Prescribing and de-prescribing psychotropics

Sami Timimi
Consultant Child and Adolescent Psychiatrist
stimimi@talk21.com

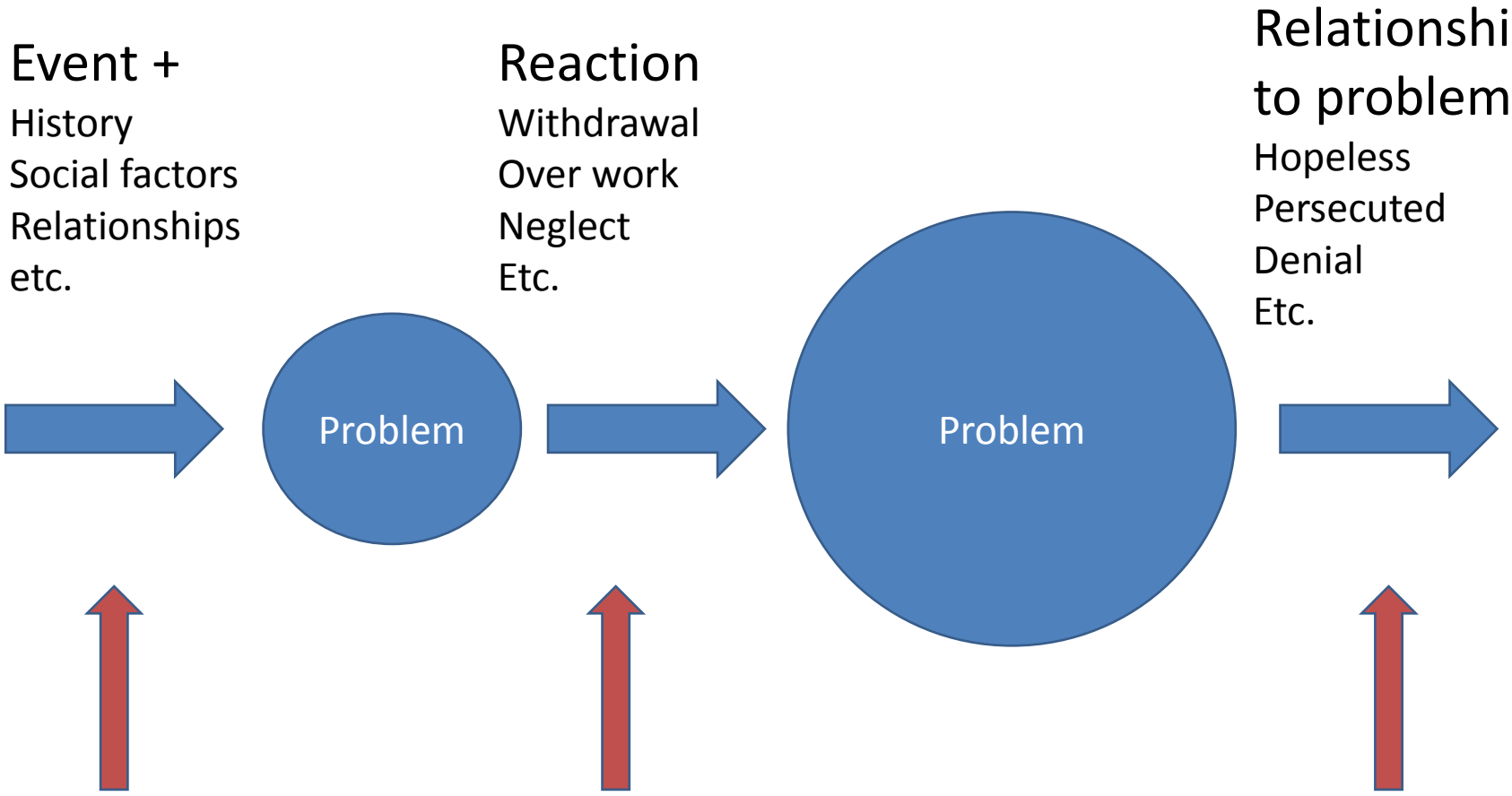
A summary of benefit/harms

- Diagnoses in psychiatry are not diagnoses – they describe but do not explain.
- Psychiatric medications do not have any disease specific effects.
- Psychotropic medications, like alcohol or street drugs, stimulate or depress certain neurotransmitters and have generic effects.
- The resulting altered mental state can help in the short term. Little evidence they improves long term outcomes.
- All psychoactive substances can produce tolerance/withdrawal effects.

