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Helping people discontinue long-term antidepressants: Views of health professionals in UK primary care

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-027837
Article Type:	Research
Date Submitted by the Author:	12-Nov-2018
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Keywords:	antidepressants, Depression & mood disorders < PSYCHIATRY, PRIMARY CARE, health professional

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Manuscripts

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4 1 Helping people discontinue long-term antidepressants: Views of health
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7 2 professionals in UK primary care
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4 1 **Abstract** (300 words max)
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6 2 Objective: The aim of this paper was to identify, characterise and explain clinician factors
7
8 3 which shape decision making around antidepressant discontinuation in UK primary care.
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10 4 Design: Focus groups and interviews were conducted and analysed using thematic analysis.
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12

13 5 Participants: GPs, GP Assistants, nurses, Community Mental Health Team Workers and
14
15 6 psychotherapists took part in focus groups and interviews.
16

17 7 Setting: Participants were recruited from seven primary care regions and two NHS Trusts
18
19 8 providing community mental health services in the South of England.
20
21

22 9 Results: Participants highlighted a number of barriers and enablers to discussing
23
24 10 discontinuation with patients. They held a range of views around responsibility, with some
25
26 11 suggesting it was the responsibility of the health professional to broach the subject, and
27
28 12 others suggesting responsibility rested with the patients. Health professionals were
29
30 13 concerned about destabilising the current situation, discussed how continuity and knowing
31
32 14 the patient facilitated discontinuation talks, and discussed how confidence in their
33
34 15 professional skills and knowledge affected whether they elected to raise discontinuation in
35
36 16 consultations.
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42 17 Conclusions: Findings indicate a need to consider support for health professionals in the
43
44 18 management of antidepressant medication and discussions of discontinuation in particular.
45
46 19 They may also benefit from support around their fears of patient relapse and awareness of
47
48 20 when and how to initiate discussions about discontinuation with their patients.
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52 21
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54 22 **Keywords** antidepressants; depression; primary care; focus group; health professional
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4 1 **Strengths and limitations of this study**

- 5
6 2 • This study explored views of primary care health professionals in relation to
7
8 3 antidepressant withdrawal
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10 4 • Focus groups allowed participants to exchange views on the topic thereby providing
11
12 topic rich data
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14 5
15 6 • Unlike previous research, this study included perspectives of non-GP health
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17 professionals
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19 7
20 8 • The use of focus groups facilitated group discussion however it is possible that the
21
22 group setting may reduce openness
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1 Introduction

2 Antidepressant prescriptions have risen steadily since the introduction of selective serotonin
3 reuptake inhibitors (SSRIs) in the late 1980s. This rise is primarily due to general
4 practitioners (GPs) continuing to prescribe for longer [1,2], with the average length of
5 treatment now at more than two years [3,4]. Around 10% of adults are currently taking
6 antidepressants (predominantly for depression, but also for anxiety and chronic pain) [5], yet
7 the prevalence of major depression is only 3% [6]. Some people need long-term
8 antidepressants to prevent relapse, but surveys suggest 30-50% have no guideline-based
9 indication for long-term use (e.g. according to the NICE Depression Guideline (2009)) [7-9].
10 This may be due to many patients on long-term treatment being given repeat prescriptions
11 and being reviewed infrequently [10,11].

12
13 The side effects of antidepressants include weight gain, sexual dysfunction, sleep
14 disturbance, and gastrointestinal bleeding, which increase with longer-term use [12]. SSRI
15 use for depression in older patients is associated with increased risk of falls, fractures,
16 seizures, stroke, and hyponatraemia [13]. In addition, long-term treatment may lead to
17 emotional blunting [14], impaired self-confidence and increased dependence on health
18 services. Antidepressants constitute a substantial proportion of the NHS drug budget: 2.5%
19 in 2010 [15] and the costs of unnecessary treatment include appointments for medical or
20 nursing reviews. The cost of GP consultations for depression exceeded £30m in 2008, in
21 addition to the cost of the 64.7 million antidepressant prescriptions of around £266m
22 (HSCIC, 2015; HSCIC, 2017; Independent Research Service of the House of Commons
23 Library, 2008). Attempts to discontinue in the 30-50% of patients taking antidepressants

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4 1 without guidance-based indication may then result in reduced NHS costs while

5
6 2 simultaneously alleviating the side effects associated with antidepressant use.

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10 4 Stopping antidepressants is challenging for doctors. Prompting GPs to review patients who

11
12 5 were eligible for withdrawal was tested in a trial in the Netherlands and found to be

13
14 6 ineffective, with only 6% of patients discontinuing antidepressants in the intervention group,

15
16 7 and 8% in the control group [19]. Similarly, an uncontrolled trial of pharmacist-prompted GP

17
18 8 review of long-term users in Scotland resulted in only 7% of people stopping [3]. Prompting

19
20 9 alone is therefore insufficient in supporting patients to discontinue antidepressants, which

21
22 10 indicates there are other factors preventing GPs from attempting to withdraw patients from

23
24 11 antidepressants.

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26 12

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28 13 While GPs play a key role in prescribing and discontinuing antidepressants, other health

29
30 14 professionals also advise patients about antidepressants in primary care. Previous research

31
32 15 with health professionals looking at antidepressant discontinuation has reported that the

33
34 16 main barrier is a lack of awareness of guidance on best practice in discontinuation [20].

35
36 17 Other barriers include a lack of awareness of patient expectations that health professionals

37
38 18 should initiate discussions of discontinuation, the availability of alternative treatments, time

39
40 19 constraints, and GP and patient fear of destabilising a currently well patient [20,21]. A

41
42 20 qualitative meta-synthesis of patient and practitioner perspectives on antidepressant

43
44 21 discontinuation highlighted a lack of consistent support and guidance for GPs and the impact

45
46 22 of time constraints on discontinuation [22]. However there is only limited evidence on the

47
48 23 health professional perspective of antidepressant discontinuation (in particular practice

49
50 24 nurses and community mental health workers) and previous studies were completed outside

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3 1 of the UK, and one within a nursing home. Insights into UK primary care health professional
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6 2 perspectives are therefore needed to determine barriers and facilitators to supporting
7
8 3 patients in discontinuing antidepressants in the UK.
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13 5 The REDUCE programme aims to identify ways of helping patients taking long-term
14
15 6 antidepressants withdraw from treatment when appropriate [23]. Normalisation Process
16
17 7 Theory (NPT) identifies, characterises and explains key mechanisms that motivate and
18
19 8 shape implementation processes [24]. It focuses attention on the work that participants in
20
21 9 these processes do when they seek to routinely incorporate components of complex
22
23 10 interventions in their everyday lives. This paper reports the findings from the health
24
25 11 professional (HP) focus groups as part of the REDUCE programme. Our aims were to
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27 12 identify, characterise and explain clinician factors which shape decision making around
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29 13 antidepressant discontinuation in UK primary care.
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44 15 **Methods**

45 17 *Participants*

46 18 HPs including GPs, GP Assistants, nurses, Community Mental Health Team Workers and
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48 19 psychotherapists were recruited from seven primary care regions and two NHS Trusts
49
50 20 providing community mental health services in the South of England between January and
51
52 21 May 2017. GP practices and individuals were recruited via email and were invited to return a
53
54 22 reply slip. HPs who expressed an interest were invited to take part in one of four focus
55
56 23 groups taking place in the South of England between March and May 2017. Twenty-one
57
58 24 sites returned a reply slip, with thirty-eight participants taking part in either a focus group or
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4 1 interview (22 females and 12 males). The reported range of years since qualified was 2-35.
5
6 2 Focus groups were chosen over individual interviews to allow participants to exchange views
7
8 3 on the topic thereby providing topic rich data as well as an insight into group and individual
9
10 4 views, including important areas of consensus and disagreement. Individual interviews were
11
12 5 offered to psychotherapists as this group was underrepresented in the focus group sample
13
14 6 (n=2) and to one GP in order to pilot the topic guide. Every participant was taken through the
15
16 7 informed consent process and given the opportunity to read the information leaflet and ask
17
18 8 questions prior to data collection. Each focus group had between seven and ten participants
19
20 9 and the length of each ranged between 43 and 59 minutes.
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30 11 *Patient and Public Involvement*

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32 12 Patient and public members of the REDUCE team were involved in discussions about the
33
34 13 design and recruitment for this study, and were invited to comment on initial drafts of the
35
36 14 topic guide.
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42 16 *Ethical Approval*

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44 17 Ethical approval to conduct the study was granted by the South Central Berkshire B
45
46 18 Research Ethics Committee and the Health Research Authority (Reference Number
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48 19 16/SC/0472).
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54 22 *Focus Groups*

55
56 23 A topic guide was developed based around the main aims of the study (supplement 1).
57
58 24 Topics explored long-term antidepressant use and knowing when discontinuation may be
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3 1 appropriate, negotiating the decision to discontinue antidepressants with patients, HP roles
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6 2 in terms of supporting and negotiating appropriateness of discontinuation, how to optimise
7
8 3 discussions around possible discontinuation, and ways to optimise implementation of a
9
10 4 discontinuation intervention in routine practice. Normalisation Process Theory [24] informed
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12
13 5 the topic guide in order to ensure the questions addressed the processes involved in
14
15 6 antidepressant discontinuation with regards to the four NPT constructs (Coherence,
16
17 7 Cognitive Participation, Collective Action, and Reflexive Monitoring). For example, to
18
19 8 address the NPT construct of cognitive participation (i.e. who does the work), participants
20
21 9 were asked 'What do you see as your role in negotiating medication discontinuation'. The
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23 10 topic guide was not limited to discussing depressive disorders and therefore was open to
24
25 11 discussion about antidepressant use in other conditions (e.g. anxiety and chronic pain).
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32 13 The focus groups were conducted face-to-face and were organised pragmatically across
33
34 14 different geographical locations in the South of England. Two groups were held with mixed
35
36 15 primary care HPs and two groups with GPs only (see table 1). Groups were held in GP
37
38 16 practices and a community-based health centre. In order to acknowledge potential "group"
39
40 17 effects (i.e. participants being unaware of the degree to which other group members' views
41
42 18 represent their own experience), free participation was encouraged by the facilitators by
43
44 19 avoiding censorship and conformity [25]. Focus groups were facilitated and co-facilitated by
45
46 20 two experienced female qualitative researchers (SW and WOB) and were audio recorded. A
47
48 21 debriefing was conducted by the two facilitators following each focus group to identify issues
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50 22 that may affect analysis (e.g. domineering or quiet members), to discuss what went well,
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52 23 what did not and suggest possible modifications to the topic guide.
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1 Table 1. Number of health professionals attending each focus group or interview.

	Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4	Interview	Total
GP	7	2	2	9	1	21
GPA	0	4	0	0	0	4
NP	0	2	5	0	0	7
CMHW or PT	0	2	2	0	2	6
Totals	7	10	9	8	3	38

2 *Notes.* GP: General Practitioner; GPA General Practitioner Assistant; NP: Nurse Practitioner; CMHW:
3 Community Mental Health team Worker; PT: Psychological Therapist.

5 *Interviews*

6 Three semi-structured face-to-face qualitative interviews were conducted with two
7 psychotherapists and a GP. The same topic guide that had been developed for the focus
8 groups was utilised in the interviews to ensure consistency. As with the focus groups, the
9 interviewer explored additional topics when brought up by the interviewee. Interviews were
10 carried out by an experienced qualitative researcher (SW) and were audio recorded.

12 *Analysis*

13 All focus groups and interviews were transcribed verbatim. Transcripts were read and re-
14 read by SW both during and after the data collection period. While the focus groups and
15 interviews were taking place, the REDUCE Study team met regularly to discuss topics raised
16 by participants and the topic guide was refined as the focus groups and interviews
17 progressed through debriefing with the two facilitators and through meetings with the wider

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4 1 research team. These discussions resulted in only minor changes regarding the order of
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6 2 questions in the schedule and the wording of questions.
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10 4 A thematic analysis approach was used to analyse data drawing on methods of constant
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13 5 comparison [26–29]. SW independently coded the seven transcripts using Nvivo, and a
14
15 6 secondary analysis team (SW, AG, HB, GL and TK) met to agree a preliminary coding
16
17 7 frame, which was then agreed by the whole team. HB independently coded two transcripts
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19 8 using the coding frame; discrepancies were minor and changes were made following
20
21 9 discussion with the team. Codes were grouped into themes by SW and HB, where both
22
23 10 within and between-participant variation was considered. Theme labelling and interpretation
24
25 11 was continually discussed in regular team meetings. Data were assessed for saturation by
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27 12 SW individually and across-group (Onwuegbuzie et al., 2009). Data saturation was
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29 13 determined when no new codes were emerging.
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48 15 **Results**

49 16 Five themes were identified from the data analysis regarding barriers and facilitators to
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51 17 discussing antidepressant discontinuation with patients (see figure 1).
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19 [insert figure 1 about here]

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21 Theme 1: Who is responsible for broaching the subject of discontinuation?

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4 1 There were differing views about who is responsible for raising the topic of discontinuation in
5
6 2 a consultation. A small number of HPs suggested it was the patient's responsibility to broach
7
8 3 the subject and that this expectation should be set when antidepressants are first prescribed.
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14 5 *I tend to say to people, 'Look, when you start it, I'd like you to continue for at least six*
15
16 6 *months after you've felt well', and then right at the outset, I put the responsibility over*
17
18 7 *to them and say, 'Look, one of the things about depression is that you lose control*
19
20 8 *and the worst thing is to come to see the doctor and the doctor takes over control.*
21
22 9 *So, as far as I'm concerned, you're in control of these tablets and it's your choice as*
23
24 10 *to when you want to stop it but usually the recommendation is six months after you've*
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26 11 *been well'. I think most people - I haven't audited it - at that stage, do come back*
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28 12 *round about six months-ish and are keen to stop and usually that works okay.*

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33 13 [GP/09/0002].
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15 One GP argued in favour of telling the patient at the initial prescription that they have the
16 responsibility to initiate stopping and the choice to discontinue is up to them. By setting the
17 expectation that it is the patient's responsibility, it opens up the possibility of them taking
18 control by broaching the subject with their GP when they are ready.

19 However HPs highlighted there are problems with relying on the patient to broach the issue.

20 Two nurses and a psychotherapist acknowledged that many patients may not instigate these
21 conversations. One psychotherapist explained that patients may be reluctant to broach the
22 subject due to their expectation of how the doctor may respond, or because they perceive
23 the doctor to be more knowledgeable about the situation.

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7 2 *Even if they do get an appointment, I've met a lot of people who are really hesitant*
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9 3 *about asking about changes in medication, because of the response from the doctor*
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11 4 *perhaps or their perceived response... I think there's often a worry, you know, the*
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13
14 5 *kind of, 'Doctor knows best, and they put me on this medication. So I don't want to*
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16 6 *offend or I don't want to question'. [PT/14/0002].*
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22 8 One GP suggested that when patients do not raise the idea of discontinuation, practitioners
23
24 9 may assume that the patient wants to continue treatment. This mutual assumption that the
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26
27 10 HP wants the patient to continue, and that the patient him/herself wants to continue, may
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30 11 result in a form of collusion to maintain the status quo.

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32 12 HPs appeared to be aware that relying on the patient to initiate discussion may be
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35 13 problematic, as evidenced through the way some HPs discussed the problem. It may
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37 14 therefore follow that the responsibility to initiate discussions around discontinuation should
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40 15 lie with the GP.

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46 17 *I think I'm guilty of this, it's very easy just to keep kicking the can down the road and*
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48 18 *the patient keeps taking the medication because they feel they should and you keep*
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50 19 *prescribing it because you assume they still want it and there's this kind of collusion*
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53 20 *that unless you actively intervene and say, 'Come and talk to me', or whatever.*
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55 21 [GP/11/0001].
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4 1 Some participants (including GPs) thought that it was the GP's responsibility to broach the
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6 2 subject with patients; arguing that the person who prescribes the medication should be the
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8 3 person to initiate discussion of discontinuation. This was especially the case if a patient has
9
10 4 been on the medication long-term and may not have considered stopping. However, taking a
11
12 5 proactive approach was not always considered feasible in practice; continuity may facilitate
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14 6 discussions of antidepressant withdrawal, though it is not always possible in primary care.
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18 7 Some of the HPs referred to the discussion of discontinuation as a shared decision process.
19
20 8 They talked about the need to assess the patient's capacity in making decisions about
21
22 9 withdrawal and also negotiating with the patient to come to a shared decision about whether
23
24 10 to discontinue. One GP also suggested it must be a shared decision as GPs are currently
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26 11 unable to manage the amount of work involved due to organisational factors which make
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28 12 having these conversations more challenging.
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14 *We'd say that because these patients are working and living in the community and*
15 *are not sectioned and have capacity, that there is definitely a shared responsibility*
16 *with the patient because it is their medicine and their mental health that we're looking*
17 *after. So I'm quite happy to say it's a shared responsibility but it definitely can't be just*
18 *a primary care clinician's because we'll not manage to cope. [GP/19/0002].*

20 The role of other HPs was also discussed with regards to conversations around
21 discontinuing antidepressants. Though nurses have been considered to play a role in the
22 discussions around withdrawal, there is acknowledgement that there are limitations
23 regarding their authority and experience in managing medications, and often patients are

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4 1 signposted to their GP by their nurse. Social workers, pharmacists, care co-ordinators and
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6 2 psychiatrists were also mentioned as potential sources of additional support in stopping
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8 3 antidepressants, in some cases.
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14 5 Theme 2: Risk of destabilising current situation
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17 6 Some HPs described it being easier to continue prescribing rather than raising
18
19 7 discontinuation with patients and acknowledged a need to initiate more discussions about
20
21 8 discontinuation with patients who may be eligible. There were concerns about instigating
22
23 9 discussions with patients who are currently well as they did not want to risk destabilising the
24
25 10 current situation. It was considered less risky to continue prescribing.
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33 12 *I think about - not just to patients but also to healthcare professionals or GPs - to*
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35 13 *reduce the medication is the concern that they might be working and reducing might*
36
37 14 *destabilise a current stable situation, especially if the patient has been very, very*
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39 15 *difficult to control in the past and hasn't got the support network perhaps.*
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41 16 [GP/12/0001].
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49 18 There was an assumption that patients also do not want to risk upsetting the current
50
51 19 situation if they are feeling well.
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57 21 *I think for a lot that are on them, there is a massive fear factor about stopping,*
58
59 22 *because they remember how awful they felt. They don't want to feel like that. They*
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4 1 *feel well again and they just think, well, you know, I'd rather just keep the status quo.*

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6 2 [GP/03/0004].

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15 5 Theme 3: Continuity and knowing the patient makes it easier to discuss discontinuation

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18 6 Involvement in the initial prescription was perceived to place responsibility on the prescriber
19
20 7 to prompt discontinuation at a later date, and an opportunity to discuss and set patient
21
22 8 expectations around withdrawal. Explaining to a patient at the initial prescription that
23
24 9 discontinuation will be discussed at a later date was seen to be a facilitator in broaching the
25
26
27 10 subject of discontinuation later down the line.

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33 12 *The very first consultation if you're actually selling the idea of some medication being*
34
35 13 *helpful, that it's for a specific time period, expecting someone to be able to be able to*
36
37 14 *come off it at about six months, so suggest your timescale of appointments and then*
38
39 15 *say, 'Oh, see you in about five months from the initiation of treatment. At that point,*
40
41 16 *we can actually make a plan for withdrawal and I would be planning to withdraw it*
42
43 17 *slowly if everything was going well in your life'. [GP/11/0004].*

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51 19 There were a number of facilitators to discussing discontinuation with patients. These
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53 20 included knowledge of the patient's experience with antidepressants, their triggers for
54
55 21 depression, why they started their medication and how things have changed since the initial
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4 1 prescription. This again suggests that continuity is beneficial, especially in terms of reducing
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6 2 risk.

