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A qualitative study on elderly patients' preferences for inpatient psychiatric services

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Abstract

Introduction Mental illnesses have a high prevalence among elderly patients. It is estimated that half of the elderly do not utilize the psychiatric care that they need. Paying attention to patient preferences can improve treatment adherence and patient outcomes. This study aims to qualitatively identify the preferences of elderly patients hospitalized in the psychiatric wards of hospitals regarding their inpatient psychiatric treatments.

Method This qualitative study was conducted at Khorshid Hospital in Isfahan, Iran. The study sample included patients in the age range of 60 years or above who had already been hospitalized due to diagnosed psychiatric diseases. Twenty-one semistructured interviews were conducted from March to September 2023. A thematic analysis method was used to analyze the data.

Results The study extracted three overarching themes, including patients' preferences regarding hospital features, patients' preferences regarding hospital staff, and patients' preferences regarding service delivery.

Conclusion The findings of this study showed that elderly patients consider different preferences when choosing inpatient psychiatric services. The findings provide new insights for decision-makers and health providers in designing and implementing psychiatric treatments by considering elderly patients' preferences, which in turn might help improve treatment outcomes and increase patient satisfaction.

Keywords Preferences, Elderly, Psychiatric patients, Treatment seeking, Qualitative study

Introduction

Patient preferences are a person's choice to decide about their health and medical treatment based on personal experiences, beliefs, and values [1]. The rationale for prioritizing patient preferences in the healthcare system is that healthcare providers are experts in diagnosis, prognosis, and treatment options but that patients are experts in their medical history, values, preferences, and backgrounds [2]. Many patients desire to be continuously informed of decision-making processes to express their views on treatment options, even if the care provider makes the final decision [3]. Several studies have demonstrated that considering patient preferences can improve clinical outcomes [4, 5]. Moreover, it increases patients'

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satisfaction with the health system and their trust in the services provided and can reduce health system costs [6–9]. One of the most important benefits of using patient preferences in health care is increasing people's adherence to treatment [10, 11]. Two main arguments can be made for including patient preferences in the decision-making process in mental health care: (a) considering preferences as part of ethical principles and respecting patients' rights and (b) as a way to improve clinical outcomes [12].

A mental disorder is a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior [13]. An estimate showed that 418 million disability-adjusted life years (DALYs) were attributable to mental disorders in 2019 (16% of global DALYs) [14]. Despite this burden, mental health services are scarce in many regions of the world, especially in low- and middle-income areas [15]. As mental illnesses are increasingly recognized as a global burden, innovations are emerging to provide accessible, affordable, and acceptable prevention, care, and treatment services for diverse populations experiencing mental health issues [16]. To ensure relevance and utility, mental health information and messages, preventive services, treatment characteristics, provider approaches, and care delivery methods must continue evolving based on stakeholder preferences [17]. However, patient participation in shaping mental health practices has been minimal, particularly in low-resource settings [18].

Regarding elderly individuals, mental illnesses have received less attention. More than 20% of people who are 60 years old or older suffer from a mental illness [19]. Moreover, more than a quarter of suicide deaths occur among the elderly [20]. It has been estimated that up to 50% of elderly individuals with mental disorders receive no treatment, although effective pharmacological and psychological treatments exist for many mental disorders in elderly patients [21, 22]. The reluctance to seek mental care results in negative consequences such as a decline in quality and expectancy of life and an increase in treatment costs [23, 24].

Many psychiatric treatment decisions are sensitive to disease prioritization, and patient participation in the decision-making process can benefit both the physician and the patient. Patient participation in medical care is generally associated with better health outcomes [25]. Examining the patient's preferences may clarify the reason for this reluctance [26]. The problem of mental disorders among the elderly in Iran is widespread. The prevalence of mental disorders among Iranian elderly individuals is as high as 38% [27]. However, until now, no study has investigated the preferences of elderly patients with psychiatric diseases hospitalized in Iranian hospitals. Therefore, the present study aimed to qualitatively identify the preferences of elderly patients hospitalized in the psychiatric departments of hospitals regarding their inpatient psychiatric treatments.

Methods

Study design

The present qualitative study was conducted via inductive content analysis via semistructured interviews with elderly patients admitted to the psychiatric department of Khurshid Hospital in Isfahan, Iran.

Setting

This qualitative study was conducted at Khorshid Hospital, affiliated with Isfahan University of Medical Sciences, Iran, from March to September 2023. The sample included patients in the age range of 60 years or above who had been hospitalized in the mental ward of the aforementioned hospital because they were diagnosed with psychiatric diseases based on the DSM-5 and were in partial remission near the time of discharge, at least two weeks after admission. Two dedicated psychiatrists performed the mental status examination. Patients with compulsory admission, active psychosis, active suicidal thoughts, major neurocognitive disorders, and language barriers, which made interviews difficult, were not recruited for the study. Written informed consent was obtained from the patients. The research was also approved by the Ethics Committee of the Medical School of Isfahan University of Medical Sciences (code: IR.ARI.MUI.REC.1401.294).

