisions on (dis)continuation, pharmacists do not feel comfortable going against (implicit) recommendations to continue treatment, due to respect for a perceived medical hierarchy. Furthermore, challenging a GP's decision was viewed as potentially increasing the risk of relapse, as described earlier.

Overall, it was clear that they either did not perceive discontinuation as primarily their responsibility, they believed it should be up to the GP (or the patient) to decide this. Therefore, they found it easier to discuss it with patients who raised the issue, but even then, encouraging the patients to speak with a GP was seen as their primary task.

Pharmacists noted that discontinuation often occurs without their involvement, illustrating that decisions are primarily made between the patient and their doctor. From their perspective, they felt that the doctors did not value their professional role in the discontinuation process. GPs rarely informed the patients' pharmacist regarding the initiation of tapering, providing a tapering plan or indicating this on prescriptions. Additionally, not all patients visited pharmacies during discontinuation, especially when they split tablets to lower doses or discontinued their antidepressant without medical support. The pharmacists expressed concerns about the risk of relapse for patients who self-discontinued their antidepressant without professional support.

> Usually, we're also not aware when a patient starts tapering until we notice a decrease in the dosage. We're left wondering if it's due to a mistake or intentional. It's a bit tricky because you have to ask the patient, and it can catch you off guard. (Pharm 10)

An antidepressant review as a facilitator?. Pharmacists confirmed that repeat prescriptions without review were common. In contrast to their reserved role in decision-making, some pharmacists take the initiative to review the antidepressant by discussing different options with patients, and advising them to consult a doctor when appropriate. They believed that regularly discussing the antidepressant use despite patient resistance may facilitate discontinuation because it may plant a seed for change in the future.

However, some of the pharmacists mentioned that there were no reasons to raise and discuss discontinuation when a patient does not ask about it. There was a belief that if patients do not raise the issue, it may indicate their intention to continue using the antidepressant. Additionally, pharmacists were hesitant to initiate a discussion without doctors' consent.

The context of a medication review may make a review of the long-term antidepressant use easier. Some pharmacists mentioned that using a screening tool like the GheOP³s (Foubert 2021)[36] or STOPP START (O'Mahony 2023)[37] to detect potentially inappropriate use of medication, helps to initiate a discussion about discontinuation. However, pharmacist pointed out that the long-term antidepressant use is often not prioritized for discontinuation during a medication review with many other potentially inappropriate medications.

> Sometimes you just get a 'no' when you mention stopping, but the fact that it's been mentioned gets them thinking. Sometimes, on a second visit, they bring it up, so I discuss it. (Pharm 9)

Pharmacists' various roles in the discontinuation process. In addition to their role in initiating discussions, pharmacists see for themselves several tasks related to the antidepressant discontinuation process.

Easy access for medicine information. Some patients expressed a wish to discontinue the antidepressant and requested support from the pharmacist before even asking their doctor. In these cases, pharmacists provide information about slow tapering and encourage patients to contact their doctor for a final decision. They emphasized their accessibility for advice, and there was a perception that it was easier for patients to discuss antidepressant-related issues with them first compared to their GP.

Magistral preparation expert. Although requests for magistral preparations (= capsules with non-commercially available strengths of antidepressants or compounded formulations) were rare, preparing these is seen as a pharmacist's core task. Moreover, pharmacists all believe that personalized preparations can increase the chance of successful discontinuation.

Discontinuation support with a safety net. Pharmacists indicated that they often encountered and/or were the first point of contact for patients experiencing issues during and after discontinuation before the patient sought advice from their doctor. They see it as their responsibility to encourage patients to consult a doctor or even to contact the patient's GP themselves, depending on the urgency. They also noted that the experience of guiding and supporting patients during discontinuation was rewarding, strengthening the therapeutic relationship, which continued long after the discontinuation period.

> It's incredible how grateful people are when we've helped them through that process, you have a completely different connection with them, and naturally, you ask how they're doing when they come in. (Pharm 8)

Advocating for patients. Pharmacists noticed that not all GPs stopped the antidepressant in response to a patient's request. Sometimes the doctor just switches to a different antidepressant even if the patient feels ready to stop. Moreover, as GPs may be hesitant to discontinue the antidepressant even if the patient asks, some pharmacists advocate for the patient by directly reaching out to doctors as well as providing a tapering schedule to facilitate and support discontinuation.

