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Deprescribing in Older People: A Clinical Practice Guideline Summary

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ABSTRACT

Introduction: Older people face higher risks of medicine-related harm due to polypharmacy and the use of potentially inappropriate medicines. Current treatment guidelines rarely specify when to stop medicines, leading to medicines often being continued indefinitely without a clear deprescribing plan. While deprescribing guidelines exist for some medicine classes, limited guidance is a major barrier to deprescribing. These new guidelines address this gap by providing structured recommendations that complement more detailed drug-specific deprescribing guidance, disease-specific therapeutic guidelines and non-pharmacological management resources. These guidelines were developed by a team of 72 experts, including consumer representatives, and were further shaped by feedback from public consultation and independent reviewers.

Main Recommendations: The guidelines are intended for all healthcare professionals involved in prescribing, dispensing or administering medicines to older people. The guidelines specifically address polypharmacy and medicines commonly dispensed for regular use in people aged ≥65 years, as well as other medicines where there is evidence to consider deprescribing in this cohort. The guidelines provide 185 consensus-based recommendations and 70 good practice statements, covering both specific medicine categories and general deprescribing principles. The guidelines are structured into four areas: (1) when to deprescribe; (2) ongoing treatment needs; (3) how to deprescribe; and (4) monitoring requirements.

Changes in Care as a Result of the Guideline: This guideline emphasises deprescribing as an integral part of the prescribing continuum. Applying a deprescribing approach encourages prescribers to consider the ongoing need for a medicine each time a prescription is re-issued, to balance benefits and harms as they evolve over time, and to ensure treatment decisions reflect an

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individual's goals through shared decision-making. The guideline was developed based on currently available evidence for deprescribing and expert multidisciplinary and consumer input. It supports health professionals in reviewing regular medicines, minimising harm and planning ongoing treatment or monitoring. The detailed guideline is available at https://deprescribing.com.
JEL Classification: Health occupations, Pharmaceutical preparations, General medicine

1 | Background

Deprescribing is a person-centred process of withdrawing medicines that are potentially harmful or no longer required, with the goal of improving health outcomes [1]. It is undertaken in partnership between individuals and their healthcare providers and is recognised as a strategy to address inappropriate polypharmacy and high-risk prescribing. When deprescribing is implemented appropriately and under medical supervision, it is safe and can effectively reduce treatment burden [2], improve medicine adherence [3] and have a positive impact on the environment [4].

Despite these benefits, deprescribing in clinical practice is often challenging, with barriers at the individual and system levels. Limited availability of guidance is often cited as a significant barrier to deprescribing [5, 6]. Clinical practice guidelines are a valuable resource for clinical decision-making, with recommendations developed through a systematic methodology and rigorous process [7]. Guidelines currently exist for deprescribing certain medicine classes, but mostly focus on broad populations (e.g., adults aged 18 years and over) [8–11] or a specific condition (e.g., deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia) [12]. Few guidelines specifically address the unique needs of older people, including the importance of maintaining health and independence while managing potential age-related functional and cognitive decline [13, 14].

To address this gap, we developed guidelines based on evidence available for deprescribing, specifically in older people (aged 65 years and over), offering comprehensive guidance for many commonly used medicines in this population. The guidelines include recommendations that complement more detailed drug-specific deprescribing guidance, disease-specific therapeutic guidelines and non-pharmacological management resources. This guideline summary provides an overview of the background, methods, key recommendations and additional considerations to support integration into routine clinical practice.

2 | Methods

2.1 | Guideline Development Group

The guideline development group (GDG) comprises 72 members, including individuals invited for their expertise and those appointed to represent their organisations. Members included consumer and carer representatives, general practitioners, specialists across multiple therapeutic areas (cardiologist, cardiology advanced trainee, clinical pharmacologists, endocrinologist, gastroenterologist and hepatologist, geriatricians, geriatric generalist, haematologist, medical oncologist, nephrologist, neurologist, ophthalmologist, psychiatrist of old age, respiratory and infectious diseases specialist, rheumatologist, urologist), dentists, a cardiology nurse practitioner, a nurse and allied health professionals such as pharmacists (including pharmacists with cardiology and renal specialties), physiotherapists, optometrists, a podiatrist and credentialled diabetes educators. The group also included an Aboriginal health expert, rural and regional health experts, as well as researchers with expertise in implementation science, health economics, public health, pharmacoepidemiology and biostatistics.

