An evaluation of a *Thinking About Medication* Group

A report by Dr Guy Holmes and Marese Hudson 05.09.06

Introduction

Not since the 1970s and the controversy of significant numbers of people being prescribed minor tranquillizers and acceptance of the difficulties many people experienced in coming off those drugs has there been so much interest in withdrawal reactions to psychiatric drugs. The response to the Panorama program about SSRIs, articles in the national press about withdrawal reactions, and a number of books written by clinicians (e.g. Breggin and Cohen, 1999) and service users (e.g. Lehmann, 2005) regarding coming off all types of psychiatric drugs are evidence of this. One of the most methodologically rigorous pieces of research into people's experiences of coming off psychiatric drugs has been commissioned by MIND (Read, 2005). This involved qualitative and quantitative data through the use of interviews and questionnaires with 204 people who had attempted to come off psychiatric medication. Findings include:

(i) the most common reasons for wanting to come off were a dislike of the adverse effects, a wish not to be on drugs long-term, people felt that they were better and no longer needed the medication, and people felt that the drugs were not useful

(ii) over half of the sample had difficulties in coming off

(iii) many withdrawal reactions mirrored psychiatric symptoms/disorders

(iv) people who had been on medication for less than 6 months had less difficulties in coming off than people who had been taking drugs for a longer period.

Some findings were quite surprising e.g. there was little evidence that doctors could predict who could successfully come off their drugs – people who came off against medical advice were just as likely to succeed as those whose doctors agreed should withdraw. In addition, Psychiatrists and General Practitioners were identified as the least helpful group of people in terms of assisting people to withdraw (less than 50% of people found them helpful compared to over 85% of the participants who had found

counsellors/psychotherapists, a support group, complementary therapists and other service users helpful). Recommendations from the report include:

(i) people need access to more information on drugs and withdrawal effects

(ii) people require access to alternatives to medication

(iii) people need to be seen as credible, and listened to and treated with respect when talking about their drugs and wishes to come off

(iv) services with adequately trained people are needed to support people through the process of coming off their medication.

This report is an evaluation of a group set up to help people think about coming off psychiatric medication that was aimed at achieving many of the above recommendations.

The Thinking about Medication Group

14 people responded to a flyer that advertised a 12-week group taking place in an Arts and Education Centre in a West Midlands town. The flyer (see www.shropsych.org for a copy) was distributed in G.P. practices, Community Mental Health Teams and other mental health settings. It outlined that the group might:

(i) help people access information about drugs they may be taking and may be considering taking

(ii) provide a place for people to talk about their experiences and exchange views, and get support in a safe and friendly environment where people respect each others' opinions

(iii) provide people with access to expertise from various sources e.g. people who have successfully come off psychiatric drugs, consultant psychiatry, community mental health nursing, substance misuse workers, people who offer alternative therapies

(iv) help people weigh up the pros and cons of taking medication and pros and cons of reducing or coming off medication

(v) help people think about and access alternative ways of getting benefits they receive from medication

(vi) provide advice and support for people who decide to reduce or come off their drugs, including advice and support regarding withdrawal reactions.

The structure and venue of the group was arrived at by discussions between the authors with input from a psychiatrist, other medical colleagues and service users. People opted into the group rather than were referred. No contact was made by the facilitators (the authors of this report) with prescribers during the group – participants were left to take up any thoughts or wishes regarding their medication with their G.P.s or psychiatrists at their usual appointments with these professionals. A non-mental health venue was sought in order to provide distance and 'thinking space' for members who might regularly have consultations in mental health settings. A key philosophy of the course was that the participants would generate their own individual aims whilst being part of the group and that these collectively would make up the group aims. During each meeting participants sat around a large table in the middle of which were books and articles about medication for them to look at and borrow for a week. The format of the group was an initial set of two meetings for people to get to know each other, express their hopes for what they wanted to get from being on the course and therefore generate individual and group aims, and agree on which experts to invite. This was followed by an 8 week period where the first part of the group involved short talks and Q&A with invited experts followed by an open discussion which may or may not relate to the themes of that talk. Although the invited speakers were called 'experts' a philosophy of the course was that the participants would be experts in their experience and it would be through the sharing and thoughtful consideration of their experiences that individual and group expertise would develop. It was also intended that the invited speakers would hopefully learn from being with the group as well as pass on their own knowledge and experiences. The two week period at the end was reserved for evaluation, reflection, and future planning. A short-break in each two hour session offered opportunities for people to provide each other with mutual support on a more informal basis, as did the fact that people frequently stayed behind to carry on discussions about medication with the facilitators and other group members. A key part of the group was utilisation of the decision making matrix tool used to weigh up the advantages and disadvantages of coming off medication and advantages and disadvantages of staying on medication as described by Holmes and Hudson (2003) – see Appendix 1. Participants were given time and encouragement to work through this process during and outside the meetings.