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12 4 Theme 4: A HP's confidence in their skills and knowledge

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15 5 HPs discussed their confidence in their skills and knowledge about antidepressant
16
17 6 discontinuation. Some of the HPs reported a lack of confidence, knowledge and skill with
18
19 7 regards to antidepressant discontinuation which could act as a barrier to broaching the
20
21 8 subject of stopping with patients. There was an awareness that discussing discontinuation
22
23 9 with patients is something that could be improved upon.
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31 11 *As a GP, I think for GPs, I think we're very good at starting patients on it. We are*
32
33 12 *good at titrating the dose up. Pretty good at picking the right medications suitable for*
34
35 13 *the patients, because they have different side effects over spectrums. But what we're*
36
37 14 *probably not good enough, at the moment, is sort of the long-term managing and the*
38
39 15 *coming-off part. [GP/12/0001]*
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46 17 HPs discussed a need for more support and information for themselves as well as for
47
48 18 patients. They spoke about NICE guidance on antidepressant discontinuation, with many of
49
50 19 the HPs being unfamiliar with the guidance or not using them. They described being
51
52 20 dissatisfied and, in one case, irritated by the current guidance. They highlighted that it is
53
54 21 unclear (especially regarding tapering regimes), limited, not accessible and at times not
55
56 22 applicable to real patients.
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I don't think there's a lot of resources out there to kind of what to say and how to do it.

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I'm sure I've looked at the guidelines before and I thought a bit pants. [NP/12/0001].

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5 Theme 5: Organisational barriers and enablers to discussing discontinuation

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18 6 The above processes are shaped by the context surrounding them, with environmental work19
20 7 contributing to decision making around discontinuation. Some aspects of the healthcare21
22 8 system were described as further barriers to antidepressant discontinuation. A lack of23
24 9 continuity was reported with patients seeing different practitioners each time, and these25
26 10 practitioners were at times providing inconsistent recommendations. This may act as a27
28 11 barrier to discussing discontinuation due to the perceived need to be familiar with a patient to29
30 12 discuss withdrawal, and the idea that the responsibility for raising the topic of discontinuation31
32 13 lies with the HP who initially prescribed the antidepressant.33
34 14 HPs repeatedly noted the challenge of time constraints in practice and how this is often a35
36 15 barrier to both initiating and managing discontinuation due to ten minute consultations not37
38 16 being long enough, and not having the time for review appointments.39
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46 1747
48 18 *things are ticking along relatively okay, you know it's not going to be necessarily a*49
50 19 *straightforward consultation and it might be time consuming, it might delay you and*51
52 20 *you haven't got enough appointments anyway and da, da, da, da, you can see how*53
54 21 *that, as a clinician, restrains you from perhaps rocking the boat. [GP/11/0002].*55
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4 1 HPs also mentioned the role of computer systems, explaining that patients can get lost in the
5
6 2 system and that systems which adequately prompt medication reviews would be useful in
7
8 3 broaching discontinuation with patients.
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10 11 4 12 13 14 5 **Discussion**

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17 6 In this paper we explored HP perspectives on discontinuing long-term antidepressants in
18
19 7 primary care. Five themes were identified and covered who is responsible for broaching the
20
21 8 subject of discontinuation, how fear of relapse can dissuade HPs from discontinuing,
22
23 9 familiarity with the patient as enabling conversations around withdrawal, the lack of
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25 10 information and support for HPs, and organisational barriers and enablers. With regards to
26
27 11 NPT, there is relational work that goes into negotiating responsibility and shared decision-
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29 12 making about antidepressant discontinuation. This relational work is founded on familiarity
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31 13 with the patient and knowledge of their experiences with depression and antidepressants.
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33 14 There is process work that goes into intervening, managing the consequences of withdrawal
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35 15 and avoiding destabilisation of a patient during and following discontinuation. This is founded
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37 16 on enacting generalisable clinical knowledge and practice with confidence. These processes
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39 17 are then shaped by contextual mechanisms and there is environmental work that goes into
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41 18 negotiating the decision to discontinue antidepressants.
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49 19 An important theme identified in the current paper is a contention in terms of who is
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51 20 responsible for broaching the topic of discontinuing antidepressants. While the majority of
52
53 21 HPs acknowledged that the responsibility may lie with the GP or be a shared decision with
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55 22 patients, they indicated that they currently do not initiate these conversations as much as
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57 23 they feel they ought to. There is limited evidence of this in previous research with one study
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4 1 reporting that some GPs expect patients to contact their practitioner when they wish to make
5
6 2 changes to or discontinue their antidepressant [20].
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9 3 The shift in recent decades in primary care towards expert patients and self-care relies on an
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11 4 expectation of agency on behalf of the patient [30]. However depression and the long-term
12
13 5 use of antidepressants are associated with reduced agency (Cartwright et al., 2018). HPs
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15 6 appear to be aware that there are barriers for patients in initiating conversations about
16
17 7 withdrawal. The logical implication of this would be that GPs take the responsibility for
18
19 8 initiating these conversations. However, despite GPs' awareness of the need to improve on
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21 9 the current situation, these conversations about discontinuation are often not routinely being
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23 10 initiated by GPs.
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29 11 GPs in the current study discussed a tension between being more proactive in their role and
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31 12 their full workload, which in effect limits opportunities to demarcate time for focused
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33 13 discussion about discontinuation. Among the factors enabling discussion about
34
35 14 discontinuation were knowing the patient and continuity of care. However, in current UK
36
37 15 primary care, patients do not always see the same GP and GPs therefore may be unable to
38
39 16 build the desired relationship with or acquire the desired knowledge of a patient before
40
41 17 broaching the subject of stopping antidepressants. This suggests that the way primary care
42
43 18 often operates does not lend itself to the desired context for discussing withdrawal, which
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45 19 results in a bias towards inaction in terms of withdrawing patients from antidepressants. One
46
47 20 implication is that familiarisation with the patient's situation should be achieved through
48
49 21 medical notes and through discussion with the patient. However, time constraints may mean
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51 22 that consultations are not long enough to gather the desired information about the patient
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53 23 before discussing withdrawal. If it were agreed that initial discussions should be triggered by
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55 24 the GP, this would bring clarity to the currently uncertain system. With a more clearly
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1 articulated plan, GPs may be better able to arrange appointments (perhaps double
2 appointments where necessary) to discuss discontinuation.
3 HPs reported fear of destabilising currently well patients by discontinuing antidepressants; a
4 fear which has been evidenced in patients and GPs [20,21,31]. This emphasis on avoiding
5 negative outcomes over focusing on the longer-term benefits of discontinuation may result in
6 a preference for deferring discussions of withdrawal. However when comparing
7 antidepressant maintenance treatment to tapering with psychological support, long-term
8 relapse rates for depression are comparable [32–34] or in some cases lower for patients
9 receiving psychological therapy [35,36]. It may therefore be useful to reassure HPs that the
10 risk of relapse may be minimised if discontinuation is accompanied by appropriate
11 psychological support (though there is still a need for further work on providing support for
12 patients who are discontinuing antidepressants) [32,36,37].
13 HPs report dissatisfaction with the current guidelines and acknowledge gaps in their own
14 knowledge regarding antidepressant withdrawal. One other study has highlighted that GPs
15 feel guidelines could provide more specific information about antidepressant treatment and
16 discontinuation [20]. This suggests a need to provide improved guidance and enhanced
17 accessibility to and awareness of guidance on discontinuation, including specific guidance
18 on reducing the doses of different antidepressants. This may increase HP confidence in their
19 ability to support patients through discontinuation. This increased confidence in the HP
20 ability to manage discontinuation may then also help to lessen the HP's fear of disrupting the
21 status quo and the risk of patient relapse.

23 **Strengths and Limitations**

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4 1 This study is the first to explore HP perspectives of antidepressant discontinuation in UK
5
6 2 primary care, with its larger sample consisting of a range of HP roles (including GPs, GP
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8 3 assistants, nurses, community mental health team workers and psychotherapists) which
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10 4 were lacking in previous research (e.g. Bosman et al., 2016; Dickinson et al., 2010; Iden et
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12 5 al., 2011; Johnson et al., 2017; Johnston et al., 2007; Pollock and Grime, 2002). GPs were
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14 6 the largest group among our interviewees, compared to the other professionals, which aligns
15
16 7 with the current prescribing activity with the large majority of long-term antidepressants
17
18 8 prescribed and monitored by GPs. This fits with our finding that GPs are often considered
19
20 9 responsible for initiating conversations around withdrawal. However we also identified that
21
22 10 there are a number of professionals who may be involved in discontinuation (e.g.
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24 11 pharmacists, social workers and care co-ordinators) and further research may be needed to
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26 12 explore these perspectives. In particular it may be of interest to explore differences between
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28 13 professions.

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35 14 The use of focus groups facilitated discussion and provided candid responses from
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37 15 participants. However it is possible for discussions to become polarised or influenced by
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39 16 more dominant members of the group. For example, in a focus group of nine GPs, there
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41 17 were two more dominant members and two members who spoke less frequently. As such,
42
43 18 some participants' views may be less well represented in a group setting. Giving participants
44
45 19 an opportunity to provide feedback on the study's findings might have helped provide greater
46
47 20 representation.