Data collection

We developed an interview guide based on literature, three pilot interviews, and the comments of three research team members: two are psychiatrists experienced in geriatric psychiatry (SM, VO), and one is experienced in qualitative research (MM). The English version of the interview guide is presented in supplementary 2 A trained interviewer conducted semistructured face-to-face interviews in private rooms in the psychiatric ward of the hospital. Before the interview, the interviewer introduced themselves, outlined the study's objectives, and obtained verbal informed consent from the participants. First, some demographic questions were asked, in addition to two main questions on the history of psychiatric diseases and history of hospitalization for psychiatric diseases. A general open-ended question followed: "Why did you choose this hospital to receive inpatient psychiatric treatment?". The interviewer also asked the patients about their experience and preferences regarding inpatient treatments for psychiatric diseases, including medical professions, health services, non-health services, the location of the hospital, and the admission process. All the interviews were audio recorded and transcribed

verbatim. Field notes were also taken during the interviews. The interviews lasted between 20 and 40 min and were based on patient patience and cooperation in one or two sessions. We followed a purposive maximum variation sampling procedure by considering the variation criteria of age, sex, and education of patients. The sampling process continued until data saturation. Theoretical data saturation was achieved with 21 participants, as iterative analysis revealed no new themes emerged after this point.

Data analysis

We applied a thematic analysis method to analyze the interview transcripts. Two research team members (MM and MHA) reviewed the data to familiarize themselves with it. They then analyzed the data separately and identified initial codes and themes. All the codes and themes were discussed and refined in a meeting with all the research team members. We synthesized the results via the six steps of Clark and Braun's thematic analysis framework [28]. The first step is to familiarize oneself with the data by reading the transcript interviews. The second step involves generating initial codes. In the third step, we generate themes. In the fourth step, we review potential themes. In the fifth step, we define and name the themes. In the last step, we prepare the report. MAXQDA 12 was used to store the data and analyze the interview transcripts.

Table 1 Characteristics of participants

Variable	Number (%) Mean (SD)
Gender	
Male	12 (57.1%)
Female	9 (42.9%)
Age	65.95 (± 5.3)
Education	
Illiterate	1 (4.7%)
Elementary	3 (14.2)
Guidance	4 (19%)
High school	4 (19%)
University	1 (4.7%)
Unknown	8 (38.1%)
Cause of hospitalization	
Anxiety and insomnia	4 (19%)
Aggression, Depression, and suicidal thoughts	7 (33.3%)
Other and uncertain	3 (14.2%)
Unknown	6 (28.5%)
History of hospitalization due to psychiatric problems	
Yes	9 (42.8%)
No	10 (47.6%)
Unknown	2 (9.5%)
History of psychiatric illness	
Yes	12 (57.1%)
No	2 (9.5%)
Unknown	7 (33.3%)
Currently suffering from a known physical illness:	
Yes	10 (47.6%)
No	2 (9.5%)
Unknown	9 (42.9%)

Quality assurance

We followed the Lincoln and Guba criteria to ensure the trustworthiness of our results [29]. The first criterion was to ensure that the findings were credible. For this purpose, the interview text and the extracted codes were presented to the participants, and they commented on them. If there were any discrepancies, they were considered and investigated. The second criterion was to ensure that the findings were transferable; we selected the participants carefully and provided a detailed description of the data in this study (so that others could apply it to their contexts). The third criterion was to ensure that the findings were dependable. We asked researchers outside the team to code some interviews and compare the codes with the extracted codes of the research team. The fourth criterion was to ensure that the findings were confirmable, which means they were not biased by our views or assumptions. To achieve this, we avoided interference with the qualitative data research and analysis process regarding our values and preconceptions.

Results

Characteristics of participants

A total of 21 participants were included. 57% of the patients were male. The average age of the participants was 65.9 years. Concerning education, 42% had more than just enough education, and 33% of patients were hospitalized due to aggression. 47% of the studied patients had no prior psychiatric hospitalization, and 57% had a history of receiving psychiatric treatment. 47% of patients reported having a concurrent physical illness [Table 1]. The main characteristics of the participants are shown in Supplement 1.

In this study, three main themes and eight subthemes were extracted. The main themes were (a) patients' preferences regarding the hospital, (b) patients' preferences regarding the providers, and (c) service delivery preferences. [Table 2 shows the themes and subthemes].

Preferences regarding the hospital

The choice of hospital to receive care in Iran is based on the patient's opinion. Because most hospitals are government-owned, costs usually play a minor role in their choice. In the present study, the type of hospital and accessibility were identified as subthemes in patients' preferences regarding the choice of hospital.

Table 2 Main themes and subthemes of the study

Main theme	Subtheme	Issue
Preferences regarding the hospital features	Type of hospital	Teaching hospital
		Multispecialized hospital
	Hospital Accessibility	Parking and Traffic
		Distance to the hospital
Preferences regarding the hospital staff	Security staff	Bodyguard
		Guard of hospital ward
	Clinical staff	Gender
		Experience and knowledge
		Interaction with the patient
Service delivery preferences	Health service	Hospitalization period
		Occupational therapy
		Medication distribution
	Inpatient ward	Other patients' conditions
		Comfort facilities
	Appointment system	Queuing for an appointment
		The method of making an appointment

Type of hospital

The presence of medical students in educational hospitals can affect patient satisfaction. In the present study, most patients had positive feelings about the presence of students in different disciplines in the psychiatric ward. They were satisfied with the educational nature of the hospital. For example, a patient noted:

"*I am happy to be in the crowd. It does not matter if there are many students.*" (P16, female, age 71).

Other participants also did not consider the presence of students or the educational nature of the hospital to be negative points and were indifferent to them. A patient said: *"I understand that these are students. They have to do something. I do not care."* (P11, male, age 62).

