

# Improving patient experience of medication discussions in a democratic therapeutic community

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## Aims and hypothesis

This quality improvement project explored potential improvements in how medication was approached and discussed in a democratic therapeutic community (DTC). The hypothesis was that holding concurrent roles of psychiatrist, prescriber and group member, could both be feasible, and be experienced positively by members of the DTC.

## Background

DTCs are a therapeutic model for those with personality disorder diagnoses<sup>1</sup>. There is wide variation in how medication is handled in these settings. This poses important questions around the role of the doctor, including if this should extend to medication management. There is also a question about whether a DTC should focus on medication management at all or whether it should sit outside this setting.

The doctor's relationships with members are likely to be affected by pre-conceptions from all sides, and the doctor's power (or lack of power) to manage medications. This is particularly relevant given that DTCs are often settings in which patients are encouraged not to rely on medication. In fact, in services locally, if patients are taking medications that can cause dependence, such as benzodiazepines, this can mean they are prevented from becoming members of the DTC.

## Methods

The project comprised an initial period of information gathering from members, after which a weekly medication discussion slot was initiated. This took place once a week for around 30 minutes and was a space where members could bring up a question about their medication, or the desire to think about stopping one. If any changes were agreed a conversation was held briefly between the member and doctor to confirm a plan and compose a letter to their GP if relevant. An anonymous questionnaire was completed by members of the DTC after 5 months to explore the impact of this change.

## Results

The questionnaire was completed by 7 members, all of whom had been a member for over 4 months. 2 members (29%) indicated that their experience of medication discussion over the previous 5 months had been done 'very well', 3 (43%) indicated 'well' and 2 (29%) indicated 'ok'. 2 members (29%) stated the approach to medication had been 'much improved', 4 (57%) said it had been 'improved' and 1 (14%) said there had been no change. The DTC agreed to continue with the discussion slot, although 3 participants still felt additional time would be helpful.

## Discussion

In some ways the essence of this project was very simple in that the practical change was introducing a definitive time to discuss medication. The challenges involved how medication was discussed within this space and in the DTC more widely, where it had not necessarily been discussed before.

A doctor being part of a DTC is required to let go of some of their usual roles and responsibilities. However, one might argue that not using knowledge that one has for the benefit of the group could lead to a splitting process whereby DTC and medication—which is often a significant part of patients' journeys and that they may currently be prescribed—are thought of as entirely separate. Therefore, the aim was an integration of approaches.

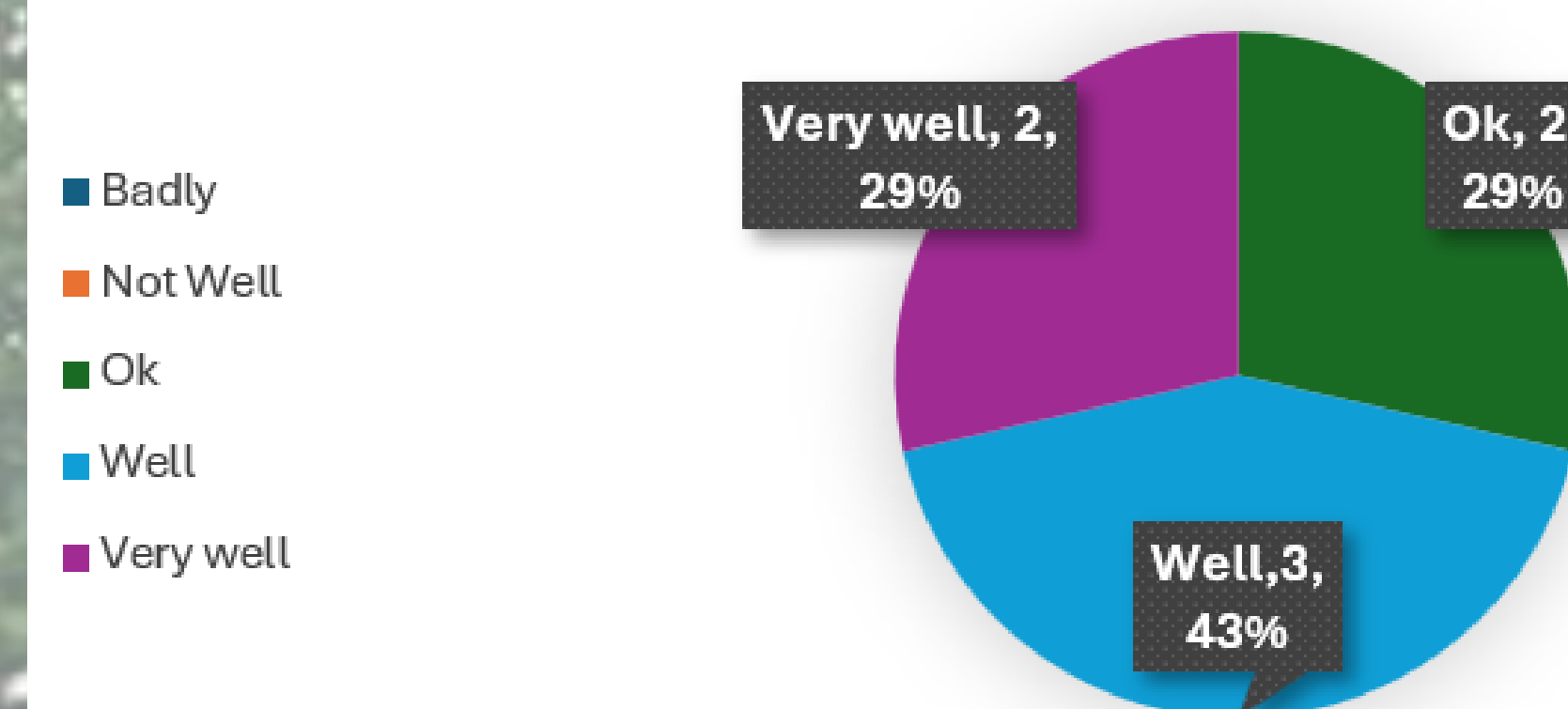
Crucially this allowed the group to think about both the practical aspects of medications, particularly deprescribing, but also the patient's relationship to their medication. Discussions were held with relational prescribing values in mind<sup>2</sup>. Therefore, we considered that an attachment (relationship) exists between a person and their medication<sup>2</sup>. With this in mind, we hypothesised, for example, that if a medication were to be stopped without discussion, this may confer unconscious meaning for the patient. The group setting allowed others to contribute to the conversation, including sharing their own related experiences. This led to a novel and flexible method of discussing deprescribing of psychotropic medication, that may be unlikely to replicated elsewhere in psychiatry.