The timetable for the meetings was:

1. Introductions, medication experiences, aims for coming, suggestions for outside speakers

2. Reflections on first meeting, medication experiences, aims for coming (listed and used as the group aims)

3. Speaker: *Craig Newnes, Head of Dept of Psychological Therapies*,
on psychological therapies and alternatives to medication

4. Speaker: *Jane Lillington, Head Pharmacist*,
on different types of psychiatric drugs, beneficial and adverse effects, research evidence

5. Speaker: *Monique Scott, Substance Misuse Team*,
on techniques for helping people come off and stay off illicit drugs

6. Speaker: *Jane Wilkinson, Community Mental Health Nurse*,
on benefits of psychiatric drugs and how to get those benefits from other sources; improving mental health by means other than medication, community support

7. Speaker: *Dr Jane Muris, Associate Specialist (Psychiatry*),
on pros and cons of psychiatric drugs, withdrawal effects and strategies for successful withdrawal, and open Q&A re psychiatric practice and mental illness

8. Speaker: *Geoff Hardy, Natural Health Centre*,
on alternative therapies (e.g. massage, homeopathy, herbal remedies, acupuncture) as alternatives to psychiatric drugs, and to help with withdrawal reactions

9. Speaker: *Dr Anil Kumar, Consultant Psychiatrist*,
open Q&A re all aspects of mental health including coming off medication

10. Speaker: *Dr Nick Swift, Associate Specialist (Psychiatry)*
re anti-depressants and coming off anti-depressants

11. Penultimate meeting, reflections on what people have got from the group

12. Final meeting, evaluation, plans for the future, saying goodbye

Group members

14 people attended the group, 13 of whom were women. The age range was 23-84. One person dropped out before the end (citing other commitments) - this person was the sole

male attendee. Average attendance was 8 sessions (range 3-11). Attendance did not seem to relate closely to whether people had their needs met e.g. the person who attended 3 sessions said: *"Just knowing the group is running has helped me reduce my olanzapine and I no longer get paranoid. I have been able to go out more. I plan to come off. I used to think of myself as a schizophrenic but this group has really opened my eyes…I now think of myself as a woman."*

The evaluation

A feedback form in the format of a two-page questionnaire and accompanying letter (see Appendix 3) were given out in the penultimate session. The questionnaire asked closed and open questions about people's medication, their aims for joining the group and whether these aims had been met, with a final question asking for general comments about the group. Participants were free to chose whether to fill in the form or not and the questionnaire was anonymous. Descriptive statistics and content analysis were conducted on the initial questions. A grounded theory analysis of the type described by Pidgeon and Henwood (1996) was conducted on the open final question asking for general comments: each participant's comments were initially broken down into data strips (i.e. pieces of text that contained a coherent idea or piece of information which could stand alone) by the two authors. This led to the identification of 55 data strips which were then coded by the authors via the method of constant comparison i.e. each data strip is compared with each one previously examined for differences and similarities and thus sifted into a number of groups which have similarities within and differences between groups. This index system is then refined where categories are developed, definitions written, and the system further refined through the process of category linking and splitting (the data strips and groups are re-examined and adjustments made e.g. data strips are re-allocated, definitions altered, categories amalgamated) until key concepts or themes can be named.

Findings

11 group members completed the questionnaire. The mean number of drugs that they listed as having taken in the past was 7.3 (range 1-16), which is an underestimation as three people stated that they had taken more drugs than they could list (e.g. "too

numerous to recall all of them"). Drugs listed came into all categories of psychiatric medication: antidepressants (tricyclics, MAOIs and SSRIs), mood stabilizers, antipsychotics/neuroleptics, atypical antipsychotics, anxiolytics, benzodiazepines, barbiturates, hypnotics and medications prescribed for adverse effects. 9 of the 11 were currently taking medication (mean number of drugs 1.5, range 0-4) including 8 people taking an anti-depressant, one person a mood stabilizer, 3 people antipsychotics and 3 people anxiolytics.

