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Implementing psychiatric drug withdrawal practices: challenges with individuals with multiple comorbid behavioral and health problems

Abstract

Treating dually diagnosed individuals with psychiatric medications is very complex as they present often with physical comorbidities and social challenges. Although the need to explore titration and withdrawal from psychiatric medications continues to be raised by consumers, professionals, researchers, and advocacy groups, such a possibility is rarely addressed in clinical practice, since it is extremely challenging and necessitates a nuanced understanding of the interplay of multiple factors (psychological, physical, social). In the article, the authors address the difficulties related to prescribing psychiatric medications and explore the possibility of withdrawal strategies, particularly for dually diagnosed clients. In this frame, they illustrate the development of a withdrawal in a clinic in the southwestern region of the US, which could potentially be considered a beginning of a model to be developed further. Also, the authors are trying to raise awareness regarding the perils of prescribing for dually diagnosed patients, without clear therapeutic objectives and goals, and the possibility of offering withdrawal paths to those individuals who could benefit from it. Moreover, they highlight the importance of peer support- recovery-based interventions, and cultural sensitivity as essential aspects of psychiatric drug prescribing practices.

Keywords: psychiatric drug withdrawal, dual diagnoses, peer specialists, culture and health, indigenous health

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Introduction

As stated in the literature, the overall use of psychiatric medications is substantial: one in six individuals in the United States is on some form of psychiatric medication, and most of them are prescribed for the long run.[1] The psychopharmacologic management of dually diagnosed individuals may be even more complex if we consider that these individuals present often with physical comorbidities and other complex social.[1–4] Moreover, individuals with dual diagnoses are treated with polypharmacy (the concurrent prescription of two or more psychiatric medications) at a very high rate, which can hurt the trajectory of recovery, if their utilization is not judiciously planned for.[5]

However, the possibility of withdrawing from psychiatric medications is rarely addressed in clinical practice, since it is extremely challenging and necessitates a nuanced understanding of the interplay of multiple factors, which will be reviewed in the article.[6] Considering that it is already a challenge to taper off psychiatric medications for individuals with a single psychiatric diagnosis, it is not hard to guess that implementing it in individuals with comorbid diagnoses may be extremely demanding for both the patients and the providers, considering that there are no clear guidelines for this cohort.[6,7] This paper tries to add some awareness to the subject of tapering off and discontinuing psychiatric medications in dually diagnosed individuals, highlighting the need for the creation of specialized "withdrawal venues" and the benefits of peer specialists' involvement in the process. Also, the article highlights the importance of awareness of the cultural aspects of behavioral health treatment, which should be emphasized during the process of drug withdrawal as well, as drugs have not only biological effects on the body but have symbolic meaning that may vary from one culture to another one.[8–10]

Safe tapering from psychiatric medications. The clinical context and realities of prescription practices and tapering individuals off psychiatric medications

Unfortunately, it seems that the prescribing of psychiatric medications is often carried out with limited attention to the long-term effects of psychiatric medications, with no mention of the possibility of tapering the medication down and of alternatives to them, including psychosocial interventions.[11,12] Unfortunately, the long-term prescription of psychiatric medications may provoke consistent problems like neurological side effects, weight gain, somnolence, constipation, and sexual dysfunction, to mention some of the most significant. It is also worthwhile to consider that individuals are often medicated for conditions that could resolve on their own or treated with alternative approaches.[13] In planning a tapering course, it is critical to emphasize that a substantial number of persons may experience withdrawal signs and symptoms if they stop their medication(s) abruptly.[14]

However, with proper support, tapering off and discontinuing medications is possible, as shown by the specialized literature and testimonials.[13] The data from a recent survey regarding the tapering of psychiatric medications are quite eloquent as they showed that about half of the individuals met their goal of discontinuing their medication. Most of the respondents indicated that concerns about medication side effects prompted the decision to explore the possibility of discontinuing them. Often withdrawal symptoms were rated as severe, but self-education and support from others were very helpful. Although best practices would recommend appropriate medical supervision during the withdrawal process, it is worthwhile to notice that, in this study, prescribers were not always rated as helpful during discontinuation. Nevertheless, most respondents

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who discontinued the medications were satisfied with their decision and stated the efficacy of support systems of individuals with lived experience, which is the basis for peer support interventions.[15] Still, there is little doubt that, especially in complex cases, the tapering should be done under medical supervision. Thorough preparation, tailored strategies, and continuous support are necessary aspects for successful medication tapering.[11]