21 22 **Conclusion**

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4 1 Previous research has highlighted time constraints and fear of relapse as barriers to GPs
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6 2 discontinuing antidepressants and one previous study found that some GPs expected
7
8 3 patients to initiate discussions of discontinuation. The current study has explored these
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10 4 barriers in detail in UK primary care health professionals and highlighted additional factors
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13 5 influencing decisions around discontinuation such as organisational barriers, a need for
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15 6 clearer guidance as well as a desire to know the patient well. Our findings highlight a need to
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18 7 support HPs in antidepressant discontinuation in terms of providing specific information and
19
20 8 guidance on how to discontinue antidepressants. They also suggest HPs would benefit from
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23 9 support and guidance around fears of patient relapse and awareness of the need to initiate
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25 10 discussions about discontinuation. Future research is needed to explore ways in which HPs
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28 11 can be supported in managing antidepressant discontinuation in primary care and in a way
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30 12 that is acceptable to and effective for patients.
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1 **Acknowledgements**

2 The authors would like to take this opportunity to thank all contributors, collaborators and
3 team members of the REDUCE programme, including our Patient and Public Involvement
4 (PPI) representatives, Bryan Palmer, Susan Collins and Margaret Bell.

6 **Funding**

7 This report is independent research funded by the National Institute for Health Research
8 (Programme Grants for Applied Research, REDUCE RP-PG-1214-20004). The views
9 expressed in this publication are those of the author(s) and not necessarily those of the
10 NHS, the National Institute for Health Research or the Department of Health.

12 **Data Sharing**

13 This is a qualitative study and therefore the data is not suitable for sharing beyond what is
14 contained within the report. Further information can be requested from the corresponding
15 author.

17 **Competing Interests**

18 None to declare.

20 **Author Contributions**

21 HB is a research fellow working on the REDUCE programme and contributed toward
22 analysis and second coding of data, and the writing of this paper. SW is the qualitative
23 researcher currently working on the REDUCE programme and led the research, data
24 collection, analysis and contributed to the writing of this paper. AG and GL are co-applicants

1
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3 1 on the REDUCE programme and contributed towards the analysis. WOB is the Programme
4
5
6 2 Manager on the REDUCE programme, had oversight of the research and data collection. TK
7
8 3 is the Chief Investigator of the research thereby leading on the programme and contributed
9
10 4 towards analysis and interpretation of data. All co-authors have substantially contributed to
11
12
13 5 the writing of this article, provided critical revision and gave final approval of the published
14
15
16 6 version. All authors agree to be accountable for all aspects of the work in ensuring that
17
18 7 questions related to the accuracy or integrity of any part of the work are appropriately
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20 8 investigated and resolved.
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1 **Figure legend**

2 Figure 1. Diagram of the relationships between themes.

For peer review only

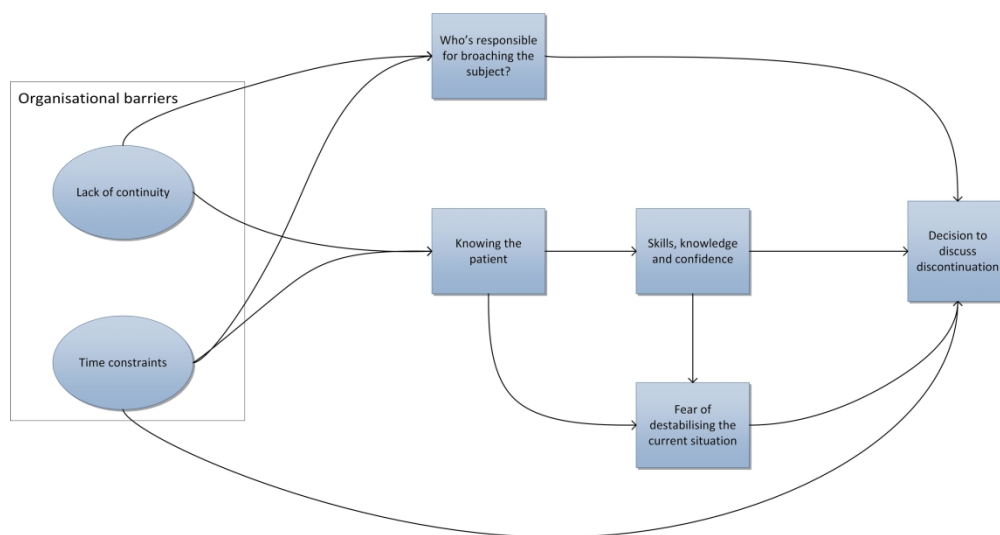


Figure 1. Diagram of the relationships between themes

270x141mm (300 x 300 DPI)

REDUCE Study Workstream 2: REviewing long-term anti-Depressant treatment Use by Careful monitoring in Everyday practice

TOPIC GUIDE FOR PRACTITIONER FOCUS GROUPS

Introduction

1. **Welcome** and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time. Name and role on study.
2. **Introduction:** This focus group discussion is designed to assess your current views and experiences with patients withdrawing from long-term antidepressants, why they might wish to withdraw, and why withdrawal might be difficult. The aim is to develop new ways of helping people withdraw from treatment, taking into account the difficulties they might face.
3. **By way of reminder:**
 - Check participants are still willing to take part, notes that observers are present, and will be audio recorded.
 - Remind them it will take approximately 60 minutes.
 - Their responses will be kept confidential, and quotes used will not identify them.
 - They can change their mind about taking part in the study and stop at any point.
4. **Rules of engagement in focus groups:**
 - To speak one at a time, and allow others to finish their point.
 - To respect each other's point of view, whilst disagreeing if they wish.
 - To be honest even when their responses may not be in agreement with the group.
 - That responses made by all participants be kept confidential – what is said here stays here.
 - The study is to ask them about their experiences and views of helping patients to stop taking antidepressants. Therefore there are no right or wrong answers as it is their views that are important to us.
5. **Ask if the participants have any questions.**
6. **Start recording.**

WARM UP

Firstly, I'd like everyone to introduce themselves. Please could you tell us your name, job role and where you're based?

Topic 1: Long-term antidepressant use and knowing when discontinuation may be appropriate

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1. I would like to invite you to share any clinical experiences you have of discontinuing antidepressants with a patient.

6 Prompts:

- 7 - Explain what happened and why?
8 - What is your current clinical practice for discontinuation?
9 - What problems have you encountered when discontinuing antidepressants?
10 - What have you found to help patients to discontinue their antidepressants?
11

- 12
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14
2. What factors would you look for that indicate a patient is appropriate to discontinue from long-term antidepressants?

15 Prompts:

- 16
17 a. Examples: Recovery, patient request, risk of side effects, potential benefits of discontinuation.
18 b. What impact might user experiences have on decision to discontinue ADs?
19 c. How do you come to the decision to stop a patients antidepressants?
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23
3. Can you think of any practical considerations that may occur when considering antidepressant discontinuation?

24 Prompts:

- 25 - How quickly do you taper antidepressants (if done)?
26 - Lack of dosage forms available to facilitate tapering.
27 - How solve these issues.
28
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31
4. What are your thoughts on current guideline recommendations for long-term antidepressant use?

32 Prompts:

- 33 - What are your thoughts on the current NICE guidelines?
34 - How easy are the guidelines to follow?
35 - What questions do the guidelines leave you with?
36 - Any thoughts on presentation?
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38 *Hand out copies of current NICE Guidelines.*

Topic 2: Negotiating the decision to discontinue antidepressants with patients.

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5. How do you negotiate discontinuation of antidepressant medication with a patient?

45 Prompts:

- 46 - Whose decision is it in the end (to stop)?
47 - At what point is the discussion usually initiated?
48 - How do you feel about broaching the subject of discontinuation? How much do you push for people to
49 withdraw? Perception of risk vs patient's wishes?
50

- 51
52
53
6. What is your involvement in discontinuing antidepressants with a patient?

54 Prompts:

- 55 - Can you explain why you might not get involved?
56 - What process do you follow if this topic is brought up by a patient?
57 - Have you ever discussed discontinuation of antidepressants with a patient?
58 - What would you like your involvement to be in the future?
59
60

CHECK FOR COMMENTS / QUESTIONS WITH CO-FACILITATOR

Topic 3: Role as a GP/NP/PCMHW in terms of supporting/negotiating appropriateness of discontinuation7. What do you see as your role in negotiating medication discontinuation?

Invite to draw on real life clinical examples and ask to explain what happened.

Prompts:

- How typically do you view your role in the stopping process from deciding to stop through to stopping (or not)?
- Role of other HPs in dealing with medication discontinuation – GP, NP, Therapist, pharmacist, psychiatrist, etc.
- Relationships between practitioners?

Topic 4: How to optimise discussions about possible discontinuation with patients8. Can you think of ways to improve discussions about possible discontinuation with patients?

Prompts:

- Usefulness of verbal / written advice to aid discontinuation.
- Role of support networks and ways of bringing others into the process where appropriate? Uses (e.g. decision making tools, source of social support, support /challenge /resistance to medical decision)? Challenges around introducing?
- How would you evaluate and monitor discontinuation (e.g. evaluate success)?

Topic 5: Ways to optimise implementation of a discontinuation intervention in routine practice9. What would you like to see in an intervention to help people stop antidepressants?

Prompts:

- Supportive needs of patients / practitioners?
- Content / mode of delivery?
- Help from other team members?
- Help from outside the practice?
- How would you like to interact with the intervention?
- Would you like to see anyone else interacting with the intervention?
- What do you see as the role of a GP/NP/PCMHW as part of the intervention?
- **PCMHWs/NPs only:** How would you view the role of providing telephone support? In principle, if trained and paid to work on this for the study (as opposed to long-term) would this be something you'd be interested in / feel able to do?

10. What would an intervention to support treatment discontinuation look like in practice?

Prompts:

- Organisational issues, e.g. GP prescription systems.
- Who would drive the use of the intervention forward in your practice / CCG / professional body?
- How would you maintain use of an intervention over time?
- What would encourage you to use it?

Anything wish to raise that hasn't been discussed?

Any questions?

Moderator to check with observer for any further questions, then close focus group.

Debrief:

- Tell participants audio recorder is now being switched off.
- Thank participants for taking part in the focus group; excellent discussion.
- Revisit consent and reply slip.
- Ask if the participants have any questions / offer opportunity to discuss further following focus group.
- Let participants know will be sending summary of results at the end of the study.
- Distribute travel claims and inform invoices will be sent to practice ASAP.
- Thank participants again for taking part.