After starting the group 7 of the nine people taking medication reduced their dose/started to come off their medication, with one of these reporting going back up to their original dose after a period of reduction and increase in distress. The other two people taking medication stated they wished to come off their drugs in the future ("when I am ready"; "over several years"). 4 people said they wanted to join a coming off medication support group on completion of the Thinking About Medication Group, with 5 people expressing an interest in joining in the future (5 people from the course are currently attending a support group along with the authors on a fortnightly basis to assist them reduce or come off medication). Table 1 lists comments made about people's experiences coming off their drugs during the period that the group ran.

Table 1 Details of participants' attempts to reduce or come off their medication during the group

Participant A: *reduced chlorpromazine, coming off depakote*

Participant B: *reduction of olanzapine from 15mg to 10mg with a further reduction to 7.5mg planned*

Participant C: *reduced (venlafaxine) from 225mg to 150mg prior to group without ill effect. Attempted further 75mg reduction after group started but suffered withdrawal effects. Now ok on 112.5mg.*

Participant D: *I have started reducing the escitalopram but I'm in the process of swapping to prozac in order to come off antidepressants completely*

Participant E: *Same dose for carbamazapine and citalopram but hardly ever take lorazepam now*

Participant F: *I am now taking 25mg quetiapine (50% less) and have slept well, even a few nights when I had no medication. I was able to do that because of regular support.*

Participant G: *But have had to go back up to my original dose (venlafaxine)*

The vast majority of participants' expressed aims were met (see Table 2). Aims fell into categories such as sharing experiences and learning from each other, learning about medication and how to safely withdraw, finding out about alternatives to medication, debating mental health theories and practices:

Table 2. Evaluation of aims of members of the group

Aims	Not met	Met to some extent	Fully Met
Sharing experiences and learning from each other			
Hear other people's stories and opinions			*
To learn from each other			*
Listen and learn from others			*
To meet like-minded people			*
To listen and learn			*
Learn from other's experiences		*	
Reassurance that there are other people in a similar situation			*
To meet others in a similar position and learn from each other			*
Support with like-minded people			*
Support for the future			*
To meet and support/receive support from other sufferers			*
Learning about medication and how to safely withdraw			
Learn more about coming off medication			*
Distinguishing between withdrawal effects and relapse		*	
Long-term effects of medication	*!not known!		
Learn as much as possible about long-term effects (years)			*
Gain more knowledge of medication and results			*
To get support in reducing or/and coming off medication			*

To get information on reducing/coming off meds	*	
Learn more about SSRIs esp. venlafaxine		*
Info on avoiding/minimising withdrawal (reactions)		*
To become more informed about withdrawal reactions		*
To learn enough to come off medication safely and confidently	*	
To access more info re drugs and side effects etc		*
Information about drugs, effects, long-term effects, safe withdrawal		*
To learn more about the effect of the medication and withdrawal		*
Finding out about alternatives to medication		
Alternatives to medication		*
Finding out more about alternatives	*	
To access other avenues of knowledge	*	
To have an holistic approach	*	
To look at alternative ways of coping with the illness		*
To debate mental health theories and practices		
Why different drs differ so much in what they prescribe	*	
To access the knowledge of the speakers		*
Be aware of human rights, particularly mental health law	*	
Gain some insights from professionals and to help them understand the subject better	*	
Knowledge and be able to ask questions of the professionals		*
Miscellaneous		
Self awareness	*	
To develop empathy and professional development	*	
To enable me to help and support others in a non-judgmental way		*

The grounded theory analysis of the open invitation to make general comments led to four revisions of concepts and definitions of categories until five main themes were arrived at:

(i) Empowerment through information and positive comments about the impact of the format of the group, principally:

(a) the speakers

Complementary comments were made about all the speakers, with the most positive comments made about the speaker on complementary/alternative therapies. Positive comments were also made about having opportunities to discuss things with people (particularly doctors) outside the context of a clinical consultation (e.g. an out-patients appointment) – how this enabled a more open and free discussion of medication issues. e.g. *"I have found it beneficial to have had access to a variety of view-points from people from different fields within mental health"*; *"Good to be able to quiz psychiatrists. Much easier when well and within the strength of a group than at a vulnerable time during a consultation"*

