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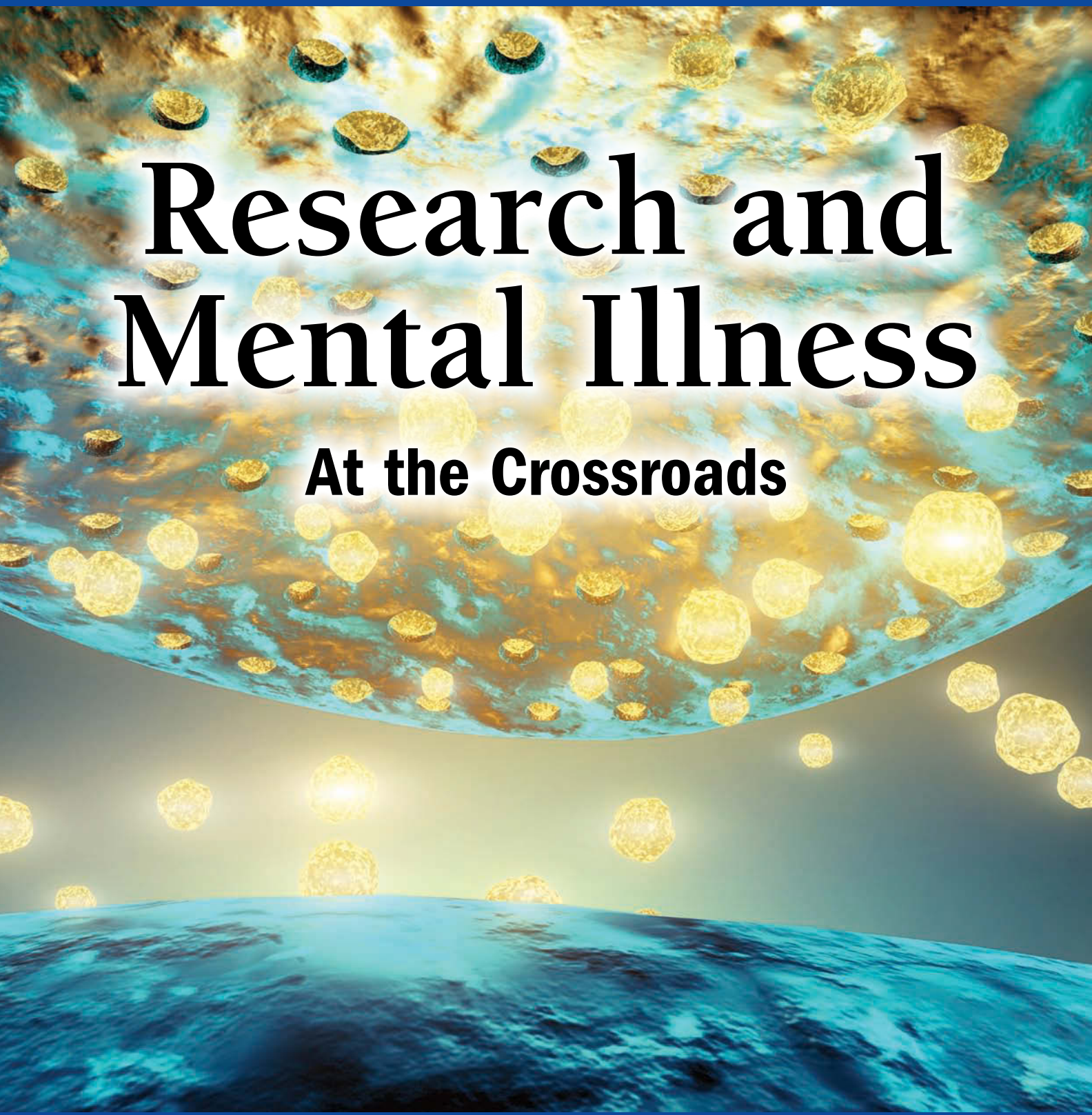

Research and Mental Illness

At the Crossroads

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The Sensible Use of Psychiatric Medications

by Ken Duckworth, M.D., NAMI Medical Director

Psychiatric medications are often essential tools for people who live with mental illness. They may be a key piece of the recovery puzzle, but they are rarely enough to promote recovery alone. As psychiatric medications also attract a fair bit of controversy, I thought I would outline two recent, and interesting, studies that shed light on these treatment options and offer a few clinical tips from my work as a psychiatrist.

How Good Are Psychiatric Medicines as a Class?

I have often wondered if our medicine options in psychiatry are in the same therapeutic ballpark as are meds for other medical conditions that are easier to measure and understand, such as high blood pressure and elevated blood sugar levels. I often envy the knowledge that cardiologists have about the heart, which is essentially a brilliantly designed and understandable pump. The brain has billions of neurons, an unknown numbers of circuits and untold gene environment interactions, so we know our quest for understanding will be harder.

A recent review paper has shed light on this compelling question. The *British Journal of Psychiatry*[1] published a meta-review paper that looked at studies and reviews comparing psychiatric medicines—like antidepressants, mood stabilizers and antipsychotics—to meds for other medical conditions such as diabetes, ulcerative colitis, multiple sclerosis and hypertension. The authors reviewed massive data sets in multiple studies and concluded that psychiatric medicines were generally "in the same range as most general medical pharmacotherapies." We aren't able to cure most medical conditions, brain-based or not, so medicine treatments emerge as a way to improve symptoms. This can be a cornerstone for building a recovery.

