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Understanding Australian general practice patients' decisions to deprescribe antidepressants in the WiserAD trial: a realist informed approach

Amy Coe , Jane Gunn, Zoe Allnutt, Catherine Kaylor-Hughes

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Department of General Practice and Primary Care, The University of Melbourne, Carlton, Victoria, Australia

Correspondence to
Ms Amy Coe;
amy.coe@unimelb.edu.au

ABSTRACT

Objectives To evaluate how an approach to antidepressant deprescribing works, for whom, and in what contexts by (1) examining the experiences and perceptions of the approach for antidepressant users, (2) identifying the mechanisms of the approach and (3) describing what contexts are associated with antidepressant tapering.

Design This mixed methods study was informed by the principles of realist evaluation and was conducted in the first 3 months of participation in the WiserAD randomised control trial.

Setting General practice, Victoria, Australia.

Participants 13 antidepressant users from general practice participating in the WiserAD trial for antidepressant deprescribing.

Intervention A patient-facing, web-based structured support tool that consists of a personalised tapering schedule, an action plan for managing withdrawal symptoms, a daily mood, sleep and activity tracker and mental health nurse support.

Primary/secondary outcome measures The outcomes of the study were revealed on data analysis as per a realist evaluation approach which tests and refines an initial programme theory.

Results The contexts of learnt coping skills, knowledge and perceptions of antidepressants and feeling well were evident. Outcomes were intention to commence, initiation of deprescribing and successful completion of deprescribing. Key mechanisms for antidepressant deprescribing were (1) initiation of the deprescribing discussion; (2) patient self-efficacy; (3) provision of structured guidance; (4) coaching; (5) mood, sleep and activity tracking and (6) feelings of safety during the tapering period.

Conclusions The WiserAD approach to antidepressant deprescribing supported participants to commence and/or complete tapering. The refined programme theory presents the WiserAD pragmatic framework for the application of antidepressant deprescribing in clinical practice.

Trial registration number ClinicalTrials.gov NCT05355025; ACTRN12622000567729; ISRCTN11562922; Pre-results.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Narrative-style interviews elicited rich responses about a complex clinical process for patients.
⇒ This study was informed by the principles of realist evaluation with adaptations of the methodological approach made to suit the nature of the randomised control trial.
⇒ The study was conducted in the early stages of a clinical trial with a small sample size.

INTRODUCTION

Antidepressants are the first-line treatment for 'more severe' depression and have been shown to be effective in this population.[1 2] Current treatment guidelines recommend that treatment continues for 6–12 months after remission of symptoms;[2 3] however, 30%–50% antidepressant users may be continuing treatment long-term (>12 months) without experiencing clinical benefit.[4] It has been suggested that long-term and unnecessary antidepressant use is contributing to the rapid increase in the rate of antidepressant prescriptions in some countries over the last 30 years.[5 6] Long-term antidepressant use may place some at unnecessary risk of experiencing adverse side effects including increased risk of cardiovascular disease,[7] emotional blunting,[8] and gastrointestinal upset (nausea, constipation and bleeding).[9 10]

Deprescribing (the planned and supervised process of tapering, reducing or ceasing)[11 12] of antidepressants is not routinely occurring in clinical practice.[13] General practitioners (GPs) prescribe the majority (86%)[14] of antidepressants placing them in a unique position to also deprescribe. However, ceasing antidepressants is complex and GPs lack guidance to conduct safe tapering and often wait for patients to initiate the deprescribing discussion.[15 16] Patients are willing to taper their antidepressants but report that GPs are

unable to provide them with education, tailored guidance and withdrawal support leading them to cease antidepressants without clinical support.[17 18] Trials of antidepressant tapering versus placebo have had limited success with high rates of relapse among the intervention group (eg, see Eveleigh *et al*[19] and Lewis *et al*[20]). The complexities of antidepressant cessation suggest that there is a need to determine what approaches are useful for patients and GPs when making the decision to stop.

Realist evaluation offers a framework for the identification of the contexts, mechanisms and outcomes of a programme (or intervention).[21 22] Rather than determining if a programme works, it provides an opportunity to explore how a programme works, for whom it works, why it works and under what circumstances.[21] Mechanisms that promote patient motivation, knowledge and capacity have been shown to be key in successfully deprescribing other medications such as benzodiazepines when the patient has been supported by a clinician.[23]

To date, only one realist evaluation has been conducted on a deprescribing intervention.[23] As such, this study is the first to use the principles of realist evaluation to investigate antidepressant deprescribing in general practice. It aimed to identify how an approach to antidepressant cessation works, for whom, and under what circumstances. Specifically, it aimed to explore and identify (1) the experiences of and perceptions of an approach to tapering by antidepressant users; (2) the key mechanisms of an approach to antidepressant deprescribing and (3) the contexts that are associated with antidepressant tapering.

