



EDITORIAL

Is it time to end our complicity with pharmacocentricity?

Psychotropic medications have traditionally dominated the treatment of mental health problems. The administration of psychotropic medications and monitoring for effects, side effects, and adherence therefore consumes considerable time for mental health nurses (MHN). While there is no doubt many people believe psychotropic medications have helped them, the weight of research evidence questioning their effectiveness and exposing their associated debilitating side effect burden (particularly over the long term) is now too compelling to be ignored. This has prompted the claim that, on balance, psychotropic medications cause more harm than good (Gotzche *et al.* 2015).

The most commonly prescribed psychotropic medications are antidepressants and antipsychotics, yet these names are misleading. They create the impression that psychotropic medications remove a pathogen like an antibiotic removes a bacteria, when this is not the case (Rosenman 2016). Unlike physical conditions such as diabetes, Crohn's disease or cystic fibrosis, for example, there is no pathophysiology or a single identifiable biomarker associated with any psychiatric diagnosis. Diagnoses such as 'schizophrenia' or 'bipolar disorder' are based on a consensus model and therefore represent simply one version of the truth, not established scientific facts (Wand 2015).

The rationale supporting psychotropic medications is based on the assumption that mental illnesses are predominantly biological and are ameliorated at a neurochemical level, conveying the message to the 'sufferer' that they are biologically inferior (Hall 2018). However, there is no evidence that mental illness is due to a chemical imbalance of the brain, and while genetics and biology play a role in all aspects of the human condition, the degree to which genetics and biology influence mental health and well-being remains a matter of speculation. What is known (without question) is that mental health and well-being are predominantly determined by what happens to people after they are born, not what they are born with. Childhood adversity and instability, abuse and neglect, socio-economic disadvantage, discrimination, bullying, rape, incarceration, war, substance misuse, and human rights violations all make

far greater contributions to mental ill-health than heredity (World Health Organization, 2013). Indeed, it is disrespectful, and unrealistic, to expect that a medication will mend such harrowing experiences. For example, it is reported that hearing voices in 77% of people diagnosed with 'schizophrenia' is related to traumatic experiences. The widely held contemporary view is that voice hearing is a normal human experience that voices have meaning for individuals and are 'parts of the self' that should not be ignored. People are encouraged to accept voices and establish a dialogue with them. Conversely, attempting to 'get rid' of voices through medication interferes with emotional processing and understanding the meaning of voices (Mosquera & Ross 2017).

THE EVIDENCE ON ANTIDEPRESSANTS

Several studies have identified that antidepressants are little or no better than placebo for the majority of people with depression (Barbui *et al.* 2011; Fournier *et al.* 2010; Khan & Brown 2015; Kirsch *et al.* 2008). This has attracted little mainstream media attention. Yet curiously, a recent systematic review and network meta-analysis published in the *Lancet* by Cipriani *et al.* (2018) which reported only modest effect sizes from 522 trials of 21 antidepressants evoked media claims that the debate on antidepressant effectiveness was now over, because this study proved antidepressants 'worked' (Boseley 2018; Rice-Oxley 2018). Following the publication of this review, numerous critiques of the study emerged online. The essence of these criticisms is encompassed by McCormack and Korownyk (2018). They highlight that the review rated 82% of studies as having moderate to high risk of bias and that 78% of studies (when declared) were funded by pharmaceutical companies. Reviews such as these do not identify who or how many people should be treated with antidepressants, especially given an estimated 30–40% of placebo groups report improvement or remission. A major criticism is that claims of antidepressant effectiveness are typically based on 6- to 8-week clinical trials. Assertions that antidepressants work neglect

long-term effects (and outcomes) from taking antidepressants, and the comparative benefits and harms relative to nonpharmacological approaches (McCormack & Korownyk 2018).

Importantly, the authors of the study were not nearly as confident of the claims made by media outlets, for example conceding that ‘Depressive symptoms tend to spontaneously improve over time and this phenomenon contributes to the high percentage of placebo responders in antidepressant trials’ (Cipriani *et al.* 2018, pp. 1363). This conforms to the widespread recognition that improvement in depressive symptoms is often due to the passage of time, or placebo effect. Individuals (and the prescriber), however, tend to give antidepressants credit they do not deserve.

THE EVIDENCE ON ANTIPSYCHOTICS

Whittaker (2016) has published an extensive review and analysis of the research literature on antipsychotics from the 1950s to the present. This longitudinal perspective reveals that antipsychotic medications may provide short-term benefits, but on the whole, they worsen long-term outcomes. The conclusion drawn is that antipsychotics induce physiological changes in the brain leaving individuals more vulnerable to psychosis. The collective research examined indicates that long-term use of antipsychotic medications worsen psychotic symptoms, and impairs functional capacities, making individuals more ‘socially dependent’ than before their illness. Conversely, longitudinal studies from the USA, Netherlands, and Australia have all found that minimal or no use of antipsychotics is associated with better outcomes. Essentially, antipsychotic medications increase the ‘chronicity of schizophrenia’ and other psychotic conditions and impede recovery (Whittaker 2016).