Therapeutic models: evidence

- In general when bad things happen more likely to feel bad.
- Identifying precise cause is like peeling a never ending onion as lives are multi-layered.
- Psychiatric diagnosis does not help choose best treatment.
- Extra therapeutic factors biggest effect on outcomes
- Therapeutic alliance (listen non-judgmentally) next biggest factor.

Therapeutic models: Where to focus



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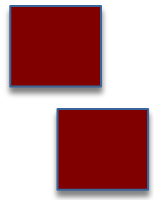

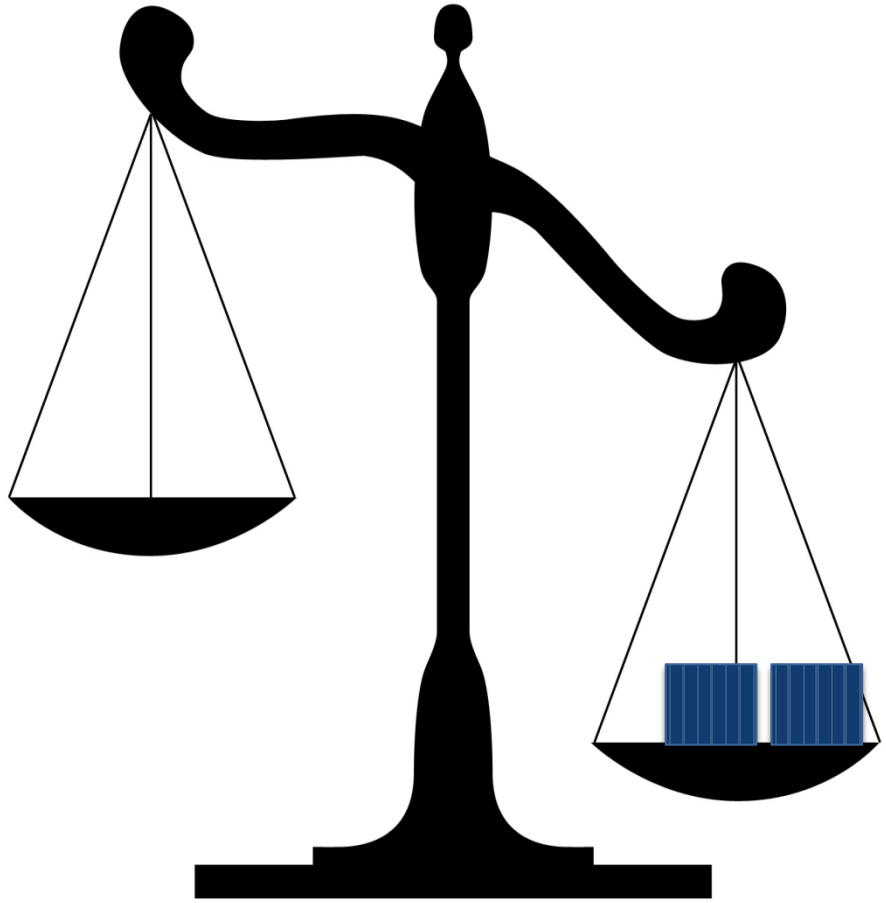

Strengths

Problems

Therapeutic models: Where to focus

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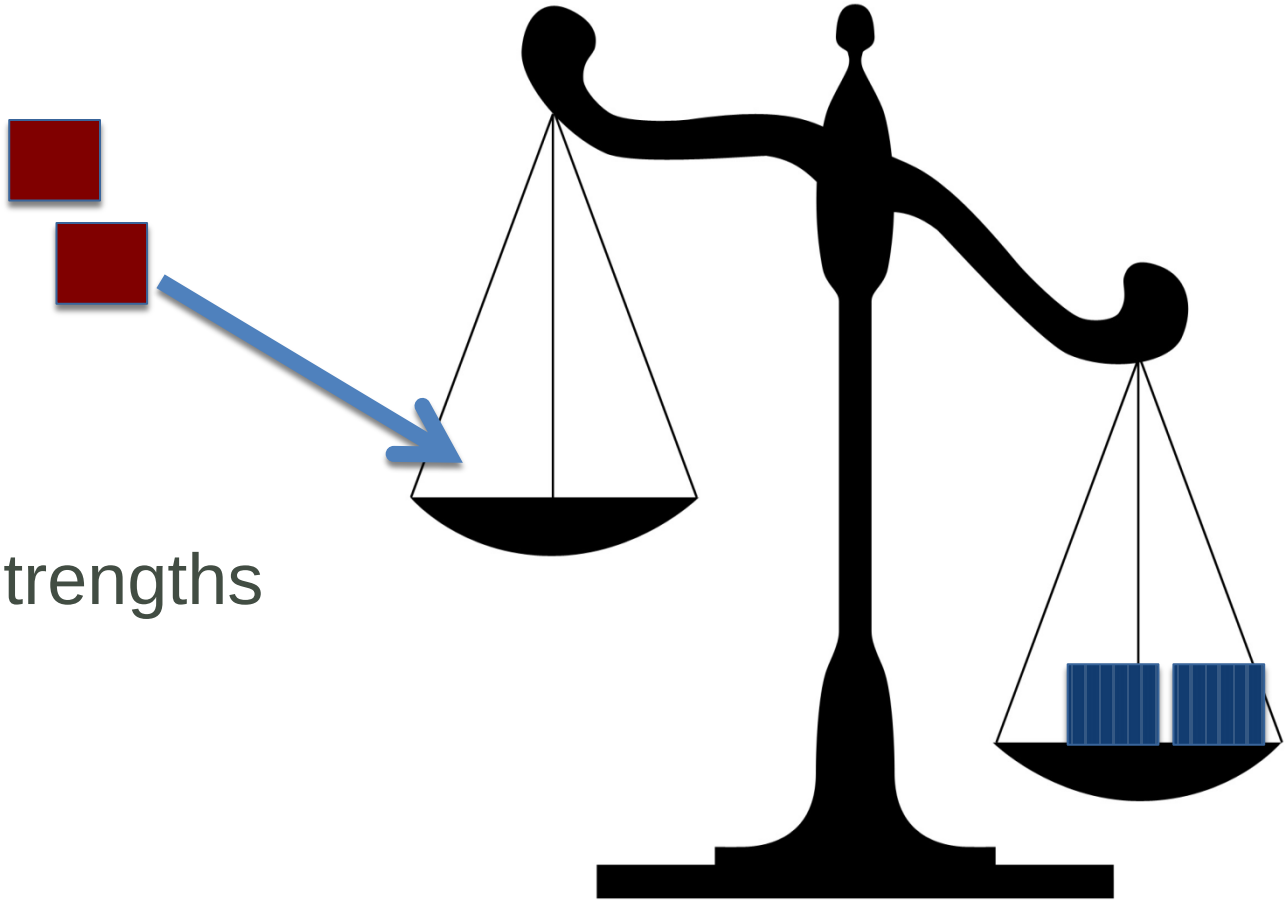