METHODS

Study setting

The WiserAD randomised control trial (RCT) (herein referred to as WiserAD or the WiserAD trial and described elsewhere[24]) aims to test a patient-facing, web-based structured support tool for patients and GPs to taper antidepressants while maintaining stable mental health and well-being. Participants aged 18–75 years and taking a selective serotonin reuptake inhibitor or serotonin and norepinephrine reuptake inhibitor from participating general practices are invited into the trial by the WiserAD team and their GP. All participants have access to the WiserAD portal during the trial. Participants in the attention control arm are provided with an antidepressant medication fact sheet. Intervention participants receive a personalised tapering schedule and action plan for withdrawal symptoms, a daily mood, sleep and activity tracker, antidepressant medication information and as-needed telephone check-ins from the WiserAD mental health nurse (for up to 6 months).

Study design

A mixed methods study informed by the principles of realist evaluation was conducted in the early stages (baseline to 3-month follow-up) of participant involvement in the WiserAD trial. The methods were also influenced by the first realist evaluation of a deprescribing trial for benzodiazepines.[23] The 3-month follow-up timepoint was chosen to investigate the early decision-making process of participants when presented with the WiserAD approach to antidepressant tapering. The study followed the principles of realist evaluation as outlined by Pawson and Tilley[21 22] and the RAMESES II guidelines.[25] In particular, it aimed to determine the mechanisms of action required to successfully taper, what contexts were involved in leading people to antidepressant deprescribing and what outcomes participants had when taking part in WiserAD. Mechanisms referred to underlying interactions of the WiserAD resources (M: Resource) and participant responses to these resources (M: Reasoning).[21 26 27] In this study, mechanisms were also considered to be the study resources (or the programme component) as per Dalkin *et al*.[28] Contexts (C) were factors that were not part of the WiserAD programme but that could influence the deprescribing process.[21 26 27]

As per realist evaluation, an initial theory of how WiserAD might work to trigger an outcome was also formulated (see Coe *et al*[24]). The specific resource mechanisms tested in this study were (1) initiation of and participating in shared decision-making with GP regarding antidepressant deprescribing; (2) provision of patient education; (3) tapering guidance; (4) availability of relational support and (5) technical support from the WiserAD portal. It was anticipated that these mechanisms would increase participant empowerment, confidence and self-management, and positively challenge participant beliefs about antidepressant medication (ie, reasoning mechanisms). Anticipated outcomes (O) ranged from no intent to deprescribe to successful completion of deprescribing. Detailed methods for the formulation of the initial programme theory tested in the current study are detailed elsewhere and depicted in figure 1.[24]

Data collection

Quantitative data collected as part of the WiserAD trial baseline and 3-month follow-up online surveys were extracted for the 13 participants in the current study. Participant demographics were collected at baseline and beliefs about medications (Beliefs About Medicines Questionnaire[29]), emotional health and well-being (Patient Health Questionnaire-9[30] and 7-item Generalised Anxiety Disorder Scale[31]) and self-efficacy and confidence to take action (Patient Activation Measure–Mental Health[32]) were collected at both timepoints to characterise the sample. Originally web analytics were to be assessed; however, these data were not available at the time.

Qualitative data were collected at the RCT 3-month follow-up using narrative interviews conducted online (Zoom) or over the telephone to identify contexts, mechanisms and outcomes. The first 22 participants enrolled in the WiserAD trial were invited to an interview