These assertions are supported by Harrow and Jobe (2018) who agree that while antipsychotic medications demonstrate short-term benefits, there are now eight major studies that fail to find better outcomes for individuals with ‘schizophrenia’ treated with antipsychotic medications on a long-term basis. In their study, Harrow *et al.* (2017) followed up 139 people diagnosed with ‘schizophrenia’ and ‘schizoaffective disorder’ over 20 years. Their findings show significant differences and large effect sizes in work functioning in favour of individuals not prescribed antipsychotic medication long term. In general, people continuously prescribed antipsychotics were significantly more likely to have negative symptoms than those not prescribed

antipsychotics at 4.5 years follow-up. Moreover, a large percentage of those individuals continuously prescribed antipsychotics were rehospitalized multiple times. The authors maintain that any hypothesis based on antipsychotics facilitating work functioning is dubious and that no strong evidence exists for the treatment of antipsychotic medication beyond three years (Harrow *et al.* 2017). Additionally, concerns have been raised over the widespread off-label use of antipsychotics such as quetiapine for the treatment of anxiety, insomnia, post-traumatic stress, ‘personality disorders’, dementia, and substance misuse when there is no evidence to support its use for these health problems (Brett 2015).

GETTING OFF PSYCHOTROPIC MEDICATIONS

There is growing awareness of the significant withdrawal and discontinuation effects of psychotropic medications, which are often distressing and can endure for many months after cessation. This phenomenon is reported in the scholarly literature (Cartwright *et al.* 2016; Hall 2018; Ostrow *et al.* 2017; Read *et al.* 2018) and mainstream media (Carey & Gebeloff 2018; Edemariam 2017). Traditionally, people have been informed that these symptoms are a ‘relapse’ of their condition and proof that the medication was working. This is not logical. For example, with regard to relapse studies and antipsychotic discontinuation, Whittaker (2016) argues it cannot be known from this research how much of the ‘relapse’ symptoms are due to a withdrawal effect, and how much might be interpreted as a (yet to be explicated) ‘return of the disease’. This uncertainty makes it impossible to draw conclusions from these studies about the long-term protective effects of antipsychotics against relapse (Whittaker 2016).

THE WAY FORWARD

Given the questionable effectiveness of psychotropic medications over the long term and their unquestionable side effect burden, the clear indication is that these medications (if prescribed at all) should be taken sparingly and for the shortest time possible, and non-pharmacological approaches emphasized. Thankfully, the number of nonpharmacological options available for enhancing mental health and well-being is extensive. From a psychiatric survivor perspective, Hall (2012) takes a pragmatic view of psychotropic medications proposing they can blunt or control symptoms of mental distress and consequently ‘take the edge’ off

extreme states. However, they do not address the underlying causes of mental distress and are therefore best understood as tools or coping mechanisms that sometimes alleviate symptoms.

A report from the Mental Health Commission of NSW (2015) titled *Medication and mental illness: Perspectives* provided valuable insights into what people want from their mental health clinicians and services with regard to psychotropic medication. While positive experiences with medications were highlighted, the far greater weight of opinion was negative. Consumers and carers identified that their concerns about medications (especially side effects and polypharmacy) were either ignored or dismissed. An emphasis on learning skills of self-care and self-management was preferred. In the report under the heading *Towards change*, a list summarized ‘what people told the Commission’;

- The first and only option should not be a prescription.
- Psychotherapeutic and social interventions should be considered in conjunction with medication.
- Nonpharmacological options alone can be sufficient.
- Mental illness may be a consequence of trauma. When this is the case clinicians should address the root cause of mental distress.
- Access to and cost of nonpharmacological interventions is problematic.
- Medical interventions are of limited effectiveness unless additional factors that affect mental health are addressed, such as housing, education, and employment.

The dilemma now facing MHNs is how to respond to the recognition that psychotropic medications are conceivably causing more harm than good, especially the longer people take them. Services such as clozapine and depot clinics would not function without the support of MHNs, who are also routinely involved in compelling people to take psychotropic medications. Moreover, while programmes developed by MHNs to monitor and screen for side effects and complications from taking psychotropic medications are commendable (especially given the physical health complications encountered by people experiencing mental ill-health are principally iatrogenic in nature), the risk versus benefit ratio does not support the traditional view that people should be maintained on psychotropic medications long term.

The ethical principle of nonmaleficence obliges MHNs to inform individuals (and their carers) of the effects, side effects, and current research on the

effectiveness of these agents. Furthermore, people should be routinely informed of the contemporary understanding that mental health challenges are predominantly attributed to human experiences of adversity, instability, and trauma, rather than simply predetermined by biology or genetics.

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