Unfortunately, insufficient information and reluctance from providers and "mainstream" medicine to consider and implement tapering practices, have led many patients to seek guidance from social media platforms. Although several online groups and sites provide adequate, and in some cases, very good and reliable information, relying on social media may be risky in the presence of complex clinical issues (i.e., strong psychological distress, substance abuse issues, medical problems). Moreover, it is not easy to predict the outcome of a withdrawal process, but paying attention to some factors may help us determine the likelihood of a successful course of tapering. Here are some of the most significant: severity of the original psychological disorder; complexity of the medication regimen (monotherapy vs polypharmacy); history of substance abuse; presence of medical co-morbidities, quality of the alliance with the provider, and consistency of support system.[11,14] Moreover, the practice of psychiatric polypharmacy is quite diffuse in psychiatry, with all the potentially negative psychological and medical consequences. A knowledgeable approach to psychopharmacology should indeed avoid injudicious polypharmacy, but with the current emphasis on biological treatments, it is challenging to avoid unnecessary and excessive prescribing patterns.[3,16]

Another reason for the scarce emphasis on tapering off psychiatric medications is that most psychiatrists and prescribers are not knowledgeable about the subject and therefore cannot support consumers who are interested in the withdrawal process.[11,13,17] This derives from a lack of proper training (Hall 2017). Unfortunately, the influence of the pharmaceutical industry on physicians' education is a major obstacle in discouraging providers from considering implementing a tapering process.[17–20] While drug treatments may positively change people's emotional state in the short run, their effectiveness and safety particularly in the long run, have not yet been conclusively proven.[17,21,22]

From what has been stated, the development of withdrawal venues, with a clear emphasis on the "real-life" clinical and social needs of individuals who are tapering off their medications should be a priority for any mental health system. An example will be illustrated in the last paragraphs of the article. In the meantime, it is necessary to find alternatives and venues that could support patients and providers to explore the possibility of tapering psychiatric medications. One approach that has proven effective, especially in situations where resources are limited, is the utilization of peer support. Peer support specialists are individuals who have successfully recovered from similar emotional distress and help others do the same. By providing shared understanding, respect, and mutual empowerment, peer support services can extend the reach of treatment beyond the clinical setting and into the day-to-day environment of those seeking a sustained recovery process.[23] This approach reduces the likelihood of relapses and utilization of higher levels of care. Withdrawal from psychiatric drugs is a difficult process that requires assistance. People with lived experience, peer support specialists, and online self-help groups guided by peer specialists can provide valuable support by sharing strategies for coping with the process of drug withdrawal and promoting self-determination.[13,24] In addition, peers foster an open and egalitarian relationship between provider and consumer to reach a point of convergence on pharmacologic interventions and withdrawal strategies.[25] The approach is also consistent with individual cultural needs, as peer support focuses on individual context.

Safe tapering practices for dually diagnosed patients in getting off psychiatric medications need to be identified

Individuals with substance use disorders are at high risk for developing one or more primary conditions or chronic diseases, and those with mental illness are more likely to experience a substance use disorder than those not affected by a mental illness. It has been reported that approximately 21.5 million adults in the United States have a co-occurring disorder (SAMHSA). Several studies show that not only a high rate of psychiatric medications but also a high rate of polypharmacy utilization in "dually diagnosed" individuals. These individuals are often prescribed more than one psychotropic medication with the risk of serious complications and side effects, considering they usually also have a high rate of physical comorbidities (i.e., metabolic syndrome, heart problems, hypertension, chronic pain). One study with dually diagnosed individuals showed consistent rates of psychotropic co-prescribing: 36.7% of individuals received a psychotropic medication in addition to their opioid substitution drug. In this cohort, 35.4% received an antidepressant, 9.2% an antipsychotic, 8.6% a benzodiazepine, and 4.5% a gabapentinoid. Moreover, a large number of these scripts seem to be prescribed off-label.[26] These rates seem to be around average for this population, as studies have shown similar problematic prescribing patterns.[27]

These practices do not represent sound examples of evidence-based treatments of comorbid mental illness, particularly in patients involved in Opioid substitution Programs. Psychiatric medications should be prescribed after careful consideration and close monitoring for adherence. For opioid dependency, without severe psychiatric symptoms, psychotherapy and support from peer specialists may be the safest and most effective management. Also, we need to consider that distinguishing between primary psychiatric symptoms versus secondary, (stemming from active drug use), may be very challenging, especially in populations with multiple comorbid issues and a tendency to continue to use, even during treatment.[28] Because of these complexities in clinical practice, the traditional approach of just "targeting the diagnosis" is getting increasingly replaced by the acknowledgment that individuals present often with complex psychological, physical, and social factors.[29] In reality, "dually diagnosed patients" often have multiple concurrent disorders amplifying each other synergistically and non-infrequently amid social and cultural challenges. That is why the concept of "multimorbidity"(referring to multiple diagnoses and contextual issues) is gaining popularity.[30] Prescribing in the presence of "multimorbidity" can be overly challenging for both the clinician and the patient. Clinicians may under-prescribe to avoid the danger of overmedication or over-prescribe when they feel that risk levels are not so high. Patients may react to prescribing practices in complex ways, including a sense of idealization of the medication regimen, followed by disenchantment, and overutilization to strive for the effects of addictive substances, but they can also develop phobic avoidance of medications and, as a consequence, underutilization.[31]