For peer review only

COREQ (CONsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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BMJ Open

Helping people discontinue long-term antidepressants: Views of health professionals in UK primary care

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-027837.R1
Article Type:	Research
Date Submitted by the Author:	19-Apr-2019
Complete List of Authors:	Bowers, Hannah; University of Southampton Faculty of Medicine, Primary Care and Population Sciences Williams, Samantha; University of Southampton, Primary Care & Population Sciences Geraghty, Adam; University of Southampton, Primary Care and Population Sciences Maud, Emma; University of Southampton Faculty of Medicine, Primary Care and Population Sciences O'brien, Wendy; University of Southampton Faculty of Medicine, Primary Care and Population Sciences Leydon, Geraldine; University of Southampton, Faculty of Medicine May, Carl; London School of Hygiene and Tropical Medicine Faculty of Epidemiology and Population Health Kendrick, Tony; University of Southampton, Primary Care and Population Sciences
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Qualitative research
Keywords:	antidepressants, Depression & mood disorders < PSYCHIATRY, PRIMARY CARE, health professional

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Manuscripts

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4 1 Helping people discontinue long-term antidepressants: Views of health
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7 2 professionals in UK primary care
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1 **Abstract** (300 words max)

2 Objective: The aim of this paper was to identify, characterise and explain clinician factors
3 which shape decision making around antidepressant discontinuation in UK primary care.

4 Design: Four focus groups and three interviews were conducted and analysed using
5 thematic analysis.

6 Participants: Twenty-one GPs, four GP Assistants, seven nurses and six Community Mental
7 Health Team Workers and psychotherapists took part in focus groups and interviews.

8 Setting: Participants were recruited from seven primary care regions and two NHS Trusts
9 providing community mental health services in the South of England.

10 Results: Participants highlighted a number of barriers and enablers to discussing
11 discontinuation with patients. They held a range of views around responsibility, with some
12 suggesting it was the responsibility of the health professional to broach the subject, and
13 others suggesting responsibility rested with the patients. Health professionals were
14 concerned about destabilising the current situation, discussed how continuity and knowing
15 the patient facilitated discontinuation talks, and discussed how confidence in their
16 professional skills and knowledge affected whether they elected to raise discontinuation in
17 consultations.

18 Conclusions: Findings indicate a need to consider support for health professionals in the
19 management of antidepressant medication and discussions of discontinuation in particular.
20 They may also benefit from support around their fears of patient relapse and awareness of
21 when and how to initiate discussions about discontinuation with their patients.

22
23 **Keywords** antidepressants; depression; primary care; focus group; health professional

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4 1 **Strengths and limitations of this study**

- 5
6 2 • This study explored views of primary care health professionals in relation to
7
8 3 antidepressant withdrawal
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10 4 • Focus groups allowed participants to exchange views on the topic thereby providing
11
12 5 topic rich data
13
14 6 • Unlike previous research, this study included perspectives of non-GP health
15
16 7 professionals
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18 8 • The use of focus groups facilitated group discussion however it is possible that the
19
20 9 group setting may reduce openness
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1 Introduction

2 Antidepressant prescriptions have risen steadily since the introduction of selective serotonin
3 reuptake inhibitors (SSRIs) in the late 1980s. This rise is primarily due to general
4 practitioners (GPs) continuing to prescribe for longer [1,2], with the average length of
5 treatment now at more than two years [3,4]. Around 10% of adults are currently taking
6 antidepressants (predominantly for depression, but also for anxiety and chronic pain) [5].
7 Some people need long-term antidepressants to prevent relapse, but surveys suggest 30-
8 50% have no guideline-based indication for long-term use (e.g. according to the NICE
9 Depression Guideline (2009)) [6–8]. This may be due to many patients on long-term
10 treatment being given repeat prescriptions and being reviewed infrequently [9,10].
11
12 The side effects of antidepressants include weight gain, sexual dysfunction, sleep
13 disturbance, and gastrointestinal bleeding, which increase with longer-term use [11]. SSRI
14 use for depression in older patients is associated with increased risk of falls, fractures,
15 seizures, stroke, and hyponatraemia [12]. Long-term treatment may lead to emotional
16 blunting [13], impaired self-confidence and increased dependence on health services.
17 Antidepressants constitute a substantial proportion of the NHS drug budget: 2.5% in 2010
18 [14] and the costs of unnecessary treatment include appointments for medical or nursing
19 reviews. The cost of GP consultations for depression exceeded £30m in 2008, in addition to
20 the cost of the 64.7 million antidepressant prescriptions of around £266m [15,16, 17].
21 Attempts to discontinue in the 30-50% of patients taking antidepressants without guidance-
22 based indication may then result in reduced NHS costs while alleviating the side effects
23 associated with antidepressant use.

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3 1 Prompting GPs to review patients eligible for withdrawal was tested in a trial in the
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6 2 Netherlands and found to be ineffective, with 6% of patients discontinuing antidepressants in
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8 3 the intervention group, and 8% in the control group [18]. Similarly, an uncontrolled trial of
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10 4 pharmacist-prompted GP review of long-term users in Scotland resulted in only 7% of people
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12 5 stopping [3]. Prompting alone is therefore insufficient in supporting patients to discontinue
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14 6 antidepressants, which indicates there are other factors preventing GPs from attempting to
15
16 7 withdraw patients from antidepressants.
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22 9 While GPs play a key role in prescribing and discontinuing antidepressants, other health
23
24 10 professionals also advise patients about antidepressants in primary care. Previous research
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26 11 with health professionals looking at antidepressant discontinuation has reported that the
27
28 12 main barrier is a lack of awareness of guidance on best practice in discontinuation [19].
29
30 13 Other barriers include a lack of awareness of patient expectations that health professionals
31
32 14 should initiate discussions of discontinuation, the availability of alternative treatments, time
33
34 15 constraints, and GP and patient fear of destabilising a currently well patient [19,20]. Further
35
36 16 to this, patients may experience withdrawal symptoms or relapse and require further
37
38 17 treatment from their practitioner [21]. A qualitative meta-synthesis of patient and practitioner
39
40 18 perspectives on antidepressant discontinuation highlighted a lack of consistent support and
41
42 19 guidance for GPs and the impact of time constraints on discontinuation [22]. However there
43
44 20 is only limited evidence on the health professional perspective of antidepressant
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46 21 discontinuation (in particular practice nurses and community mental health workers) and
47
48 22 previous studies were completed outside of the UK, and one within a nursing home. Insights
49
50 23 into UK primary care health professional perspectives are therefore needed to determine
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52 24 barriers and facilitators to supporting patients in discontinuing antidepressants in the UK.
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6 2 The REDUCE programme aims to identify ways of helping patients taking long-term
7
8 3 antidepressants withdraw from treatment when appropriate [23]. Normalisation Process
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10 4 Theory (NPT) identifies, characterises and explains key mechanisms that motivate and
11
12 5 shape implementation processes [24]. It focuses attention on the work that participants in
13
14 6 these processes do when they seek to routinely incorporate components of complex
15
16 7 interventions in their everyday lives. This paper reports the findings from the health
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18 8 professional (HP) focus groups as part of the REDUCE programme. Our aims were to
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20 9 identify, characterise and explain clinician factors which shape decision making around
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22 10 antidepressant discontinuation in UK primary care.
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30 12 **Methods**

31 13 32 14 *Participants*

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35 15 HPs including GPs, GP Assistants, nurses, Community Mental Health Team Workers and
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37 16 psychotherapists were recruited from seven primary care regions and two NHS Trusts
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39 17 providing community mental health services in the South of England between January and
40
41 18 May 2017. GP practices and individuals were recruited via email and were invited to return a
42
43 19 reply slip. HPs who expressed an interest were invited to take part in one of four focus
44
45 20 groups taking place in the South of England between March and May 2017. Twenty-one
46
47 21 sites returned a reply slip, with thirty-eight participants taking part in either a focus group or
48
49 22 interview (22 females and 12 males). The reported range of years since qualified was 8-34.
50
51 23 Focus groups were chosen over individual interviews to allow participants to exchange views
52
53 24 on the topic thereby providing topic rich data as well as an insight into group and individual
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3 1 views, including important areas of consensus and disagreement. Individual interviews were
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5
6 2 offered to psychotherapists as this group was underrepresented in the focus group sample
7
8 3 (n=2) and to one GP in order to pilot the topic guide. Every participant was taken through the
9
10 4 informed consent process and given the opportunity to read the information leaflet and ask
11
12
13 5 questions prior to data collection. Each focus group had between seven and ten participants
14
15 6 and the length of each ranged between 43 and 59 minutes.
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18 7

19 8 *Patient and Public Involvement*

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21
22 9 Patient and public members of the REDUCE team were involved in discussions about the
23
24 10 design and recruitment for this study, and were invited to comment on initial drafts of the
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26
27 11 topic guide.
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31 13 *Ethical Approval*

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34 14 Ethical approval to conduct the study was granted by the South Central Berkshire B
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37 15 Research Ethics Committee and the Health Research Authority (Reference Number
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39 16 16/SC/0472).
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48 20 *Focus Groups*