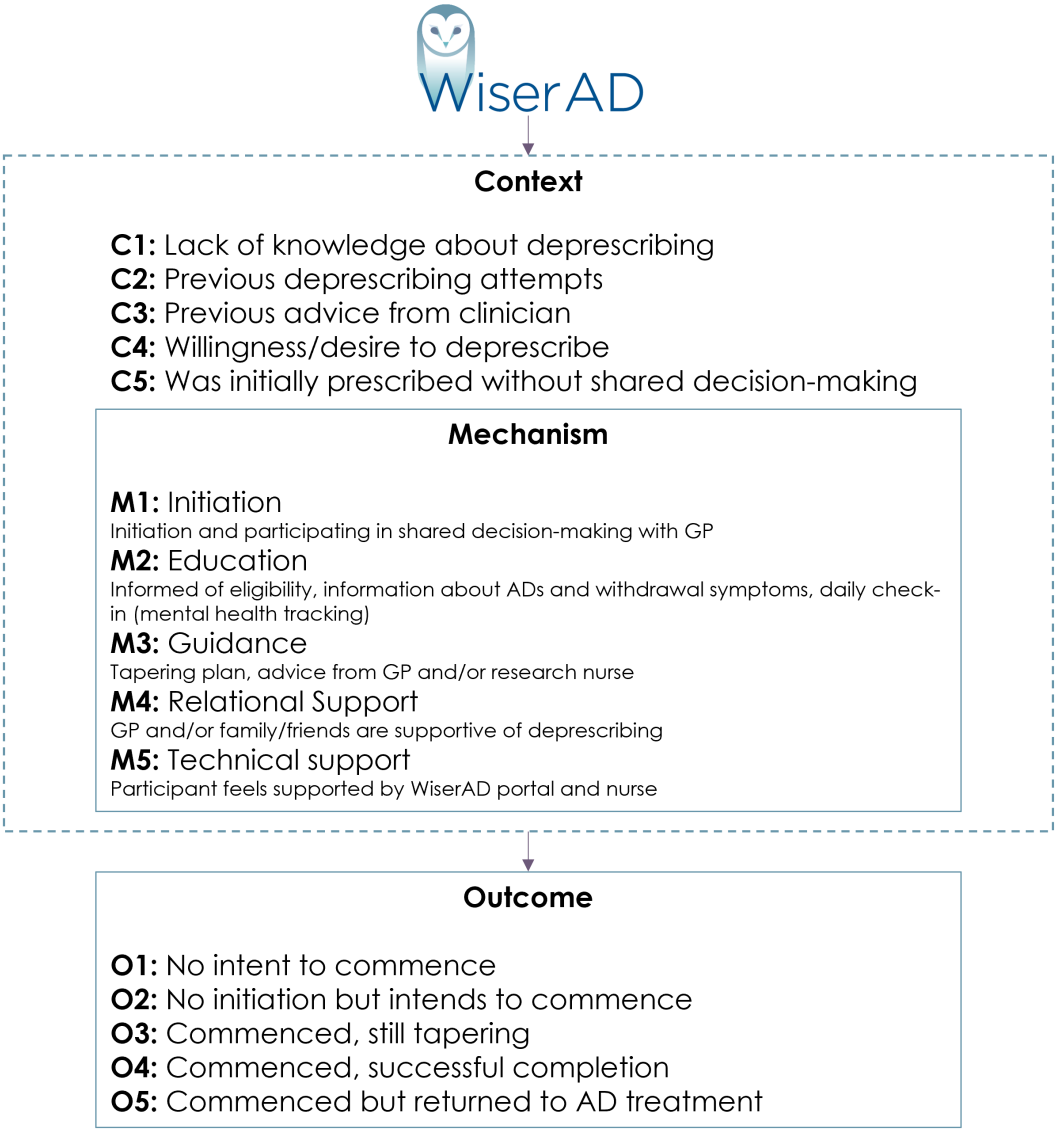

Figure 1 The initial programme theory for the WiserAD approach to antidepressant cessation.[24] AD, antidepressant; GP, general practitioner.

at 3-month follow-up via email which contained a plain language statement and consent form. Participants were then followed up by telephone call a week later. To ensure that the study findings could be fed back into the early stages of the trial, the first 22 participants were invited to an interview. A diverse sample in terms of gender, age, education and marital status was achieved through this recruitment method (see online supplemental file 1). A narrative approach[33] was used in the interviews to elicit rich responses from participants with minimal prompting rather than following a question and answer pattern (see online supplemental file 2). Interviews lasted approximately 45 min, were audio recorded with informed consent, deidentified and transcribed by AC (n=9) and a professional transcriptionist (n=4) and uploaded to NVivo V.12 software[34] for analysis. The interviewer (AC) was blinded to participant randomisation allocation at commencement of the interview, though participant responses to the interview questions were indicative of trial arm. Baseline and 3-month survey data were collected and followed up by a researcher independent of the current study. The interviews were conducted between October 2022 and April 2023.

Analysis

The raw scores from quantitative data at baseline and 3-month follow-up were calculated for each participant. Two participants completed baseline only and the PHQ-9 and GAD-7 data for one participant were excluded at 3-month follow-up due to concerns about unreliability. AC and CK-H independently read the narrative interview transcripts and compared initial notes. Iterative coding was conducted by AC who coded data as mechanisms, contexts or outcomes using the initial programme theory as a guide. Coding was discussed extensively between AC, CK-H

and JG with final coding agreed on after three iterations. Individual participant mechanisms of action frameworks were then created and compared and contrasted across each participant to develop the refined programme theory (see online supplemental file 3 for an example of an individual framework). A pattern of responses was observed within the first five interviews, with subsequent interviews confirming and shaping the final themes. The coding and findings were fed back to the study team iteratively via weekly meetings.

