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ORIGINAL ARTICLE

Attitudes towards deprescribing in geriatric psychiatry: A survey among older psychiatric outpatients

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Abstract

Understanding the patient perspective is a significant part of the deprescribing process. This study aimed to explore the attitudes of older patients with psychiatric disorders towards deprescribing. A total of 72 of psychiatric outpatients (68% women; median age 76 years) completed the validated Danish version of the revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire. Patients used a median of eight medications (interquartile range 6–12), with 88%, 49% and 24% using antidepressants, antipsychotics and anxiolytics, respectively. Fifty-one percent of patients reported an intrinsic desire to stop one of their medications, while 92% would be willing to stop one on their physician's advice. Seventy-five percent of patients would be worried about missing out on future benefits following deprescribing and 37% had previous bad deprescribing experiences. Use of ≥8 regular medications was associated with more concerns about stopping medication and greater perceived burden of using medication, while use of antipsychotics was not associated with any differences in rPATD factor scores. It is crucial for health care professionals to be aware of patients' specific concerns and past experiences to promote a patient-centred deprescribing approach that takes into account the needs and preferences of older patients with psychiatric disorders.

KEYWORDS
attitudes, deprescribing, geriatric psychiatry, older people, psychotropics

1 | INTRODUCTION

Use of psychotropics, such as antidepressants, antipsychotics and anxiolytics, for treatment of psychiatric disorders is common among older people, including psychotropic polypharmacy (i.e., use of two or more psychotropics).[1–3] Although psychotropic polypharmacy can be appropriate, there is increasing risk of adverse

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effects in older people related to these drugs, including falls, sedation and cognitive impairment.[4,5] Conversely, evidence of clinical benefit from these therapies is limited.[1,4] For some people, deprescribing (planned, supervised dose reduction or discontinuation)[6] may therefore be considered. Psychotropic deprescribing can, however, be a complex process.[7] Psychotropics are often used long-term and patients may be reluctant to stop these medications,[8] while underlying psychiatric morbidity, pharmacological dependence and withdrawal symptoms may further complicate the deprescribing process. In addition, health care professionals report multiple barriers to psychotropic deprescribing, for example, lack of qualifications and resources.[9,10]

Understanding patients' perspectives on deprescribing is crucial in promoting patient-centred deprescribing.[11] Qualitative literature has reported some willingness among older patients to try deprescribing long-term antidepressant use and barriers that might affect the process, including fear of symptom recurrence and relapse, lack of confidence in deprescribing capabilities and previous unsuccessful deprescribing attempts.[8,12,13] Multiple studies have also explored deprescribing attitudes of older patients in larger scale, mainly by use of the (revised) Patients' Attitudes Towards Deprescribing (PATD/rPATD) questionnaire,[14,15] and similarly found that older patients are generally willing to try deprescribing in general.[16] Although the PATD/rPATD questionnaire has been applied in multiple health care settings, there has been limited investigation of patient attitudes in a geriatric psychiatry setting.[17] A better understanding of the needs and preferences of older patients with psychiatric disorders can potentially facilitate patient-centred psychotropic deprescribing in clinical practice.

With this study, we aimed to explore attitudes of older psychiatric outpatients towards deprescribing.

2 | METHODS

2.1 | Setting and patients

The study was conducted in the Region of Southern Denmark. Patients were recruited from three geriatric psychiatry outpatient clinics from November 2021 to March 2023. Patients are eligible for referral to these clinics if aged ≥70 years and having relevant psychiatric disorders, such as depression, anxiety and bipolar disorder; however, patients aged <70 years may sometimes be referred. Nurses identified Danish-speaking patients aged ≥65 years who were interested in study participation and deemed medically stable by the treating physician (i.e., patients that had not recently initiated psychotropic treatment or were currently undergoing changes to psychotropic treatment). All patients were taking at least one medication although this was not a formal eligibility criterion. Patients' name, contact information, medication list, name of contact physician/nurse and time of next appointment in the clinic were sent to one author (MN) who scheduled a meeting between the patient and one of three authors (MN, TS, SG) in either the clinic/hospital, the patient's home or online, depending on the patient's preference. During this meeting, the patient's final study eligibility was assessed by use of the Orientation-Memory-Concentration (OMC) test[18] (eligibility score of ≥8) and, if found eligible, the patient was ultimately invited to participate in the study and to provide written consent.