49 21 A topic guide was developed based around the main aims of the study (supplement 1). This
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51 22 guide was developed based on a review of existing literature and discussion within a team of
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53 23 academics, GPs, psychiatrists and patient contributors. Topics explored long-term
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55 24 antidepressant use and knowing when discontinuation may be appropriate, negotiating the
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4 1 appropriateness of discontinuation, optimising discussions around possible discontinuation,
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6 2 and optimising implementation of a discontinuation intervention in routine practice.
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8 3 Normalisation Process Theory [24] informed the topic guide so that the questions addressed
9
10 4 the processes involved in antidepressant discontinuation with regards to the four NPT
11
12 5 constructs (Coherence, Cognitive Participation, Collective Action, and Reflexive Monitoring).
13
14 6 For example, to address cognitive participation (i.e. who does the work), participants were
15
16 7 asked 'What do you see as your role in negotiating medication discontinuation'. The topic
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18 8 guide was not limited to discussing depressive disorders and therefore was open to
19
20 9 discussion about antidepressant use in other conditions (e.g. anxiety and chronic pain).
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27 11 The focus groups were conducted face-to-face and were organised pragmatically across
28
29 12 different geographical locations (in GP practices and a community-based health centre) in
30
31 13 the South of England. Two groups were held with mixed primary care HPs and two groups
32
33 14 with GPs only (see table 1). To acknowledge potential "group" effects (i.e. participants being
34
35 15 unaware of the degree to which other group members' views represent their own
36
37 16 experience), free participation was encouraged by the facilitators by avoiding censorship and
38
39 17 conformity [25]. Focus groups were facilitated by two experienced female qualitative
40
41 18 researchers (SW and WOB) and were audio recorded. A debriefing was conducted by the
42
43 19 two facilitators following each focus group to identify issues that may affect analysis (e.g.
44
45 20 domineering or quiet members) and suggest possible modifications to the topic guide. No
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47 21 repeat interviews or focus groups were conducted.
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56 23 Table 1. Number of health professionals attending each focus group or interview.
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	Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4	Interview	Total (n female)
GP	7	2	2	9	1	21 (10)
GPA	0	4	0	0	0	4 (3)
NP	0	2	5	0	0	7 (6)
CMHW or PT	0	2	2	0	2	6 (3)
Totals	7	10	9	8	3	38

Notes. GP: General Practitioner; GPA General Practitioner Assistant; NP: Nurse Practitioner; CMHW: Community Mental Health team Worker; PT: Psychological Therapist.

Interviews

Three semi-structured face-to-face qualitative interviews were conducted with two psychotherapists and a GP. The same topic guide that had been developed for the focus groups was utilised in the interviews to ensure consistency. As with the focus groups, the interviewer explored additional topics when brought up by the interviewee. Interviews were carried out by an experienced qualitative researcher (SW) and were audio recorded.

Analysis

All focus groups and interviews were transcribed verbatim. Transcripts were read and re-read by SW both during and after the data collection period. While the focus groups and interviews were taking place, the REDUCE Study team met regularly to discuss topics raised by participants and the topic guide was refined as the focus groups and interviews progressed through debriefing with the two facilitators and through meetings with the wider research team. These discussions resulted in only minor changes regarding the order and wording of questions.

1

2 A thematic analysis approach was used to analyse data drawing on methods of constant
3 comparison [26–29]. SW independently coded the seven transcripts using Nvivo, and a
4 secondary analysis team (SW, AG, HB, GL and TK) met to agree a preliminary coding
5 frame, which was then agreed by the whole team. HB independently coded two transcripts
6 using the coding frame; discrepancies were minor and changes were made following
7 discussion with the team. Codes were grouped into themes by SW and HB, where both
8 within and between-participant variation was considered. Theme labelling and interpretation
9 was continually discussed in regular team meetings. Data were assessed for saturation by
10 SW individually and across-group (Onwuegbuzie et al., 2009). Data saturation was
11 determined when no new codes were emerging.

12

13 Results

14 Five themes were identified from the data analysis regarding barriers and facilitators to
15 discussing antidepressant discontinuation with patients (see figure 1).

16

17 [insert figure 1 about here]

18

19 Theme 1: Who is responsible for broaching the subject of discontinuation?

20 There were differing views about who is responsible for raising the topic of discontinuation in
21 a consultation. A small number of HPs suggested it was the patient's responsibility to broach
22 the subject and that this expectation should be set when antidepressants are first prescribed.

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I tend to say to people, 'Look, when you start it, I'd like you to continue for at least six

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months after you've felt well', and then right at the outset, I put the responsibility over

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to them and say, 'Look, one of the things about depression is that you lose control

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13 5

and the worst thing is to come to see the doctor and the doctor takes over control.

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15 6

So, as far as I'm concerned, you're in control of these tablets and it's your choice as

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to when you want to stop it but usually the recommendation is six months after you've

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been well'. I think most people - I haven't audited it - at that stage, do come back

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round about six months-ish and are keen to stop and usually that works okay.

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[GP/09/0002].

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12 One GP argued in favour of telling the patient at the initial prescription that they have the

13 responsibility to initiate stopping and the choice to discontinue is up to them. By setting this

14 expectation, it opens up the possibility of them taking control by broaching the subject with

15 their GP when they are ready.

16 However HPs highlighted there are problems with relying on the patient to broach the issue.

17 Two nurses and a psychotherapist acknowledged that many patients may not instigate these

18 conversations. One psychotherapist explained that patients may be reluctant to broach the

19 subject due to expectations of how the doctor may respond, or perceiving the doctor to be

20 more knowledgeable about the situation.

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4 1 *Even if they do get an appointment, I've met a lot of people who are really hesitant*
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6 2 *about asking about changes in medication, because of the response from the doctor*
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8 3 *perhaps or their perceived response... I think there's often a worry, you know, the*
9
10 4 *kind of, 'Doctor knows best, and they put me on this medication. So I don't want to*
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12 5 *offend or I don't want to question'. [PT/14/0002].*
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19 7 One GP suggested that when patients do not raise the idea of discontinuation, practitioners
20
21 8 may assume that the patient wants to continue treatment. This mutual assumption that the
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23 9 HP wants the patient to continue, and that the patient him/herself wants to continue, may
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26 10 result in a form of collusion to maintain the status quo.

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29 11 HPs appeared to be aware that relying on the patient to initiate discussion may be
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31 12 problematic, as evidenced through the way some HPs discussed the problem. It may
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33 13 therefore follow that the responsibility to initiate discussions around discontinuation should
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35 14 lie with the GP.
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43 16 *I think I'm guilty of this, it's very easy just to keep kicking the can down the road and*
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45 17 *the patient keeps taking the medication because they feel they should and you keep*
46
47 18 *prescribing it because you assume they still want it and there's this kind of collusion*
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49 19 *that unless you actively intervene and say, 'Come and talk to me', or whatever.*
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51 20 [GP/11/0001].
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4 1 Some participants (including GPs) thought that it was the GP's responsibility to broach the
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6 2 subject with patients; arguing that the person who prescribes the medication should be the
7
8 3 person to initiate discussion of discontinuation. This was especially the case if a patient has
9
10 4 been on the medication long-term and may not have considered stopping. However, taking a
11
12 5 proactive approach was not always considered feasible in practice; continuity may facilitate
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14 6 discussions of antidepressant withdrawal, though it is not always possible in primary care.
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18 7 Some of the HPs referred to the discussion of discontinuation as a shared decision process.
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21 8 They talked about the need to assess the patient's capacity in making decisions about
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23 9 withdrawal and negotiating with the patient to come to a shared decision about whether to
24
25 10 discontinue. One GP also suggested it must be a shared decision as GPs are currently
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27 11 unable to manage the amount of work involved due to organisational factors which make
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29 12 having these conversations more challenging.
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36 14 *We'd say that because these patients are working and living in the community and*
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38 15 *are not sectioned and have capacity, that there is definitely a shared responsibility*
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40 16 *with the patient because it is their medicine and their mental health that we're looking*
41
42 17 *after. So I'm quite happy to say it's a shared responsibility but it definitely can't be just*
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44 18 *a primary care clinician's because we'll not manage to cope. [GP/19/0002].*
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52 20 The role of other HPs was also discussed with regards to conversations around
53
54 21 discontinuing antidepressants. Though nurses have been considered to play a role in these
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56 22 discussions, there is acknowledgement that there are limitations regarding their authority
57
58 23 and experience in managing medications, and often patients are signposted to their GP by
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3 1 their nurse. Social workers, pharmacists, care co-ordinators and psychiatrists were also
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5
6 2 mentioned as potential sources of additional support in stopping antidepressants, in some
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8 3 cases.
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14 5 Theme 2: Risk of destabilising current situation
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17 6 Some HPs described it being easier to continue prescribing rather than raising
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20 7 discontinuation with patients and acknowledged a need to initiate more discussions about
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22 8 discontinuation with patients who may be eligible. There were concerns about instigating
23
24 9 discussions with patients who are currently well as they did not want to risk destabilising the
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26
27 10 current situation. It was considered less risky to continue prescribing.
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33 12 *I think about - not just to patients but also to healthcare professionals or GPs - to*
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35 13 *reduce the medication is the concern that they might be working and reducing might*
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37
38 14 *destabilise a current stable situation, especially if the patient has been very, very*
39
40 15 *difficult to control in the past and hasn't got the support network perhaps.*
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42 16 [GP/12/0001].
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48
49 18 There was an assumption that patients also do not want to risk upsetting the current
50
51 19 situation if they are feeling well.
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57 21 *I think for a lot that are on them, there is a massive fear factor about stopping,*
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59 22 *because they remember how awful they felt. They don't want to feel like that. They*
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4 1 *feel well again and they just think, well, you know, I'd rather just keep the status quo.*

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6 2 [GP/03/0004].

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15 5 Theme 3: Continuity and knowing the patient makes it easier to discuss discontinuation

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18 6 Involvement in the initial prescription was perceived to place responsibility on the prescriber
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20 7 to prompt discontinuation later, and an opportunity to discuss and set patient expectations
21
22 8 around withdrawal. Explaining to a patient at the initial prescription that discontinuation will
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24
25 9 be discussed at a later date was seen to be a facilitator in broaching the subject of
26
27 10 discontinuation.
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34 12 *The very first consultation if you're actually selling the idea of some medication being*
35
36 13 *helpful, that it's for a specific time period, expecting someone to be able to be able to*
37
38 14 *come off it at about six months, so suggest your timescale of appointments and then*
39
40 15 *say, 'Oh, see you in about five months from the initiation of treatment. At that point,*
41
42 16 *we can actually make a plan for withdrawal and I would be planning to withdraw it*
43
44 17 *slowly if everything was going well in your life'. [GP/11/0004].*
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52 19 There were a number of facilitators to discussing discontinuation with patients. These
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54 20 included knowledge of the patient's experience with antidepressants, their triggers for
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56 21 depression, why they started their medication and how things have changed since the initial
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4 1 prescription. This again suggests that continuity is beneficial, especially in terms of reducing
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6 2 risk.