Patient and public involvement

Co-design Living Labs[35] members with lived experience of depression and antidepressant use provided feedback on the quantitative survey prior to the commencement of the WiserAD trial. Researchers with expertise in co-design and working with people with lived experience of mental disorders provided feedback on the interview guide.

RESULTS

Thirteen interviews with Australian (Victoria) general practice patients taking part in the WiserAD trial were conducted (see online supplemental file 1 for demographic information). One intervention participant completed tapering and returned to treatment 2 months later. Another intervention participant reduced to half of their initial dosage but returned to the full dose. Three intervention participants had reduced to half their initial dosage and five control participants had not commenced tapering.

Contexts, mechanisms and outcomes of antidepressant deprescribing

The findings verify and challenge the initial programme theory, leading to the development of a refined programme theory (figure 2).

Mechanisms that produce outcomes

Initiate discussion

All participants spoke about receiving the invitation to enrol in the WiserAD study. Two participants reported not considering tapering previously and that the invitation was the trigger for thinking that they would like to come off.

> No, I hadn't [thought about coming off]. It was, it sparked the interest that, if [the medication] is doing that to my emotional roller coaster, what else is it doing to various other parts of my life that aren't really what they were, or what they might be, and I haven't really noticed all that much. And if I don't, if I don't need to be on it, why would I be on it? It was sort of like trying to get to the stage where this would be