2.2 | Questionnaires

PATD were explored using the Danish version of the rPATD questionnaire.[19] The rPATD questionnaire consists of four 5-item factors exploring patients' level of involvement in medication use, perceived burden of taking medication, belief in appropriateness of using medication and concerns about stopping medication. It further includes two global questions exploring patients' satisfaction with medication and willingness to stop a medication on a physician's advice. The questionnaire uses a 5-point Likert response scale (1–5 points) and is reported as a total score for each of the four factors (calculated as the average of the summed score for the five questions in each factor; possible score range 1–5). Higher total scores indicate more involvement, greater perceived burden, greater belief in appropriateness and more concerns about stopping.[14] In the validation of the Danish version, items 9 (inconvenience of taking medication) and 10 (medication expenses) were omitted from the final version to adjust to Danish context. However, as this applied specifically to the Danish nursing home setting,[19] responses for these items were also collected and included for analysis in this study.

In addition to the rPATD questionnaire, the Abbreviated Wake Forest Trust in Physician (Trust in Physician) Scale[20] and the Beliefs about Medicines Questionnaire (BMQ) Specific-Concerns Scale[21] were included in the data collection. Both scales use a 5-point Likert response scale (1–5 points) and are reported as one total score (possible score range: 5–25). Higher scores indicate more physician trust[20] and more concerns about prescribed medication,[21] respectively.

2.3 | Data collection

We used a similar approach to our data collection as has been described in detail elsewhere.[19,22] In brief, patients

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completed the questionnaires by interview with one of the three authors (MN, TS, SG). Response options were presented to the patients on papers in a large font. Questions were registered as missing if the patients did not provide an answer after having a question read three times. To ensure consistency in the data collection, the three authors completed the first four interviews in pairs. All data was stored using REDCap.[23]

2.4 | Statistics

Patient characteristics and rPATD responses were reported and compared using descriptive statistics. To adjust for missing items, all questionnaire scores were converted to a 0–100 scale using proportional recalculation.[24] In the calculation of scores,[14,20,21] patients with two or more missing items within the same factor did not receive a total score. rPATD factor scores as well as responses to the two global questions (as proportion of patients answering strongly agree or agree) were compared across selected predefined patient characteristics, including sex, age, OMC score, number of regular medications, use of antipsychotics, medication administration (self-administration or administration by relative/caregiver) and Trust in Physician and BMQ Specific-Concerns scores. All analyses were performed using Stata 17 (StataCorp, College Station, TX, USA).

2.5 | Ethics

The study was registered in the Region of Southern Denmark's repository (approval 20/12045). The Regional Committees on Health Research Ethics waived registration (case number 20202000-218). Patient inclusion was based on informed and written consent. The study was conducted in accordance with the Basic & Clinical Pharmacology & Toxicology policy for experimental and clinical studies.[25]

TABLE 1 Patient characteristics.

Characteristic	Study population ($n = 72$)
Women	49 (68%)
Age, median (IQR)	76 (73–79)
OMC score[a]	
Median (IQR)	24 (20–26)
8–17	9 (13%)
18–24	33 (46%)
25–28	30 (42%)
Use of regular medications	
Median (IQR)	8 (6–12)
1–4	9 (13%)
5–9	35 (49%)
≥10	28 (39%)
Use of psychotropic medications	
Antidepressants	63 (88%)
Antipsychotics	35 (49%)
Anxiolytics	17 (24%)
Medication administration	
Self-administration	39 (54%)
Administration by relative or caregiver	33 (46%)
Educational level	
Elementary school	22 (31%)
High school or business school	11 (15%)
Bachelor or Master	14 (19%)
Other	25 (35%)
Trust in Physician score[b], median (IQR)	80 (70–95)
BMQ Specific-Concerns score[b], median (IQR)	42 (30–65)

Abbreviations: BMQ, Beliefs about Medicines Questionnaire; IQR, interquartile range; OMC, Orientation-Memory-Concentration.
[a]OMC scores: 8–17: Moderate cognitive impairment; 18–24: Slight cognitive impairment; 25–28: Normal or minimal cognitive impairment.[18]
[b]Possible score range: 0–100. Higher scores indicate more physician trust[20] and more concerns about prescribed medication,[21] respectively.