> Doctors aren't really resistant, but rather a bit cautious about it. In such situations, we always reach out to the doctor ourselves to request the tapering and to collaboratively create a tapering plan. (Pharm 1)

Optimizing pharmacists' role in antidepressant discontinuation

Collaboration makes discontinuation easier. Pharmacists advocated strongly for a collaborative approach to improve the discontinuation process. They emphasized the need for collaboration with the GP, with clear delineation of roles and improved communication, which is currently lacking in practice. Overall, the current lack of collaboration and the predominantly one-way communication hinder pharmacists' active involvement in the process. However, there was pessimism about overcoming these interprofessional boundaries due to the strong longstanding hierarchy and resistance to change.

> If there was a multidisciplinary approach with coordinated efforts involving doctors, and if we could increase doctors' awareness, I believe many more people could successfully stop their medication. (Pharm 9)

Empowering pharmacists. Pharmacists expressed a need for more knowledge, communication skills, and training in managing the discontinuation process. They highlighted a lack of guidance for antidepressant discontinuation including tapering schedules. Furthermore, they proposed a standardized tool to monitor patients' symptoms and general well-being, to help identifying changes and assess patient's readiness to reduce and/or stop. Some pharmacists believed that an electronic alert signaling the end of treatment would be beneficial, along with providing a patient information letter. In addition, pharmacists emphasized the importance of having access to relevant medical information.

A good patient relationship, knowledge about the patient's experience with the antidepressant, and understanding the reason for starting it facilitate conversations about discontinuation making it possible to provide appropriate support.

> If you see them regularly, you understand how they approach life, you can check in with them; how are you feeling now, you've been taking this for a year or so, isn't it time to consider tapering. (Pharm 10)

Change in pharmacists' practice. Pharmacist acknowledged various challenges in their work practice such as workload issues, time constraints, and the lack of financial incentives (including those for preparing magistral preparations or compounded formulations). These barriers hinder a more active role in the discontinuation process. One pharmacist suggested a specific consultation for antidepressant management, in analogy with the reimbursed asthma and chronic obstructive pulmonary disease management consultations.

Discussion

Summary

Our study provides valuable insights into how community pharmacists perceive the discontinuation of the long-term use of antidepressants. Pharmacists viewed GPs as pivotal in the discontinuation process, as they make the decisions, while they see themselves in a supportive role, following the doctor's decision. Key facilitators included a GP's decision to stop antidepressant treatment and a motivated patient, especially when the patient experiences side effects. Regular reviews by pharmacist could also facilitate discontinuation.

Despite handling various tasks related to discontinuation, pharmacists often felt undervalued for their contributions. Yet, this perception highlights opportunities to improve the discontinuation process, by empowering pharmacists to play a more proactive counseling role alongside GPs, thereby bridging gaps and serving as a missing link in this process.

However, barriers exist such as social stigma around antidepressants and mental health, concern about patient relapse, the lack of medical information about the patient, and a reluctance to contradict the GP (who possesses more comprehensive patient information). Pharmacists voiced a strong need for better collaboration with clearly defined roles and improved communication with GPs. More support and guidance may improve their confidence to support patients during and after antidepressant cessation.

Comparison with existing literature

This study is concordant with barriers previously identified by a systematic review of GPs and other healthcare professionals' perspectives regarding the cessation of long-term antidepressant use. These include concerns about the long-term effects of antidepressants, fear of relapse and withdrawal symptoms, unclear roles and responsibilities concerning discontinuation, lack of confidence in managing discontinuation, patients' resistance to stop and insufficient support from other healthcare professionals.[18]