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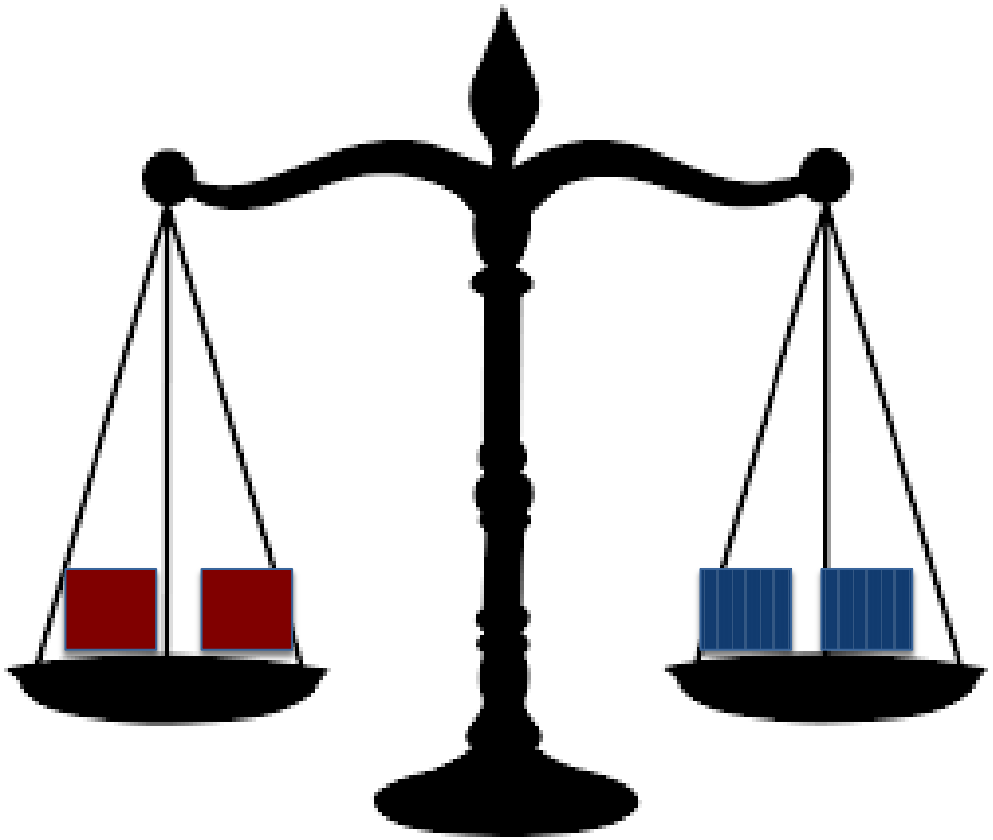


