

24

Pharmacological abuse

The problem 275

The dynamics of abuse 276

Prescription 'rights' 278

Awareness of the problem 279

The management of abuse 281

When chlorpromazine was first introduced, doctors prescribed and patients took what they were given. The prescription of a medicine now, however, is much more likely to be based on the assumption that a patient should understand the condition for which the prescription is given, the nature of any treatment, its duration, its chances of success and the risks of side effects. Patients should be free to ask for any information they want from the prescriber, who will respond genuinely.

Clearly, respect for the autonomy of the patient has to be balanced against a respect for the autonomy of others. Uniquely in psychiatric practice it is necessary on occasion to give treatment without consent, but society has put mechanisms in place to compensate for a patient's loss of autonomy in such situations.^{12,13}, although it is rarely noticed that despite these arrangements patients detained within mental health settings often have fewer rights than prisoners. The argument outlined below does not apply to these emergency situations or to the small number of situations facing all practitioners that amount *de facto* to a community treatment order, where clinicians may be operating with partial or grudging consent from patients. The

argument is aimed at situations, particularly with antipsychotics, where a paternalistic approach to patients may involve an insidious loss of autonomy that may be counter-therapeutic and ethically dubious.

THE PROBLEM

Consider the following. Many patients, when first admitted to hospital, will be started on medication regimens that they will not know exceed local or national formulary limits and greatly exceed the regimens that have been shown by research to be optimally effective. They are unlikely to know that there is rarely a pharmacological justification for the co-prescription of two different oral antipsychotics or for a combination of both an oral and depot antipsychotic, or for cocktails of anticonvulsants and antipsychotics. If given an anticholinergic agent they may not know that this has been given as an antidote to the side effects of the primary medication. If they do know this, they are unlikely to know that, quite commonly, it would be possible to avoid the need for an anticholinergic agent. If they are on a combination of antidepressants and antipsychotics, they almost certainly will not know that their 'depression' may be a consequence of treatment with antipsychotics and, if so, will not be responsive to antidepressant medication.

On a broader front, the worry is that patients admitted to hospital will have their treatment discontinued abruptly with a new treatment started immediately with little or no consideration being given to the possibility of withdrawal from the earlier treatment. In practice antidepressants and antipsychotics are treated as though switching from one to another involved no more than switching between vitamins. This however is not the case. Putting patients on psychotropic drugs is better regarded as giving people a pharmacological life event.

Doubts have been expressed as to how often, in practice, patients validly consent to many prescribed regimens, and growing concerns have prompted a working party of the Royal College

of Psychiatrists to issue guidelines covering some aspects of prescribing.¹⁴ Against this background, it seems certain that in clinical practice betrayals of trust occur, and that situations may arise that are 'abusive'. Let us consider therefore to what extent dynamics that are familiar from the sexual abuse arena might also apply in this domain.

THE DYNAMICS OF ABUSE

As in other forms of abuse, a 'victim' of 'abusive prescribing' may be dependent on the 'abuser'.¹⁵ This dependence may be brought about by virtue of an unavailability of psychiatric services in the victim's area other than through the prescriber, and by virtue of the unavailability of psychotropic compounds other than by prescription. The victim, therefore, may have to maintain an interaction with the perpetrator and may in the process have to cope with the fact that the perpetrator at some level may be or may be regarded as showing concern for them. A common response to this point is that there is a difference between the intent to take advantage of children found in child abuse and the worst that clinicians can be accused of, which is adherence to out-of-date treatment practices: doctors do not casually or deliberately 'violate' their patients. This probably overestimates the degree of conscious intent to harm in many cases of child abuse and sexual harassment and underestimates the harm that can be done by clinicians 'who know best'.

As with other forms of abuse, there will necessarily be a low incidence of disclosure to others, for a number of reasons. First, it is necessary to disclose the illness in order to disclose the abuse, and victims may understandably be reluctant to do this. Second, there may be a legitimate fear of reprisals should complaints be made, which many suspect might take the form of an increase in the dose of the treatment being complained about. Third, in addition to being seen as ill, just as any other victim of abuse, a victim of abusive prescribing risks further

stigmatisation as victim as a 'loser'. Fourth, there are difficulties in ventilating concerns in this area as complaining about nervousness and other problems as a consequence of treatment leaves the subject open to the perception that all that has been demonstrated is the problem that led to the initial prescription.