2.2 | Guideline Development Process

The guidelines adhered to the National Health and Medical Research Council (NHMRC) Guideline Development Methodology [15] and the Appraisal of Guidelines for Research & Evaluation (AGREE) II Instrument and User's Manual [16], with adaptations made to suit this initiative's purpose, available resources and the urgent need for recommendations to support clinical decision-making. This project was initially registered with the NHMRC in 2016. A guideline committee, including external experts, supported the genesis and initial development of the guideline development plan. The initial guideline committee met on 19 April 2016 to determine the proposal of the guideline, including the purpose and scope. Unfortunately, substantial delays, including the coronavirus disease 2019, meant that work did not resume until 2023, after which a GDG was re-established. The original NHMRC registration for the NHMRC Guideline Approval Program has lapsed. As development had already commenced at the time of re-engagement with NHMRC, the guideline was ineligible for acceptance into the programme under the current NHMRC process. However, the guidelines may be considered for approval in future updates. Given the deliberately broad scope of the guidelines, a comprehensive systematic review and meta-analysis was undertaken to establish the evidence base. Although this pragmatic approach enabled the synthesis of a large body of evidence focused on mortality and health outcomes in a structured and timely manner, we acknowledge that it may potentially limit some other aspects relevant to clinical care. Nonetheless, every effort was made to uphold guideline development standards within resource constraints, including conducting an updated and repeated search.

A detailed description of the methodology is accessible through the main guideline document [17] and the accompanying technical report [18]. The specific methodology for the evidence-reviewing and consensus-deriving phases of the guideline development process has also previously been described in detail in the published protocol (Figure 1) [19]. Briefly, guideline development involved a systematic review and meta-analysis [20], and the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach [21] was used to assess the certainty of evidence at the outcome-level