(b) information provided

The most favourable feedback regarding reading material provided was for the *UK Psychiatric Pharmacy Group's Information Leaflets* about individual medications, *Psychiatric Drugs Explained* (Healy, 2005), *Coming off Medication* (Holmes and Hudson, 2003) and *Coming off Psychiatric Drugs* (Lehmann, 2005). A full bibliography of resources made available can be found in Appendix 2. Comments made include: *"Availability of books to borrow – much better than just having a reading list which I might or might not have got around to investigating"; "The reading literature catered for everyone from 'easy to read' single page handouts to scientific papers on drug trials"*; *"I have a greater understanding of pharmaceutical drugs and have recognised side effects that I have suffered that have been overlooked by hospital staff"*; *"the reading material (and information available)…has helped me move on as I am familiar now with 'jargon' and language required to get my rights understood"*

(c) general structure

e.g. *"The way the hopes/aspirations of everyone were collected and expressed as a formula for the group I found very good"*

(ii) Making informed and thoughtful decisions about medication and taking responsibility for decisions about taking, reducing or coming off medication

Before the group was set up some anxieties were expressed that the group might be 'anti-medication' or lead to people abruptly stopping their medication and rejecting psychiatric staff and their advice. In fact the opposite seemed to happen, with members taking much more care about taking, reducing or coming off their medication, and entering into more collaborative relationships with their prescribers rather than having disagreements that occasionally led to what was perceived by participants as reckless stopping of medication through anger and frustration with being told they had to take drugs they were very ambivalent about e.g. *" I now feel more confident that I can make informed decisions with regards to medication"*; *"Knowledge gained enabled me to restore my medication to a higher level when I experienced difficulties and importantly to speak to my G.P. about my dosage and get my prescription changed"; "I certainly felt it helped me want to be more sensible in my methods and decisions involving taking and not taking medication"*; *"I have learned to take absolute responsibility for my health and well-being. It is up to me and no-one else, but to recognise when things are unbalanced and take action by seeking help and be open to medication AT A LOW DOSE!"*; *"I found the group bonded well and this in itself to me is supportive and gives me that bit more determination to safely reduce my meds as in the past I have just stopped taking everything with disastrous results"*; *"After attending this group I feel more able to go forward with my own recovery and feel more in control of the treatment I am receiving. I am clearer about what I want from the mental health professionals that I receive care from, but also more aware that they do not have all the answers"*.

(iii) Changing relationships with doctors and changing the wider mental health system

Members of the group expressed a wish to change their relationships with their own doctors (e.g. go from passive recipients to a more collaborative approach) and reported helpful changes to these relationships as a result of attending the group. In addition to this, participants expressed a desire to be part of a movement to change the ways that all patients and doctors interact and to change things in the wider mental health system regarding medication, whether that be in terms of attitudes and practices, or in practical terms e.g. campaign for medication to be available in small doses to help people who want to reduce their dose slowly. For example, it has been recommended, especially for

people suffering withdrawal reactions to reductions in dose, that they reduce their dose in 10% incremental steps. But this is not possible with drugs such as venlafaxine where the smallest dose tablet of Efexor is 37.5mg so reductions in daily dose might start at 17% for someone on a dose of 225mg but end up at 50% as someone tries to reduce down from 75mg. Participants comments on these themes include: "*I am taking back some control in my life by communicating my mistreatment from the psychiatric services. I hope to do this by sending the Yellow Card and outline my best course of action and treatment with an Advanced Directive. I hope to earn respect as my self-respect restores. I am living proof that I am recovering and can and will change the system from the inside"*; *"It appears unfortunately not the norm but both my G.P. and psychiatrist have been very supportive with regards to me coming off medication…I think it is important to recognise that some doctors are willing to listen. Hopefully this group will have given people confidence to express their views to those doctors who are currently unwilling to listen"*; *"If I can find the time I will contact drug companies and request that lower doses are available to be flexible and are available in liquid form so one is able to take responsibility for one's own health and cleverly self-medicate"*.

(iv) Therapeutic effects of a safe and supportive group where people were able to share ideas and experiences with each other

e.g. *"The group gelled very quickly and there was an immediate sense of safety (might it have had something to do with the facilitators?!)"; "The group has been very helpful and inspiring…I have felt I am not on my own trying to reduce or come off medication"*; *"Individual differences and common themes ran throughout. The participants, some clearly distressed and concerned about their problems with medication, showed courage and their intellect, thoughtfulness and kindness shone through"*.

(v) General positive comments, tips for improvements, encouragement to run the group again and requests for a coming off medication support group

Tips included running the sessions for half hour longer i.e. 2.5 hours and having more time to spend on alternatives to medication. Several participants expressed a belief that many other people would benefit from a similar group e.g. *"There needs to be a further*

course as I'm sure there are a number of people out there who could benefit from the knowledge provided" .

