May 4, 2026

Dear Colleague:

The Department of Health and Human Services (HHS) is committed to advancing evidence-based, person-centered care for individuals with mental health conditions and substance use disorders. In support of that goal, the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF) write to emphasize the importance of ensuring that treatment planning for mental health conditions includes meaningful access to evidence-based non-pharmacological interventions. When clinically indicated, such treatment should include careful assessment of patient's symptoms, medication review for efficacy, and when appropriate, deprescribing.[1]

Psychiatric medications can play an important and, at times, essential role in treatment (National Institute of Mental Health, 2023). For many individuals, such medications reduce symptoms, improve functioning, prevent relapse, and support recovery. At the same time, medication should not be understood as the only treatment option, nor should it be initiated, continued, or discontinued without a careful and individualized discussion of the risks, benefits, and available alternatives (Goldberg et al., 2026). For many mental health conditions, such as depression, evidence supports the use of psychotherapy, individual or group therapy and other non-pharmacological interventions either as first-line treatment or as important concurrent components of a comprehensive treatment plan, depending on the individual's symptom severity, treatment history, functional needs, and preferences (Simon et al., 2024).

Accordingly, HHS encourages clinicians and provider organizations to support a treatment approach grounded in shared decision-making, patient autonomy, and fully informed consent. Individuals should receive clear, understandable information regarding the potential benefits and risks of psychiatric medications at initiation, during ongoing treatment, and when discontinuation is being considered. That discussion should include the purpose of the medication, expected benefits, possible adverse effects, monitoring needs, potential discontinuation symptoms, the risks of abrupt cessation when relevant, the possibility of relapse or recurrence, and the availability of evidence-based non-pharmacological interventions. Evidence from mental health settings suggests that shared decision-making interventions may improve patients' perceived involvement in decision-making and related person-centered outcomes (Aoki et al., 2022).

Evidence-based non-pharmacological interventions may include, when clinically appropriate, psychotherapy, social connection, behavioral approaches, sleep-focused treatments, physical activity interventions, and dietary and nutrition-related strategies (Mauro, et al., 2025). These approaches should not be viewed as interchangeable with medication in every circumstance, nor

[1] This letter does not address substance use disorders as a primary topic. However, the principles described here may also be relevant for individuals with co-occurring mental health and substance use conditions, provided that care remains individualized and consistent with evidence-based standards for each condition.

should they be presented as sufficient for all individuals. Rather, they should be made available as part of a full continuum of evidence-based mental health care so that treatment decisions reflect the best available evidence, sound clinical judgment, and the goals and preferences of the individual receiving care. Recent syntheses have found that exercise can reduce depressive symptoms and that dietary improvement interventions may also improve depressive symptoms in some populations (Noetel et al., 2024; Firth et al., 2019).

HHS also encourages regular and deliberate review of psychiatric medication regimens to ensure that each medication remains necessary, beneficial, and aligned with the individual's current clinical needs and treatment goals. In some circumstances, continued pharmacotherapy remains clearly indicated. In others, clinicians and patients may determine that a medication is no longer providing meaningful benefit, is contributing to adverse effects, has become part of an unnecessarily complex regimen, or should be reduced or discontinued following a thoughtful risk-benefit review (Bain et al., 2008). Recent expert consensus in clinical psychopharmacology emphasizes that psychotropic medications should be periodically reassessed, that deprescribing decisions should involve active patient participation, and that tapering or discontinuation should be followed by close clinical monitoring (Goldberg et al., 2026).

Deprescribing is not synonymous with abrupt discontinuation or blanket medication reduction. Rather, it is a deliberate, individualized clinical process that may be appropriate when treatment goals have been met, when adverse effects or polypharmacy create unnecessary burden, when a medication has not provided meaningful benefit after an adequate trial, or when a patient's informed preferences favor a carefully monitored taper. Decisions should be individualized and should not be undertaken abruptly or in a manner that undermines patient trust, safety, or continuity of care.

These principles are particularly important for populations that may be more vulnerable to medication-related harms or to reduced access to non-pharmacological care, including children and adolescents, older adults, pregnant and postpartum individuals, and people with multiple chronic conditions or complex medication regimens. They are also important in settings where mental health treatment is delivered in primary care or other integrated environments, where support for screening, diagnosis, consultation, and referral can strengthen access to appropriate care.

Federal agencies are taking steps to support these efforts. HRSA's Pediatric Mental Health Care Access Program provides mental health consultation, training, and support to pediatric primary care and other providers, across several states, and tribal entities using telehealth. Statewide or regional pediatric mental health teams composed of child and adolescent psychiatrists, licensed mental health professionals, and care coordinators provide consultation, training, technical assistance, and care coordination support services to pediatric primary care and other providers. This support enables providers to deliver high quality and timely detection, assessment, treatment, and referrals for children and adolescents with behavioral concerns, using evidence-based practices and methods such as web-based training sessions.