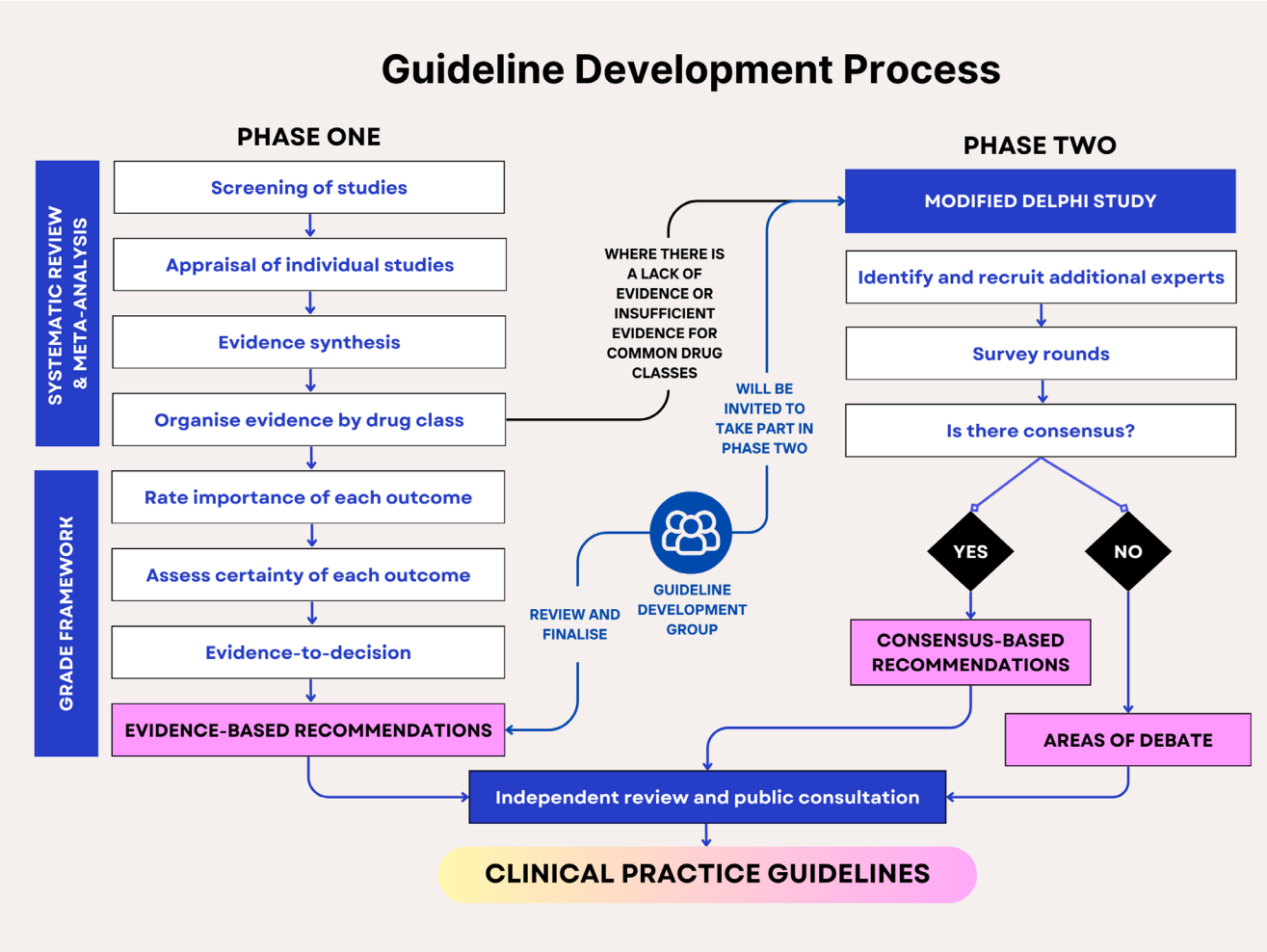


FIGURE 1 | Guideline development process. Figure reproduced from [19] under CC BY 4.0 licence. This figure presents the protocol originally proposed for developing the deprescribing guideline. Following completion of the systematic review and evidence appraisal, no high- or moderate-certainty evidence was identified to support evidence-based recommendations. The originally proposed pathway has been retained for transparency and future updates. During the Delphi process, the need for good practice statements to support implementation was identified, and these were subsequently developed.

and formulate recommendations. The recommendations were developed, based on evidence from literature published up to 15 March 2025.

Each critical or important outcome was assessed for certainty using the GRADE framework, after which the guideline steering committee drafted the recommendations and assigned a preliminary recommendation category. Each recommendation was classified as one of three possible types: evidence-based recommendation (EBR), consensus-based recommendation (CBR) or good practice statement (GPS). The nomenclature and description for classifying recommendations are shown in Box 1. Figure 2 presents the processes used to determine the types of guideline recommendations. At the time of guideline development, the NHMRC was seeking feedback on its draft Procedures and Requirements for Meeting the NHMRC Standards for Clinical Practice Guidelines (version 2.0) [22]. Our categorisation of recommendation types was informed by the 2022 standards (version 1.2) [15], while also considering the proposed transition from 'Practice Points' to 'Good Practice Statements' in the newer version under consultation. In this guideline, no recommendations were classified as EBRs, due to the absence of high- or moderate-certainty evidence required to support such recommendations. For common medicines where the systematic review found no studies evaluating deprescribing outcomes (prochlorperazine, macrogol, iron/vitamin B12, corticosteroids for skin and eyes, antigout preparations, antiglaucoma preparations/miotics and ocular lubricants), recommendations were also drafted and assigned as CBRs. All drafted recommendations were subsequently entered into Phase Two (Delphi surveys) to determine consensus (Figure 1).

As part of the Delphi process, the draft recommendations and any supporting evidence were presented to the GDG for deliberation. The evidence was provided in the form of GRADE evidence summary tables, a narrative summary and full evidence profiles included as appendices. Each member was asked to review the evidence, cast an explicit vote (agree or disagree) on the draft recommendations and suggest any changes to the recommendation category or wording through free-text responses if needed. These expectations were outlined in the terms of reference prior to members joining the GDG. The development

BOX 1 | Recommendation Types, Description and Nomenclature.

Evidence-based recommendation (EBR)	Recommendations developed based on high or moderate quality evidence identified from a systematic literature search.	The wording 'we recommend'. represents a strong EBR, whereas 'we suggest'. represents conditional EBR.
Consensus-based recommendation (CBR)	Recommendations developed in the absence of high or moderate quality evidence where a systematic review of the evidence was conducted.	'We suggest'.
Good practice statement (GPS)	Actionable statements developed to support recommendations or to guide deprescribing processes when there is indirect but high-quality supportive evidence, and other criteria for GPS development are met.	The statement 'ungraded good practice statement' is used in parentheses after each GPS. This was decided to clarify that GPS is not graded, and a formal evidence review was not conducted.