This project was performed on a small scale which potentially limits its wider applicability to other settings. It would be valuable to trial similar interventions across multiple centres. It is also notable that discussions did not involve initiation of medications but rather focussed on the deprescribing of psychotropics including benzodiazepines and antidepressants<sup>3</sup>. Relevant future work could include application of relational prescribing approaches to challenging situations such as request to initiate medication which would not usually be part of a DTC approach.

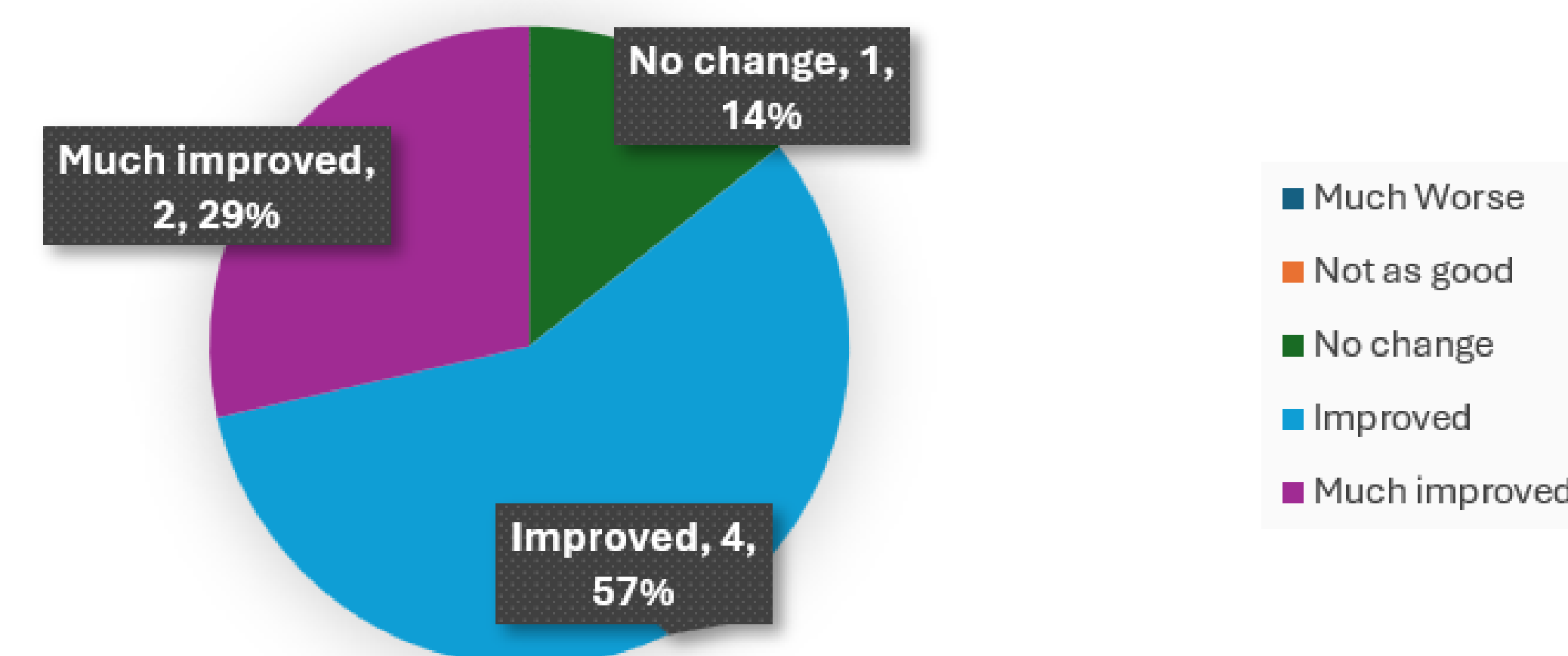
## Conclusion

This project suggested that a relational and inclusive approach to discussing medication can be experienced positively by members of a DTC, and it may be possible for a psychiatrist to hold roles as both a prescriber and member in this setting. This area requires further exploration, including considering the experience of other doctors in similar settings, and across larger participant groups.

How well do you feel medication has been discussed/explored in the community over the last 5 months?



If you have been a member for longer than 4 months have you noticed a change in how medications are approached in the TC more recently?



## References

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