Moreover, patients prefer multispecialty hospitals rather than hospitals specializing in patients with mental illnesses. Some patients point to the ease of access to other health services they would need. Physical diseases are common due to the advanced age of the studied patients. These patients may simultaneously have metabolic diseases, diseases caused by old age, or physical weakness. Multispecialty hospitals can provide the opportunity to receive physical and mental services simultaneously. One patient noted, "*Yes, if one-time need if I had another illness, I could treat my illness here* (P13, female, age 71).

Others mentioned that admission at multispecialty hospitals has less stigma than admission at psychiatric hospitals. In this regard, a participant noted, *"... I will not go Because very give... [psychiatric hospital] from many times ago that is mean mad house set for me, Harassment doer."* (P11, male, age 62).

Hospital accessibility

Ease of access to the hospital was one of the patients' preferences for themselves and their family members. Some patients found the hospital's convenient public transportation access a good experience. In addition, some patients reported that the short home-to-hospital distance convinced them to choose it. On the other hand, some other patients reported that the most important issue for them was the quality of the services provided and the treatment of the disease, and they did not consider the distance and proximity of the hospital to be important.

"Of course, it is better to be closer." (P20, male, age 69).

"Being away is not important to me. Finally, the man takes himself to the hospital. Facilities and recovery are important to me, that is why I come to Isfahan and this hospital as soon as I get sick." (P21, male, age 63).

Patients' preferences regarding hospital staff

Health service providers in psychiatric wards have close and long relationships with patients. Moreover, the presence of other staff is crucial in psychiatric wards. Some of the patients' preferences in these wards are related to clinical staff, and some are related to nonclinical staff.

Clinical staff

In the present study, patients had preferences regarding nurses and doctors. In the case of nurses, patients expected sympathy and passion from patients and their companions. Some patients had negative feelings toward providing uniform nursing care. They also expect nurses to intervene in the treatment process when the doctor is not present and have more freedom of action regarding giving medicine to patients. As an example, participants said:

"Here Personnel was Good. However, in my headache and pains, I ask for a pill; they say Must your doctor prescribe." (P20, male, age 69).

Concerning physician characteristics, there are more diverse preferences. Patients preferred their doctor to be an experienced and older adult. They believed that older doctors could be more knowledgeable about the treatment process. Another preference of patients was related to the gender of the doctors. Patients reported that they were more comfortable expressing their feelings with a same-sex doctor. In addition, some patients believe that female doctors are more compassionate and interact better with patients.

"It is important. Only a female doctor could be comfortable. My body problem is special and private. The woman can consult with a male doctor if she needs to". (P12, female, age 60)

"*Women are generally better. This is God's creation. Women are more law-abiding. By nature, they are*

teachers and material. I want my doctor to be a woman. Because they have children themselves. I chose a female doctor." (P19, male, age 81).

Another category of preferences regarding doctors is related to humor and explaining treatment protocols to patients. Patients believe that doctors should have proper interactions with patients. "*Good manners are important. A doctor cannot be rude. One should be comfortable with it.*" (P1, female, age 62).

Security staff

Patients with psychiatric diseases need the services provided by security staff, mainly bodyguards and guards of the ward, more than other patients do. As a result, psychiatric patients are sensitive to the interaction of security staff with themselves and their companions. The patients in this study expected guards and bodyguards to be more easy-going and companionate. They also expected the hospital managers to address their complaints regarding the security staff.

"Some of these guards are very rude. One of them is scary. Some of them are well-mannered; may God bless them… I have insomnia; this gentleman (hint to a guard) hurts me. At night, I cannot walk because of this gentleman. They do not allow it. "(P18, male, age 60).

Service delivery preference

Hospitals play an essential role in providing health services. These services constitute an essential part of patients' preferences. Patients expressed their preferences regarding medical services, features of the inpatient ward, appointment mechanisms, and waiting list preferences related to providing services in the hospital.

Health service

Most patients preferred a short hospital length because of homesickness and inconvenient conditions of hospitalization for their companions and family members. In addition, some patients were not satisfied with the process of giving medicine to them. Some complained that the staff did not give the medicine to the patients at the right time. One of the services provided to female psychiatric patients in the studied hospital was occupational therapy services. Some patients complain that there is no availability of occupational therapy services for male patients.

"*I will stay to complete my treatment but to miss my son.*" (P13, female, age 71).

"I would like to use it, but occupational therapy is only for women." (P6, male, age 68).

Inpatient ward

The studied patients had preferences regarding the characteristics of the inpatient ward. Owing to the age of the studied patients, the quietness of the room and silence in the ward were some of the issues they were concerned about. Patients preferred to avoid crowds and to have enough peace to relax. They also preferred that patients of the same age be in the ward or room: "*Our room is not crowded, but the ward is crowded.* (P3, female, age 61)

Comfort facilities

Hospitals should consider facilities for psychiatric ward patients who are hospitalized for a more extended period, which not only pay attention to health needs but also consider the comfort and well-being of patients. The studied patients preferred rooms with natural light and ventilation and windows to be opened. One of the patients' preferences was the presence of amenities such as televisions, clocks, refrigerators, and telephones in the patients' rooms. Patients preferred uniforms suitable for the season and liked to have more freedom in choosing the type of clothing. They believed that the hospital's concern about the patient harming themselves prevented freedom in their choice of clothing.