The appropriate clinical approach could include the establishing of provisions for safe use; frequent monitoring; conveying tolerance for idiosyncratic use within safe limits; exploring the meaning of the medication as it relates to the history of addiction and the patient-

provider relationship; offering frequent psychoeducation and exploring the possibility of a tapering process.[13,28] All this requires skills, resources, and time. There should be no problem with the notion that the development of venues with a specific focus on withdrawal protocols is indeed part of the provision of safe and effective mental health care. These should offer individuals the necessary support for a safe and effective tapering process while keeping in mind that all therapeutic interventions can have both positive and negative effects and that, therefore, it is crucial to evaluate these pharmacologic therapies thoroughly, without any bias towards a particular direction.[13] Also, this evaluation should consider the individual's subjective experience and context, including social and cultural factors, as they have a significant impact on treatment outcomes.[13,32,33] During the course of withdrawal, psychological support is of paramount importance. It should focus on understanding the individual's personal history, experiences, and reasons for taking these drugs. Peter Breggin's "consciousness-raising" model encourages individuals to become more aware of their emotions, thoughts, and actions. Family and social support are also crucial during this process.[11] His framework for treating psychiatric conditions emphasizes the importance of contextual and systemic aspects, promoting mental and physical well-being through therapies and lifestyles such as meditation, exercise, and a balanced diet.[11] Also, Peer support specialists and legitimate online self-help groups (carefully evaluated) can provide valid support to individuals with a history of recovery from emotional distress.[34,35]

However, it is important to consider that different consumers and peers have varying opinions about psychotropic drugs. The recovery approach recognizes that judicious, short-term drug treatment can sometimes be beneficial, as long as it is followed by a safe course of tapering and withdrawal. At the same time, it is worth noting that many people have reported improvements without the use, or with minimal use, of these drugs.[11,13] Two promising approaches to emotional distress that minimize or avoid the use of psychiatric medications are Open Dialogues and the Soteria House project.[36–38] It is worth mentioning that these two types of interventions utilize recovery strategies similar to those of support specialists' interventions. Peers may empower individuals by sharing strategies to cope with the withdrawal process, including developing an open dialogue with their prescriber. The objective is to reach a common ground where self-determination and a collaborative relationship between provider and consumer are recognized as crucial to achieving positive outcomes.[25] This openness is essential as individuals may be hesitant to express their views and needs regarding medications due to fear of negative judgment from their healthcare provider. Patients' uncertainty is often reinforced by unpleasant and traumatic experiences during previous attempts at tapering, which may have been misguided and poorly executed.[13] Also, a peer specialist can be of great help by providing bibliographical references, links to specialized websites, and connecting individuals with other professionals who are knowledgeable about this subject.[25,39]

It is important to note that peer specialists do not replace healthcare providers but rather work alongside them to help individuals improve their quality of life while respecting their freedom of therapeutic choice.[40]

The strategies peer specialists use regarding psychopharmacology align with the views and recommendations of Patricia Deegan, a prominent figure in the recovery movement. Deegan's approach emphasizes "personal medicine," which refers to using our intuition and experience to survive, improve our well-being, and increase our quality of life. This approach is an alternative to "pill medicine," which is often prescribed without acknowledging our ability to manage life stressors.[41] Peer specialists work within the context of personal medicine, seeking to enhance and value the individual's ability to cope with emotional distress, and manage pharmacological treatments, including tapering off, and withdrawing from drugs. Deegan's approach, which summarizes the principles of recovery regarding pharmacological treatment, can serve as a useful guide for both the individual in recovery and the peer specialist.

Cultural aspects in the practice of psychopharmacology and its relevance to withdrawal from psychiatric medications

To keep in the right contextual perspective the practice of psychopharmacology, which is utilized in the treatment of people from traditional and indigenous backgrounds, it is necessary to understand the philosophical and ideological foundations of the current dominant medical models and approaches based on the principles of western medicine, which typically presents itself as "scientific and neutral," unaffected by ideological, social, or cultural processes. In reality, historical and ideological analyses, as well as feedback from consumers and communities, reveal a huge influence of ideological, social, and cultural factors within its practice.[42] The biomedical dogma, which views diseases as a disruption of underlying physical mechanisms is considered an unquestionable truth in Western medicine.[43] Nevertheless, this perspective conflicts with the more traditional, cultural understanding of the origins of physical and behavioral problems, which highlights the importance of connectedness with the broader community and the natural environment. In this view, individual well-being is intertwined with the health of their family, tribe, and the land they inhabit.[44]

At birth, Native children construct relationships with other members of their community that develop into long-lasting connections. Members of their community, with a deep, holistic understanding based on generational experience and built upon trust, can respectfully challenge an individual when they find themselves in conflict. This process establishes a community of peers, who assist each other in developing new behaviors to move collectively beyond Western practices built on illnesses, disability, and diagnosis.