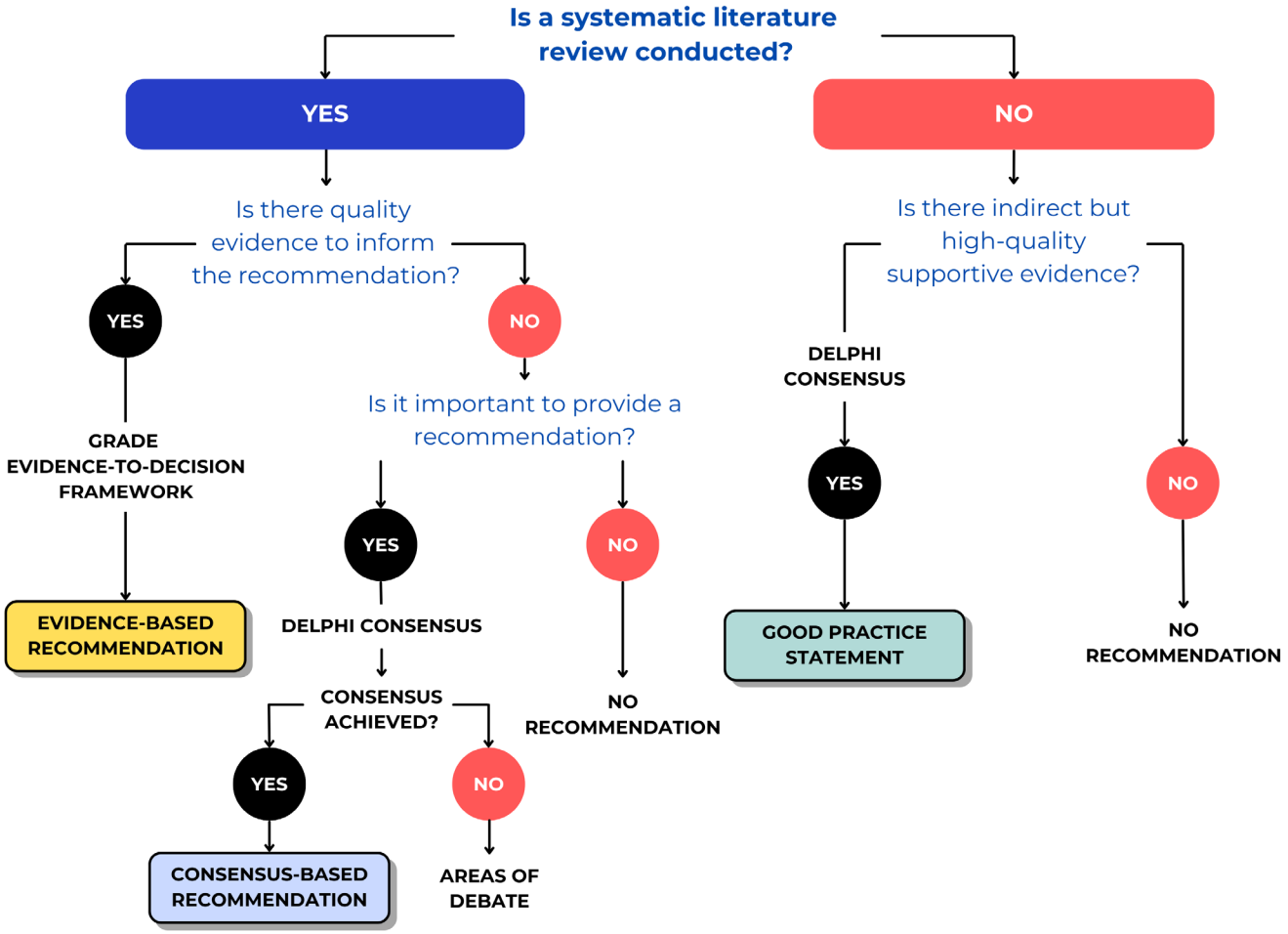


FIGURE 2 | Types of guideline recommendations. Figure reproduced from [18] with permission. The guidelines present 185 consensus-based recommendations and 70 good practice statements across specific medication categories and general deprescribing principles. High-quality evidence to support the development of evidence-based recommendations is lacking in this iteration of the guideline.

process also involved several online meetings, drop-in sessions and asynchronous manuscript reviews, facilitated through collaborative software and shared documents. The Delphi questionnaires were designed so that members could select and respond only to the therapeutic areas relevant to their expertise or lived experience. All final recommendations achieved at least 75% explicit group consensus, determined a priori, through the Delphi method in either the first or second round.

Before finalising, the draft guidelines were open for public consultation for 38 days from 24 April to 31 May 2025, during which 313 submissions were received (public consultation report [23]). In parallel with the public consultation, two international reviewers with expertise in geriatric pharmacotherapy and clinical pharmacology independently appraised the guideline using the AGREE II checklist [16]. Notably, one reviewer is currently leading the development of an

evidence-based diuretic deprescribing clinical practice guideline [24]. The AGREE II checklist assessment is available in the administrative report of the guidelines. Both independent AGREE II reviewers returned a score of six out of seven, with seven being the highest possible quality. All comments received from the reviewers were carefully considered by the GDG, and the revised recommendations were subsequently presented to the GDG for further deliberation and refinement. Point-by-point responses to reviewer feedback were agreed on by the GDG, provided to reviewers and included in the administrative report. The guidelines were also reviewed by two independent reviewers from the Royal Australian College of General Practitioners (RACGP) as part of their guideline endorsement process.