"I hate clothes; I like to wear my clothes. If I want to suffocate myself, I can suffocate myself with this scarf, I can suffocate myself with a mask; why do they bother me? Now they will not let me wear a Tress." (P21, male, age 61).

Another preference of the patients was regarding the quality of the food. The patients complained about the low quality of the food. Having a specific room to meet family members was also one of the preferences for patients; they considered meeting in front of the room's entrance an undesirable situation. Access to sports and games facilities was one of the preferences of the studied patients. They believed that entertainment helped them be involved in mental activity. Peaceful quietness is an essential issue for patients; although they are satisfied with the capacity of their rooms, they believe that the crowdedness of the room has reduced their comfort.

"*Last year, the food was better. Rice, for example, all patients throw rice into the trash.*" (P5, male, age 70).

"If *Ping Pong something That fewer his voice Harassment tick Play intellectual Board backgammon And Chess OK good _ Music Both OK.*" (P21, male, age 63).

Other patient conditions

Some patients complained that the severe mental condition of other patients could hurt their mood. Patients also preferred to be separated from people undergoing drug abuse treatment during hospitalization. Smoking in wards can cause problems for patients. Patients strongly preferred no smoking rule in the ward, as is usually implemented in other hospital wards.

"*Look at this: they smoke ten packs of cigarettes a day. They used to play Tonbak (Iranian musical instrument)*

very well, but now everyone has a cigarette in their hand." (P5, male, age 70).

Appointment system

The studied patients preferred rapid hospitalization. Prolonging the patient admission process can be boring and cause problems for the patient and the hospital. The appointment system for inpatient admission or outpatient visits in the studied hospital was mostly online. This approach might be more convenient for patients' companions: "*My daughter can make an appointment for me online.*". (P15, female, age 63)

Discussion

The process of population aging in Iran is occurring rapidly [30], and mental illnesses are highly prevalent in the elderly population in Iran [31]. To date, no qualitative study has been conducted to investigate the preferences of elderly Iranian individuals with psychiatric diseases regarding related inpatient treatments. In this study, three main themes were extracted, namely, hospital-related preferences, hospital staff-related preferences, and service delivery-related preferences, which differ from other studies. In a Chinese study conducted by Zhang et al. (2020), patients' preferences in primary care centers were evaluated according to three categories: service-related preferences, staff-related preferences, and hospital-related preferences [32]. Amini-Rarani et al. (2023) identified three main themes related to male patient preferences for opioid treatment in Iran: treatment concerns, treatment attributes, and treatment type [33]. In a study conducted by Dehbarez et al. (2018), women had two main preferences for choosing the hospital where they would give birth: decision-making and the priority of women's health in hospital matters [34]. In a study by Luck-Sikorski et al. (2016) regarding the treatment preferences of elderly patients with depression in Germany, drug therapy, psychotherapy, talking with friends and family, and exercise were the preferred treatment options [35]. Furthermore, in a study conducted by Raue et al. (2011) on the preferences of patients with depression in America, it was found that most patients prefer active treatment to passive treatment [26]. Finally, in a Spanish study by Cuevas et al. (2014), patients with psychiatric diseases reported that most patients preferred to accept a participatory role in decision-making, followed by the passive role and the active role [25].

The first main theme was hospital-related preferences, including the type of hospital and hospital accessibility. In the Iranian health system, hospitals are owned mainly by the Ministry of Health and Medical Education. As a result, specialized hospitals usually serve as teaching hospitals. Patients preferred that the hospital where they received services was a teaching hospital. In a study by Ghimire et al. (2019), patients believed that the presence of students in beds for training increases the quality of services, and consequently, they preferred it [36]. The presence of students at the patient's bedside changes the atmosphere for them and can be considered a positive interaction. Another issue that patients are concerned about when choosing a hospital is the multispecialty nature of the hospital. Admission to single-specialty psychiatric hospitals in Iran is stigmatized, and patients do not have positive feelings toward it. In addition, the patients in the present study were older adults who, due to various physical diseases, were considered attending a multispecialty hospital to receive appropriate treatment for other physical comorbidities. In a study by Perera et al. (2020), the change in the role of psychiatric hospitals, from centers for providing medical services and disease control to centers for treating both acute mental and physical diseases, was mentioned [37]. Liggins et al. (2005) reported a different result in New Zealand and reported that the hospitalization of mental patients in psychiatric wards of general hospitals can lead to more stigma [38]. This difference may be caused by the differences in the studied age groups. The long-term presence of elderly patients with psychiatric diseases may make the need for other specialties more important for treating patients' physical diseases.

The patients preferred access to the hospital via public transportation. However, patients believed that this ease of access cannot substitute for the quality of care. In a study by Schuldt et al. (2017), a small percentage of patients considered proximity and ease of access essential in choosing a hospital [39]. In a study by Pfeiffer et al. (2016), the most important barrier to psychiatric service utilization was the weakness of the transportation system and difficulty accessing the hospital [40]. In the present study, patients' preferences for accessing hospitals were examined regardless of their economic and social status or whether they lived in urban or rural areas. This may be due to the difference in socio-economic status between Iran, a developing country, and Germany, a developed country.