Hence, from an Indigenous perspective (in general, not representative of all) the importance of communal connections and cultural factors essential in the management of behavioral health cannot be overstated. Indigenous traditional cultures deeply intertwine with spiritual beliefs, community values, and holistic approaches to well-being. For many Indigenous People, mental, emotional, and spiritual health are not separate from physical health; rather, they are interconnected parts of a person's overall balance and harmony.[45] Cultural practices and traditions, such as ceremonies, storytelling, and traditional healing methods, promote mental wellness and address behavioral health issues.

Indigenous belief systems and practices often highlight the interconnectedness of all living beings and the natural world. This worldview fosters a sense of belonging and connections within communities, providing individuals with a support network that extends beyond immediate family members. During stressful situations or moments of crisis, this extensive network can offer emotional support, guidance, protection, and a sense of identity, all of which are essential for maintaining mental well-being.[46]

Indigenous cultural/traditional ceremonies, storytelling, and healing practices also play a significant role in promoting mental health among Native American communities. Ceremonies, such as

sweat lodges or powwows, provide opportunities for individuals to connect with their cultural heritage, commune with their ancestors, and find spiritual renewal. Storytelling, whether through oral tradition or artistic expression, serves as a means of transmitting cultural knowledge, values, and healing narratives from one generation to the next. Traditional healing methods, which may include herbal remedies, meditation, healing circles, sweat lodge ceremonies, or talking circles, offer holistic approaches to addressing mental and emotional imbalances. Highlighting the significance of these ceremonies, Duran[47] remarked, "Tribal ritual and ceremonial practices provide a code for ethical behavior and social organization which contributes to the meaning of life. It also provides a means for intervening in individual and social dysfunction."

According to the Office of the Surgeon General, Center for Mental Health Services, and National Institute of Mental Health,[48] cultural identity itself serves as a protective factor against mental health challenges. Research has shown that a strong sense of cultural identity can buffer against the negative effects of discrimination, trauma, and other stressors experienced by Indigenous peoples. By reclaiming and revitalizing cultural practices, languages, and traditions, Native American communities can strengthen their resilience and promote mental well-being among their members. In summary, the Native American Indian perspective underscores the critical importance of cultural aspects in behavioral health. By honoring and preserving traditional practices, fostering a sense of interconnectedness, and reclaiming cultural identity, Indigenous communities can promote resilience, healing, and overall well-being for generations to come. Engagement with Indigenous culture and positive family, school, and community connections have been found to contribute to better mental health outcomes for Indigenous youth.[49]

Utilizing the knowledge and understanding of the local history, culture, community, and cultural factors of an Indigenous community, the local mental health workers may help maintain rapport and retention in care with community members seeking mental health services and treatment. Familiarity with the interconnections between physical, mental, emotional, spiritual, and the environment supports Indigenous worldviews of health and wellness,[50] leading to a holistic approach for Indigenous individuals receiving mental health services.

Recognizing the intricate and multifaceted Indigenous cultural elements that are interconnected within the realms of spirituality, mental, emotional, and behavioral health, as well as physical health, will lead Western practitioners to an understanding that these cultural factors contribute to Indigenous resilience, improved quality of life, enhanced psychological well-being, emotional stability, and holistic health and well-being. Unfortunately, the discord between the biomedical model and an individual's personal, social, and cultural experience of illness can compromise the accurate identification of issues and hinder the development of effective intervention plans. Furthermore, healthcare providers may hold biased views due to their backgrounds, values, and social class. Moreover, the formal medical training and professional qualifications of healthcare providers contribute to a perception of authority where "the doctor knows best." This can lead to a unilateral and ethnocentric outlook on physical and psychological health issues, which becomes particularly problematic when Western-trained providers treat individuals from traditional and Indigenous backgrounds.[51] The implications for the prescriber who is trying to help people withdraw from psychiatric medications is paramount and may need inclusion and consultation of and with professionals, peer specialists, and support networks with specific cultural knowledge and expertise, keeping in mind that the psychological and symbolic meaning of medications may vary from culture to culture.[8,9]

Example of one project focused on psychiatric drugs withdrawal.

What has been said so far leads to acknowledging the need for the development of withdrawal venues to help people explore the possibility of withdrawing from psychiatric medications. The authors will illustrate in the next paragraph an initiative of this kind, which is taking place in a clinic in the Southwestern region (*for reasons related to confidentiality and privacy the name and location of the clinic have not been disclosed).* The Project is an effort to address the needs of those individuals who take medications for both their psychiatric and substance disorders (opioid substitution therapy: methadone and suboxone) and are planning to initiate a partial or total tapering of those medications for legitimate reasons (i.e., side effects, intent to explore medication-free treatment modalities).