3 | RESULTS

3.1 | Patient characteristics

A total of 72 patients were included in the study of which 68% ($n = 49$) were women and with a median age of 76 years (interquartile range [IQR] 73–79) and a median OMC score of 24 (IQR 20–26) (Table 1). Patients used a median of eight regular medications (IQR 6–12), with 88% ($n = 63$), 49% ($n = 35$) and 24% ($n = 17$) using antidepressants, antipsychotics and anxiolytics, respectively. About half of patients (54%; $n = 39$) were self-administering their medications, while the remaining (46%; $n = 33$) had their medications administered by a relative or caregiver. Patients generally lived in private homes, while few ($n < 5$) lived in care homes, sheltered housing or similar. About one-third of patients (31%; $n = 22$) were interviewed in the clinic, while the remaining (69%; $n = 50$) were interviewed in the patient's home (data not shown).

3.2 | Attitudes towards deprescribing

Overall, 52% ($n = 37$) of patients considered their medications necessary and 77% ($n = 55$) were satisfied with their

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current medications (Table 2). More than two-thirds of patients (69%; $n = 50$) felt they were taking many medications, about half (52%; $n = 38$) felt they were sometimes taking too many medications, almost half (47%; $n = 34$) believed that one or more of their medications were currently causing side effects and a fourth (25%; $n = 18$) believed that one or more of their medications were possibly not working. About half of the patients (51%; $n = 37$) would like to try stopping one of their medications on their own, while 92% ($n = 66$) would be willing to stop one of their regular medications if their physician said it was possible. Three in four patients (75%; $n = 54$) would be worried about missing out on future benefits if one of their medications were stopped and 41% ($n = 30$) would be reluctant to stop a long-term medication. More than one-third of patients (37%; $n = 27$) had a previous bad experience with stopping a medication.

3.3 | Associations between rPATD factor scores and patient characteristics

The entire score range was generally used for each rPATD factor (Figure 1).

Use of antipsychotics was not associated with any pronounced differences in any of the four rPATD factor scores (Table 3). The most notable differences in factor scores were related to the number of regular medications used by patients and their concerns about prescribed medication (i.e., their BMQ-Specific Concerns score). Specifically, using ≥8 regular medications was linked to higher "concerns about stopping" and "burden" scores (median 55 vs. 35; median 55 vs. 40). Additionally, having more concerns about prescribed medication was linked to a higher "burden" score (median 60 vs. 37) and a lower "appropriateness" score (median 42 vs. 60). Finally, minor differences in factor scores were observed based on sex (with men having a slightly higher "burden" score and women having slightly higher "appropriateness" and "concerns about stopping" scores), age (with patients aged ≥75 years having a slightly higher "concerns about stopping" score), OMC score (with patients with an OMC score of <24 having a slightly higher "burden" score) and physician trust (with patients having lower trust in their physician showing a slightly lower "involvement" score and a slightly higher "burden" score).

Responses to the global questions were generally similar across patient characteristics, with the most notable differences being related to patients' concerns about prescribed medication, that is, their BMQ-Specific Concerns score (Table 3). Specifically, patients with more concerns about prescribed medication were less satisfied with their current medications (56% vs. 97%).

4 | DISCUSSION

In a sample of older psychiatric outpatients, we found that a considerable proportion of patients were open to the idea of deprescribing: about half expressed an intrinsic desire to stop one of their medications, while more than 90% would be willing to stop one on their physician's advice. Patients would generally be worried about missing out on future benefits following deprescribing and a considerable proportion had previous bad deprescribing experiences. Use of more regular medications was associated with more concerns about stopping medication and greater perceived burden of using medication, while use of antipsychotics specifically was not associated with any pronounced differences in rPATD factor scores.