The second main theme extracted in the current study was preferences regarding hospital staff. Patients in psychiatric wards are usually hospitalized for a long time, so they have preferences for both clinical and nonclinical hospital staff. Patients preferred ward guards and bodyguards to treat them more appropriately. Some patients believed that the hospital did not pay attention to their complaints regarding the behavior of the security personnel. Lekas et al. (2016) reported in a study in the United States about addiction treatment centers that consumers prefer to see better behavior from protection staff. They stated that despite complaints about the bad behavior of protection staff, they had not witnessed a change

in their behavior or replacement [41]. The belief in the bad behavior of security personnel is due more to the nature of their duty than to actual bad behavior. Patients preferred proper interactions between patients and providers with respect to the clinical staff. In the study conducted by Karyani et al. (2021), patients preferred to visit hospitals with better staff interactions to receive services [42]. In a study by Janssen, patients preferred doctors with better communication skills than other doctors [43]. In Ting et al.'s 2016 study, although patients preferred to receive patient-centered care, they preferred less participation in decision-making [44]. In general, patients valued the excellent behavior of providers as equivalent to their professional knowledge.

Another preference of the patients in the present study was related to specialist knowledge and the experience of the doctor. In a study by Janssen and Janssen (2012), patients preferred experienced and sometimes older doctors, believing that the quality of doctors' work increases with patients' visits. Moreover, in Ting et al.'s 2016 study, young doctors had more communication skills and provided patient-centered care [44]. Patients in the current study preferred same-sex doctors and female doctors. In a study by Mandil et al. (2015) conducted in Saudi Arabia, patients considered male providers better regardless of sex [45]. However, in Fink et al.'s (2020) study, both male and female patients preferred that their healthcare providers be similar to themselves [46]. The preference for a female doctor is accepted by patients because of the feeling of more appropriate interaction.

The third main theme of the present study was service delivery-related preferences, including health services, inpatient wards, and appointment systems. For health service preferences, patients mentioned the hospitalization period, occupational therapy, and medication distribution. In this study, patients preferred short-term hospitalization. In a study conducted by Florey (2009), an increase in the duration of hospitalization was also related to an increase in the desire to share a room [47]. Patients preferred occupational therapy services to be available to them without gender discrimination at different hours of the day on weekdays. In a study by Eyres and Unsworth (2005), occupational therapy exercises led to increased self-confidence and patient satisfaction with the services received in the hospital [48]. In the present study, however, it was difficult for psychiatric ward patients, especially male patients, to access occupational therapy. Patients preferred that the medication be given to them on time and with proper training. This finding is similar to that of a study by Wilder et al. (2010), who reported that paying attention to patients' preferences during drug administration can improve patients' adherence to the regular and correct use of prescribed drugs [49].

For the inpatient ward, the conditions and characteristics of other patients were considered. The patients in the present study preferred to be in a more quiet ward, with various ages and fewer diagnoses, but single rooms were not acceptable to them. In the study by Alalouch et al. (2009) in Scotland, most elderly patients preferred to be hospitalized in private rooms [50]. The issue of patients' need for an interactive space has led to a preference for a nonsingle room. Patients in the present study wanted a separate room for meeting with relatives and friends. Biabani et al. (2021) reported that the presence of family members as the patient's companion can effectively reduce patients' anxiety about treatment processes [51]. These facilities in the hospital have led to patient satisfaction.

When choosing a hospital, patients also pay attention to the comfort facilities. The patients in the present study preferred to be hospitalized in multibed rooms. They also had preferences regarding the cleanliness of the rooms and sanitary facilities and considered it one of the reasons for choosing a hospital. In a study by Kazemi-Karyani et al. (2021), the cleanliness of wards and sanitary facilities was also one of the issues that could affect the choice of hospital [42]. The existence of a system to monitor the cleanliness of the ward can address this preference of patients. Food was one of the patients' preferences. Patients preferred hospital food to be of greater quality, and in the process of preparing hospital food, being healthy was not considered to be the same as a bad taste. In a study by Vivanti et al. (2008), patients had different food preferences and preferred hot foods [52].

The studied patients preferred clothes with a more accessible and more attractive design. Kam and Yoo (2021) suggested that patients' clothes should be considered a medium for patients to hope that they can be cured. In their research, patients paid attention to the arrangement, motif, and characteristics of the elements used in clothes [53].

Patients further preferred comfortable facilities such as television, mobile phones, and proper light and ventilation in the hospital. In a study conducted by Wensley et al. (2020), the availability of distractions such as television and Wi-Fi and facilities (e.g., light, temperature, and access to fresh air) was determined as one of the patient's preferences [54]. In the present study, the participants also preferred access to games and entertainment during hospitalization. These entertainments can also reduce stress [55]. For example, patients can interact with their surroundings by playing joint games, improving their mental condition.

One main issue in the present study is the waiting list. Patients preferred to have shorter waiting times to complete the hospital admission process and receive services at a favorable speed. In a study by Mehrotra et al. (2022),

in the trade-off between the quality of medical services and the waiting list, patients might give up more quality because of the long waiting list [56]. In a study by Lendado et al. (2022), having a short waiting list was one of the essential preferences of patients when choosing a hospital [57]. Finally, we found that the patients in the present study needed the help and accompaniment of their family members to obtain appointments. In a study by Yu et al. (2013), elderly patients preferred to use more traditional systems based on face-to-face appointments to make appointments when receiving care, and online appointment systems did not accept and satisfy them [58]. Simple appointment systems for the elderly should still be used in hospitals. The demographic characteristics of the participants were studied. Some of these characteristics are related to their treatment preferences in psychiatric care. In the present study, one of the patients' preferences was to be hospitalized in a multispecialty hospital to avoid stigma. Corrigan's 2004 study revealed that elderly patients are more concerned about social stigma than other patients [59].

