

# A Patient Bill of Rights for Psychotropic Prescription: A Call for a Higher Standard of Care

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## ABSTRACT

*The pharmaceutical industry has made it very difficult to know what the clinical trial evidence actually is regarding psychotropics. Consequently, primary care physicians and other front-line practitioners are at a disadvantage when attempting to adhere to the ethical and scientific mandates of evidence based prescriptive practice. This article calls for a higher standard of prescriptive care derived from a risk/benefit analysis of clinical trial evidence. The authors assert that current prescribing practices are often empirically unsound and unduly influenced by pharmaceutical company interests, resulting in unnecessary risks to patients. In the spirit of evidenced based medicine's inclusion of patient values as well as the movement toward health home and integrated care, we present a patient bill of rights for psychotropic prescription. We then offer guidelines to raise the bar of care equal to the available science for all prescribers of psychiatric medications.*

**Keywords:** Psychotropics, Risk/Benefit Analysis, Patient Rights, Primary Care Physicians, Pharmaceutical Company Influence

## 1. Introduction

Largely because of the unprecedented marketing by the pharmaceutical industry as well as the transition of behavioral health to primary care venues, spending for psychiatric medications in the US increased from nearly \$8 billion in 1997 to \$20 billion in 2004 [1], reaching over \$40 billion in sales in 2010 [2]. Concurrently, the use of psychotherapy has declined [3] and community behavioral intervention has fallen or remained flat [4].

Are these patterns justified by the clinical trial evidence? Unfortunately, the pharmaceutical companies have made it very difficult for everyday practitioners to have an accurate picture of the trial data. Marcia Angell, former editor of the *New England Journal of Medicine* concludes:

It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine*" [5].

The vast reach of the pharmaceutical industry in psychotropic prescription practices extends to the Internet, print, and broadcast media, direct-to consumer-advertising, "grassroots" consumer-advocacy organizations, professional guilds, medical schools, prescribing physicians, and research—even into the board rooms of the FDA [5,6]. Antonuccio *et al.* conclude, "It is difficult to think of any arena involving information about medications that does not have significant industry financial or marketing influences." [6] Given the infiltration of industry influence, relying on press reports, web pages, and even the academic literature can be misleading as a basis for sound clinical decisions.

Compounding the problem, primary care and other front line practitioners often do not have the time, formal education, and training to properly evaluate the clinical trial literature, or to know the range of treatment options available to permit matching with patient preferences. The unfortunate result is an over reliance on psychotropics as a first line intervention and an under-reliance on safer and comparably effective psychosocial options.

Building on earlier efforts to establish patient informed consent regarding psychotropics [7,8], this article calls for a higher standard of prescriptive care derived from a risk/benefit analysis of clinical trial evidence [9,10]. The authors assert that many current prescribing practices are empirically unsound and unduly influenced by pharmaceutical company interests, which tend to inflate benefits and minimize risk.

In the spirit of evidenced based medicine's inclusion of patient values as well as the movement toward health home (*i.e.*, an approach to providing comprehensive primary care that emphasizes physician/patient collaboration), we present a patient bill of rights for psychotropic prescription. The Bill of Rights is the name of the first ten amendments to the U.S. Constitution introduced by James Madison to the First U.S. Congress in 1789. The Bill of Rights limits the power of the U.S. Federal Government, protecting the natural rights of liberty and property, including freedom of speech, free press, free assembly, and freedom from cruel and unusual punishment. This article proposes a bill of rights designed to preserve the autonomy and freedom of patients who are prescribed psychotropic drugs in the hopes of creating an evolving document and ongoing discussion of this critical issue. We then offer guidelines to raise the bar of care equal to the available science for all prescribers of psychiatric medications.