Several limitations should be acknowledged in the interpretation of our study findings. Firstly, nurses identified patients that were willing and seemingly able to participate in the study, based on a subjective consideration of general health and cognitive function, after which we assessed final study eligibility by use of the OMC test.[18] The initial patient identification by nurses may have resulted in inclusion of patients with better cognitive function than the average older psychiatric outpatient population. In a previous analysis of rPATD factor scores in a similar population of non-psychiatric geriatric patients, we only observed minor effects of OMC scores on the "appropriateness" factor,[22] suggesting limited impact on our findings. We, however, find it likely that the patients included in our study are selected among more well-functioning older psychiatric outpatients, as some patients will likely have declined study participation. Further, we excluded patients with recent initiation of or changes in psychotropic treatment who could potentially have different perspectives on deprescribing. Secondly, our sample size was relatively small, which led to some comparisons, in particular of patient subgroups, to be based on small numbers with the inherent uncertainties that follows from that. Our restriction of patient recruitment to the Region of Southern Denmark may similarly have influenced generalizability. Thirdly, we did not record the number of patients who were offered study participation, limiting our ability to assess the representativeness of our sample. Fourthly, our application of interviews introduces the possibility of social desirability bias (i.e., with patients responding what is perceived socially acceptable).[26] Finally, our patient recruitment proved to be challenging, with several factors contributing to this issue. The COVID-19 pandemic significantly impacted our study, leading to a pause in patient recruitment for several months during 2021 and 2022. The pandemic also resulted in an increased workload among the nurses in the clinics (during as well as following the

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TABLE 2 Attitudes of older psychiatric outpatients ($n = 72$) towards deprescribing[a].

Item number and question	Strongly agree	Agree	Unsure	Disagree	Strongly disagree	Missing
1. Overall, I am satisfied with my current medicines[b]	39% ($n = 28$)	38% ($n = 27$)	13% ($n = 9$)	11% ($n = 8$)	-	-
2. I like to be involved in making decisions about my medicines with my doctors	47% ($n = 34$)	39% ($n = 28$)	8% ($n = 6$)	6% ($n = 4$)	-	-
3. I have a good understanding of the reasons I was prescribed each of my medicines	49% ($n = 35$)	42% ($n = 30$)	6% ($n = 4$)	4% ($n = 3$)	-	-
4. I like to know as much as possible about my medicines	58% ($n = 42$)	28% ($n = 20$)	10% ($n = 7$)	4% ($n = 3$)	-	-
5. I always ask my doctor, at the pharmacy or the nursing staff if there is something I do not understand about my medicines	42% ($n = 30$)	40% ($n = 29$)	10% ($n = 7$)	6% ($n = 4$)	3% ($n = 2$)	-
6. I know exactly what medicines I am currently taking, and/or I keep an up to date list of my medicines	50% ($n = 36$)	31% ($n = 22$)	6% ($n = 4$)	13% ($n = 9$)	1% ($n = 1$)	-
7. If my doctor said it was possible I would be willing to stop one or more of my regular medicines[b]	49% ($n = 35$)	43% ($n = 31$)	3% ($n = 2$)	3% ($n = 2$)	3% ($n = 2$)	-
8. I feel that I am taking a large number of medicines	36% ($n = 26$)	33% ($n = 24$)	8% ($n = 6$)	21% ($n = 15$)	1% ($n = 1$)	-
9. Taking my medicines every day is very inconvenient	4% ($n = 3$)	7% ($n = 5$)	6% ($n = 4$)	51% ($n = 37$)	32% ($n = 23$)	-
10. I spend a lot of money on my medicines	21% ($n = 15$)	22% ($n = 16$)	14% ($n = 10$)	32% ($n = 23$)	11% ($n = 8$)	-
11. Sometimes I think I take too many medicines	19% ($n = 14$)	33% ($n = 24$)	10% ($n = 7$)	29% ($n = 21$)	8% ($n = 6$)	
12. I feel that my medicines are a burden to me	7% ($n = 5$)	18% ($n = 13$)	15% ($n = 11$)	42% ($n = 30$)	18% ($n = 13$)	-
13. I would like to try stopping one of my medicines to see how I feel without it	15% ($n = 11$)	36% ($n = 26$)	6% ($n = 4$)	28% ($n = 20$)	15% ($n = 11$)	-
14. I would like my doctor to reduce the dose of one or more of my medicines	13% ($n = 9$)	32% ($n = 23$)	25% ($n = 18$)	24% ($n = 17$)	7% ($n = 5$)	-
15. I feel that I may be taking one or more medicines that I no longer need	7% ($n = 5$)	15% ($n = 11$)	26% ($n = 19$)	39% ($n = 28$)	13% ($n = 9$)	-
16. I believe one or more of my medicines may be currently giving me side effects	19% ($n = 14$)	28% ($n = 20$)	14% ($n = 10$)	32% ($n = 23$)	7% ($n = 5$)	-
17. I think one or more of my medicines may not be working	6% ($n = 4$)	19% ($n = 14$)	19% ($n = 14$)	39% ($n = 28$)	17% ($n = 12$)	-
18. I have had a bad experience when stopping a medicine before	18% ($n = 13$)	19% ($n = 14$)	7% ($n = 5$)	44% ($n = 32$)	11% ($n = 8$)	-
19. I would be reluctant to stop a medicine that I had been taking for a long time	19% ($n = 14$)	22% ($n = 16$)	19% ($n = 14$)	33% ($n = 24$)	6% ($n = 4$)	-