The final guidelines represent the culmination of a collaborative and iterative process involving contributions from a broad range of stakeholders. This included the guideline authors, the public and independent peer reviewers who provided critical appraisal to strengthen the clarity, accuracy and applicability of the recommendations. This multidisciplinary, participatory approach aimed to ensure that the guidelines are not only evidence-based and methodologically rigorous, but also practical, relevant and responsive to the needs of those who will use them in clinical practice and those whose lives will be affected by the guidelines.

The guidelines have been endorsed by leading national peak bodies, including the RACGP, Australian and New Zealand Society for Geriatric Medicine, Australasian College of Pharmacy, Advanced Pharmacy Australia, Pharmaceutical Society of Australia, Optometry Australia, Australian Diabetes Educators Association, Australian Dental Association and Australian Podiatry Association.

Ethics approval has been granted by the University of Western Australia Human Research Ethics Committee (reference: 2023/ET001118).

3 | Recommendations

The resulting guidelines provide deprescribing recommendations for specific medicine categories as well as general recommendations for deprescribing. The guidelines contain 185 CBRs and 70 GPSs. These recommendations cover medicines commonly dispensed for regular use in people aged ≥ 65 years (e.g., lipid-lowering agents, antihypertensives and analgesics), as well as other medicines where deprescribing evidence exists (e.g., potassium, digoxin, nitrates, genitourinary anticholinergics, teriparatide, bisphosphonates, levodopa, lithium, cholinesterase inhibitors). Common medicines were defined as the 100 most commonly dispensed Pharmaceutical Benefits Scheme (PBS) medicines in this age group in the year 2023.

It is worth noting that when developing these guidelines, high- or moderate-quality evidence required to support such evidence-based recommendations was not available. However, given the rapid increase in deprescribing research and the evolving guideline standards, this classification may change in future guideline iterations.

The guidelines are intended for all health professionals involved in prescribing, dispensing or administering medicines to older people. For each section, the recommendations are presented as four areas:

- When to deprescribe
- Ongoing treatment needs
- How to deprescribe
- Monitoring requirements

The first section in the guidelines, 'Polypharmacy/Multiple Drug Classes', outlines general deprescribing principles (Table 1). Subsequent sections focus on recommendations tailored to specific medicines (Table S1). A common statement across all sections in the guidelines highlights the importance of informed consent and shared decision-making, ensuring that individuals, their family members and/or carers are actively involved in discussions about their treatment options. The guidelines stress the need to tailor care to each individual's health status, preferences and goals, as well as encourage collaboration between healthcare providers. The full guidelines, including evidence and recommendations for all topics, as well as individual medicine handouts, are available to download on https://deprescribing.com.

This guideline summary focuses on the first section in the guidelines ('Polypharmacy/Multiple Drug Classes'). This section provides the broad principles for deprescribing based on evidence from studies that targeted:

- general polypharmacy (commonly defined as the concurrent use of five or more medicines)
- medicines with a certain pharmacological action spanning multiple drug classes (e.g., medicines with anticholinergic and sedative properties)
- three or more drug classes.

The considerations guiding recommendations for this section are summarised below, following the GRADE evidence-to-decision framework. The GDG considered: (i) the balance between the benefits and risks of medicine continuation and medicine discontinuation; (ii) acceptability; (iii) resource and feasibility of implementation; and (iv) equity.

3.1 | Evidence for Recommendations (Polypharmacy/Multiple Drug Classes Section)

3.1.1 | Evidence Summary (Benefits and Risks)

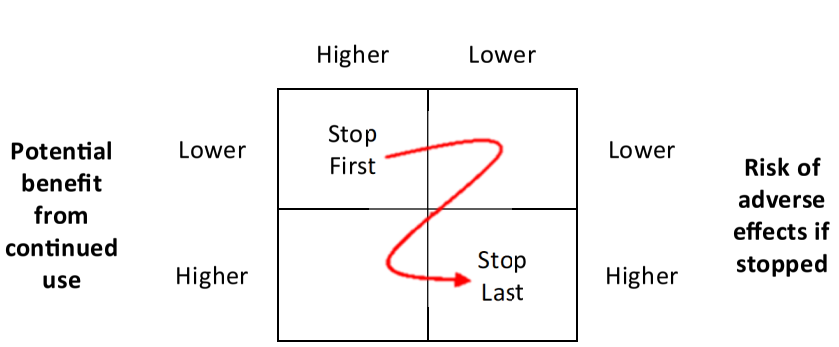
In randomised controlled trials, deprescribing to reduce polypharmacy or multiple drug classes had no significant effect on mortality (odds ratio [OR], 0.97; 95% confidence interval [CI], 0.87–1.08; 25 studies; $n = 15{,}374$; low certainty), with similar findings in non-randomised studies (OR, 0.70; 95% CI, 0.36–1.38; 6 studies; $n = 853$; very low certainty). Deprescribing was associated with increased adverse drug withdrawal effects (OR, 1.98; 95% CI, 1.48–2.66; 4 studies; $n = 3096$; low certainty),

TABLE 1 | Summary recommendation table for deprescribing polypharmacy or multiple drug classes.