## **2. A Patient Bill of Rights for Psychotropic Prescription**

### **2.1. Patients Have a Right to a Thorough Diagnostic and Functional Assessment by a Behavioral Health Care Specialist**

While diagnosis is critical to providing evidence based medical treatment, diagnosis in behavioral healthcare arising from the Diagnostic and Statistical Manual of the American Psychiatric Association has notoriously poor reliability and validity [11]. An over-reliance on this descriptive, symptom-based diagnostic view can lead to a "pill for every ill" prescriptive practice [12]. More important than a diagnostic label is an assessment of how a patient's problems impact his or her life [13] and what can be done about it [14]. Closely aligned with a health home perspective and integrated care, a thorough and systematic assessment gathers information from all significantly involved persons and includes developmental, environmental, familial, and socio-cultural understandings of both problems and solutions. Given that up to 50% of patients referred for mental health services do not make the first appointment [15], it is arguably best that the assessment and treatment be a part of routine care rather than conducted elsewhere. When they are, benefits

ensue. For example, a recent meta-analysis reported improvements in both mental and physical health when brief psychotherapy was incorporated into primary care settings to treat anxiety and depression [16].

A thorough assessment includes the possibility that the problem(s) in question may be best described as part of the human condition or a natural response to the stress of life, particularly poverty and injustice, or in other words, the right not to have normal behavior labeled as pathological. Pharmaceutical marketing has led to what has been called "disease mongering," or the creation or expansion of disorders to increase revenues of a for-profit industry [17]. For example, a recent study compared the number of visits of patients diagnosed with bipolar disorder for ages 0 - 19 for the years 1994-1995 and 2002-2003 [18]. Investigators found a 40-fold increase in visits for this diagnosis, a questionable increase despite the ostensible explanation of advances in detection of a heretofore undetected illness. Of these patients diagnosed with bipolar disorder, more than 90% were treated with psychoactive medications, approximately one half given an antipsychotic and one third given an anticonvulsant. Despite the fact that no evidence supports polypharmacy with youth, most were prescribed more than one medication, and only 4 out of 10 received psychotherapy. A thorough assessment starts with an understanding of the patient within the realm of normal human behavior.

### **2.2. Patients Have a Right to Be Informed about the Safety and Efficacy of Treatment Options Including Psychological Treatment Alone, Medication Alone, Psychological Treatment Combined with Medication, as Well as No Treatment**

The risks and benefits of any intervention should be transparently discussed. Such open discussions allow patients to decide which treatment offers the best option in line with their own values and cultural contexts [8]. For example, parents of children struggling with depression can be shown the efficacy and safety data about cognitive behavioral therapy (CBT) vs. antidepressant treatment, alone or in combination. CBT alone had comparable outcome at 30 weeks while the antidepressant treatment groups had significantly more psychiatric adverse events; six suicide attempts occurred in the medication groups v. one in the nonmedication group [10, 19-21]. Similarly, patients should be informed about recent meta-analytic data showing that antidepressants are not more effective than placebo except for a small portion of patients in the very severe range [22,23]. Paradoxically, despite the growing evidence of the minimal therapeutic effects of antidepressants, sales for them increased in 2010 in the US [2] Concomitant to a risk/

benefit discussion, patients should be informed about the likely outcome of no treatment at all. Problems or conditions often improve without intervention. With depression, for example, spontaneous remission ranges from 20% to 60% for any given episode [24,25].

As part of a risk/benefit discussion, patients also should be informed that medical science has yet to reliably identify any biological markers or chemical imbalances for any psychiatric diagnosis [12,26]. Similarly, there is no evidence that any psychotropic medications repair chemical imbalances or other proposed neurochemical substrates of disorders [e.g., 27]. Understanding the limits of scientific understanding paves the way for an informed choice about treatment options.

### **2.3. Patients Have a Right to Be Treated with Psychosocial Interventions Alone If They So Choose**

Based on recent reviews of the evidence regarding the efficacy and safety of psychiatric medications, a risk/benefit analysis suggests that psychotherapy be considered first, depending on patient preferences [9,10]. Patients, therefore, have a right to be treated by a physician who sees psychosocial options as viable first line, stand alone treatments (including psychotherapy, exercise and nutrition, problem solving, community, spiritual, and peer options) for emotional and behavioral problems. For example, in the case of depression, contrary to conventional wisdom, psychological treatments have been shown to be as effective as medication treatments in the short run with more durable benefits in the long run, especially when patient rated measures are considered, even if the depression is severe [28-30]. Combined treatments have not consistently fared better than psychological treatments alone over long term outcome but they have tended to have better results than medication treatment alone [31-34].