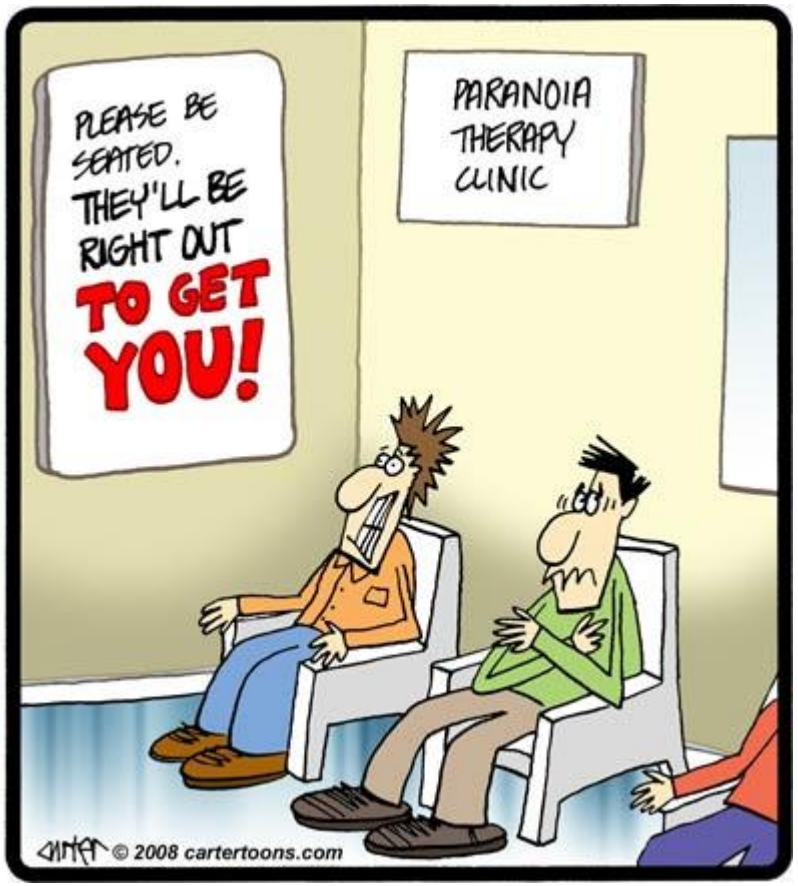
Problems

Brief therapy models

Focus on

Changing relationship to problem

Building on innate strengths and resilience



Treatments focussing on problems do worse than treatments focussing on strengths

Yes or no?

A prescribing narrative

- Provide a narrative for how the drug works. Psychiatric medications are basically 'enablers' creating windows of opportunity.
- Remember no drug makes a decision or initiates an action, it's people who do that. Psychiatric drugs are a bit like alcohol – they make you feel a little different, but relying on them long term can be a problem.
- The drug works best when we take advantage of feeling a little bit better to make what changes we can. It's like the oil that helps the cogs turn again. The cogs are you and it is you that will be the one that then drives the change not the drugs.
- You will maybe need the drug for 3 to 6 months and then we can gradually wean you off.

Narratives for prescribing- The Miracle question

Find simple goal (s) “Consider I had the perfect prescription and you only had to take it once and so you take it before you go to bed tonight. While you’re asleep it works perfectly. What would tomorrow be like? What might you notice? What might others notice?”

Narratives for prescribing- Visualising change

Find simple goal (s) – Go from absence of negatives and generalisation to presence of specific behaviours.

“So you’d feel happier, I see, can you describe what I would see you doing if you were feeling happier?”

“ So if you weren’t loosing your temper, what would you be doing instead?”

Narratives for prescribing-measuring goals

Give your goal(s) a score from 0 to 10 – 0 is total absence of any of the desired goals 10 present all the time. Note any non 0 score.

"So you'd give yourself a 2 right now. Sounds like things are tough. But I wonder what the 2 is about. It suggests you're able to do some things right now. Can you tell me about what you have been able to do"

Note any example of functioning and ask how they have managed this "How did you still manage to take your child to school despite how you feel? That's what we call **resilience**, still functioning in spite of how we feel. You're clearly a **resilient person**"

Narratives for prescribing- imagining change

Setting a small task – Remind them that change that lasts often happens in small steps, so best to aim for small changes

"Can you think of anything that you might do related to your goals that will help you go from 2 out of 10 to 2.5?" or

"I'd like you to make a note, mental or written, of anything, however small or temporary, that is a moment where you felt just a little bit better and I'll ask you about this next time we meet"

Narratives for prescribing- Engage their system

Who else is there who can support you?

How about making a list of people and inviting them round to discuss how they might help?

Are there people you could visit or even clubs/activities you could join?

Sometimes just saying hello and having small talk with someone can make a big difference to feeling alone with these problems

Narratives for prescribing- follow up

Embed the notion that the patient and their system are the agents of change – Ask about their score out of 10. If it's more than last session ask them **what they did or noticed** to achieve that.

"So you're at 2.5 now. I'm curious to know what you noticed or what decisions you made that helped this change? What have you reconnected with in yourself? Who has helped you? "

Embed the notion of resilience "This is a sign you are **reconnecting with your inner resources, your resilience**"

If no change

- Perhaps they need more time.
- Who else might help with ideas (from their support system).
- Consider stopping medication.
- Perhaps try one other class only. Do not get drawn into escalating dose or polypharmacy. If it doesn’t work meds will not be part of the solution.

The ‘Miracle question’ helps the patient visualise getting better

Yes or no?