Type	Recommendation/statement
CBR	Given the potential clinical and economic benefits in reducing inappropriate polypharmacy, we suggest that in addition to applying a targeted approach to deprescribe specific drug classes, regular medication review is offered to older people taking multiple long-term medicines. We suggest deprescribing medicines that meet one of the categories below: • With no clear indication, an obvious contraindication, or if there is an inappropriate prescribing cascade • With adverse effects or interactions that outweigh the potential benefits • Used for symptomatic relief, where the symptoms are resolved and unlikely to recur • Used for prevention, when the potential benefits are uncertain or unlikely to be realised
GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
GPS	In the context of multimorbidity and polypharmacy, healthcare providers should refer to existing high-quality disease-specific guidelines relevant to the condition to identify medicines that may be suitable for deprescribing (ungraded good practice statement).
GPS	Deprescribing should be a preference-sensitive decision, requiring a shared decision-making approach (ungraded good practice statement).
CBR	We suggest continuing medicines after confirming that the pharmacotherapy is clearly indicated, the benefits of the medicine are expected to outweigh the potential harms and that this aligns with the individual's goals and preferences. In the context of multimorbidity and polypharmacy, deprescribing one medicine may necessitate a change in other pharmacotherapies due to a potential increase or reduction in risks (e.g., drug–drug or drug–disease interactions). There may be a need for a 'deprescribing cascade' or prescribing of another more suitable medicine to optimise therapy.
CBR	**Methods** When a medicine is identified as being suitable for deprescribing, we suggest developing an individualised deprescribing plan in collaboration with the person and/or their carers/family members, by referring to the specific guidance in individual drug sections in this guideline. Broadly, for medicines where adverse drug withdrawal events (ADWEs) or disease recurrence are likely, we suggest tapering the dose rather than abrupt cessation. For tapering,* we suggest halving the dose at 2–4 weeks intervals, until half of the lowest standard dose formulation is reached, then ceasing the medicine completely. However, smaller dose reductions may be appropriate (e.g., high baseline dose or high risk of symptom recurrence). We suggest switching from regular doses to pro re nata doses be considered if appropriate (e.g., antipsychotics). For medicines with longer half-lives, we suggest tapering may not be required. We suggest deprescribing one medicine at a time. However, up to three medicines may be deprescribed simultaneously if unlikely to cause ADWEs and practical, or if withdrawal effects can be clearly attributed to an individual medicine. If deprescribing cannot be fully implemented and/or maintained, we suggest the following options be considered and offered to the individual as appropriate: • Continue with a tapered dose and delay further dose reductions by an agreed interval for stabilisation; or • Continue with the tapered dose but forego further dose reductions; or • Restart the target medicine(s) at approximately 75% of the previously tolerated dose; or • Restart the target medicine(s) at the original dose. *When deprescribing fixed-dose combinations, if tapering of one active component is required, consider prescribing separate (i.e., free-dose) combination products.

(Continues)

TABLE 1 | (Continued)

Type	Recommendation/statement
CBR	**Sequence of deprescribing target medicines** Once the medicines for deprescribing are agreed upon, we suggest the order of deprescribing be decided collaboratively between the individual and their prescriber. We suggest considering the priorities of the person, including their preference and impact on well-being, alongside the characteristics of the medicines, taking into account the balance of potential: • Risk of harm from continued use; • Benefit from continued use; • Adverse drug withdrawal events if the medicine is stopped; and • Cost burden **Prioritisation matrix for deprescribing** 
GPS	With informed consent from the individual or their supported decision-maker, prescribers should provide written prescribing and deprescribing plans to relevant healthcare providers involved in the person's care (ungraded good practice statement).
GPS	Prescribers should document informed consent, the rationale for prescribing or deprescribing, and, if applicable, the dose tapering schedule, order of withdrawal and monitoring plan (ungraded good practice statement).
CBR	In general, we suggest closely monitoring for ADWEs and any health-related outcomes (e.g., physical/psychological changes) every 2 weeks following each dose adjustment until at least 4 weeks after the medicine is fully discontinued. After this initial period, we suggest monthly monitoring for at least 3 months, followed by monitoring every 6 months thereafter. If in-person visits are not practical, we suggest informing people to report symptom recurrence and/or any appearance of new symptoms during monitoring and setting parameters for people for which point to initiate contact. We suggest individualising monitoring intervals (more or less frequent) in partnership with the person and their carers based on practicality, individual preferences, responses and tolerance. For instance, deprescribing multivitamins taken without a current indication in a robust person may require less frequent monitoring than other drug classes such as an antihypertensive or an antipsychotic. For specific guidance, we suggest referring to the individual drug sections in the guideline. Additionally, we suggest monitoring should occur at any time there is a change in the individual's risk–benefit profile (e.g., if the person becomes unwell or there is a change in their clinical status or preferences).