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12 4 Theme 4: A HP's confidence in their skills and knowledge

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15 5 Some of the HPs reported a lack of confidence, knowledge and skill with regards to
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17 6 antidepressant discontinuation which could act as a barrier to broaching the subject of
18
19 7 stopping with patients. There was an awareness that discussing discontinuation with patients
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21 8 is something that could be improved upon.

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25 9
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28 10 *As a GP, I think for GPs, I think we're very good at starting patients on it. We are*
29
30 11 *good at titrating the dose up. Pretty good at picking the right medications suitable for*
31
32 12 *the patients, because they have different side effects over spectrums. But what we're*
33
34 13 *probably not good enough, at the moment, is sort of the long-term managing and the*
35
36 14 *coming-off part. [GP/12/0001]*

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44 16 HPs discussed a need for more support and information for themselves as well as for
45
46 17 patients. They spoke about NICE guidance on antidepressant discontinuation, with many
47
48 18 being unfamiliar with the guidance or not using them. They described being dissatisfied and,
49
50 19 in one case, irritated by the current guidance. They highlighted that it is unclear (especially
51
52 20 regarding tapering regimes), limited, not accessible and at times not applicable to real
53
54 21 patients.

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4 1 *I don't think there's a lot of resources out there to kind of what to say and how to do it.*

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6 2 *I'm sure I've looked at the guidelines before and I thought a bit pants. [NP/12/0001].*

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12 4 Theme 5: Organisational barriers and enablers to discussing discontinuation

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15 5 The above processes are shaped by the context surrounding them, with environmental work
16
17 6 contributing to decision making around discontinuation. Some aspects of the healthcare
18
19 7 system were described as further barriers to antidepressant discontinuation. A lack of
20
21 8 continuity was reported with patients seeing different practitioners each time, and these
22
23 9 practitioners were at times providing inconsistent recommendations. This may act as a
24
25 10 barrier to discussing discontinuation due to the perceived need to be familiar with a patient to
26
27 11 discuss withdrawal, and the idea that the responsibility for raising the topic of discontinuation
28
29 12 lies with the HP who initially prescribed the antidepressant.
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35 13 HPs repeatedly noted the challenge of time constraints in practice and how this is often a
36
37 14 barrier to both initiating and managing discontinuation due to ten minute consultations not
38
39 15 being long enough, and not having the time for review appointments.
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46 17 *things are ticking along relatively okay, you know it's not going to be necessarily a*
47
48 18 *straightforward consultation and it might be time consuming, it might delay you and*
49
50 19 *you haven't got enough appointments anyway and da, da, da, da, you can see how*
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52 20 *that, as a clinician, restrains you from perhaps rocking the boat. [GP/11/0002].*
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4 1 HPs also mentioned the role of computer systems, explaining that patients can get lost in the
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6 2 system and that systems which adequately prompt medication reviews would be useful in
7
8 3 broaching discontinuation with patients.
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10 11 4 12 13 14 5 **Discussion**

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17 6 In this paper we explored HP perspectives on discontinuing long-term antidepressants in
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19 7 primary care. Five themes were identified and covered who is responsible for broaching the
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21 8 subject of discontinuation, how fear of relapse can dissuade HPs from discontinuing,
22
23 9 familiarity with the patient as enabling conversations around withdrawal, the lack of
24
25 10 information and support for HPs, and organisational barriers and enablers. With regards to
26
27 11 NPT [24], there is relational work that goes into negotiating responsibility and shared
28
29 12 decision-making about antidepressant discontinuation. This relational work is founded on
30
31 13 familiarity with the patient and knowledge of their experiences with depression and
32
33 14 antidepressants. There is process work that goes into intervening, managing the
34
35 15 consequences of withdrawal and avoiding destabilisation of a patient during and following
36
37 16 discontinuation. This is founded on enacting generalisable clinical knowledge and practice
38
39 17 with confidence. These processes are then shaped by contextual mechanisms and there is
40
41 18 environmental work that goes into negotiating the decision to discontinue antidepressants.
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49 19 An important theme identified in the current paper is contention in terms of who is
50
51 20 responsible for broaching the topic of discontinuation. While the majority of HPs
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53 21 acknowledged that the responsibility may lie with the GP or be a shared decision with
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55 22 patients, they indicated that they currently do not initiate these conversations as much as
56
57 23 they feel they ought to. There is limited evidence of this in previous research with one study
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4 1 reporting that some GPs expect patients to contact their practitioner when they wish to make
5
6 2 changes to or discontinue their antidepressant [19].
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9 3 The shift in recent decades in primary care towards expert patients and self-care relies on an
10
11 4 expectation of agency on behalf of the patient [30]. However depression and the long-term
12
13 5 use of antidepressants are associated with reduced agency [31]. GPs appear to be aware
14
15 6 that there are barriers for patients in initiating conversations about withdrawal. The logical
16
17 7 implication of this would be that GPs take the responsibility for initiating these conversations.
18
19 8 However, despite GPs' awareness of the need to improve on the current situation, these
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21 9 conversations about discontinuation are often not routinely being initiated.
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26 10 GPs in the current study discussed a tension between being more proactive in their role and
27
28 11 their full workload, which limits opportunities to demarcate time for focused discussion about
29
30 12 discontinuation. Among the factors enabling discussion about discontinuation were knowing
31
32 13 the patient and continuity of care. However, in current UK primary care, patients do not
33
34 14 always see the same GP and GPs therefore may be unable to build the desired relationship
35
36 15 with or acquire the desired knowledge of a patient before broaching the subject of stopping
37
38 16 antidepressants. The way primary care often operates therefore does not lend itself to the
39
40 17 desired context for discussing withdrawal, which results in a bias towards inaction. One
41
42 18 implication is that familiarisation with the patient's situation should be achieved through
43
44 19 medical notes and discussion with the patient. However, time constraints may mean that
45
46 20 consultations are not long enough to gather the desired information before discussing
47
48 21 withdrawal. If it were agreed that initial discussions should be triggered by the GP, this would
49
50 22 bring clarity to the currently uncertain system. With a more clearly articulated plan, GPs may
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52 23 be better able to arrange appointments (perhaps double appointments where necessary) to
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54 24 discuss discontinuation.
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4 1 HPs reported fear of destabilising currently well patients by discontinuing antidepressants; a
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6 2 fear which has been evidenced in patients and GPs [19,20,32]. This emphasis on avoiding
7
8 3 negative outcomes over focusing on the longer-term benefits of discontinuation may result in
9
10 4 a preference for deferring discussions of withdrawal. However when comparing
11
12 5 antidepressant maintenance treatment to tapering with psychological support, long-term
13
14 6 relapse rates for depression are comparable [33–35] or in some cases lower for patients
15
16 7 receiving psychological therapy [36,37]. It may therefore be useful to reassure HPs that the
17
18 8 risk of relapse may be minimised if discontinuation is accompanied by appropriate
19
20 9 psychological support (though there is still a need for further work on providing support for
21
22 10 patients who are discontinuing antidepressants) [33,37,38].

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28 11 HPs report dissatisfaction with the current guidelines and acknowledge gaps in their own
29
30 12 knowledge regarding antidepressant withdrawal. One other study has highlighted that GPs
31
32 13 feel guidelines could provide more specific information about antidepressant treatment and
33
34 14 discontinuation [19]. This suggests a need to provide improved guidance and enhanced
35
36 15 accessibility to and awareness of guidance on discontinuation, including specific guidance
37
38 16 on reducing the doses of different antidepressants. This may increase HP confidence in their
39
40 17 ability to support patients through discontinuation. This increased confidence in the HP
41
42 18 ability to manage discontinuation may then also help to lessen the HP's fears around
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44 19 destabilisation and relapse.

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51 52 53 21 **Strengths and Limitations**

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56 22 This study is the first to explore HP perspectives of antidepressant discontinuation in UK
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58 23 primary care, with its larger sample consisting of a range of HP roles (including GPs, GP
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4 1 assistants, nurses, community mental health team workers and psychotherapists) which
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6 2 were lacking in previous research [e.g. 20,21,32,39,40], and data reached saturation. GPs
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8 3 were the largest group among our interviewees, compared to the other professionals, which
9
10 4 aligns with the current prescribing activity with the large majority of long-term
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13 5 antidepressants prescribed and monitored by GPs. This fits with our finding that GPs are
14
15 6 often considered responsible for initiating conversations around withdrawal. However we
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18 7 also identified that there are a number of professionals who may be involved in
19
20 8 discontinuation (e.g. pharmacists, social workers and care co-ordinators) and further
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23 9 research may be needed to explore these perspectives. For example, none of the practices
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25 10 in the current study managed discontinuation using practice pharmacists, who may play an
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27
28 11 important role in antidepressant withdrawal. In particular, it may be of interest to explore
29
30 12 differences between professions.

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33 13 The use of focus groups facilitated discussion and provided candid responses from
34
35 14 participants. However it is possible for discussions to become polarised or influenced by
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37
38 15 dominant members of the group. For example, in a focus group of nine GPs, there were two
39
40 16 more dominant members and two members who spoke less frequently. As such, some
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43 17 participants' views may be less well represented in a group setting. Giving participants an
44
45 18 opportunity to provide feedback on the study's findings might have helped provide greater
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48 19 representation.

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51 52 53 21 **Conclusion**

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56 22 Previous research has highlighted time constraints and fear of relapse as barriers to GPs
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59 23 discontinuing antidepressants and one previous study found that some GPs expected
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1 patients to initiate discussions of discontinuation. The current study has explored these
2 barriers in detail in UK primary care health professionals and highlighted additional factors
3 influencing decisions around discontinuation such as organisational barriers, a need for
4 clearer guidance as well as a desire to know the patient well. Our findings highlight a need to
5 support HPs in antidepressant discontinuation in terms of providing specific information and
6 guidance on how to discontinue antidepressants. They also suggest HPs would benefit from
7 support and guidance around fears of patient relapse and awareness of the need to initiate
8 discussions about discontinuation. These findings have informed intervention development
9 within the REDUCE programme. Future research is needed to explore ways in which HPs
10 can be supported in managing antidepressant discontinuation in primary care and in a way
11 that is acceptable and effective for patients.