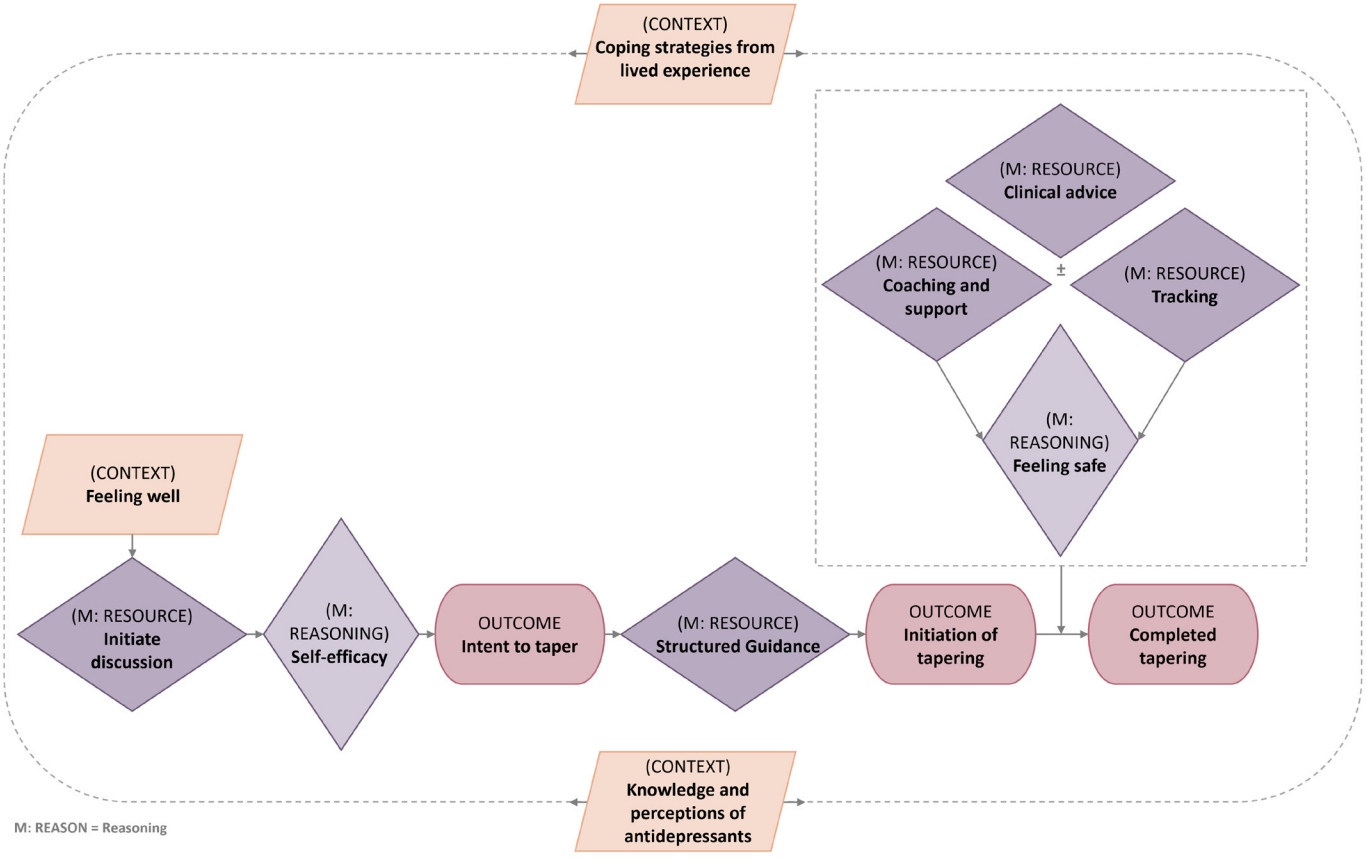

Figure 2 The WiserAD pragmatic framework for antidepressant deprescribing (refined programme theory).

something I don't really need to be on, best I get off it if I can. (Participant 3, Intervention)

Some participants had initiated the cessation discussion with their GP prior to learning about WiserAD but the tapering process was not initiated at that time. For these participants, the commencement of the WiserAD study appeared to act as a reminder or trigger for GPs to refer people for cessation. All participants valued receiving the invitation to take part in WiserAD.

Next time I saw [the doctor], which, I can't remember when, fortunately I don't need to go to the doctor very often, I said "Thank you so much for recommending it." It's a great opportunity particularly because I've been taking it for 24 years. (Participant 9, Intervention)

Self-efficacy

After the initial tapering discussion had occurred, most participants felt confident in their ability to taper and felt ready to commence the process. The belief that their GP was responsible for their invitation into the WiserAD study enhanced participants' feelings of self-efficacy.

But until that original letter and that came, I was just taking it and how it said, you know, the [doctor] thought I could be a good candidate for this trial. I thought well, I can only give it a go… Because like I say most of the time, I feel fine. (Participant 4, Control)

Structured guidance

Once participants intended to commence tapering, structured guidance to taper was needed by all participants as a next step. All intervention participants followed the written tapering plan provided by WiserAD with most using the plan in combination with advice from their GP.

Kind of a bit of a combo of both, talk through with the GP, in terms of the two different strategies, I think it was you could half a dose for two weeks. Oh no sorry, maybe like half a dose for a month. I can't exactly remember now but it was basically half dose, or you could just go cold turkey and just stop because I was on a pretty low dose. I think I was only on like 25 milligrams of Sertraline, so I kind of offered to do the half dose and WiserAD kind of coordinated. (Participant 9, Intervention)

There was a marked distinction between the participants who did and did not have access to a tapering plan or advice where the tapering process was stalled as they waited for someone to provide them with the next step.

I would say the next step, like what do I do from here? Because it's such a big step, and just knowing that you can't just stop a medication and you can't do it without speaking to your doctor first. Because that could lead to all kinds of things. It's the same as people that increase their dose just because they had a bad day and your kind of like you can't be doing that. So I just think the most important thing is being able to reach out and make that initial appointment, and then start, just start. (Participant 11, Control)

Coaching and support

All intervention participants found the coaching provided by the WiserAD nurse to be highly valuable.

I like that someone can chat, just stuff like that because… The support there… Sometimes you can feel like you're alone so, if there's something that's not, you know… You're not sitting 100% well with, there's support there and communication. So 100% that. I don't think I'd get this far without it. I seriously don't. [WiserAD nurse] is so good. It's just nice because she's genuine and caring. Like someone really does look out for you. Yes, just feeling that is really nice. So, motivation to stay the course. (Participant 9, Intervention)

Control participants spoke of the need to have a support person in place to help them in the instance they were able to proceed with tapering.

I think there's things that I will possibly have to put in place. One is probably a phone number that I could, you know, that I could ring if I felt in a bad place. (Participant 8, Control)

Some intervention participants also mentioned receiving support from friends and loved ones who had experience of antidepressant tapering as being helpful throughout the tapering period.

I think [my partner] was asking how I was doing each day, and he would check in and kind of ask: how I was, how the withdrawal was going a few times as well. So I think, for me a lot of support stuff is things like hugs, that kind of stuff. (Participant 7, Intervention)

Clinical advice

Participants found it useful to have a person with clinical knowledge who could be their 'sounding board' and provide motivation and troubleshooting tips if experiencing withdrawal symptoms, and help to keep them accountable throughout the tapering period. The ability to adjust the length and dose reduction amounts with the WiserAD nurse was also valued.