Note: Consensus-based recommendations (CBRs) are developed following a systematic review when the certainty of evidence, assessed using the (Grading of Recommendations, Assessment, Development and Evaluation) GRADE approach, is low or very low. Good practice statements (GPSs) are not derived directly from a systematic review but are formulated to support recommendations or guide deprescribing when indirect yet high-quality evidence exists and GPS criteria are met.

Abbreviations: CBR, consensus-based recommendation; GP, general practitioner; GPS, good practice statement.

defined as clinically significant signs or symptoms from drug discontinuation.

No significant differences were observed between deprescribing and continuation groups for: exacerbation of underlying conditions (OR, 6.75; 95% CI, 0.33–136.91; 1 study; $n = 58$; very low certainty), falls (OR, 0.88; 95% CI, 0.66–1.17; 11 studies; $n = 8416$; very low certainty), fractures (OR, 0.97; 95% CI, 0.60–1.57; 5 studies; $n = 4867$; low certainty), adverse drug events (OR, 1.11; 95% CI, 0.64–1.91; 3 studies; $n = 5492$; very low certainty), emergency department presentations (OR, 0.85; 95% CI, 0.72–1.01; 6 studies; $n = 4287$; low certainty) or unplanned hospital admissions (OR, 0.99; 95% CI, 0.82–1.21; 13 studies; $n = 11{,}157$; low certainty). Outcomes such as morbidity, physical function, cognition and quality of life varied widely. Certainty assessments for each outcome and the references for each study are detailed in the technical report [18], including outcomes reported in other study designs. The systematic review and meta-analysis is published elsewhere [20].

Methods for withdrawal schedules in deprescribing, as well as measurements of the impact of deprescribing, varied among the included studies, with no single method identified as superior. However, compared with abrupt cessation, dose tapering is likely more acceptable for most people and practical to determine the lowest effective dose for individuals requiring dose reduction rather than complete cessation.

The benefits and risks described above, along with the certainty of outcomes, were considered, with an emphasis placed on outcomes rated as critical or important by the GDG.

3.1.2 | Acceptability

Our consumer advisory group expressed that many people regard their medicines as essential, even when experiencing side effects. Evidence suggests that patients with more severe disease and greater treatment exposure are often more tolerant of risk [25]. According to the consumer advisory group, willingness to consider deprescribing depends on perceived benefits, severity of adverse effects and trust in their healthcare providers. Individuals are generally receptive to collaborative deprescribing when it is suggested by their doctor and when the benefits and risks are explained, and when medicines can be restarted if needed [26]. The consumer advisory group emphasised the importance of informed consent and clear information on expected outcomes and potential interactions. Cost can be a barrier to ongoing medicine use, especially when frequent refills are needed. A holistic approach that considers physical, mental, social and emotional well-being is preferred. Timely follow-up and good communication between prescribers are also critical.

Health professionals generally viewed deprescribing as beneficial but its implementation is often hindered by time constraints, limited knowledge or resources to initiate deprescribing, reluctance to stop medicines prescribed by others, complexity in multimorbidity, concerns about undertreatment or deviation from guidelines in the absence of robust evidence, and individual requests for specific medicines [5, 27, 28]. Some health professionals described deprescribing as 'swimming against the tide' of individual expectations [29].

3.1.3 | Resources and Feasibility of Implementation

Policymakers increasingly recognise deprescribing as a cost-saving and quality improvement strategy, as reflected in initiatives such as the National Strategy for Quality Use of Medicines and the National Medicines Policy. These guidelines align with Outcome 5.3 (Safe and Quality Use of Medicines) under the Strengthened Aged Care Quality Standards. Although short-term implementation costs and potential impacts on individual care warrant consideration [30], a comprehensive economic evaluation was beyond the scope of this work. However, inappropriate polypharmacy contributes to higher overall medicine costs and increased costs associated with medicine errors and adverse events. The World Health Organization estimates that 0.3% of global healthcare expenditure (US$18 billion) could be avoided through optimised polypharmacy management [31]. In 2023, older Australians visited their prescribers a median of five times a year and visited the pharmacy 16 times annually for PBS medicine supply [32], highlighting the potentially wide-reaching social and economic impact of medicine-related healthcare use on individuals and families. Evidence from the pharmacist-led OptiMed deprescribing study in residential aged care facilities projected national annual savings of AU$1–16 million from discontinuing inappropriate medicines [33] without compromising quality of life [2, 34].