It is important to note that while our participants mention the fear of relapse, they did not explicitly address the issue of antidepressant withdrawal symptoms. This is surprising, as withdrawal symptoms are relatively common with up to about half of the patients may experience them (however variation exists).[38–40] Withdrawal symptoms are often misinterpreted as relapse and as a need for medication contributing to long-term use of antidepressants.[41] It is possible that our participants were not aware of the distinction between withdrawal symptoms and relapse when reducing the dose of antidepressants as withdrawal symptoms have also, until very recently, been neglected by patients, healthcare providers, and researchers. Additionally, pharmacists can play a crucial role in addressing this issue by preparing magistral preparations (compounded formulations) that allow for slower tapering regimens. Such approaches, including hyperbolic tapering with very low doses of antidepressants, support a patient-centered method that minimizes withdrawal symptoms and may increase the changes of successful discontinuation.[42] To simplify the process of magistral preparations (compounded formulations) and overcome barriers such as the lack of time and resources to do this, tapering strips were developed in the Netherlands which enable patients to gradually reduce the dose in unequal (daily) steps, with the steps becoming progressively smaller as the dose decreases.[42]

The core task of community pharmacists, recognized as drug therapy experts, is promoting appropriate medication use by improving adherence, monitoring patient side effects, and drug interactions among patients with depression, as acknowledged by patients.[31,43] However, our study revealed that Belgian community pharmacists are mainly trained and involved in supporting the initiation of medication and monitoring adherence, but not in reviewing and discontinuing antidepressant use when appropriate, as GPs are.[26] This aligns with a recent UK study that explored the learning needs of the general practice pharmacists. The study found that although reviewing antidepressants was considered as important by the pharmacists, their self-rated performance for this task was perceived as rather low.[44] Similar to GPs, we found that pharmacists perceive discontinuation of antidepressants as a complex issue, with a major concern being the risk of relapse after cessation.[18] While relapse is a legitimate concern, recent studies showed that up to half of patients can successfully stop the antidepressant.[45,46] Moreover, evidence from a Cochrane systematic review suggests that with psychotherapeutic support, between 40% and 75% of individuals with recurrent depression can successfully stop taking their antidepressants.[47]

Providing resources and clear guidance could improve pharmacists' confidence in managing discontinuation and supporting patients, potentially reducing their fear of relapse and increasing self-efficacy.

Another interesting finding is that the stigma around antidepressants and mental health, a barrier not previously reported by other healthcare professionals,[18] hinders discussions about discontinuation. This aligns with previous findings that pharmaceutical care for mental illness is more challenging for pharmacists compared to care for physical conditions, as observed in Belgian as well as international studies.[48–54] This difficulty may be explained by the type of interaction and the setting in which these interactions occur. While patient counseling rooms and privacy are often available (in Belgium mandatory), the "ad hoc" and transactional nature of patient interactions in a business-consumer environment, with other patients or customers nearby, can make it challenging to engage in detailed discussions about mental health and antidepressant use. Additionally, the frequent but typically brief nature of pharmacists' interactions hinders the development of strong patient relationships and discussions about mental health issues. Despite these challenges, pharmacists perceive themselves as easily accessible healthcare professionals, a viewpoint supported by patient studies.[31] Pharmacists are often the initial point of contact for health information, which contributes to their role of trusted healthcare professionals.

Our study underscores several arguments for giving a more proactive role to pharmacists in the discontinuation process, such as a regularly reviewing the antidepressant or providing an easy accessible support during tapering. Although pharmacists are already involved in many tasks related to discontinuation, they tend to defer responsibility to GPs and support their decisions. Additionally, we found that pharmacists often wait for patients to initiate discussions. This passivity may contribute to the prolonged use of antidepressants and missed opportunities for review and discontinuation, as previous research found that both GPs and patients are also reluctant to start conversations about discontinuation.[17,26] This study suggests that pharmacists could be the missing link in breaking this status quo through a regular review of the long-term antidepressant by the pharmacist, which was identified as a facilitator in our study. However, this requires empowering pharmacists, stimulating collaboration, and establishing clear agreements about each professional's role and responsibilities. These steps are necessary for effectively reducing long-term antidepressant use.