CMS has also taken important steps to strengthen access to appropriate mental health care. The "Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to

17" quality measure on the Medicaid and Children's Health Insurance Program (CHIP) Child Core Set is mandatory for states to report to CMS. CMS publicly reports state performance on this measure on the Core Set Data Dashboard. CMS issued the "State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements" to support states in improving children's behavioral health access and delivery. In addition, CMS announced the ASPIRE (Accelerating State Pediatric Innovation Readiness and Effectiveness) Model, a state-based Innovation Center model intended to support whole-person, coordinated care for children and youth in Medicaid and CHIP who have, or are at risk of developing, complex medical and/or behavioral needs. The model is designed to promote coordinated care delivery, wrap-around services, and family partnership for high-risk and rising-risk children and youth. CMS also announced the ACCESS (Advancing Chronic Dare with Effective, Scalable Solutions) Model, which aims to expand access to new technology-supported care options that help people improve their health and prevent and manage chronic disease. The model is designed to complement traditional care and includes a focus on behavioral health conditions, including depression and anxiety.

In addition, practitioners should be aware that a number of non-pharmacological services relevant to behavioral health care may already be covered when clinically appropriate.[2] For example, diet modification and medical nutrition therapy may be reported using CPT codes 97802 for initial nutrition assessment and intervention, 97803 for reassessment and subsequent intervention, and 97804 for group medical nutrition therapy. Psychotherapy and family-based interventions may also support lifestyle-related treatment planning and behavior change, including 90832, 90834, and 90837 for individual psychotherapy of varying duration, as well as 90846 and 90847 for family psychotherapy without or with the patient present, and 90849 for multiple family group psychotherapy. These coding pathways can help support the integration of nutrition, psychotherapy, and family-based services into comprehensive, person-centered behavioral health care.

ACF is also invested in this issue as foster youth are particularly vulnerable to overprescribing. Federal law (Title IV-B, Subpart 1 of the Social Security Act) requires states and other jurisdictions to describe their oversight of prescription medications for children in foster care, including specific protocols used regarding psychotropic medication. ACF monitors these annual reports to ensure states and other jurisdictions have appropriate protocols in place for prescription. In recent years, ACF has also moved toward the use of evidence-based therapies and other non-pharmacological interventions. Kin, caseworkers, and state child welfare agencies closest to youth in foster care have the best knowledge of the needs of children in their care. By supporting a wide range of interventions at the federal level, ACF gives states and agencies the flexibility to treat foster youth without relying too heavily on prescription medication.

ACF launched its A Home for Every Child initiative to support this goal by aiming to increase the ratio of foster homes to foster youth and carefully reducing the number of children who enter the foster care system. ACF is leveraging federal funding to advance this mission and is coming alongside state agencies to give broad latitude, flexibility, and technical support to reimagine

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[2] State Medicaid and CHIP coverage for these codes varies. Practitioners should confirm covered services, eligible provider types, and any prior authorization requirements with their state Medicaid and CHIP agencies or, when applicable, Medicaid and CHIP managed care plans before billing.

community-specific interventions. ACF is eliminating outdated bureaucratic barriers that discourage families from stepping forward, including streamlining foster family licensing, supporting kinship caregivers, and encouraging faith-based partnerships to expand the network of caring families.

SAMHSA is likewise supporting this work through workforce development, technical assistance, and provider education focused on evidence-based psychiatric medication management, including appropriate prescribing, shared decision-making, safe tapering, deprescribing practices, review of polypharmacy, and facilitation of access to evidence-based non-pharmacological interventions. These efforts are intended to support clinicians across settings, including integrated primary care and mental health environments.

Taken together, these activities reflect a shared federal commitment to ensuring that people with mental health conditions have access to the full range of evidence-based care. That includes medication when clinically indicated, but it also includes psychotherapy, family engagement, and lifestyle and behavioral interventions, with careful reassessment of ongoing treatment over time. It also includes ensuring that individuals are meaningfully involved in decisions about their care.

HHS encourages states, tribes, territories, health systems, payers, clinicians, and community-based providers to review current policies, workflows, training, and referral pathways to ensure that evidence-based non-pharmacological options are available and that medication management practices reflect shared decision-making, informed consent, and appropriate clinical review.

Treatment should be individualized. Alternatives should be discussed. Medication regimens should be reassessed over time, and, when tapering or deprescribing is clinically appropriate, it should occur in a safe, thoughtful, and collaborative manner.

Thank you for your continued work to advance high-quality, person-centered mental health care.

Sincerely,

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