(Continues)

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TABLE 2 (Continued)

Item number and question	Strongly agree	Agree	Unsure	Disagree	Strongly disagree	Missing
20. If one of my medicines was stopped I would be worried about missing out on future benefits	24% ($n = 17$)	51% ($n = 37$)	14% ($n = 10$)	8% ($n = 6$)	1% ($n = 1$)	1% ($n = 1$)
21. I get stressed whenever changes are made to my medicines	13% ($n = 9$)	11% ($n = 8$)	19% ($n = 14$)	46% ($n = 33$)	11% ($n = 8$)	-
22. If my doctor recommended stopping a medicine I would feel that he/she was giving up on me	3% ($n = 2$)	7% ($n = 5$)	4% ($n = 3$)	60% ($n = 43$)	26% ($n = 19$)	-

[a]Item wording from the English version of the revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire is used.[14] One exception concerns item 5 for which pronounced changes were made during the validation of the Danish version (replacement of 'my pharmacist' and 'other health care professional' with 'at the pharmacy' and 'the nursing staff', respectively). For further details, see previous works.[19]
[b]Global question, that is, the item is not included in any of the four factors.

pandemic), which affected their ability to identify patients for study participation. As a result of the pandemic, we attempted to offer online interviews but ultimately had to abandon this setup due to lack of acceptability among the patients.

In our study, about half of patients considered their medications necessary, while around three in four patients were satisfied with their current medications. These findings suggest a higher level of scepticism regarding treatment among our study population than what has been reported in other studies involving non-psychiatric patients. For example, in a similar population of non-psychiatric geriatric patients, we found that 64% and 84% considered their medications necessary and were satisfied with their current medications, respectively.[22] Similar rates have also been reported in multiple other studies using the PATD/rPATD questionnaire.[16] Despite potential treatment scepticism, the patients in our study also expressed reluctance towards deprescribing. For example, three in four patients would be worried about missing out on future benefits if one of their medications were stopped, while more than one-third reported previous bad experiences with deprescribing. In comparison, this only applied to 55% and 22%, respectively, in a similar population of non-psychiatric geriatric patients.[22] While it is important to consider the specific context and limitations of our study, including the fact that our study population's responses do not necessarily apply specifically to their psychiatric medications, these observed differences may have important implications for understanding and addressing the unique concerns and preferences of geriatric psychiatric patients in the deprescribing process. For example, deprescribing psychotropics can be challenging due to withdrawal symptoms, which could possibly explain the large proportion of patients reporting previous bad deprescribing experiences in this study. Such concerns should thus be carefully considered when addressing deprescribing in this patient population. In fact, more concerns have been shown to decrease patients' willingness to try deprescribing.[27] Thus, developing a thorough understanding of patients' potential treatment scepticism, specific concerns and past experiences can potentially help health care professionals better support them throughout the deprescribing process, ultimately promoting a more patient-centred approach that takes into account the needs and preferences of older patients with psychiatric disorders. Further investigation in larger and more representative samples is needed to confirm these findings and to better understand factors affecting deprescribing willingness in this patient population.

Our finding that most patients would be willing to stop one of their regular medications on their physician's