Conclusions

The results of the formal evaluation described above matched informal feedback from participants, invited speakers and the group facilitators that the group was highly successful. In our opinion it provides a good example of multi-disciplinary work in the area of medication: having an ex-service user as a group facilitator helped participants to feel safe to open up and speak their mind in the group, as did having a co-facilitator trained and experienced in groupwork; the fact that the facilitators did not have a clinical role with individual participants (beyond organising and running a successful group) and did not have an agenda or aim for individual people to increase, stay on, reduce or come off their medication was also felt to be significant. Speakers were able to speak in a somewhat different way in the arena of debating things with a group of interested people compared to the confines and pressures of clinical appointments. There was time to debate benefits and risks of medications, research evidence, drug company profits and marketing strategies, consent issues, etc without the time pressures and patient and family pressures to come up with 'cures' that can categorise ward rounds, out-patients appointments and other clinical consultations. Although psychiatrists did not facilitate the group, their input was crucial not just in terms of being invited experts, but also in terms of meeting with the facilitators to plan the group (e.g. recommending that the group have no input re prescribing but leave participants to take up any issues with prescribers; meeting at a non-medical venue; thinking about the structure and philosophies of the group). Time pressures did not allow a psychiatrist to co-facilitate the group – a problem that mirrors difficulties for doctors trying to help people think through the complexities of taking, reducing and coming off medication and monitoring people during a process of withdrawal. This group revealed that people can become better at monitoring themselves and engaging the help of other services users and friends/family during a process of reduction and withdrawal from psychiatric drugs, which does not negate the need for medical involvement during withdrawal, but does increase the number of people who can be part of the helping and monitoring of this process.

The *Thinking About Medication Group* model offers an alternative approach to compliance based strategies. For group participants, a history of repetitively being told of the reasons why they should take psychiatric drugs had clearly started to grate: many of the participants described previous conflicts with consultant psychiatrists and other prescribers regarding medication issues, had had multiple hospital admissions, been on many different medications, and in the past had abruptly stopped medication (in their words) "with disastrous results." Empowerment and taking responsibility through being enabled to become better informed and encouraged to make up their own minds has worked for this group of people. Of course it was a self-selecting group and almost exclusively female, raising questions about its effectiveness and utility for people (especially men) who do not opt into being part of a group like this, but it does provide an example of multi-disciplinary work in the area of medication that provides multiple benefits and meets many of the recommendations in the MIND report *Coping with Coming Off* (Read, 2005).

References

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Pidgeon, N. & Henwood, K. (1996) Grounded theory: practical implications. In *Handbook of Qualitative Research Methods for Psychology and the Social Sciences* (ed J. Richardson). Leicester: British Psychological Society.

Read, J. (2005) *Coping with Coming Off: MIND's research into the experiences of people trying to come off psychiatric drugs*. London: MIND Publications.

United Kingdom Psychiatric Pharmacy Group information leaflets on individual drugs www.ukppg.org.uk

Appendix 1: Decision Making Matrix to help decide whether to come off or stay on medication

Coming off Medication

Good things/Advantages	Bad things/Disadvantages

Staying on Medication

Good things/Advantages	Bad things/Disadvantages

Appendix 2 Some of the books and articles available to borrow each week during the Thinking about Medication Group:

Breggin, P. & Cohen, D. (1999) *Your drug maybe your problem; how and why to stop taking psychiatric medications.* Massachusetts: Perseus.

British Medical Association. (2006) *British National Formulary*. London: BMA.

Campbell, P., Cobb, A. & Darton, K. (1998) *Psychiatric drugs: users' experiences and current policy and practice*. London: MIND.

Fisher, S and Greenberg, R. P. (1997) *From Placebo to Panacea: Putting Psychiatric Drugs to the Test.* Chichester: Wiley.

Healy, D. (2005*) Psychiatric Drugs Explained*. Guildford: Mosby.

Healy D. (2005) *Halting SSRIs.* see www.mind.org.uk

Holmes, G. and Newnes, C. (1996) Medication: The holy water of psychiatry. *Open Mind, 82*, 14-15.

Holmes, G. & Hudson, M. (2003) Coming off medication. *OpenMind, 123*, 14-15.

Holmes, G. & Wallcraft, J. *Food, Mood and Psychiatric Treatments*. www.shropsych.org

Lehmann, P. (ed.) (2005) *Coming Off Psychiatric Drugs*. Berlin: Peter Lehmann Publishing.