Patient cultural conditions such as gender attitudes can influence patient preferences. Patients in the present study preferred doctors of the same sex, and some male patients also preferred female doctors. Temkin et al. (2024) reported that the preference for same-sex healthcare providers reflects cultural norms that prioritize gender sensitivity in patient–provider interactions and increase comfort and trust [60]. These insights underscore the need for culturally sensitive and accessible healthcare services tailored to the unique preferences of older psychiatric patients.

Strengths and limitations

The study highlights mental health care for elderly individuals, precisely the gap between the need for psychiatric treatment and actual care utilization. By focusing on the preferences of elderly patients, this study provides valuable insights that can inform healthcare providers and policymakers about how to tailor inpatient psychiatric services better to meet the needs of elderly patients in psychiatric hospitals. Qualitative methods, including semistructured interviews, allow for a nuanced understanding of patient perspectives, which is often overlooked in quantitative studies.

The present qualitative study has limitations. Given the nature of qualitative research, participants may have provided responses that conformed to social norms or may not have fully recalled their experiences and preferences. Patient preferences may be influenced by socioeconomic status, however, this issue was not addressed in the present study. Also, excluding individuals with active psychosis, suicidal ideation, or significant cognitive impairment may limit the generalizability of findings to the elderly psychiatric population, especially as these individuals may be more likely to be hospitalized than other groups. Although we used purposive maximum diversity sampling to capture a wide range of perspectives, the sample size may still not be sufficient to represent the diverse experiences of all elderly patients in psychiatric care. In particular, conducting the study in a single hospital may limit the applicability of the findings to other healthcare settings, as local healthcare systems, cultural factors, and specific characteristics of the hospital environment may influence patient preferences.

Conclusion

The present study provides new insights into the preferences of elderly individuals hospitalized in psychiatric wards, revealing that patients prefer multispecialty hospitals over psychiatric hospitals, value effective communication with clinical and non-clinical staff, and prioritize welfare facilities and service provision. These findings have significant global implications as aging populations grow worldwide, highlighting the need for patient-centered, integrated care models that address both physical and mental health needs. It is suggested that health policymakers and hospital managers should provide conditions for improving patient satisfaction and providing more patient-centered care by quantitatively and qualitatively examining the preferences of elderly patients hospitalized in psychiatric wards of hospitals and considering them in planning hospital activities. The present study can be a guide for designing future studies in psychiatric wards of elderly patients in hospitals. By prioritizing elderly patients' preferences, global mental health services can become more inclusive, equitable, and effective, fostering better outcomes for aging populations.

Abbreviations

P	Participant
DALYs	Disability-Adjusted Life Years
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions

S.M. and M.M. developed the theoretical formalism, V.O. and SM got the interviews. SM supervised the project. M.J. and M.M. and K.P. contributed to the final version of the manuscript. All authors read and approved the final manuscript and are responsible for questions related to the article.

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Data availability
The data that support the findings of this study are not openly available due to reasons of ethical and are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
The research was also approved by the Ethics Committee of the Medical School of Isfahan University of Medical Sciences (code: IR.ARI.MUI.REC.1401.294). Owing to medical research ethics committee regulations in Iran, written informed consent was obtained from all participants in the research in Persian. In addition, only one illiterate patient participated in the present study, the contents of the informed consent form were read in the presence of the patient's companion, and the consent of the patient and his companion to participate in the study was obtained. With respect to the patient's ability to provide informed consent, his doctor's opinion was obtained in the hospital.

Consent for publication
Not applicable.

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The authors declare no competing interests.