When I first reduced the medicine, I experienced insomnia and the WiserAD nurse told me—after one month, I still felt sleeping difficulties and [the WiserAD nurse] told me that I cannot further reduce the medicine and she suggested that I still keep taking

five milligrams. I followed her suggestions and after two weeks, I felt better. So, without [WiserAD nurse] there is no person there—if she doesn't give me the suggestion, I may have reduced the medicine further. But I think she made it very right for me. (Participant 12, Intervention)

Tracking

Nearly all intervention participants spoke about the utility of the daily tracker. Most found it useful to check in and see how their mood, sleep and activity levels were tracking over the tapering period. Participants also found that even if they did not log symptoms daily, it was still useful as an opportunity for self-reflection.

> With the tracker yes, you have to stop and think, you can't just go tick, tick, tick. You have to think well—no, I find the tracker good actually. Actually what it makes you do; it makes you recall your day. It makes you stop and think, now what have I actually done today? I know that sounds weird but it does make you stop and think, yes I did do that. It makes you accountable. (Participant 10, Intervention)

Some participants saw the usefulness of the tracker but found its functionality limited. They suggested that it would have been helpful to provide reasons for their responses to accurately track their progress.

> With the tracker. It was probably hard like in terms of the data capture, I found hard to fill in accurately, like it was asking me how well did I sleep last night, which I could place in the context of probably what the question is asking are you affected by more mental health issues. My sleep is just naturally not that good at the moment, because I've got two little kids. It's very broken. So like, most nights, a bad night's sleep for a very different reason. (Participant 6, Intervention)

Feeling safe

Most participants spoke about withdrawal when coming off the medication. Control participants in particular reported that they were unsure about how coming off would change them as a person and that they would want professional support to help through the tapering period:

> I also wanted to be in therapy first, before I went off them because, sort of the feeling of a safety net like a therapist can help me mentally walk through everything and if, and I didn't know how my body was going to or how my body was going to react coming off as well and if I was going to revert back. (Participant 1, Control)

Whereas intervention participants reported experiencing withdrawal effects including irritability, insomnia, fatigue and anxiety but were able to move past them over time and by maintaining their current dosage level for an extended period of time (usually an additional period of 1–2 weeks).

> Yeah this is going pretty well, it was probably only last week, last weekend I sort of, was feeling that gloomy, dark and angry, yeah that was actually last Saturday I was thinking "oh no not this, not this". Yeah, sort of a level of frustration. I just don't want to be like that, you're no good to anyone like that. But yeah, I feel like it's a lot better now. I'm feeling good. (Participant 9, Intervention)

Intervention participants also found that the support given by the WiserAD nurse was useful in helping them to understand and overcome the fear of withdrawal symptoms. For some, the additional support by a loved one with lived experience of deprescribing was also helpful (as described in the coaching theme). Some participants spoke about the support of loved ones, monitoring of the daily tracker and/or clinical advice by WiserAD nurse as providing reassurance that they provided them during the tapering period either in combination or independently:

> All of a sudden I got a cold, like bronchitis. And just woke up several times during the night and just couldn't breathe. Well, it's not that I couldn't breathe, my brain was telling me I couldn't breathe. So went into panic attack mode, and then it didn't matter what I did the slightest trigger made me sort of like start to panic about things again. I talked to [WiserAD nurse] to see if I can stabilize and then we might go back to the 50s [mg] eventually, or a bit later on. (Case 3, Intervention)

Contextual factors that support mechanisms of antidepressant tapering

Feeling well

All participants had no to mild depressive and anxiety symptoms at the time of initial tapering discussion. Some reflected that even though they felt well, taking the medication had become routine.

> I think it's just really everything in my life is good as it has been for a while. So like I've now changed jobs, I'm in a much less stressful job in terms of the kind of pressures which I was looking for the support for, I've been out of that for quite a while. Personal life is good. Loving family life and love where I live, like, I just didn't feel like there's things that I needed, were there anymore. It was more just kind of keeping up the status quo. So then the confidence was especially to kind of sort of see what [the antidepressant] was providing. (Participant 6, Intervention)

Others began to question why they were still taking the medication if they were well.

> I don't think I've had any major real flat, depressed situations where self-harm would come into thought or anything like that again. And you sort of question

why am I still on it? I think the fact that it was in [the GPs] eyes considered such a low dose. (Participant 5, Control)

For others, it made them curious to 'test the waters' and see what it would be like to stop taking antidepressants.