Indeed, a further problem is that many individuals may not explicitly make the connection between their treatment regimens and the way they are feeling.^{16,17} It may only be when they are evaluated by someone else that they become consciously aware of a connection between their treatment and symptoms such as anxiety, depression, demotivation, fatigue, a variety of psychosomatic symptoms, nervousness, impulsiveness, irritability, weight gain, sexual disturbances, suicidality, emotional blunting and other problems.

Finally, if a patient complains, there will often be a lack of support from significant others. This, as in other forms of abuse, may be important in its own right. Indeed, there may be considerable external pressure on the individual – from relatives and friends as well as from mental-health professionals – to accommodate to the situation and to internalise blame. This will lead to a sense of defectiveness on the patient's part or denial of the difficulties that are being experienced. This is compounded by blanket company denials that treatment could cause problems and indeed company suppression of the data indicating that there can be problems.

As with other forms of abuse, unpredictability may make things worse, as may the duration of the abuse, the extent to which the abuse pervades all aspects of the subject's life, and the extent to which prescribing is seen as reactive to conflicts rather than aimed at rational and agreed therapeutic ends. Particular difficulties are raised in the case of violent incidents in clinical settings. In such circumstances mental-health staff risk assuming the role of both judge and jury.

Ongoing abuse has also traditionally found justification from evidence that the discontinuation of treatment leads to serious problems. This is invariably interpreted as a re-emergence of the illness, a situation that, ethically, all but demands the resumption of treatment. However, there is a considerable body of evidence to indicate that what is typically taken as a new illness episode following a reduction or discontinuation of medication may in a large number of cases be evidence of a dependence syndrome (see Chs 1 & 22).¹⁸ It is known that clinicians routinely fail to warn patients about the risk of tardive dyskinesia owing to their own emotional discomfort at raising this possibility. Probably for similar reasons, they appear to have managed to ignore evidence indicating the existence of tardive dysthymias and other drug-induced stress syndromes. Clinicians seem in practice all but unable to inform their patients of these significant risks.

PRESCRIPTION 'RIGHTS'

Some of this potential for abuse may arise from the prescription-only status of psychotropic medicines. A significant reason for the extension of prescription-only arrangements to all medicines in the 1950s lay in an assessment that the amount of information regarding the proper use of the new medications was too extensive to fit on the label and that making the drugs available only on prescription-only would ensure that any information a patient needed would be given to them by their prescriber.

One consequence of prescription-only status is that it is not only when a patient has been formally detained that a prescriber is given more than the usual amount of power in determining the outcome of a clinical condition. Every writing of a prescription involves a potential deferral to a medical opinion in a manner that does not happen when people manage their own conditions by non-pharmacotherapeutic means or by means of over-the-counter medications or health food

supplements. The potential for abuse in prescription-only arrangements was recognised by Senator Estes Kefauver, who chaired the hearings that led to the 1962 Amendments to the US Food and Drugs Act, when he noted that ‘he who orders does not buy and he who buys does not order’.

Potentially abusive prescribing of the type outlined probably applies in the case of all medications, given recent indicators that drug-induced conditions are now the fourth leading cause of death and may lead to up to one-third of admissions to hospital.¹⁹ The issue, however, probably applies with extra force in the case of the psychotropic agents, in that the problematic effects of medication are most pernicious in this domain. The recent development of mental health advocacy recognises the potential for abuse in current mental health services. However, where the women’s movement has been able to lobby effectively for a consideration of sexual abuse and harassment both on a legal level and in terms of raising consciousness in society, mental-health patients have fewer levers available to them and would seem to be even more vulnerable.