### **2.4. Patients Have a Right to Be Exposed to the Lowest Risk of Adverse Events from Psychotropic Medications—A Right to a “First Do No Harm Approach”**

Since we are unaware of any scientific studies addressing the combination of more than two psychotropic medications [35] with adults (or more than one with children), this should be the upper limit. Even two medication combinations have been rarely studied, and when they have, underwhelming results seem the norm. For example, “treatment resistant depression” prompted the STAR\*D (Sequenced Treatment Alternatives to Relieve Depression), a study that examined the impact of augmentation or medication switching strategies for depression when a traditional regimen of a single SSRI failed

[36]. The average remission rate (which was less than the traditional placebo response) based on the primary outcome measure was 28% (Level 1—initial regimen of a single SSRI) and 25% (Level 2—patients augmented or switched), or a total remission rate of 39% when considering those who remitted at both levels together out of a total of 2876 participants. A more stringent perspective would take each level as a different treatment episode, resulting in an average remission rate of 27% across levels. Moderate to intolerable adverse events were experienced by 28% of participants at Level 1 [37] and 51% at Level 2 [38,39]. In addition, overall results from the large scale Combining Medications to Enhance Depression Outcomes (CO-MED) [40] study showed that a single antidepressant produced the same remission rate as combined antidepressants and that therapy with 2 medications resulted in more adverse events.

Prescribing psychotropics without FDA or other governing body approval, so called off-label prescribing should also be rare. Although polypharmacy and off label prescriptions of psychotropics tend to expose patients to increased risks and side effects, such practices have become increasingly popular, particularly in vulnerable populations of children and the elderly [12,41]. For example, a study of 11,700 youth covered by Medicaid found that the number of children newly treated with antipsychotics increased from 1482 in 2001 to 3110 in 2005 [42]. This means that 26% of these youth were taking antipsychotics in 2005, suggesting many off label prescriptions. Other studies have found that children covered by Medicaid were prescribed antipsychotics at a rate four times higher than children with private insurance, were more likely to receive antipsychotics for unapproved uses, and were more likely to receive multiple medications [43,44], despite the fact that not one randomized clinical trial to our knowledge has examined polypharmaceutical intervention with children. Poor children, apparently, are vulnerable to psychotropics used as interventions of control rather than therapy.

Finally, patients have a right for psychotropic medications to be used as primarily a short term treatment. Most of the scientific psychiatric database consists of controlled studies of 6 to 12 weeks in duration [8,45]. There are not enough controlled investigations beyond 12 weeks to guide patients or prescribers in terms of safety and efficacy. When longer trials are done, results are unimpressive. For example, the STAR\*D reported that 58% of those who responded through the four levels relapsed at one year follow-up [38]. In a large scale investigation of antipsychotics with adults with schizophrenia, 74% of participants discontinued before 18 months, largely due to inefficacy and intolerable side effects [46]. Finally, a study of antipsychotics with youth diagnosed with

schizophrenia reported that only 12% of youth both responded and stayed on antipsychotics for a year [47]. Long term use of psychotropics does not appear to be empirically supported.

### **2.5. Patients Have a Right to Monitor Their Treatment Response with Patient Rated Outcome Measures**

Clinicians and patients often differ substantially in their judgment of improvement in clinical trials [44]. A meta-analysis of 22 antidepressant studies (N = 2230) found that antidepressants showed an approximate 20% advantage over placebo on clinician-rated measures, but none on patient-rated measures [48]. This is the rule rather than the exception [21,49]. The lack of endorsement of efficacy by patients in clinical trials begs the question: If patients don't notice advantage over placebo, how significant can the advantage rated by others be?

Using patient rated measures of treatment response not only in clinical trials but also in practice will allow more accurate assessment of medication benefit and may even improve outcomes. Incorporating patient-rated outcomes into treatment, for example, has been found to significantly improve outcomes in psychotherapy, allowing the clinician to tailor intervention based upon patient response [14,50]. Monitoring treatment outcomes would allow patients to change treatment approaches if any given treatment was not working after a reasonable period of time.