That's where I am with antidepressants and still take them every day. Do I think I need it anymore? I think? I don't think I do. But like I was saying before, I think it does help me through difficult stages. But I think that I don't know what it's like on the other side anymore, I don't know what it's like without it, because to be perfectly honest, I'm a bit scared to go back. I'd like, I'd like to. I'd like to see if I could deal with it. I'm sure that I can. I just don't know whether I can or not. (Participant 8, Control)

Coping strategies from lived experience

Nearly all participants talked about the coping skills that they had learnt over time to manage their mental health which included meditation, exercise, positive self-talk, eating and sleeping well, faith-based practices, engaging in psychotherapy and talking about their mental health challenges with others. Participants felt that these coping strategies played the most important part in their recovery.

For me, the physical things help most of my mental health. So I started running and I you know, joined like a fitness class gym, like a boutique gym, sort of thing. So all that stuff always helps. And I know when I stopped doing it, I tend to revert back to that depressed, depressive state or anxious state that sometimes my body wants to revert to. So I try to not let that happen as much as I can. (Participant 5, Control)

Knowledge and perceptions of antidepressants

While participants generally viewed their antidepressants as useful, they were also keen to not be on them for any longer than necessary and many were concerned about the long-term effects.

I figure that if, if you're meant to be, have that as part of a normal life, that evolution would have given us the ability to produce that particular chemicals in enough form to do it ourselves. I mean, I'm on other blood pressure medication and other bits and pieces, but I wouldn't have thought that something to keep your mood under control is something that would be good for you very long term. It'd be good to not be on it. (Participant 3, Intervention)

Some long-term users wished that they had proper clinical monitoring and that they had been referred to psychotherapy rather than having taken antidepressants for so long.

You know I just wish, perhaps, the medications having been a bit more closely monitored rather than just sort of… I'm not saying it was just given to me and "oh just take this and be on your way" or anything like that. I think that these medicines should be used to sort of get you going and then from there you need to put the work into… Medicines great to start with but it can't be, it's sort of like a bandaid sort of thing, you need to work on the healing side, you need to work on lifestyle. (Participant 9, Intervention)

Participants had had previous experience with attempting to come off their medication. Most participants who reported coming off in the past said that there was no or minimal clinical supervision and they experienced withdrawal effects.

So I really would have preferred to not have been on for so, so long. Yeah I had two attempts, probably, one was probably about ten years ago, to come off it, I was trying to, yeah, no real guide or coaching, if you like, of how to get off it, so I sort of stopped it, oh the withdrawals are huge and it was really unpleasant, so. Oh and I asked the GP and things, he was sort of like oh, I can't remember exactly, I don't remember him being very helpful. (Participant 9, Intervention)

However, these past experiences did not seem to deter participants from wanting to taper in the future, rather they were more determined to find appropriate information and support.

When I saw the study I was like that's interesting because I'd like to find out more about, if I was going to, what it might look like and if there are other—other than kind of like—I don't think I've ever had access to information or a process by which I would think about being able to do that successfully in the long term. It's just been kind of my own strategies or decisions around it, so that was part of the interest in the study. (Participant 13, Control)

Refined program theory

The refined programme theory based on the quantitative and qualitative data informed a pragmatic framework for antidepressant deprescribing based on the WiserAD approach (figure 2). All elements in the initial programme theory were present in the refined programme theory though the results revealed slight deviations for where and how these elements occurred. For example, willingness to taper (or intent to taper as per this study) was an anticipated context; however, testing of the theory found it to be better placed as an outcome as indicated by the control participants who did not proceed with tapering without the next step, but all intended to commence when appropriately guided. We also assumed that the provision of education would be an important mechanism for the commencement of tapering. While the elements of education are still present in the refined programme theory, the mechanisms of being invited to taper, the

provision of clinical support and coaching and self-reflection via the daily tracker were more important than explicit educational information about antidepressant medications and the risks of deprescribing. Coping strategies learnt from lived experiences were found to be a new and important context for commencing and completing tapering.

DISCUSSION

This evaluation using a realist approach found that initiation of the deprescribing discussion, participant self-efficacy, provision of structured guidance, coaching, mental health, sleep and activity tracking and feelings of safety during the tapering period, together with learnt coping skills, knowledge of antidepressants and feeling well all contribute to supporting antidepressant deprescribing for general practice patients. As quality guidance for antidepressant tapering is currently lacking, the resulting WiserAD pragmatic framework provides the key components to engage patients and GPs in the tapering process, leading to successful antidepressant cessation.