It is based on the principles of Recovery and includes the assistance of peer specialists. In essence, it is a clinical project, that utilizes the "best practices" available to assist individuals with a safe withdrawal from medications.[11,52]

The project is evolving in an established "MAT Clinic" located in the Southwestern region, MAT (Medication-Assisted Treatment) is an intervention that utilizes medications in combination with counseling and behavioral therapies to help individuals with opioid use disorders (OUD) in their path of recovery. The clinic provides a wide range of services including Behavioral Health Disorders and an Opioid Treatment Program (OTP). It offers the following interventions: individual counseling; group therapy; family/couples therapy; psychiatric care; peer support services and Methadone, Suboxone (buprenorphine), and Vivitrol (naltrexone) treatments for Opioid dependence.[53]

The presence of a full-time pharmacist in the clinic is extremely helpful in monitoring the medication regimen of all consumers, including those involved in the path of withdrawal. The clinicians and peer specialists work together to provide the appropriate support to the individuals going through the process of withdrawal from psychiatric medications. Also, guidelines have been developed for the transfer to appropriate levels of care of individuals with particularly complex clinical problems, who cannot be assisted in the clinic. The team dedicated to the project includes one psychiatrist, therapists, one pharmacist, specialized nurses, and Peer Specialists.

There seem to be no programs offering pathways to both the withdrawal from the so-called "licit and illicit" addictive substances and psychotropic drugs. There are certainly some isolated initiatives by prescribers, therapists, and individuals with "life experience," focused on this effort, but a systematic approach throughout the behavioral health system seems to be lacking. Therefore, the project could contribute to the knowledge and expertise in the field, as it considers the needs of dual-diagnosed individuals interested in the course of withdrawal from psychiatric medications, with the assistance of a clinical team that includes Peer Specialists.

Professionals who play a role in the "withdrawal project" are aware of the importance of appropriate prescribing practices, while also keeping in mind the possibility of tapering off psychiatric medications and of alternatives based on recovery principles. In essence, this is a "pilot project," applying knowledge and techniques already partially in use, to assist the individual during a safe course of withdrawal from psychiatric medications, with the broader intent of providing useful

data for clinic expansion and the design and implementation of similar projects. The authors will explain the project in detail to give an idea of its complexities at its different stages of development. Although not a full-fledged research project, it is nevertheless conducted with intent and criteria that seek to ensure testable validity from its results. It could best be described as a "real-life research project," as it implements and tests interventions and responses to treatment within the contextual social and cultural reality of the consumer. The project was designed in three phases (listed below), but their sequence was changed along the way as needed. Unfortunately, the recent COVID-19 pandemic slowed down and substantially altered the course of the project.

Phase 1 Pilot project development (originally planned for 1-3 months)

This phase of the project, from a clinical perspective, consists primarily of identifying appropriate individuals to begin a course of discontinuation and prioritizing benzodiazepines for individuals with opioid dependence problems. Other psychotropic drugs (e.g., antidepressants, mood stabilizers, stimulants, antipsychotics) have been selectively included and will continue to be included gradually as the project develops. Other important objectives, approximately 70% achieved, are: setting up withdrawal guidelines/protocols; development of informed consent forms; identification of a compound pharmacist to help with minimal dosages or particular dosages and combinations; allocation of resources (e.g., space, medical staff, therapists, peer specialists, social networks); identification of questionnaires to measure and document outcomes; and training of staff and personnel, based on literature and material that can be considered as "evidence-based" according to current knowledge.

Phase 2 Implementation of the pilot project (originally planned for 3-6 months)

In this phase, which continues to develop and consolidate, we are trying to adapt to the needs of each individual, modifying, as much as possible, the protocols and health services offered to better meet the needs of individuals. Coordination of care within the clinic and with outside providers and clinics is an essential aspect of the project. Peer Specialists assist consumers and clinicians and share their recovery experience with them. In addition, protocols have been developed for the transferring of individuals with particularly complex clinical problems to more appropriate levels of care. The progress of the project is evaluated regularly with biweekly or "ad hoc" meetings attended by staff taking part in the project. Also, we have begun to analyze clinical preliminary data and to identify gaps and opportunities for improvement.

Phase 3 (originally planned for 1 month)

This phase has yet to begin formally, even though we are already evaluating progress in our routine meetings. In the data analysis, we will emphasize the narrative based on the qualitative data from the visits and will identify the contextual dimension of the individual experience (i.e., social, cultural). More specifically, at this stage, we aim at the following objectives: Analysis of both qualitative and quantitative data; presentation of the program and project results in various venues (such as mental health entities governmental entities, tribal entities, etc.); publication in peer-reviewed journals; "marketing" of the initiative; planning for clinic expansion.