Strengths and limitations

To our knowledge, this is the first qualitative study exploring community pharmacists' views on the cessation of long-term antidepressants. We selected 14 pharmacists from different regions in Flanders (Belgium), to capture a diverse range of perspectives and achieve saturation of the data. Although saturation was reached, the study may not have fully captured the full range of pharmacists' opinions, particularly those with limited interest in this topic or in participating in interviews. We did not ask issues related to the professional training that could lead to different perspectives,[29] however being a community pharmacy with experience with dispensing antidepressants was necessary. Different types of pharmacists, for example, specialist mental health clinical pharmacists or pharmacists in general practices may add different perspectives.[55]

Some data may be specific to the Belgian context, particularly regarding the responsibilities of pharmacists and their collaboration with GPs. However, Belgium's situation, where pharmacists are not integrated into general practice, is comparable to that of most pharmacists across Europe and internationally.[48–54]

The interviewer had limited experience with qualitative research, but this was mitigated by the guidance and collaboration of experienced supervisors. To strengthen the study's credibility, the researchers used strategies such as peer debriefing, maintaining self-awareness about potential biases (reflexivity), and cross-checking between researchers and supervisors (triangulation). While some researcher bias may have influenced the findings, efforts were made to minimize this risk. As a GP and a clinical pharmacologist with a vested interest in the research topic and familiarity with the context, the supervisor's role could be seen as both an advantage and a potential source of bias, as this personal perspective may have influenced the analysis.[56] To counterbalance this, analysis of the data was undertaken by a multidisciplinary team including three disciplines (pharmacists, GPs, and clinical pharmacologists) and with offering one an international perspective (C.J.), enhancing the validity of our findings. Although participants were not given the opportunity for member checking, which could have strengthened the credibility of

the findings by incorporating their perspectives, the study's findings remain robust.

Study participants were predominantly female; however, this aligns with the national demographic distribution of community pharmacists (73% female in 2018).[57]

Implications for practice and research

Practice. The findings suggest that pharmacists may lack knowledge and feel uncertain about antidepressant treatment including starting the treatment and the discontinuation of it. This highlights the need for training programs for pharmacists focusing on antidepressant treatment including starting, review, and discontinuation, incorporating our findings, and this aligns also with recent UK study findings on pharmacists' training needs on antidepressant reviewing.[29]

Additionally, communication training for discussing antidepressants seems necessary, given the significant taboo around this topic. For example, online e-learning modules or workshops could be developed to improve their knowledge and skills concerning antidepressant treatment.

Another finding points to limited collaboration between GP and pharmacist in managing AD treatment including discontinuation. This could lead to more discussion on how pharmacists could play a more active role. However, more research is needed to understand the expectations of both professions.

Research. Quantitative research on barriers and facilitators.

1. To build on the qualitative findings of this study, further quantitative investigation is now needed to strengthen our findings and identify the most significant barriers and those that need to be prioritized for interventions.
2. Investigate the role of pharmacist in patient support.

Future research should explore the role of community pharmacists in actively supporting the patient during the discontinuation process especially given that some patients stop and restart medications on their own.[23] Pharmacists, as easily accessible healthcare professionals, could play a key role in guiding and supporting these patients.

3. Examine patient motivation and pharmacist contributions

Specifically, studies could explore the effectiveness of different levels of pharmacist involvement, from providing basic information to reviewing the long-term antidepressant and offering intensive, ongoing support, in collaboration with GPs. Additionally, pharmacists could support patients experiencing issues related to discontinuation, such as withdrawal symptoms.

Research is required to understand how to best motivate patients to attempt discontinuation as many hesitate because of fear of relapse. Studies should also assess how pharmacists can best contribute to this process, both through direct patient engagement and by facilitating communication between patients and GPs.

Conclusion

Our study reveals that pharmacists viewed GPs as pivotal in the discontinuation process, as they make the decisions, while their role as supportive, following the doctor's decision. However, significant barriers such as fear of relapse, societal taboo, and unclear responsibilities prevent pharmacists from playing a more active role. To overcome these barriers, actionable steps include providing pharmacist with more education on antidepressant discontinuation and withdrawal symptoms, and improving their communication skills, to build more self-confidence in managing discontinuation, and fostering a stronger collaboration and communication with GPs, to improve the overall antidepressant discontinuation process.

Declarations

Ethics approval and consent to participate

Ethical approval was granted by the Ethics Committee of Ghent University Hospital (reference number: BC-07027). All participants provided written informed consent prior to participation in the study.

Consent for publication

All participants provided written informed consent for publication.

Author contributions

Ellen Van Leeuwen: Conceptualization; data curation; formal analysis; investigation;

methodology; project administration; writing—original draft; writing—review and editing.