Of course, we treat individual people, not populations of people. I think one essential clinical answer to "how good are these meds?" is to see how they are helping you and to compare the benefits you get with the risks and side effects that come with the treatment. This is the concept of experience-based medicine (which is complementary to evidence-based medicine). I have many patients who feel that meds are essential to their symptom control and well-being, but there are some that do not get such a robust response. There is clearly an individual dimension to treatment response, and we need to understand more about how to best use these treatments for individual people. We still have a lot to learn, but we are on the hunt for better treatments along with the rest of the medical world.

Overuse of Antipsychotic Medications in Children and Teens

Another study tells us that second-generation antipsychotics (SGA) prescriptions are rising rapidly in children and adolescents aged 3-18 who have Medicaid.[2] This is quite concerning, as the side effects of these medicines, such as weight gain and increased risk of diabetes, are particularly acute in children and teenagers. The study noted that the use is rising in children and adolescents with diagnoses such as ADHD or conduct disorder. The authors report that in 2007 (the latest year for which data was available), 50 percent of the prescriptions for SGAs were given to children with ADHD, and one in seven had ADHD as a sole diagnosis. There are no FDA indications for this use. The rate of increase in this population is alarming and calls for a more educated individual who lives with mental illness and for practitioners and policymakers to better understand the practice so that this trend does not continue to accelerate.

1. Leucht et al., *British Journal of Psychiatry*, Feb. 2012.
2. Health Services Research, Sept. 2012.

To put this practice into a clinical perspective, I have not prescribed an antipsychotic medication to a child or teen with ADHD or another condition that is not a core psychotic illness or bipolar disorder. Resorting to medicines in areas that don't have a material research base should be the last choice of strategies, not the first, and if undertaken, it should be done with full knowledge of the parent and the individual taking the medication. I imagine that in times when other strategies have been unsuccessfully tried these interventions might have been worth trying, but this study indicates that these medicines are being used too early and too often.

Approaching a child's behavior or symptoms requires a comprehensive evaluation that looks at all aspects of his or her life: school, family supports and stressors, as well as the family history of psychiatric vulnerability. There are multiple pieces to include in treatment planning to address the child's vulnerabilities that can help a child manage his/her experience or behavior. These include but are not limited to behavioral therapy for ADHD, family and school engagement in multi-systemic therapy (MST), applied behavioral analysis (ABA) for pervasive developmental disorder (PDD), and dialectical behavioral therapy (DBT) for impulsivity and self-harming behavior. The increased use of antipsychotic medications in populations they were not designed for is also a possible commentary on the lack of access people have to non-medication alternatives.

Clinical Tips

We know that psychiatric medicines can be at least moderately effective, and we know that they can be overused as well. What other thoughts might help inform decision-making around their use?

Target the symptoms. Know and identify the symptoms that you are targeting with treatment, such as auditory hallucinations or symptoms of major depression. In many cases, using measurement scales to track the progress of treatment can help inform medicine selection over time.

Know the side effects. Both common and rare side effects should be explained to you when a medicine is being offered so that you can anticipate these effects and in some cases plan for them. Be sure to ask if you are not given this information. SSRI antidepressants commonly impact sexual function, and in people under age 25 they sometimes activate suicidal thoughts. Weight gain and risk of diabetes are common side effects of most of the second-generation antipsychotics. Strategies to combat these side effects can be found at www.nami.org/heartsandminds.

The risks of non-treatment. If you are living with a serious psychiatric illness, remember that opting to not take medicines also comes with risks. People who elect to stop their medicines often run the risk of recurring symptoms and rehospitalization. My philosophy is to work collaboratively with your doctor to see what can be learned from every medication trial and to work toward a plan of care that you can endorse.

Psychosocial treatments. Use of non-medication strategies is crucial for most clinical situations. For people who live with auditory hallucinations, for example, using cognitive behavioral therapy (CBT) strategies to better manage voices has a strong role in ensuring optimal outcomes. In treating bipolar disorder, medicines are often a strong foundation yet they will be more useful if they are combined with managing sleep and stress, getting regular exercise and avoiding drugs and alcohol to reduce recurrence. Meds plus other strategies or services are almost always better than meds alone.

Know the research base. Know whether your medicine is FDA approved or "off label" for your condition. Off-label use is legal and can be a reasonable idea—but it is important for you to understand the often-more-limited research base behind an off-label recommendation. Be sure to ask why the medicine is being recommended. For example, prazocin, an old-fashioned antihypertensive, has a growing body of literature supporting its use in reducing nightmares in people living with PTSD, yet it isn't FDA approved for this use.

Be honest. Review all side effects with your doctor; if you aren't taking your meds, then the doctor and you can work together to understand what side effects are bothering you and to try and attack the issue from another angle. Side effects like weight gain and sexual dysfunction can be important reasons to try alternative strategies.

Engage your loved ones. I have observed that people who involve their loved ones in their care plan do better over time. This is often a great personal challenge, as psychiatric illnesses may activate shame and other uncomfortable feelings. The people who love you want you to do well. Consider bringing them into the situation to see how they can support your recovery.

Stay with it. In many cases, people who do not have a good response to one treatment may do better with another. The STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study revealed that staying with antidepressant treatment could still produce results even after multiple trials of the medicine had already failed. A patient approach isn't easy, to be sure, but it may help to find the right combination of treatments.

For more useful talks and tips from Dr. Duckworth, listen to his podcasts from his "Ask the Doctor" series at www.nami.org/askthedoctor.