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References

1. Russo S, Jongerius C, Faccio F, Pizzoli SF, Pinto CA, Veldwijk J, et al. Understanding patients' preferences: a systematic review of psychological instruments used in patients' preference and decision studies. Value Health. 2019;22(4):491–501.
2. Gurmu Y. Patient preferences in Shared decision making during Healthcare and Associated factors among adult admitted patients at Public Hospitals of West Shoa Oromia, Ethiopia. Patient Prefer. Adherence. 2022:1781–6.
3. Bernhardsson S, Samsson KS, Johansson K, Öberg B, Larsson ME. A preference for dialogue: exploring the influence of patient preferences on clinical decision making and treatment in primary care physiotherapy. Eur J Physiotherapy. 2019;21(2):107–14.
4. Tringale M, Stephen G, Boylan A-M, Heneghan C. Integrating patient values and preferences in healthcare: a systematic review of qualitative evidence. BMJ open. 2022;12(11):e067268.
5. Gluyas H. Patient-centred care: improving healthcare outcomes. Nurs Standard (2014+). 2015;30(4):50.
6. Brennan PF, Strombom I. Improving health care by understanding patient preferences: the role of computer technology. J Am Med Inform Assoc. 1998;5(3):257–62.
7. Ng C-J, Lee P-Y, Lee Y-K, Chew B-H, Engkasan JP, Irmi Z-I, et al. An overview of patient involvement in healthcare decision-making: a situational analysis of the Malaysian context. BMC Health Serv Res. 2013;13(1):1–7.
8. Barnea R, Tur-Sinai A, Levtzion-Korach O, Weiss Y, Tal O. Patient preferences and choices as a reflection of trust—A cluster analysis comparing postsurgical perceptions in a private and a public hospital. Health Expect. 2022;25(5):2340–54.
9. Utens CM, Goossens LM, van Schayck OC, Rutten-van Mölken MP, van Litsenburg W, Janssen A, et al. Patient preference and satisfaction in hospital-at-home and usual hospital care for COPD exacerbations: results of a randomised controlled trial. Int J Nurs Stud. 2013;50(11):1537–49.
10. Eidam A, Roth A, Lacroix A, Goisser S, Seidling HM, Haefeli WE et al. Methods to assess patient preferences in old age pharmacotherapy–a systematic review. Patient Prefer Adherence. 2020;14:467–97.
11. Tan GTH, Shahwan S, Abdin E, Lau JH, Goh CMJ, Ong WJ, et al. Recognition of depression and help-seeking preference among university students in Singapore: an evaluation of the impact of advancing research to eliminate mental illness stigma an education and contact intervention. Front Psychiatry. 2021;12:582730.
12. Swift JK, Mullins RH, Penix EA, Roth KL, Trusty WT. The importance of listening to patient preferences when making mental health care decisions. World Psychiatry. 2021;20(3):316.
13. organization wh. mental disorder fact sheet. 2021.
14. Arias D, Saxena S, Verguet S. Quantifying the global burden of mental disorders and their economic value. EClinicalMedicine. 2022;54.
15. Rathod S, Pinninti N, Irfan M, Gorczynski P, Rathod P, Gega L, et al. Mental health service provision in low-and middle-income countries. Health Serv Insights. 2017;10:1178632917694350.
16. Pandya A, Shah K, Chauhan A, Saha S. Innovative mental health initiatives in India: a scope for strengthening primary healthcare services. J Family Med Prim Care. 2020;9(2):502–7.
17. Tambuyzer E, Pieters G, Van Audenhove C. Patient involvement in mental health care: one size does not fit all. Health Expect. 2014;17(1):138–50.
18. Larsen A, Tele A, Kumar M. Mental health service preferences of patients and providers: a scoping review of conjoint analysis and discrete choice experiments from global public health literature over the last 20 years (1999–2019). BMC Health Serv Res. 2021;21(1):589.
19. Petrova N, Khvostikova D. Prevalence, structure, and risk factors for mental disorders in older people. Adv Gerontol. 2021;11:409–15.
20. organization wh. Mental health of older adults 2023 Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults#:~:text=Prevalence,%2C%20DALYs)%20among%20older%20adults
21. Mackenzie CS, Scott T, Mather A, Sareen J. Older adults' help-seeking attitudes and treatment beliefs concerning mental health problems. Am J Geriatric Psychiatry. 2008;16(12):1010–9.
22. Elshaikh U, Sheik R, Saeed RKM, Chivese T, Alsayed Hassan D. Barriers and facilitators of older adults for professional mental health help-seeking: a systematic review. BMC Geriatr. 2023;23(1):516.
23. Speerforck S, Schomerus G. Social milieu: a relevant concept for a better understanding of stigma and help-seeking? Nervenarzt. 2020;91:785–91.
24. Schnyder N, Panczak R, Groth N, Schultze-Lutter F. Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. Br J Psychiatry. 2017;210(4):261–8.
25. De las Cuevas C, Peñate W, de Rivera L. Psychiatric patients' preferences and experiences in clinical decision-making: examining concordance and correlates of patients' preferences. Patient Educ Couns. 2014;96(2):222–8.
26. Raue PJ, Weinberger MI, Sirey JA, Meyers BS, Bruce ML. Preferences for depression treatment among elderly home health care patients. Psychiatric Serv. 2011;62(5):532–7.
27. Fakhari A, Herizchi S, Sadeghi-Bazargani H, Amiri S, Noorazar SG, Mirzajanzade M, et al. Prevalence of psychiatric disorders in the aging population in the northeastern of Iran. Middle East Curr Psychiatry. 2023;30(1):25.
28. Clarke V, Braun V. Thematic analysis. J Posit Psychol. 2017;12(3):297–8.
29. Lincoln YS. Naturalistic inquiry: sage; 1985.
30. Doshmangir L, Khabiri R, Gordeev VSJTL. Policies to address the impact of an ageing population in Iran. The Lancet. 2023;401(10382):1078.
31. Sarokhani D, Parvareh M, Dehkordi AH, Sayehmiri K, Moghimbeigi AJI. Prevalence of depression among Iranian elderly: systematic review and meta-analysis. Iran J Psychiatry. 2018;13(1):55.
32. Zhang W, Ung COL, Lin G, Liu J, Li W, Hu H, et al. Factors contributing to patients' preferences for primary health care institutions in China: a qualitative study. Front Public Health. 2020;8:414.
33. Amini-Rarani M, Moeeni M, Ponnet K. Male patients' preferences for opioid use treatment programs. BMC Psychiatry. 2023;23(1):1–12.
34. Dehbarez NT, Lou S, Uldbjerg N, Møller A, Gyrd-Hansen D, Søgaard R. Pregnant women's choice of birthing hospital: a qualitative study on individuals' preferences. Women Birth. 2018;31(6):e389–94.
35. Luck-Sikorski C, Stein J, Heilmann K, Maier W, Kaduszkiewicz H, Scherer M, et al. Treatment preferences for depression in the elderly. Int Psychogeriatr. 2017;29(3):389–98.
36. Ghimire C, Acharya S, Thapa A, Shrestha A, Basnet D, Rajak K. Patients' preference to Bedside Teaching encounters in four major wards in a Tertiary Care Centre. JNMA: J Nepal Med Association. 2019;57(220):429.
37. Perera IM. The relationship between hospital and community psychiatry: complements, not substitutes? Psychiatric Serv. 2020;71(9):964–6.
38. Liggins J, Hatcher S. Stigma toward the mentally ill in the general hospital: a qualitative study. Gen Hosp Psychiatry. 2005;27(5):359–64.
39. Schuldt J, Doktor A, Lichters M, Vogt B, Robra B-P. Insurees' preferences in hospital choice—A population-based study. Health Policy. 2017;121(10):1040–6.