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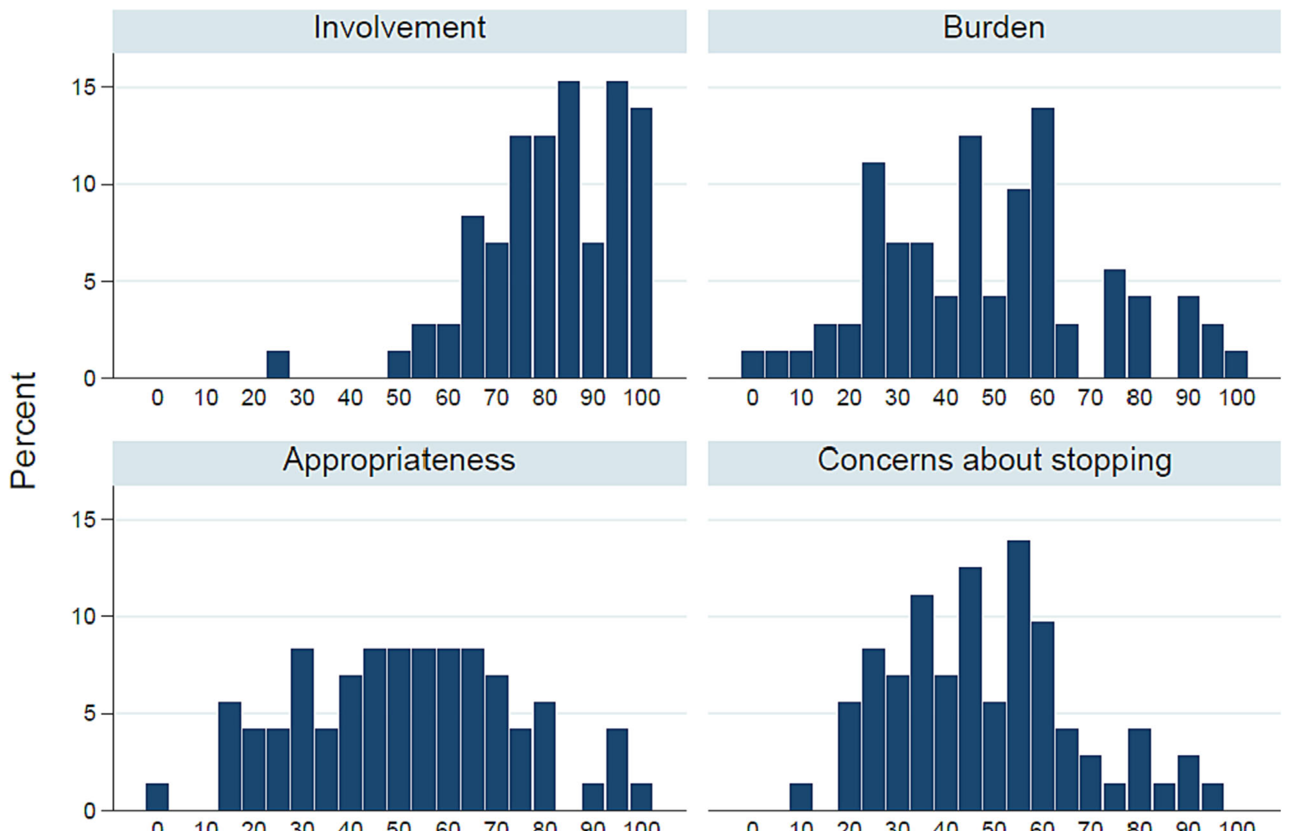

FIGURE 1 Revised Patients' Attitudes Towards Deprescribing (rPATD) factor score distributions for older psychiatric outpatients ($n = 72$).

advice is generally in line with previous PATD/rPATD literature, regardless of patient population and health care setting.[16] Nevertheless, the findings discussed above (i.e., the potential influence of specific concerns and past experiences on patients' deprescribing willingness) as well as the qualitative literature on patient barriers to psychotropic deprescribing[8,12,13] suggest that most older psychiatric outpatients do have significant barriers to engage in deprescribing in an actual clinical situation, in particular of their psychotropic treatment. Although some studies have adjusted the PATD/rPATD questionnaire to focus on specific drug classes (e.g., alpha-blockers,[28] proton pump inhibitors),[29] the original questionnaire is not medication-specific.[14,15] It is reasonable to assume that some patients will likely put emphasis on certain medications when completing the questionnaire, meaning that it may not necessarily represent their attitudes towards their full medication list. For example, in the process evaluation of the SPPiRE trial,[30] many patients indicated that they were open to the idea of deprescribing but reluctant to deprescribe specific drug classes, such as benzodiazepines.[31] The hypothesis that application of the PATD/rPATD questionnaire outside an actual clinical situation might exaggerate patients' willingness to deprescribe treatment is supported by research demonstrating low predictive validity of the PATD questionnaire.[32] To better understand deprescribing willingness among older psychiatric outpatients, future research could use a revised version of the rPATD questionnaire focused on patients' psychiatric treatment or a specific group of psychotropics, such as the recently adapted and validated French version for benzodiazepine receptor agonists,[33] and preferably as part of an actual clinical situation.