Lynch, T. (2004) *Beyond Prozac: Healing Mental Distress*. Ross: PCCS.

MIND (2005) *Making Sense of Coming Off Psychiatric Drugs.* London: MIND.
(Other informations leaflets from MIND include: *Making sense of treatments and drugs: Major tranquillizers*; *Minor tranquillizers; Lithium;* etc).

Moncrieff, J. & Double, D. (2003) Double blind random bluff: we're too busy swallowing prozac to ask if it actually works. *Mental Health Today*, November, 24-25.

Neild, L. (1990) *Escape from Tranquillizers and Sleeping Pills: A Proven DIY Withdrawal Plan.* London: Ebury.

Newnes, C., Holmes, G. & Dunn, C. (eds.) (1999) *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*. Ross: PCCS.

Newnes, C., Holmes, G. & Dunn, C. (eds.) (2001) *This is Madness Too: Critical Perspectives on Mental Health Services*. Ross: PCCS.

Read, J. (2005) *Coping with Coming Off: MIND's Research into the experiences of people trying to come off psychiatric drugs*. London: MIND Publications.

United Kingdom Psychiatric Pharmacy Group information leaflets on individual drugs
www.ukppg.org.uk

Additional resources available on request:

Baker, E., Newnes, C. & Myatt, H. (2003) Drug Companies and Clinical Psychology. *Ethical Human Sciences and Services, 3*, 247-253.

Breggin, P. (1997) *Brain Disaling Treatments in Psychiatry: Drugs, Electro-shock and the role of the FDA*. New York: Springer.

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Healy, D. (1997) *The Anti-depressant Era*. London: Harvard University.

Johnstone, L. (2000) *Users and Abusers of Psychiatry*. London: Routledge.

Newnes, C.& Radcliffe, N. (eds.) (2005) *Making and Breaking Children's Lives.* Ross: PCCS.

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Taylor, D., McConnell, D., McConnell, H. & Kerwin, R. (2001) *The Maudsley Prescribing Guidelines*. London: Dunitz.

Whittaker, R. (2004) The case against antipsychotic drugs: a 50 year record of doing more harm than good. *Medical Hypotheses, 62*, 5-13.

Appendix 3: **Questionnaire and accompanying letter**

The Gateway Arts and
Education Centre
Chester Street
Shrewsbury
SY1 1NB
Tel: 01743 355159

30th March 2006

Dear

We are writing to request your help in learning from the experience of the *Thinking About Medication* Group. We want to think carefully about any follow-up to the group, about running the group again, and to learn how to make any changes for the better in the future – your comments will be fundamental to this process.

We would also like to write a report that would appear on the Department of Psychological Therapies website www.shropsych.org and perhaps at some time be submitted to a journal for publication. This would publicise this type of group and hopefully act as an encouragement for similar groups to set up elsewhere in the country. It would be impossible to identify any participant in the group from any report written.

The enclosed form is anonymous; there is no way of identifying you from it. Please write as much or as little as you like. The questions reflect some of our interests, but there is a space at the end to write anything that seems relevant to you.

You are not obliged to complete the form and there is no penalty regarding joining any future groups or accessing any other services should you decide not to.

Please return the form in the enclosed envelope to ourselves next week, or give it to the receptionists at The Gateway by April 18th.

We thank you for your help with this.

Best wishes

Guy Holmes Marese Hudson

Thinking About Medication Feedback

1. Which psychiatric drugs have you taken in the past? …….....
   ……..…….
   ……
2. At the start of the group, which drugs (if any) were you taking?
   ……..……
   ……

3. Have you reduced your dose or come off your drugs since starting the group?
(i) Yes
(ii) No
Please detail……..
…….
……..

4. Do you intend to come off any of your drugs in the future?
(i) Yes, I have already started
(ii) Yes, but not yet, when I am ready
(iii) No

5. Do you want to join a Coming Off Medication Support Group?
(i) Yes, immediately
(ii) Maybe sometime in the future
(iii) No

6. What were your aims in joining the group, and were these met? Please list and tick below

Aims	Not met	Met to some extent	Fully Met
(i) …….....			
……			
(ii) …….			
…….			
(iii) …….			
…….			

7. Please make any comments that you feel are relevant about the group. These might include what you liked and did not like, what you found helpful and unhelpful, and tips for improvements. Please continue over the page if necessary.

……

……

Thank you for your help with this.