Some pointers for withdrawing from psychotropics

Withdrawal effects

- **SSRIs**: dizziness, tinnitus, electric ‘zaps’, burning sensation, paresthesia, tremor, anxiety, low mood, strange dreams, nightmares, akathisia, nausea, stomach cramps, aches and pains, flu-like symptoms, sexual dysfunction.
- **Neuroleptics**: Confusion, thought disorder, paranoia, hallucinations, agitation, movement disorders (tremor, tardive dyskinesia), despair, fatigue, flu-like symptoms, nausea, vomiting.
- **Stimulants**: dysphoria, suicidal feelings, jittery, impulsive, anxiety, dulled senses, slowed speech, loss of interest, slow heart rate, irritability, hallucinations, paranoia, fatigue, depression, increased appetite, impaired memory, insomnia or hypersomnia, unpleasant dreams.

If you decided to stop/reduce psychiatric medications, how might you do so safely?

Know the half life

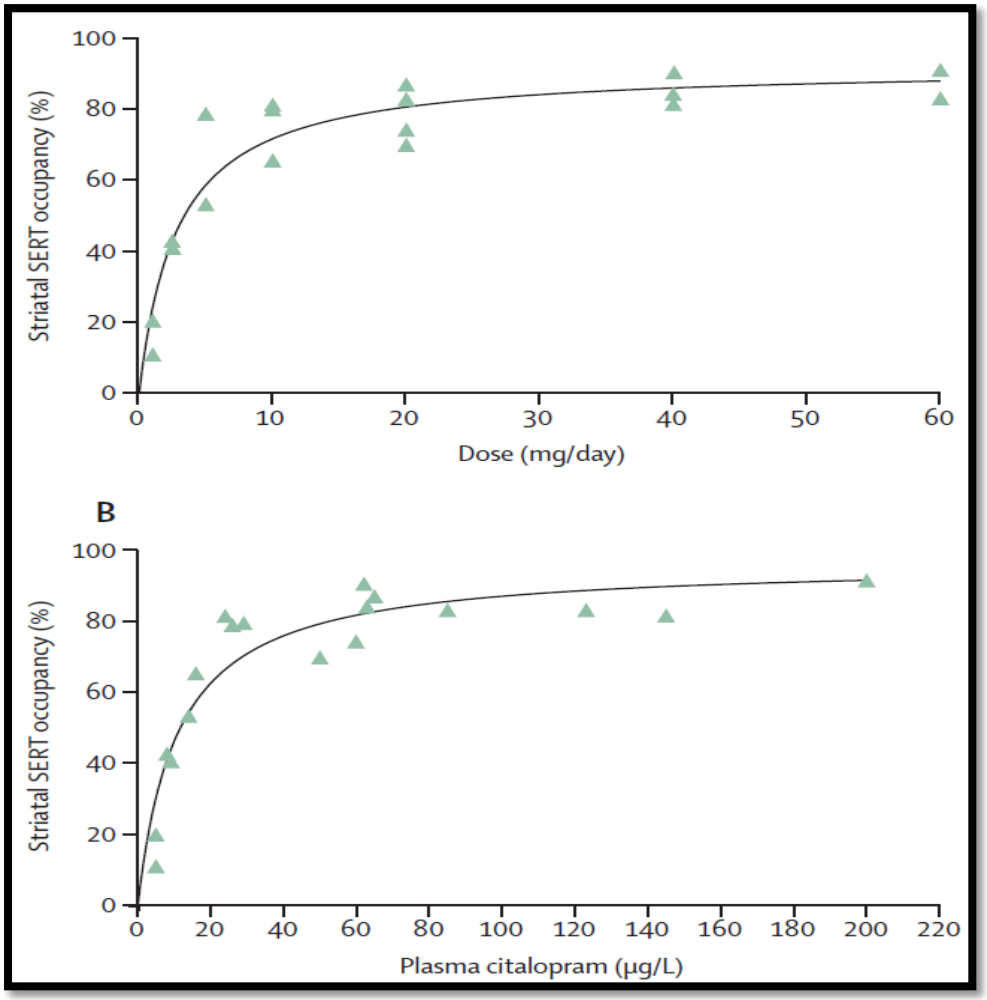
- **Benzodiazepines**: Diazepam 20-50hr, Lorazepam 10-20hr, Alprazolam 6-12hr.
- **SSRIs**: Fluoxetine 4-6 days, Citalopram 22-36hr, Sertraline 22-36hr.
- **SNRIs**: Venlafaxine 4-7hr, Duloxetine 8-17hr.
- **Neuroleptics**: Haloperidol 20hr, Risperidone 24hr, Olanzapine 32-25hr, Aripiprazole 3-6 days, risperidone (depot) 4-6 days, Aripiprazole (depot) 30-47 days.
- **Stimulants**: Methylphenidate 3-6hr, Dexedrine 10-12hr, Concerta XL 24hrs (Slow release capsules however are longer).