Project progress

The project, as mentioned above, progressed slowly mainly because its evolution coincided with the evolution of the "COVID-19 pandemic," which created an overload of work and a shortage of resources for the clinic, diverting them from the project to more critical aspects related to the pandemic. However, other factors contributed to slowing down the development of the project. Among the most important was, and still is the difficulty of identifying, among dual-diagnosed individuals, suitable candidates for the pathway of withdrawal from psychotropic drugs, as a large percentage of them lack the emotional and physical stability necessary to face such an intervention on an outpatient basis. But there are other barriers as well. For example, the therapists and clinic staff, despite having been involved in training sessions regarding the potentially negative aspects of long-term psychiatric drug administration and polypharmacy in the "dually diagnosed" cohort, have not yet totally "digested" the fallacies inherent in the concept of the biological etiology of psychiatric disorders (which has to be demonstrated yet). Therefore, they do not fully comprehend that long-term drug treatment not only may not be necessary but may even contribute to more difficulties, as documented in the literature.[11,13] Several training sessions have been held to try to change this perspective. However, the impact has been only partially effective. In the same vein, practicing professionals in the area are hesitant to refer consumers who might benefit from withdrawal interventions. Moreover, the patients themselves are heavily influenced by the conditioning of the biological model. Probably most of them have internalized it and therefore see psychotropic drugs as the "sine qua non" for dealing with the manifestations of emotional distress.

Going into detail, currently, the clinic is treating a total of six patients on the withdrawal path. Five of them are also taking Methadone. Four patients are going through a course of withdrawal from benzodiazepines, one from Gabapentin, and another is in the early stages of "switching" from a "long-acting" antipsychotic to an oral equivalent (the only patient in the group not taking methadone). Users in the benzodiazepine group identified vague episodes of anxiety, but a definite diagnosis of anxiety disorder was not reached because of their ongoing use of addictive substances. For these individuals, the course of discontinuation has been quite methodical and slow, with difficulty in adapting to lower doses of medication (moderate reductions not exceeding 10 percent of the current dose, as frequently suggested in the specialized literature).

Unfortunately, the lack of insurance coverage for several drugs "in liquid form" limits the possibility of more consumer-friendly and effective withdrawal protocols. To make up for some of these shortcomings, the clinic is seeking the assistance of a compound pharmacist. The most encouraging development, so far, is that all four patients have demonstrated the ability to taper off benzodiazepines, although none of them has progressed to total discontinuation. As mentioned earlier, the presence of opiate addiction problems, even if under control with methadone, requires very close monitoring of psychoactive drugs and the clinical situation in general. For example, it is essential not to activate a benzodiazepine withdrawal syndrome that could potentially cause a relapse into opiate abuse. In addition, the frequent presence of issues arising from traumatic experiences is a central aspect of the withdrawal pathway, which is addressed during psychotherapy sessions. The consistent presence of social, financial, and family problems often constitutes barriers that are extremely difficult to manage. The clinic's therapists, with the limitations described above, do their best to support patients during the process of tapering, with weekly meetings that focus on the management of possible withdrawal symptoms (they often consult with the psychiatrist and medical team on this aspect) and on underlying psychosocial issues. Returning to the specific cases, regarding the

consumer taking gabapentin for a chronic pain syndrome, without a clear psychiatric diagnosis, and under methadone therapy, we were able to conduct a "scaling-down" that reduced his daily dosage to one-third of the initial dose.

As previously stated, one of the consumers began the switch from "long-acting antipsychotic," to the oral form. This individual, with a history of episodes of psychosis and an uncertain diagnosis of schizophrenia, went through a period of lengthy preparation for withdrawal with weekly visits with the therapist and biweekly visits with the psychiatrist.

As part of this preparatory process, "specialized literature" on the subject of discontinuation was recommended, which the consumer read and, as a result, felt motivated to ask questions relevant to his case. The course of suspension was outlined in as minute detail as possible, making it clear that it would not be predictable. Meetings with the therapist helped to keep the consumer's anxiety under control by offering further clarification about symptoms that might occur and how they would be dealt with during the suspension. In general, family, emotional, and social issues were addressed in therapy, helping consumers manage current critical situations and prevent others.

Involvement of peer specialists

The involvement of Peers has been crucial to the progress of the project. The peers involved in the project come from histories of substance addiction and psychological distress, treated, at times, with psychotropic drugs. They strongly believe that it is possible to discontinue psychotropic drugs. The clinical staff often elicits their input and cooperation. For example, their interventions with the consumers on subjects like their confusion as to why they are on psychotropic drugs and the strategies to follow to discontinue them, have been extremely helpful not just for the consumers, but also for the clinical staff. Their willingness to act as support for consumers and clinical staff has been of great benefit, especially when consumers have difficulties in expressing their needs and anxieties, during the withdrawal. Moreover, all consumers have repeated several times that they felt comfortable with the peer specialists, with whom they shared their anxieties and fears related to "giving up" medications to which they had become used. Also, peers have helped to reframe the information that clinicians shared with consumers, thus contributing to strengthening the therapeutic bond between the two. Although a more accurate scientific evaluation of the interventions provided by the peer specialists has not yet been carried out, their efficacy has been confirmed by both consumers and clinical staff.