In the absence of benefit, patients also have a right not to have their dosage increased. There appears to be a weak dose response relationship with psychotropic medications. Response does not typically improve with doses higher than those already in the recommended therapeutic range, for example, with antidepressants [51,52]. However, side effects and the risk of adverse events significantly increase with higher doses. Finally, patients have a right to be tapered off ineffective medications before additional medications are prescribed given that augmentation studies have shown limited benefits. In other words, patients have a right to experience a medication free period to see if they feel better before a new medication is added.

### **2.6. Patients Have a Right to Untainted Scientific Data Conveyed in a Consumer Friendly Way Regarding Psychotropic Medication**

This would require a publicly accessible database of all published and unpublished data, as well as a straightforward presentation of the risks and benefits free of spin and marketing [53]. Unfortunately our scientific database appears to be distorted by ghost written articles and skewed by publication bias, *i.e.*, publishing studies that

are favorable to the pharmaceutical industry products [54,55], sometimes recasting unfavorable outcomes into the conclusion that the medication is “efficacious, safe, and well tolerated.” Until an unvarnished database that includes all the data (including raw data) becomes available, the Cochrane database may serve as the best resource.

## **3. A Higher Standard of Psychotropic Prescriptive Care**

- Prescribers should secure patient informed consent after full disclosure of the risks and benefits of psychotropic prescription [7].
- Psychosocial options, including psychotherapy, should be tried first consistent with patient preference.
- Practices that are not empirically supported—off label prescribing, polypharmacy (especially with children), dosages outside recommended ranges, and lifetime regimens—should be limited and include full patient consent as well as close monitoring.
- Patient rated measures of outcome should be used in both research and practice.
- Pharmaceutical company influence should be separated from science and practice.
- A data base of the risks and benefits of psychotropics, independent of industry influence, should be available to prescribers and patients.

## **4. Conclusions**

The methodology of medication trials needs wholesale reform to address inherent flaws: analysis to detect penetration of the double blind and/or the use of psychoactive placebos; use of patient rated measures; long term evaluation of efficacy and safety; inclusion of investigators without pharmaceutical company affiliations; and independent reporting of the findings to remove marketing spin. Regarding practice, untainted information should be made available to prescribers of psychotropics. Pharmaceutical company press releases and “detailing” from sales representatives should include independent evaluation of claims as well as non-medication options. Incentives and benefits to prescribers should be eliminated. Psychosocial interventions have neither marketing representatives nor budgets and therefore a more concerted effort to include them is needed.

The STAR\*D is but one example that demonstrates the need for straightforward reporting of the clinical trial evidence so that physicians can discern science from spin and draw their own conclusions. The STAR\*D investigators posited a 67% cumulative remission rate but qualified that the estimate: “... assumes no dropouts, and it assumes that those who exited the study would have had the same remission as those who stayed in the pro-

tolcol” [38]. As the 67% figure is often repeated while the unrealistic assumptions on which it is based are forgotten, it is easy for prescribers to conclude that augmentation/switch strategies are soundly supported. On the other hand, if one looks at the remission across all levels, which at each level was quite meager and less than typical placebo response, combined with a 51% adverse reaction profile after augmentation/switch, and a 58% relapse rate, a different conclusion would likely result [10, 56]. A more stringent perspective reveals that after a year of continuation treatment following remission, of the 4041 patients who entered the program only 108 (3%) had a sustained remission—all the other patients either dropped out or relapsed [38].

The unprecedented promotion of the pharmaceutical industry that targets all players in health care forms the basis of pharmacology’s growing centrality in psychiatric treatment. While some patients may be helped with this focus, it misdirects primary care away from a safer intervention with comparable efficacy—psychotherapy, as well as other community-based, culturally sensitive options. Additionally, it promotes prescriptive treatments of questionable sustainability, fraught with potentially dangerous effects.

This article proposed a patient bill of rights and psychotropic prescription guidelines that embody a higher standard of care, making the patient a partner in the selection and administration of treatment. Such a collaboration allows the integration of the best research evidence with clinical expertise and patient values [57,58]. The proposed higher standard of care aligns the prescriber with the patient, the evidence, and the outcome of intervention, and perhaps more importantly, the commitment to first do no harm [59]. We believe that a careful reading of the 6 rights identified in this article will reveal them to reflect a scientifically supported, common sense, practical, and respectful approach to the use of psychotropic medications.

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