1 **Acknowledgements**

2 The authors would like to take this opportunity to thank all contributors, collaborators and
3 team members of the REDUCE programme, including our Patient and Public Involvement
4 (PPI) representatives, Bryan Palmer, Susan Collins and Margaret Bell.

6 **Funding**

7 This report is independent research funded by the National Institute for Health Research
8 (Programme Grants for Applied Research, REDUCE RP-PG-1214-20004). The views
9 expressed in this publication are those of the author(s) and not necessarily those of the
10 NHS, the National Institute for Health Research or the Department of Health.

12 **Data Sharing**

13 This is a qualitative study and therefore the data is not suitable for sharing beyond what is
14 contained within the report. Further information can be requested from the corresponding
15 author.

17 **Competing Interests**

18 None to declare.

20 **Author Contributions**

21 HB is a research fellow working on the REDUCE programme and contributed toward
22 analysis and second coding of data, and the writing of this paper. SW is the qualitative
23 researcher currently working on the REDUCE programme and led the research, data
24 collection, analysis and contributed to the writing of this paper. AG and GL are co-applicants

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4 1 on the REDUCE programme and contributed towards the analysis. WOB is the Programme
5
6 2 Manager on the REDUCE programme, had oversight of the research and data collection. TK
7
8 3 is the Chief Investigator of the research thereby leading on the programme and contributed
9
10 4 towards analysis and interpretation of data. All co-authors (HB, SW, AG, GL, CM, EM, WOB
11
12 5 and TK) have substantially contributed to the writing of this article, provided critical revision
13
14 6 and gave final approval of the published version. All authors agree to be accountable for all
15
16 7 aspects of the work in ensuring that questions related to the accuracy or integrity of any part
17
18 8 of the work are appropriately investigated and resolved.
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1 **Figure legend**

2 Figure 1. Diagram of the relationships between themes.

For peer review only

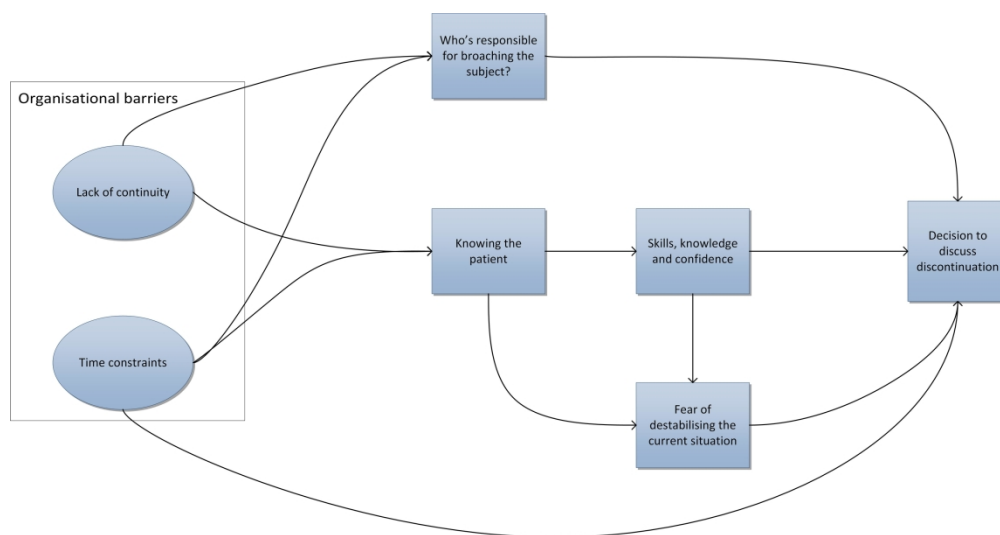


Figure 1. Diagram of the relationships between themes

270x141mm (300 x 300 DPI)

REDUCE Study Workstream 2: REviewing long-term anti-Depressant treatment Use by Careful monitoring in Everyday practice

TOPIC GUIDE FOR PRACTITIONER FOCUS GROUPS

Introduction

1. **Welcome** and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time. Name and role on study.
2. **Introduction:** This focus group discussion is designed to assess your current views and experiences with patients withdrawing from long-term antidepressants, why they might wish to withdraw, and why withdrawal might be difficult. The aim is to develop new ways of helping people withdraw from treatment, taking into account the difficulties they might face.
3. **By way of reminder:**
 - Check participants are still willing to take part, notes that observers are present, and will be audio recorded.
 - Remind them it will take approximately 60 minutes.
 - Their responses will be kept confidential, and quotes used will not identify them.
 - They can change their mind about taking part in the study and stop at any point.
4. **Rules of engagement in focus groups:**
 - To speak one at a time, and allow others to finish their point.
 - To respect each other's point of view, whilst disagreeing if they wish.
 - To be honest even when their responses may not be in agreement with the group.
 - That responses made by all participants be kept confidential – what is said here stays here.
 - The study is to ask them about their experiences and views of helping patients to stop taking antidepressants. Therefore there are no right or wrong answers as it is their views that are important to us.
5. **Ask if the participants have any questions.**
6. **Start recording.**

WARM UP

Firstly, I'd like everyone to introduce themselves. Please could you tell us your name, job role and where you're based?

Topic 1: Long-term antidepressant use and knowing when discontinuation may be appropriate

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1. I would like to invite you to share any clinical experiences you have of discontinuing antidepressants with a patient.

6 Prompts:

- 7 - Explain what happened and why?
8 - What is your current clinical practice for discontinuation?
9 - What problems have you encountered when discontinuing antidepressants?
10 - What have you found to help patients to discontinue their antidepressants?
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2. What factors would you look for that indicate a patient is appropriate to discontinue from long-term antidepressants?

15 Prompts:

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17 a. Examples: Recovery, patient request, risk of side effects, potential benefits of discontinuation.
18 b. What impact might user experiences have on decision to discontinue ADs?
19 c. How do you come to the decision to stop a patients antidepressants?
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3. Can you think of any practical considerations that may occur when considering antidepressant discontinuation?

24 Prompts:

- 25 - How quickly do you taper antidepressants (if done)?
26 - Lack of dosage forms available to facilitate tapering.
27 - How solve these issues.
28
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4. What are your thoughts on current guideline recommendations for long-term antidepressant use?

32 Prompts:

- 33 - What are your thoughts on the current NICE guidelines?
34 - How easy are the guidelines to follow?
35 - What questions do the guidelines leave you with?
36 - Any thoughts on presentation?
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38 *Hand out copies of current NICE Guidelines.*

Topic 2: Negotiating the decision to discontinue antidepressants with patients.

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5. How do you negotiate discontinuation of antidepressant medication with a patient?

45 Prompts:

- 46 - Whose decision is it in the end (to stop)?
47 - At what point is the discussion usually initiated?
48 - How do you feel about broaching the subject of discontinuation? How much do you push for people to
49 withdraw? Perception of risk vs patient's wishes?
50

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6. What is your involvement in discontinuing antidepressants with a patient?

54 Prompts:

- 55 - Can you explain why you might not get involved?
56 - What process do you follow if this topic is brought up by a patient?
57 - Have you ever discussed discontinuation of antidepressants with a patient?
58 - What would you like your involvement to be in the future?
59
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CHECK FOR COMMENTS / QUESTIONS WITH CO-FACILITATOR

Topic 3: Role as a GP/NP/PCMHW in terms of supporting/negotiating appropriateness of discontinuation7. What do you see as your role in negotiating medication discontinuation?

Invite to draw on real life clinical examples and ask to explain what happened.

Prompts:

- How typically do you view your role in the stopping process from deciding to stop through to stopping (or not)?
- Role of other HPs in dealing with medication discontinuation – GP, NP, Therapist, pharmacist, psychiatrist, etc.
- Relationships between practitioners?

Topic 4: How to optimise discussions about possible discontinuation with patients8. Can you think of ways to improve discussions about possible discontinuation with patients?

Prompts:

- Usefulness of verbal / written advice to aid discontinuation.
- Role of support networks and ways of bringing others into the process where appropriate? Uses (e.g. decision making tools, source of social support, support /challenge /resistance to medical decision)? Challenges around introducing?
- How would you evaluate and monitor discontinuation (e.g. evaluate success)?

Topic 5: Ways to optimise implementation of a discontinuation intervention in routine practice9. What would you like to see in an intervention to help people stop antidepressants?

Prompts:

- Supportive needs of patients / practitioners?
- Content / mode of delivery?
- Help from other team members?
- Help from outside the practice?
- How would you like to interact with the intervention?
- Would you like to see anyone else interacting with the intervention?
- What do you see as the role of a GP/NP/PCMHW as part of the intervention?
- **PCMHWs/NPs only:** How would you view the role of providing telephone support? In principle, if trained and paid to work on this for the study (as opposed to long-term) would this be something you'd be interested in / feel able to do?

10. What would an intervention to support treatment discontinuation look like in practice?

Prompts:

- Organisational issues, e.g. GP prescription systems.
- Who would drive the use of the intervention forward in your practice / CCG / professional body?
- How would you maintain use of an intervention over time?
- What would encourage you to use it?

Anything wish to raise that hasn't been discussed?

Any questions?

Moderator to check with observer for any further questions, then close focus group.

Debrief:

- Tell participants audio recorder is now being switched off.
- Thank participants for taking part in the focus group; excellent discussion.
- Revisit consent and reply slip.
- Ask if the participants have any questions / offer opportunity to discuss further following focus group.
- Let participants know will be sending summary of results at the end of the study.
- Distribute travel claims and inform invoices will be sent to practice ASAP.
- Thank participants again for taking part.

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