Conclusion

Prescribing psychiatric medications for dually diagnosed individuals is very complex, as they present often with physical comorbidities and other complex social challenges. Moreover, individuals with dual diagnoses are frequently prescribed and treated with polypharmacy (the concurrent prescription of two or more psychiatric medications), which may contribute to both physical and psychological long-term complications. The prescribing dynamics are also part of the complexity of treatment as individuals in this group may change their disposition toward pharmacologic treatment, moving from a phase of idealization of treatment to one of disenchantment. But the possibility of tapering and withdrawal from psychiatric medications is rarely addressed in clinical practice, partly because is extremely challenging and necessitates a nuanced understanding of the interplay of multiple factors involved (psychological, physical). Unfortunately, the lack of support from providers and "mainstream" medicine to consider and implement tapering practices, has led many patients to seek guidance from social media platforms and online peer-led groups, which have shown some positive results. Peer support specialists can be very supportive of Patients' choices and could help them evaluate the appropriateness of a course of withdrawal and also assist clients while they are going through it. It appears clear that there is a need for the development of withdrawal venues to help people explore the possibility of withdrawing from psychiatric medications. The authors have illustrated the development of such a project in a MAT clinic, based on the principles of recovery, in the Southwestern region of the US. The lessons so far learned and to be learned from it could be useful for developing other similar and more sophisticated withdrawal venues.

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Conflicts of interest

Neither author has any conflict of interest.

References

1. Miller SG. Americans takes a psychiatric drug.
2. Woody G. The challenge of dual diagnosis. *Alcohol health and research world*. 1996;20(2):76–80.
3. Kukreja S, Kalra G, Shah N, et al. Polypharmacy in psychiatry: A review. *Mens Sana Monogr.* 2013;11:82–99.
4. Jobe LB, Mårtensson S, Düring SW. Polypharmacy in antipsychotic pharmacological treatment among patients with dual diagnosis in Denmark. *Nord J Psychiatry*. 2024;78(2):112–119.
5. Mort Jane R, Rajender R Aparasu. Prescribing potentially inappropriate psychotropic medications to the ambulatory elderly. *Archives of internal medicine.* 2000;160(18):2825–31.
6. Eserian JK, Blanco VP, Mercuri LP, et al. Current strategies for tapering psychiatric drugs: Differing recommendations, impractical doses, and other barriers. *Psychiatry research*. 2023;329:115537.
7. Halli–Tierney AD, Scarbrough C, Carroll D. Polypharmacy: Evaluating risks and deprescribing. *American family physician*. 2019;100(1):32–38.
8. Bentley KJ. Psychiatric medication and meaning–making in a residential program for adults with serious mental illness. *Qualitative Social Work*. 2010;9(4):479–499.
9. Fainzang S. Drugs and society: the patient, medicines, and prescriptions [in French]. Paris: University Press of France; 2001.
10. Shoemaker SJ, Ramalho de Oliveira D. Understanding the meaning of medications for patients: the medication experience. *Pharm World Sci*. 2008;30(1):86–91.
11. Breggin P. Psychiatric drug withdrawal: a guide for prescribers, therapists, patients and their families. New York: Springer; 2012.
12. Cosgrove L, D'Ambrozio G, Herrawi F, et al. Why psychiatry needs an honest dose of gentle medicine. *Frontiers in psychiatry*. 2023;14:1167910.
13. Hall W. Harm reduction guide to coming off psychiatric drugs. 2d ed. The Icarus project and freedom center. 2017.
14. Fiammetta Cosci, Guy Chouinard. Acute and persistent withdrawal syndromes following discontinuation of psychotropic medications. *Psychother Psychosom*. 2020;89(5):283–306.
15. Laysha Ostrow, Lauren Jessell, Manton Hurd, et al. Discontinuing psychiatric medications: a survey of long–term users. *Psychiatr Serv.* 2017;68(12):1232–1238.

16. Sowers W, Golden S. Psychotropic medication management in persons with co–occurring psychiatric and substance use disorders. *J Psychoactive Drugs*. 1999;31(1):59–70.

17. Gøtzsche PC, Young AH, Crace J. Does long term use of psychiatric drugs cause more harm than good? *BMJ.* 2015;350:h2435.

18. Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021.

19. Whitaker R. Anatomy of an epidemic. New York: Broadway Paperbacks; 2015.

20. Whitaker R, Cosgrove L. Psychiatry under the influence. New York, Palgrave MacMillan; 2015.

21. Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022.

22. Whitaker R. The case against antipsychotic drugs: a 50–year record of doing more harm than good. *Med Hypotheses*. 2004;(1):5–13.

23. Davidson L, Bellamy C, Guy K, et al. Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*. 2012;11(2):123–128.

24. Maviglia M, Hume D, Cooeyate NJ. Peer support's role in helping individuals withdraw from psychiatric medications. *J Psychol Clin Psychiatry*. 2023;14(6):157–162.

25. Drake RE, Deegan PE. Shared decision–making is an ethical imperative. *Psychiatric Services*. 2009;60(8):1007–1007.

26. Gale–Grant O, Bailey J, Burke O, et al. Use of Prescribed Psychotropic Medications in an Opioid Substitution Therapy Cohort. *Journal of dual diagnosis*. 2019;15(4):254–259.