Our findings that using more regular medications was associated with more concerns about stopping medication and greater perceived burden of using medication is consistent with findings from a previous rPATD study in a similar population of non-psychiatric geriatric patients. This also applies to the associations of having more concerns about prescribed medication and greater perceived burden of using medication and lower belief in appropriateness of using medication, respectively.[22] We did not find any pronounced associations between use of antipsychotics and rPATD factor scores. This is possibly partly explained by the small sample size and the fact that patients may not necessarily have put emphasis on their antipsychotic treatment when completing the

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TABLE 3 Patients' attitudes towards Deprescribing (rPATD) factor scores[a] and responses to global questions[b] for older psychiatric outpatients (n = 72) across patient characteristics.

	Involvement, median (IQR)	Burden, median (IQR)	Appropriateness, median (IQR)	Concerns about stopping, median (IQR)	Global question 1 (item 1)[c]	Global question 2 (item 7)[d]
Study population (n = 72)	85 (75–95)	45 (30–60)	50 (35–65)	45 (35–60)	77%	92%
Sex						
Women	80 (75–95)	45 (30–60)	55 (40–70)	55 (35–65)	76%	88%
Men	85 (70–90)	55 (40–60)	45 (20–60)	40 (35–45)	78%	100%
Age						
<75 years	80 (75–90)	50 (30–60)	50 (30–70)	40 (31–55)	67%	90%
≥75 years	85 (75–95)	45 (30–60)	55 (35–65)	50 (35–60)	80%	92%
OMC score						
<24	85 (75–95)	55 (40–65)	50 (30–75)	45 (40–60)	71%	84%
≥24	85 (75–95)	45 (25–60)	50 (40–65)	45 (30–55)	80%	98%
Number of regular medications						
<8	85 (70–95)	40 (25–55)	50 (35–70)	35 (30–55)	80%	91%
≥8	80 (75–90)	55 (40–75)	55 (35–65)	55 (45–65)	73%	92%
Use of antipsychotics						
Yes	80 (70–90)	45 (30–60)	50 (30–65)	45 (35–60)	74%	89%
No	85 (75–95)	45 (30–75)	55 (35–70)	45 (30–60)	78%	95%
Medication administration						
Self-administration	80 (65–90)	55 (40–60)	45 (30–60)	45 (35–60)	73%	91%
Administration by relative or caregiver	85 (75–95)	45 (25–60)	50 (40–70)	45 (30–60)	79%	92%
Trust in Physician score[e]						
<80	75 (70–85)	55 (40–60)	47 (30–60)	45 (35–55)	71%	97%
≥80	85 (80–95)	42 (25–60)	52 (40–70)	45 (35–60)	82%	87%
BMQ Specific-Concerns score[e]						
<42	85 (75–95)	37 (25–45)	60 (45–75)	47 (30–60)	97%	89%
≥42	82 (72–90)	60 (47–75)	42 (27–60)	45 (35–55)	56%	94%

Abbreviations: BMQ, Beliefs about Medicines Questionnaire; IQR, interquartile range; OMC, Orientation-Memory-Concentration.

[a]Possible score range: 0–100. Higher scores indicate more involvement, greater perceived burden, greater belief in appropriateness and more concerns about stopping.[14]

[b]Proportion of patients answering strongly agree or agree.

[c]Overall, I am satisfied with my current medicines.

[d]If my doctor said it was possible I would be willing to stop one or more of my regular medicines.

[e]Possible score range: 0–100. Higher scores indicate more physician trust[20] and more concerns about prescribed medication,[21] respectively.

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questionnaire. Further, we recruited patients specifically from the psychiatry and not primary care, meaning that treatment of many of these patients is likely more complex compared to similar geriatric patients in a primary care setting.

In conclusion, our study findings suggest that this sample of older psychiatric outpatients are open to the idea of deprescribing but may exhibit more scepticism towards their treatment compared to non-psychiatric geriatric patients. Further, they may have specific concerns and past bad experiences related to deprescribing that need to be addressed during the deprescribing process. It is crucial for health care professionals to be aware of these distinct challenges and to adopt a patient-centred approach when considering deprescribing in a geriatric psychiatry setting, taking into account the needs and preferences of older patients with psychiatric disorders.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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