Els Mehuys: Writing—review and editing.

Chris F. Johnson: Writing—review and editing.

An-Sofie De Keyzer: Data curation; formal analysis; investigation; writing—review and editing.

Koen Boussery: Writing—review and editing.

Thierry Christiaens: Conceptualization; formal analysis; methodology; writing—review and editing.

Acknowledgements
We wish to thank the pharmacists who participated in this study. We also thank Prof Tony Kendrick, Dr Catharine J. Woods, Dr Hannah Bowers for their valuable comments on the manuscript. This manuscript was presented at the British Journal of General Practice Research & Publishing Conference March 22, 2024, and published in the conference abstracts Book.

Funding
The authors received no financial support for the research, authorship, and/or publication of this article.

Competing interests

The authors declare that there is no conflict of interest.

Availability of data and materials
Data will be made available on request

ORCID iD
Ellen Van Leeuwen https://orcid.org/0000-0002-3155-4095

Supplemental material
Supplemental material for this article is available online.

References

1. Organisation for Economic Co-operation and Development (OECD). *Pharmaceutical consumption, in Health at a Glance 2023: OECD Indicators*. Paris: OECD Publishing, 2023
2. Moore M, Yuen HM, Dunn N, et al. Explaining the rise in antidepressant prescribing: a descriptive study using the general practice research database [published correction appears in BMJ. 2009;339:b4361]. *BMJ* 2009; 339: b3999.
3. IMA/AIM. Data on long-term use of antidepressants, https://www.aim-ima.be/Atlas-AIM (2022, accessed 31 August 2024).
4. The Scottish Government. *Quality prescribing for antidepressants: a guide for improvement 2024–2027*. Edinburgh: The Scottish Government, 2024.
5. Taylor S, Annand F, Burkinshaw P, et al. *Dependence and withdrawal associated with some prescribed medicines: an evidence review*. London: Public Health England, 2019.
6. Mojtabai R and Olfson M. National trends in long-term use of antidepressant medications: results from the U.S. National Health and Nutrition Examination Survey. *J Clin Psychiatry* 2014; 75(2): 169–177.
7. National Institute for Health and Care Excellence. Depression in adults: recognition and management, https://www.nice.org.uk/guidance/cg90 (2022, accessed 31 August 2024).
8. Declercq T, Habraken H, Van den Ameele H, et al. Depressive disorder in adults, www.domusmedica.be/richtlijnen/depressie-bij-volwassenen (2017, accessed 30 August 2024).
9. Bakken MS, Engeland A, Engesæter LB, et al. Increased risk of hip fracture among older people using antidepressant drugs: data from the Norwegian Prescription Database and the Norwegian Hip Fracture Registry. *Age Ageing* 2013; 42(4): 514–520.
10. Sterke CS, van Beeck EF, van der Velde N, et al. New insights: dose-response relationship between psychotropic drugs and falls: a study in nursing home residents with dementia. *J Clin Pharmacol* 2012; 52(6): 947–955.
11. Jiang HY, Chen HZ, Hu XJ, et al. Use of selective serotonin reuptake inhibitors and risk of upper gastrointestinal bleeding: a systematic review and meta-analysis. *Clin Gastroenterol Hepatol* 2015; 13(1): 42–50.e3.
12. Kendrick T. Long-term antidepressant treatment: time for a review? *Prescriber* 2015; 26(19): 7–10.
13. Cartwright C, Gibson K, Read J, et al. Long-term antidepressant use: patient perspectives of benefits and adverse effects. *Patient Prefer Adherence* 2016; 10: 1401–1407.
14. Goodwin GM, Price J, De Bodinat C, et al. Emotional blunting with antidepressant treatments: a survey among depressed patients. *J Affect Disord* 2017; 221: 31–35.
15. Maund E, Dewar-Haggart R, Williams S, et al. Barriers and facilitators to discontinuing antidepressant use: a systematic review and thematic synthesis. *J Affect Disord* 2019; 245: 38–62.

16. Meißner C, Meyrose AK and Nestoriuc Y. What helps and what hinders antidepressant discontinuation? Qualitative analysis of patients' experiences and expectations. *Br J Gen Pract* 2024; 74(744): e466–e474.