40. Pfeiffer PN, Bowersox N, Birgenheir D, Burgess J, Forman J, Valenstein M. Preferences and barriers to care following psychiatric hospitalization at two veterans affairs medical centers: a mixed methods study. J Behav Health Serv Res. 2016;43:88–103.
41. Lekas H-M, Alfandre D, Gordon P, Harwood K, Yin MT. The role of patient-provider interactions: using an accounts framework to explain hospital discharges against medical advice. Soc Sci Med. 2016;156:106–13.
42. Kazemi-Karyani A, Ramezani-Doroh V, Khosravi F, Miankali ZS, Soltani S, Soofi M, et al. Eliciting preferences of patients about the quality of hospital services in the west of Iran using discrete choice experiment analysis. Cost Eff Resource Allocation. 2021;19(1):1–8.
43. Janssen SM, Lagro-Janssen AL. Physician's gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: a systematic review. Patient Educ Couns. 2012;89(2):221–6.
44. Ting X, Yong B, Yin L, Mi T. Patient perception and the barriers to practicing patient-centered communication: a survey and in-depth interview of Chinese patients and physicians. Patient Educ Couns. 2016;99(3):364–9.
45. Mandil AM, Alhayyan RM, Alshalawi AA, Alemran AS, Alayed MM. Preference of physicians' gender among male and female primary health care clinic attendees in a university hospital in Saudi Arabia. Saudi Med J. 2015;36(8):1011.
46. Fink M, Klein K, Sayers K, Valentino J, Leonardi C, Bronstone A, et al. Objective data reveals gender preferences for patients' primary care physician. J Prim Care Community Health. 2020;11:2150132720967221.
47. Florey L, Flynn R, Isles C. Patient preferences for single rooms or shared accommodation in a district general hospital. Scot Med J. 2009;54(2):5–8.
48. Eyres L, Unsworth CA. Occupational therapy in acute hospitals: the effectiveness of a pilot program to maintain occupational performance in older clients. Aust Occup Ther J. 2005;52(3):218–24.
49. Wilder CM, Elbogen EB, Moser LL, Swanson JW, Swartz MS. Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. Psychiatric Serv. 2010;61(4):380–5.
50. Alalouch C, Aspinall P, Smith H. On locational preferences for privacy in hospital wards. Facilities. 2009;27(3/4):88–106.
51. Biabani F, Bagherian S, Salmani Mood M, Sanaei H, Helal Birjandi M. The Effect of Scheduled Care Companion Program in primary nursing care on patients' anxiety in Cardiac Intensive Care Unit. Evid Based Care. 2021;11(3):7–14.
52. Vivanti A, Banks M, Aliakbari J, Suter M, HANNAN-JONES M, McBride E. Meal and food preferences of nutritionally at-risk inpatients admitted to two Australian tertiary teaching hospitals. Nutr Dietetics. 2008;65(1):36–40.
53. Kam S, Yoo Y. Patient clothing as a healing environment: a qualitative interview study. Int J Environ Res Public Health. 2021;18(10):5357.
54. Wensley C, Botti M, McKillop A, Merry AF. Maximising comfort: how do patients describe the care that matters? A two-stage qualitative descriptive study to develop a quality improvement framework for comfort-related care in inpatient settings. BMJ open. 2020;10(5):e033336.
55. Prey JE, Woollen J, Wilcox L, Sackeim AD, Hripcsak G, Bakken S, et al. Patient engagement in the inpatient setting: a systematic review. J Am Med Inform Assoc. 2014;21(4):742–50.
56. Mehrotra S, Gonzalez JM, Schantz K, Yang J-C, Friedewald JJ, Knight R. Patient preferences for waiting time and kidney quality. Clin J Am Soc Nephrol. 2022;17(9):1363–71.
57. Lendado TA, Bitew S, Elias F, Samuel S, Assele DD, Asefa M. Effect of hospital attributes on patient preference among outpatient attendants in Wolaita Zone, Southern Ethiopia: discrete choice experiment study. BMC Health Serv Res. 2022;22(1):1–11.
58. Yu W, Yu X, Hu H, Duan G, Liu Z, Wang Y. Use of hospital appointment registration systems in China: a survey study. Global J Health Sci. 2013;5(5):193.
59. Corrigan P. How stigma interferes with mental health care. Am Psychol. 2004;59(7):614.
60. Temkin SM, Salles A, Barr E, Leggett CB, Reznick JS, Wong MS. Women's work: gender and the physician workforce. Soc Sci Med. 2024;351:116556.

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