The situation in fact is likely to get worse rather than better. Pharmaceutical companies have been gearing up in recent years to increase sales by increasing compliance. There is at present an active “Recovery” movement in psychiatry that aims at helping people situate even the most serious mental illness within the context of their lives, rather than having the illness dominate therapeutic exchanges, so that a person’s larger concerns are visible to those who may be treating them. This movement is being actively co-opted by pharmaceutical companies whose message is that the only way to recover is to keep taking the medication.

The companies are set to bypass doctors. All the tricks used to sell us things we do not need in other areas of life are set to be deployed into health and mental health – from loyalty

cards, to mobile phones with text messaging to remind us to have our meds. Nurses are being donated to mental health teams to ensure the patient stays on the company's medication²⁰. Company input to the formation of guidelines (Section 11) makes it increasingly difficult not to prescribe the latest drug. And increasingly doctors are only paid if they reach targets which specify having a certain percentage of patients with particular conditions on treatment. Politicians and service managers are being sold the message that 85% of readmissions are linked to non-compliance, at a huge annual cost that could be saved if compliance were ensured. More ominously perhaps companies talk the language of relationships, education and joint expertise in a way that mental health professionals have not. It is becoming and will become even more difficult to step back from this – how Dr Healy do you justify denying a patient a treatment that works or colluding with them to avoid treatment?

These factors and concerns about violence from psychotic patients have led in a number of countries to a variety of Community Treatment Orders which some have argued are needed for the occasional risky patient who refuses to take their medication on discharge. There were initial estimates that this would apply to no more than 1% of psychotic patients but in practice up to 25% of patients are being put on depot antipsychotics under orders of this kind, without in some cases any rights of appeal. This is a situation that is wide open to profound abuse.

AWARENESS OF THE PROBLEM

As with sexual harassment and other forms of abuse, there has been a tendency to put up with the situation as an inevitable fact of life. Many will think that the extent of and consequences of abusive prescribing hinted at here are overstated. Many will feel that, if things were this bad, more would have been made of the problem before this. The failure to recognise the problem may stem from the extent to which we ourselves have been abused. Most medical and nursing

staff, while training, will have been instructed by their superiors at various times to administer doses of medication that they considered were unwarranted. Most colleagues I trained with will have seen haloperidol narcosis being administered to young female patients who were not unduly disruptive. This involved giving haloperidol 10 mg intravenously every hour for several days at a stretch. In the hospital where I worked until the mid-1990s, the standard regimen on which all admitted psychotic patients were commenced – even frail women in their sixties – was haloperidol 10 mg four times daily. Regimens of up to 1000 mg per day of flupentixol (equivalent to 20 000 mg chlorpromazine) were not uncommon in the management of young women until recently.²¹

Indeed, it is a moot point as to whether many of the benefits of monotherapy with clozapine stem from the fact that, in such circumstances, some of the patients most at risk of prescription abuses are much less likely to be poisoned than they once were (see Ch. 1). The experiences of researchers working with healthy volunteers here are of relevance. Some researchers have, for example, made videos of the effects of small doses of antipsychotics on these subjects, who are transformed so much that they appear to be indistinguishable from patients who are thought to have schizophrenia with predominantly negative features. Similar outcomes have been recorded using rating scales such as the Positive and Negative Symptoms Scales: volunteers develop ‘negative’ symptoms. In the main, these findings have not reached the public domain owing to concerns among researchers that their impact would damage healthy volunteer research.

A single 5 mg dose of droperidol given blind to healthy volunteers will invariably produce agitation and dysphoria, even suicidality in some.^{16,22} These effects can last up to a week. Alcohol and taking to bed, in an effort to minimise external stimulation, may be one of the

best ways to handle the problem. But these behaviours when undertaken by patients, of course, are taken as indicators of illness. The views of patients that a considerable part of the problem may be drug induced are typically discounted.