17. Van Leeuwen E, Anthierens S, van Driel ML, et al. Should I, can I, dare I? Patients' view on stopping long-term antidepressant use, a qualitative study. *Acta Clin Belg* 2022; 77(6): 962–969.

18. Van Leeuwen E, Maund E, Woods C, et al. Health care professional barriers and facilitators to discontinuing antidepressant use: a systematic review and thematic synthesis. *J Affect Disord* 2024; 356: 616–627.

19. Framer A. What I have learnt from helping thousands of people taper off antidepressants and other psychotropic medications. *Ther Adv Psychopharmacol* 2021; 11: :2045125321991274.

20. Scholten W, Batelaan N and Van Balkom A. Barriers to discontinuing antidepressants in patients with depressive and anxiety disorders: a review of the literature and clinical recommendations. *Ther Adv Psychopharmacol* 2020; 10: 2045125320933404.

21. Schofield P, Crosland A, Waheed W, et al. Patients' views of antidepressants: from first experiences to becoming expert. *Br J Gen Pract* 2011; 61(585): 142–148.

22. Read J, Moncrieff J and Horowitz MA. Designing withdrawal support services for antidepressant users: patients' views on existing services and what they really need. *J Psychiatr Res* 2023; 161: 298–306.

23. Guy A, Brown M, Lewis S, et al. The "patient voice": patients who experience antidepressant withdrawal symptoms are often dismissed, or misdiagnosed with relapse, or a new medical condition. *Ther Adv Psychopharmacol* 2020; 10: 2045125320967183.

24. Bowers HM, Williams SJ, Geraghty AWA, et al. Helping people discontinue long-term antidepressants: views of health professionals in UK primary care. *BMJ Open* 2019; 9(7): e027837

25. Kelly D, Graffi J, Noonan M, et al. Exploration of GP perspectives on deprescribing antidepressants: a qualitative study. *BMJ Open* 2021; 11(4): e046054.

26. Van Leeuwen E, Anthierens S, van Driel ML, et al. General practitioners' perspectives on discontinuation of long-term antidepressants in nursing homes. *Eur J Gen Pract* 2022; 28(1): 23–31.

27. Anderson K, Stowasser D, Freeman C, et al. Prescriber barriers and enablers to minimising potentially inappropriate medications in adults: a systematic review and thematic synthesis. *BMJ Open* 2014; 4: e006544.

28. Reeve E, Thompson W and Farrell B. Deprescribing: a narrative review of the evidence and practical recommendations for recognizing opportunities and taking action. *Eur J Intern Med* 2017; 38: 3–11.

29. Harbiye S. *Guiding discontinuation of antidepressants by community pharmacists: a mixed-methods study*. Master Thesis, https://studenttheses.uu.nl/handle/20.500.12932/46962 (2024, accessed 16 December 2024).

30. OECD. *Health at a glance 2023: OECD indicators*. Paris: OECD Publishing, 2023.

31. Guillaumie L, Ndayizigiye A, Beaucage C, et al. Patient perspectives on the role of community pharmacists for antidepressant treatment: a qualitative study. *Can Pharm J (Ott)* 2018; 151(2): 142–148.

32. Guillaumie L, Moisan J, Grégoire JP, et al. Contributions of community pharmacists to patients on antidepressants: a qualitative study among key informants. *Int J Clin Pharm* 2017; 39(4): 686–696.

33. Van Leeuwen E, Anthierens S, van Driel ML, et al. "Never change a winning team": GPs' perspectives on discontinuation of long-term antidepressants. *Scand J Prim Health Care* 2021; 39(4): 533–542.

34. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3(2): 77–101.

35. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19(6): 349–357.

36. Foubert K, Capiau A, Mehuys E, et al. Ghent Older People's Prescriptions Community Pharmacy Screening (GheOP3S)-Tool Version 2: Update of a Tool to Detect Drug-Related Problems in Older People in Primary Care. *Drugs Aging* 2021; 38(6): 523–533.

37. O'Mahony D, Cherubini A, Guiteras AR, et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 3. *Eur Geriatr Med* 2023; 14(4): 625–632.

38. Davies J and Read J. A systematic review into the incidence, severity and duration of antidepressant

withdrawal effects: are guidelines evidence-based? *Addict Behav* 2019; 97: 111–121.