27. Grau–López L, Roncero C, Daigre C, et al. Observational study on medications prescribed to dual–diagnosis outpatients. *Journal of addiction medicine*. 2014;8(2):84–89.

28. Stimmel B. Prescribing psychotropic agents in opiate dependency: the need for caution. *Advances in alcohol & substance abuse.*1985;5(1–2):121–133.

29. Chelak K, Chakole S. The role of social determinants of health in promoting health equality: a narrative review. *Cureus*. 2023;15(1):e33425.

30. Bhalla IP, Rosenheck RA. A change in perspective: from dual diagnosis to multimorbidity. *Psychiatric services*. 2018;69(1):112–116.

31. Malat Jan, Kahn David A. Clinical barriers to effective pharmacotherapy in co–occurring psychiatric and substance use disorders. *Journal of Psychiatric Practice*. 2011;17(5):360–367.

32. Renato D Alarcón. Culture, cultural factors and psychiatric diagnosis: review and projections. *World Psychiatry.* 2009;8(3):131–9.

33. Dinesh Bhugra, Cameron Watson, Rajiv Wijesuriya. Culture, and mental illness. *Int Rev Psychiatry*. 2021;33(1–2):1–2.

34. Read J. Online antidepressant withdrawal support groups. *Psychology Today blog*. 2021.

35. White E, Read J, Julo S. The role of Facebook in the management and raising of awareness of antidepressant withdrawal: is social media filling the void left by health services? *Ther Adv Psychopharmacol.* 2021;11:2045125320981174.

36. Lenroot R, Maviglia M, Tai–Seale M, et al. Open dialogue approach to treating serious mental illness. In: Marta Elliott, editor. Research Handbook on Society and Mental Health, Edward Elgar Publishing; 2022.

37. Jaakko Seikkula, Jukka Aaltonen, Birgittu Alakare, et al. Five–year experience of first–episode nonaffective psychosis in open–dialogue approach: Treatment principles, follow–up outcomes, and two case studies. *Psychotherapy Research*. 2007;16(2):214–228.

38. Bola JR, Mosher LR. Treatment of acute psychosis without neuroleptics: two–year outcomes from the Soteria project. *J Nerv Ment Dis.* 2003;191(4):219–229.

39. Framer A. What I have learnt from helping thousands of people taper off antidepressants and other psychotropic medications. *Ther Adv Psychopharmacol*. 2021;11:2045125321991274.

40. Maviglia M, Charzuk A, Hume D. Senior peer specialists' concerns regarding peer specialist roles and functions under medicaid managed care in New Mexico. *Journal of Recovery in Mental Health*. 2023;6(1).

41. Deegan PE, The importance of personal medicine: a qualitative study of resilience in people with psychiatric disabilities. *J Public Health Suppl*. 2005.

42. Luke J, Verbunt E, Zhang A, et al. Questioning the ethics of evidence–based practice for Indigenous health and social settings in Australia. *BMJ Glob Health.* 2022;7(6):e009167.

43. Hewa S, Hetherington RW. Specialists without spirit: limitations of the mechanistic biomedical model. *Theoretical medicine*. 995;16(2):129–139.

44. Lupton D. Medicine as culture: illness, disease, and the body in Western societies. Thousand Oaks, Calif.: Sage Publications; 1994.

45. O'Keefe VM, Cwik MF, Haroz EE, et al. Increasing culturally responsive care and mental health equity with indigenous community mental health workers. *Psychol Serv*. 2021;18(1):84–92.

46. Stringer H. The healing power of Native American culture is inspiring psychologists to embrace cultural humility. *Monitor on Psychology*. 2023;54(7):1.

47. Duran BES. American Indian belief systems and traditional practices. University of Oklahoma Evaluation Research Center, School of Social Work; 2002. p. 1–6.

48. Office of the surgeon general (US), Center for mental health services (US), National Institute of mental health (US). Mental Health: culture, race, and ethnicity: a supplement to mental health: a report of the surgeon general. Rockville (MD): Substance abuse and mental health services administration (US); Chapter 4, Mental health care for American Indians and Alaska Natives. 2001.

49. Burnett C, Purkey E, Davison CM, et al. Spirituality, community belonging, and mental health outcomes of indigenous peoples during the COVID–19 pandemic. *Int J Environ Res Public Health*. 2022;19(4):2472.

50. Koenig HG. Religion, spirituality, and health: the research and clinical implications. ISRN Psychiatry. 2012:278730.

51. Putsch RW III, Joyce M. Dealing with patients from other cultures. In: Walker HK, Hall WD, Hurst JW, editors. Clinical methods: the history, physical, and laboratory examinations. 3rd ed. Boston: Butterworths; 1990.

52. Moncrieff J. The bitterest pills. Basingstoke: Palgrave Macmillan; 2013.

53. Co–occurring disorders and other health conditions. SAMSHA.

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