A vignette may bring some of the issues home. MC is a 65-year-old well- educated articulate woman who became depressed for the first time in her life. She had concomitant osteoporosis that restricted the choice of antidepressant medication that might have suited her. She was accordingly put on sertraline. After several weeks on this she developed chest pain, probably anginal, and breathlessness. After attendance at a clinic, I wrote to her general practitioner recommending a change from this antidepressant. He did nothing. A follow-up letter copied to the patient, suggesting that this was selective serotonin reuptake inhibitor (SSRI)-induced angina and an SSRI-induced respiratory dyskinesia, again advising a change of medication from SSRIs, also had no effect. The doctor's interpretation was that the angina was unrelated to her treatment. He interpreted her breathlessness as panic attacks, and therefore as evidence that she should continue with treatment and preferably with an SSRI. The woman herself continued with treatment, afraid that if she stopped, given her evident problems, and had to call her general practitioner out in an emergency and he were to find that she had gone against his instructions he would refuse to treat her when she really needed it. The general practitioner was finally persuaded to change to a non-SSRI, and after several weeks MC's chest pains and breathlessness cleared up.

This vignette illustrates how dependent people can become in therapeutic situations. Children are almost certainly even less capable of maintaining their perceptions of drug-induced abnormality in the face of contradictory interpretations from both clinicians, and their parents who are not suffering the effects. This is not just a theoretical issue. In recent years, there has

been a huge increase in antidepressant and antipsychotic prescribing to children, with estimates that there are several million prescriptions per year in the USA alone.^{23,24,25} This increase has taken place even though the randomised trials of these drugs undertaken in pediatric populations have shown no benefit of the drugs over placebo. There is an ethical issue as to whether this kind of treatment should take place at all in the face of so much negative evidence but, more to the point, the potential for abuse would seem to be huge in such situations.

THE MANAGEMENT OF ABUSE

As with other situations of abuse, the adverse effects of abusive prescribing will remain invisible as long as the existence of abusive prescribing remains unacknowledged. If recognised, it may be possible to put a cost on the consequences of such prescribing. This cost may be substantial if the increased hospitalisation, compromised compliance and decreased employment resulting from abusive prescribing are taken into account.

The doctrine that medical practices are all but immune to prosecution if a significant minority of the profession can be shown to practise similarly means that, in the case of abusive prescribing, a legal recourse is unlikely to be helpful in all but the most extraordinary cases. This will be the case even though the documentary proof of abuse in the form of a prescription record is likely to be available in a way that evidence in the case of child abuse or sexual harassment rarely is. Few people will want to take legal action, anyway, partly because they may fear it will affect their relations with all prescribers and not just with one.

The potential for abuse is inherent in all therapies and, in practice, may occur to an even greater extent in psychotherapy than in routine pharmacotherapy. The question of abuse in therapy formed the heart of the key legal case in this area, the Osheroff case, in which an individual who was depressed was treated for 9 months with psychotherapeutic approaches that

had not been shown to work. Subsequent treatment with antidepressants brought about a prompt improvement in his condition, but this was too late to save his marriage or his job. The issues were debated at length in the pages of the *American Journal of Psychiatry*.^{26,27} In brief, there was no agreement that therapy should necessarily follow evidence of efficacy, but there was agreement that persistence with one therapeutic line, in the face of a lack of progress without a genuine review of other options, was indefensible. Even where the therapy being delivered has been shown to have some evidence of efficacy, a failure to review may well be abusive.

The Osheroff case makes it clear that it would be good practice for all therapists, including pharmacotherapists, to specify what outcomes they are aiming at, the period of time for which they are likely to persist in a particular course of action in the face of non-response or partial response, and what other treatment options they would consider should the current course of treatment fail to deliver the expected benefits. Exactly these recommendations were written into a 1997 British Association for Psychopharmacology consensus statement on prescribing for childhood and learning disability indications.²⁸

However, it is possible to go further. Just as the Mental Health Act is supposed to sanction the treatment that would be given to the detained patient as if their relatives were present to witness what was being done, so also, if the prescription-only status of psychotropic agents is not to be revoked, therapists ideally should do pharmacotherapy with the genuineness they would bring to bear if a medical relative or advocate were present with the patient to monitor what was happening – and this should involve some recognition that if a relative or friend of mine had a serious psychosis we really know very little about what to do and anything other than genuine teamwork in such situations cannot be defended.