Withdrawal regimes

- **Talk about it**. Be flexible. Make agreements. Involve young people and parents/carers.
- Anything over 3 months – careful staged withdrawal months to years. Patient controls pace, through discussion and feedback.
- **Go slow and use collaborative approach**.
- Best to do daily regimes. Longer half life can do different dosing each day (e.g. Fluoxetine). Shorter (below 24hrs) has to be daily dose regimes.
- **Flexible**, particularly where there is 'polypharmacy'.
- Polypharmacy (multiple medications) – leave more sedative ones or drugs prescribed for side effects of other ones till later.

Steep decline at low doses

As you get to lower doses, a similar dose decrease is equivalent to a larger decrease in receptor occupancy.



Steep decline at low doses 2

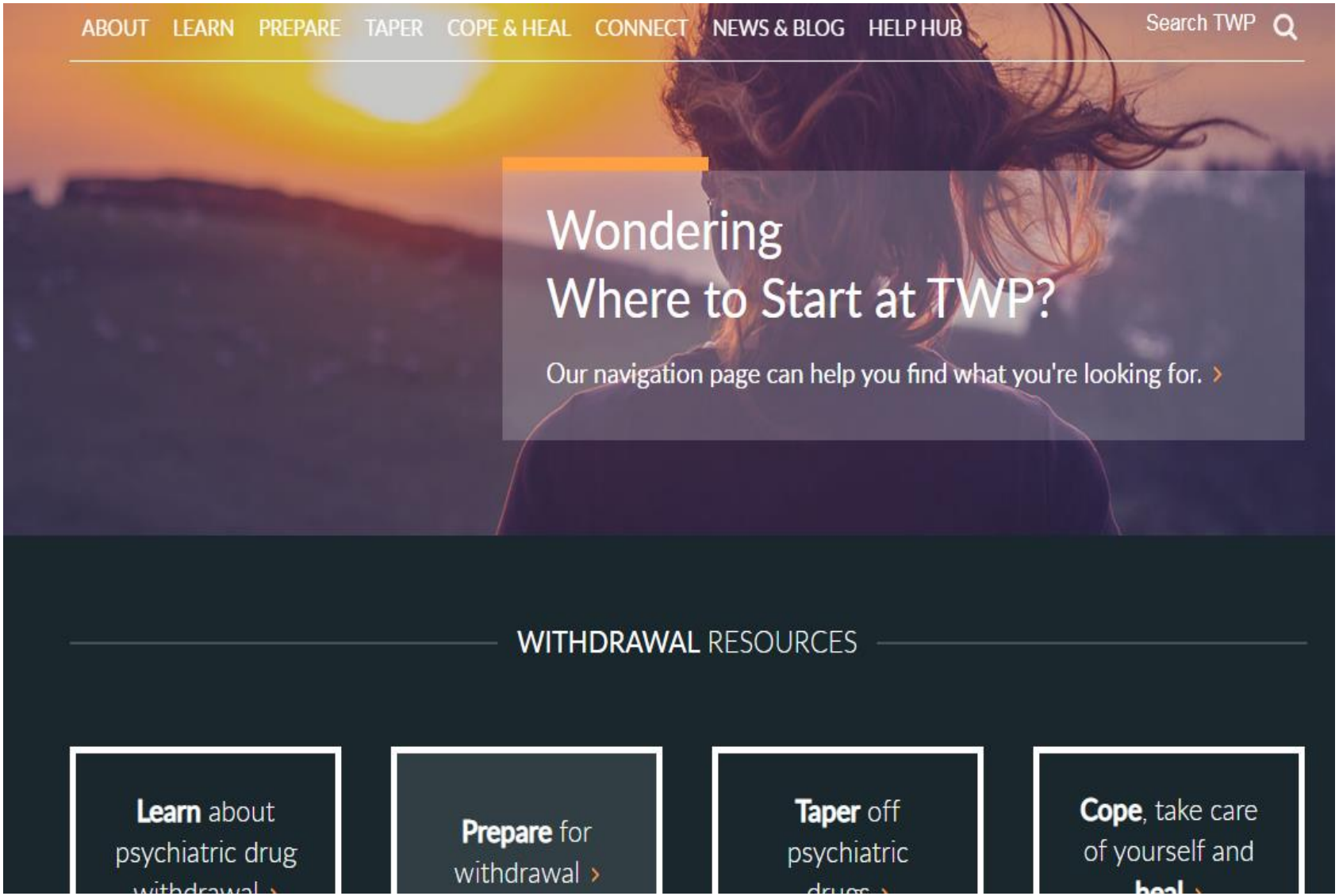
Citalopram dose (mg)	SERT occupancy (%)
60·0	87·8%
40·0	85·9%
20·0	80·5%
19·0	80·0%
9·1	70·0%
5·4	60·0%
3·4	50·0%
2·3	40·0%
1·5	30·0%
0·8	20·0%
0·37	10·0%