3.1.4 | Equity

There is limited research examining the barriers to deprescribing in the context of health inequities. Older people experiencing inappropriate medicine use may benefit disproportionately through reduced medicine burden, lower costs and simplified regimens. However, equitable implementation requires addressing health literacy, access to healthcare, and the needs of culturally and linguistically diverse groups, Aboriginal and Torres Strait Islander peoples, individuals of low socio-economic status and those in rural or remote locations.

3.2 | Additional Considerations

Older individuals represent a highly heterogeneous population. While they are generally defined as those aged 65 years and over [35], chronological age alone does not necessarily reflect a person's health status, which ranges from robust to frail. Although anatomical and physiological changes naturally occur with advancing age [36, 37], individuals can experience markedly different ageing trajectories across the lifespan [38]. In this guideline, we provide explicit considerations and criteria to support the nuanced decision-making required for deprescribing, emphasising that it should occur through shared decision-making between the patient and their healthcare professional or team. For example, within the diabetes medicine section, we outline three broad thresholds to guide appropriate glycated haemoglobin targets, taking into consideration comorbidities, cognitive and

functional status, and life expectancy. These thresholds inform decisions regarding the potential de-intensification of diabetes medication management.

3.3 | Beyond the Scope of the Guideline

Although the scope of the guideline is restricted to older people, some recommendations may apply to other population groups. Individuals aged 50 years and over are considered older among Aboriginal and Torres Strait Islander peoples [35]. Younger populations, including those living with chronic conditions or experiencing polypharmacy, may also benefit from deprescribing; however, these groups are beyond the intended scope of this guideline. Clinical judgement should be applied with care when extrapolating evidence and applying these recommendations to people outside the intended scope.

Additionally, some communities face greater health risks due to social disadvantage or barriers to healthcare access. Individual social determinants of health equity should be integral to deprescribing considerations.

Underprescribing is another important aspect of medicine management, which occurs when a clinically indicated medicine is not prescribed for a patient [39]. The absence of appropriate medicines is beyond the scope of a deprescribing guideline. However, in some cases, the deprescribing process may incidentally reveal clinically indicated medicines that are missing from a person's regimen. Deprescribing complements prescribing by recognising that a person's health status can change over time, whether due to progression or remission of existing medical conditions, lifestyle modifications or the emergence of new conditions that may lead to interactions with existing therapies.

3.4 | Dissemination, Implementation and Evaluation

The dissemination and implementation plan for the guidelines [40] was informed by feedback received during the public consultation period. Outcome evaluation will focus on four domains (knowledge, health, economic and social) guided by the NHMRC Research Impact Position Statement [41]. To support this, we are currently developing a logic model to provide a structured approach for assessing alignment with the overarching project aim and tracking measurable progress within the Objectives and Key Results framework [42]. The logic model offers a diagrammatic representation of the project's logical sequence [43] and is recommended by organisations such as NHMRC as a structured method for describing and evaluating research impact [41].

4 | Conclusion

A deprescribing approach encourages prescribers to consider the need for a medicine each time a prescription is re-issued, to balance benefits and harms as they evolve over time, and to ensure decisions continue to reflect the individual's goals through shared decision-making. These clinical practice guidelines represent a major step in supporting safe and appropriate use of medicines in older people. By providing clear and practical consensus-based recommendations and good practice statements, the guidelines can potentially reduce the risk of medicine-related harm as well as improve individual health outcomes. The complete guideline, including supporting evidence, is available at https://deprescribing.com.

Author Contributions

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Not commissioned, externally peer reviewed.

Conflicts of Interest

The contents of this publication are solely the responsibility of the authors. None of the affiliated institutions or organisations had any role in decisions regarding the methodology, findings, recommendations or the writing of these guidelines. Members declared a range of potential interests, including financial interests such as speaker fees, grant/research funding, consulting fees and advisory board fees from multiple pharmaceutical companies, as well as royalties from developed innovations. Institutional interests were also noted. Several members reported relationships and affiliations, such as employment or serving in leadership roles within professional or hospital organisations. Other influences included involvement in deprescribing research and participation in advisory boards and consultancy projects for aged care programmes. No serious conflicts were identified during the guideline development process. A full register of conflicts of interest is available in Table S2. The administrative report [44] documents the non-technical aspects of guideline development, including the processes used to declare and manage conflicts of interest.

Data Availability Statement

All data and materials generated or analysed during the development of this guideline are available in the associated technical report, which has been made publicly accessible on the website https://deprescribing.com.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Summary recommendation table for deprescribing individual medicines, alphabetically ordered. **Table S2:** Conflicts of interest.