Antidepressant users have previously reported attempting to taper or abruptly cease their medication without clinical support when feeling well[36 37] which can increase the risk of relapse, recurrence and withdrawal symptoms.[38 39] As such, clinical initiation of the deprescribing discussion is an important mechanism in engaging eligible people in the tapering process in a safe and supportive way. Feeling well and being presented with the opportunity to taper also lead to people feeling confident in their ability to commence deprescribing.[23] As a next step, structured guidance for tapering is central for the commencement of the tapering period. Some participants in the current study chose to share their tapering plan with their GP while others found the tapering plan alone sufficient. As people become increasingly responsible for their own healthcare,[40 41] the provision of a tapering plan by a web tool may help to overcome the often-reported GP barrier of a lack of quality deprescribing guidelines and engage both patients and GPs in the tapering process.[42] During the tapering period, expert coaching and self-tracking tools may overcome the oft-reported barrier of fear of relapse and recurrence.[15 43] Many antidepressant users report experiencing withdrawal symptoms which can often mimic relapse or recurrence[44] and recent studies have found that a lack of clinician skill and knowledge about withdrawal can result in individuals returning to antidepressant treatment when adequate support may have helped them to successfully deprescribe.[17 18]

Strengths and limitations

The principles of realist evaluation were beneficial in identifying the necessary elements of a process for stopping antidepressants. In particular, by focusing on patient needs, it has provided much-needed guidance for people and clinicians to implement and engage in antidepressant deprescribing. This may assist in reducing potentially inappropriate antidepressant prescriptions and mitigate unnecessary risks to individuals. The study findings were enhanced by the inclusion of intervention and control participants and highlighted where the deprescribing process stalls if the preceding component or mechanism is not presented. Testing of an initial programme theory also meant that the results could be fed back into the trial in the early stages. Had any challenges become evident in participants' experiences, then immediate revisions could have been made; however, no changes were required.

It is important to acknowledge that this is a small study conducted in the early phase of the full RCT and that a complete realist evaluation may have provided further explanatory information (ie, context+mechanism = outcome (CMO) configurations). As such some of the more nuanced details still remain unidentified. For example, participants may worry (reasoning) about being told to stop their tapering attempts if they perceive that they are not participating in the trial correctly which may influence responses and outcomes. Additionally, three stages of the deprescribing process ((1) initiation of the deprescribing discussion, (2) initiation of tapering and (3) the tapering period) were emerging as potential CMO configurations[21 28]; however, the reasoning mechanisms require further investigation (see online supplemental file 4). Another consideration is that tapering periods can vary for individuals and that restarting and reattempts at tapering may occur. Of the 13 participants in the current study, 2 returned to their antidepressants after a period of tapering. Though these participants felt confident to reattempt deprescribing at a later stage, it suggests that further evaluation in the late stages of the WiserAD trial is warranted and with a larger sample size. Finally, participants reported awareness of feeling well prior to enrolling in the WiserAD trial. As such self-efficacy and willingness to deprescribe may have already been high.

Implications

The WiserAD pragmatic framework may help support the process of successful cessation for patients and GPs in general practice. WiserAD can elicit patient and GP engagement in the initial stages of the process and encourage continuance throughout the tapering period. Initiation of the deprescribing discussion by GPs may also bolster the doctor–patient relationship as indicated by participants who appreciated their GPs' personal recommendation to participate in the trial and may encourage the application of routine deprescribing into clinical practice. Future evaluations should investigate the key mechanisms and contexts for deprescribing in GPs and doctor–patient dyads to determine how the current framework aligns with GP and patient needs in practice.

Future realist evaluations should aim to confirm the mechanisms found in this study and identify any additional or more in-depth mechanisms. For example, the provision of coaching may work via multiple avenues including the ability to adjust tapering schedules and/or providing clinical reassurance. The current study also suggests that support for antidepressant cessation does not need to be provided by a GP. Primary care or mental health nurses are well-positioned to provide expert guidance and support during the tapering period. The WiserAD tool was also sufficient in delivering a structured tapering plan for people to follow.

CONCLUSIONS

This study, informed by a realist evaluation approach and conducted in the early stages of the WiserAD trial, provides insight into patient's perspectives and experiences of antidepressant deprescribing and their early decision-making processes. Underlying mechanisms that lead to successful deprescribing outcomes were related to participants' feelings of wellness and support to commence. Implementation of the WiserAD approach to antidepressant deprescribing in clinical practice may help to curb the increase in antidepressant prescriptions and decrease unnecessary long-term treatment.

Twitter Amy Coe @amy_x_coe

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ORCID iD

Amy Coe http://orcid.org/0000-0003-3723-7645

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