SERT occupancy was calculated using the Michaelis-Menten equation of best fit derived by Meyer and colleagues.[60] Common clinical doses and doses corresponding to 10% decrements of SERT inhibition are displayed. These doses could be produced by a combination of tablets and liquid formulations. Approximations might be necessary. SERT=serotonin transporter.

Table 2: **Derivation of SERT occupancy from citalopram dose using the Michaelis-Menten equation of best fit**

- Withdrawal should proceed in roughly 10% reduction of dose steps when you get lower doses.
- Can take between 1 month and several years to withdraw.
- If after a reduction symptoms/distress appear, go back to previous dose and stay for longer.
- Some find it very hard to do the last reduction, but can stabilise on a very small dose.

https://withdrawal.theinnercompass.org/



https://www.taperingstrip.org/

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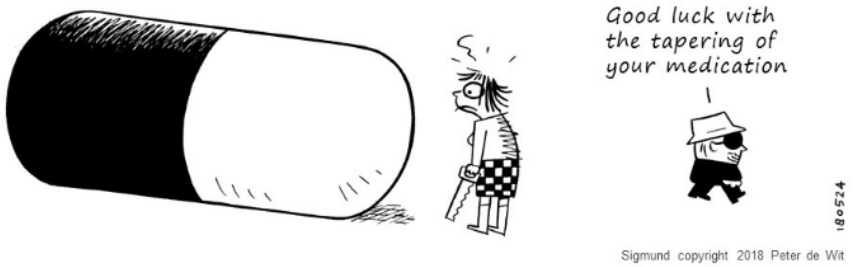
Tapering strips

The reduction or discontinuation of psychiatric medications such as antidepressants, antipsychotics or anxiolytics can cause physical and psychological withdrawal and rebound symptoms. Withdrawal symptoms may be so severe that patients are unable to continue reducing the dose, regardless of the medication's efficacy.
In 2010, the Tapering Project was started to address these problems through the development of tapered doses of medication provided in strip packaging: **tapering strips**.



Patients are more likely to experience withdrawal symptoms when the regime reaches lowest doses

Yes or no?

Withdrawal regime life context

- May wish to **avoid significant transitions/life events** (e.g. starting school term).
- **Dealing with nocebo:** Is it me or the drug? Reminding that change when it happens cannot be made by a drug. A drug does not have agency.
- **Helping anxious parents**: As they come off drugs, the youngster will experience their emotions in a way they haven't for a long time.
- **DO NOT withdraw without friend/family support.**