39. Zhang MM, Tan X, Zheng YB, et al. Incidence and risk factors of antidepressant withdrawal symptoms: a meta-analysis and systematic review. *Mol Psychiatry*. Epub ahead of print October 2024. DOI: 10.1038/s41380-024-02782-4.
40. Henssler J, Schmidt Y, Schmidt U, et al. Incidence of antidepressant discontinuation symptoms: a systematic review and meta-analysis. *Lancet Psychiatry* 2024; 11(9): e11.
41. Horowitz MA and Taylor D. Distinguishing relapse from antidepressant withdrawal: clinical practice and antidepressant discontinuation studies. *BJPsych Adv* 2022; 28(5): 297–311.
42. van Os J and Groot PC. Outcomes of hyperbolic tapering of antidepressants. *Ther Adv Psychopharmacol* 2023; 13: 20451253231171518.
43. Brown JVE, Walton N, Meader N, et al. Pharmacy-based management for depression in adults. *Cochrane Database Syst Rev* 2019; 12(12): CD013299.
44. Johnson CF and Earle-Payne K. Identifying mental health training needs of general practice pharmacy workforce to advance practice: a training needs analysis survey. *Int J Clin Pharm* 2022; 44(6): 1454–1463.
45. Lewis G, Marston L, Duffy L, et al. Maintenance or discontinuation of antidepressants in primary care. *N Engl J Med* 2021; 385(14): 1257–1267
46. Kendrick T, Stuart B, Bowers H, et al. Internet and Telephone support for discontinuing long-term antidepressants: the REDUCE Cluster Randomized Trial. *JAMA Netw Open* 2024; 7(6): e2418383.
47. Van Leeuwen E, van Driel ML, Horowitz MA, et al. Approaches for discontinuation versus continuation of long-term antidepressant use for depressive and anxiety disorders in adults. *Cochrane Database Syst Rev* 2021; 4(4): CD013495.
48. Liekens S, Smits T, Laekeman G, et al. Pharmaceutical care for people with depression: Belgian pharmacists' attitudes and perceived barriers. *Int J Clin Pharm* 2012; 34(3): 452–459.
49. Scheerder G, De Coster I and Van Audenhove C. Pharmacists' role in depression care: a survey of attitudes, current practices, and barriers. *Psychiatr Serv* 2008; 59(10): 1155–1160.
50. Shami R, Alam MF and ElHajj MS. The role of community pharmacists in depression management: a survey of attitudes, practices and perceived barriers. *Int J Clin Pharm* 2022; 44(1): 214–226.
51. Anosike C, Adibe MO and Ani DN. Extent of community pharmacists' care of clients with depression in Enugu, Nigeria: a cross-sectional survey. *Int J Pharm Pract* 2024; 32(2): 186–189.
52. Rubio-Valera M, Chen TF and O'Reilly CL. New roles for pharmacists in community mental health care: a narrative review. *Int J Environ Res Public Health* 2014; 11(10): 10967-10990.
53. Bell S, McLachlan AJ, Aslani P, et al. Community pharmacy services to optimise the use of medications for mental illness: a systematic review. *Aust New Zealand Health Policy* 2005; 2: 29.
54. Cannon-Breland ML, Westrick SC, Kavookjian J, et al. Pharmacist self-reported antidepressant medication counseling. *J Am Pharm Assoc (2003)* 2013; 53(4): 390–399.
55. Henry R and Baldwin DS. Incorporation of a specialist mental health clinical pharmacist within a primary care network: patient referrals, prescribing decisions, and clinical outcomes. *Ther Adv Psychopharmacol* 2024; 14: 20451253241247368.
56. Braun V and Clarke V. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a *knowing* researcher. *Int J Transgend Health* 2022; 24(1): 16.
57. Jouck P, Durand C, Miermans P-J, et al. PlanKad Apothekers 2018, Cel Planning van het Aanbod van de Gezondheidszorgberoepen, Dienst Gezondheidszorgberoepen en Beroepsuitoefening, Directoraat-generaal Gezondheidszorg, FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu, https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/plankad_apoth_all_nl_0.pdf (2021, accessed 31 August 2024).