PE1627/CC
Fiona French submission of 13 February 2018

1 Robust assessment of harms is needed

At the meeting of the Public Petitions Committee on 18 January, the Minister for Mental Health, Maureen Watt, stressed the importance of early intervention and prevention which is of course the best way to avoid young people with mental health issues being in the situation where medication needs to be prescribed at all. We all welcome greater openness about mental health issues and the reduction of stigma. However, it cannot just be assumed that this has resulted in increased prescribing of antidepressants or that increased prescribing is necessarily a good thing. Research in England has demonstrated that increased prescribing rates are due to patients staying on the drugs for longer rather than more patients coming forward. Without a robust assessment of the harms caused by these drugs, including drug-related suicides, one cannot assume anything about their safety or effectiveness. Yet, Dr Mitchell stated during the discussions for PE01651 that there was no way of knowing how often patients of all ages were seriously harmed by these drugs. Increased prescribing among young people could also of course simply indicate a lack of alternative services available to these patients and their prescribing doctors.

2 Explicit and accurate information is needed about the drugs

Professor David Healy, one of the world's foremost psychopharmacologists and expert in SSRI antidepressants, spoke at a global health conference recently in Aberdeen[1]. He said that, in 29 paediatric clinical trials of antidepressants, every single one failed to produce an obvious benefit. Moreover, "*In every single one of these trials it has produced more harms than benefits in the sense that* ***it has made children become suicidal who wouldn't have become suicidal if they hadn't been put on these drugs***." He also said: "We have a situation where, if you are following the evidence, no-one should be using these drugs. At the same time, in teenagers, these drugs have become the most commonly used drugs."

Dr Jane Morris, consultant psychiatrist, Cornhill Hospital, Aberdeen, spoke on behalf of the Royal College of Psychiatrists. She was astonished at Prof Healy's assessment of the evidence but she did not explain what was wrong with Prof Healy's statements or in what way they were wrong. She expressed the view that antidepressant prescribing is effective and appropriate. And so the listening public was once again left confused, much like the patient in the consulting room when given less than clear information about the drugs they are being advised to consume. What is one to believe and disbelieve? The public and patients alike are not given facts and figures on which they can base an informed decision. They are not presented in such a way that allow for an informed assessment of the benefits and the risks. Why is this information not presented to the public in a format that they can understand it? So how can a young person possibly be expected to make an informed decision when there is such a huge gulf between one set of experts on the one hand and the Royal College of Psychiatry on the other? Which set of opinions will be presented to the young patient in the consulting room? Surely the issue is not the capacity to consent but the quality and accuracy of the information being offered by the prescribing doctor.

3 Antidepressant prescribing is too high

[1] http://www.bbc.co.uk/news/uk-scotland-42917452

The Minister for Mental Health and Dr John Mitchell both asserted that there is no evidence that antidepressants are being prescribed inappropriately by GPs in Scotland. Dr Mitchell said they are being used for the right indications and they are being reviewed. I find this surprising given the research results being reported in England and the recently announced Public Health England year long review of drugs of dependence, including antidepressants. Prof Tony Kendrick, Southampton University, estimates that around 33 - 50% of patients could taper off their antidepressant drugs and avoid future side effects and become more self-reliant[2]. He also says that up to one half of patients could be given an alternative treatment. The Minister however stated that "there is no evidence that people having greater access to psychological therapies will reduce antidepressant prescribing". The views of the Scottish Government seem to be completely at odds with thinking south of the border.

4 Medical training in pharmacology?

There was much discussion about training and education for GPs in mental health, particularly diagnosis of depression. Also the issues around safeguarding and obtaining consent. The Committee discussed GP undergraduate and postgraduate training in psychiatry and opportunities for continuing professional development, as well as the nature of appraisal and revalidation.

I would wish to once again focus on the drugs.

- How much education and training do GPs receive in relation to the drugs they prescribe and the adverse effects of those drugs?

- How much time is spent on pharmacology for example in the undergraduate and postgraduate courses? I understand that time in the undergraduate curriculum for this subject has been reduced as curricular changes have taken place over the years and this has been a cause of considerable concern.

- How much of the information received by prescribing doctors is in fact from the pharmaceutical industry and biased in their favour?

It is now clear from the experiences of patients reported for Petition PE01651, that GPs seem to have limited understanding of the issues of dependence or the need for slow and safe tapering. They often do not recognise the adverse effects of the drugs, assuming that such effects are signs of deteriorating mental health. If there is such limited understanding of the drug effects then they may not be in a position to give patients accurate information in order for informed consent to be obtained. Nor will they be in a position to monitor the patient appropriately after the drug has been prescribed. Young adults should be informed of all the risks associated with these drugs as should adults of all ages. These include of course the risk of dependence and the difficulties of withdrawal.

The issue of safeguarding was then discussed. Young adults who seek help for mental health problems are likely to be anxious or depressed or both. If they have a history of self-harming that would of course ring alarm bells. A young person in these circumstances may well have no intention of taking their own life, but the prescribing of powerful neurotoxic drugs could well propel them towards that very act. And so while it would be the

[2] https://www.southampton.ac.uk/news/2016/07/antidepressent-study-kendrick.page

case that the young person has the capacity to give consent, at the same time that young person may have little idea of what might lie ahead. It is one thing to be told that a drug might have a particular effect, it is quite another to experience it. The experience may bear no resemblance to the expectations of the patient. Rational thought may no longer be possible. This of course can happen to patients of any age after being prescribed antidepressants. Even with regular reviews, the GP may not be able to prevent a patient's suicide. If family members or other trusted adults are fully involved that should lessen the risks but even then that may not be sufficient. It is crucial that GPs therefore understand the harmful and dangerous effects of these drugs for patients of all ages and that they clearly warn patients about these and any family members or trusted adults who are involved in that decision-making process for young adults.

5 NICE Guidelines on depression

Dr Mitchell referred to the NICE guidelines on depression, last revised in 2016. I was recently made aware of these guidelines by Dr Philip Gaskill, GP but with respect to the section on antidepressant withdrawal. There are about two pages on this subject. I checked every research reference on which the advice was based and to my astonishment discovered that the studies are short term studies when in practice patients are on these drugs for many years or even decades. Clearly there has been no attempt to revise them with respect to withdrawal. I cannot of course comment on the rest of the document but I would ask again what exactly is known about these drugs and in particular what do GPs know about them? if GPs follow the tapering guidance in this document they may well put patients at risk but they will be legally covered because they had followed the guidelines. In my case, after a catastrophic withdrawal from a benzodiazepine, my GPs main concerns were to deny all knowledge or understanding of what had happened to me. Antidepressants have been on the market for decades and the tapering guidelines have never been revised to take account of the length of time patients are being kept on these drugs.

6 Written consent forms

Perhaps a written consent form is needed for the prescribing of mental health drugs whether they are prescribed for a physical or a mental health problem. Patients could be provided with a detailed information sheet about the perceived benefits and known risks of these drugs and this would ensure every patient receives hopefully accurate and unbiased information and is not dependent on what may be the partial knowledge of the prescribing doctor. The quality of the information would require honesty on the part of those compiling the document. There is no point in medical experts providing conflicting opinions if they do not explain exactly what they are talking about and why their opinions differ. The patient could take that information sheet away with them, reflect on it, discuss it with family members if they so choose before the drug is prescribed. As these drugs are not to be prescribed as a first line of treatment for young adults, consent would not normally be required at first consultation. Perhaps a trusted adult could be involved in the consent process with the agreement of the young adult. If the young adult does not wish anyone else to be involved then this could be documented and it would be clear that they young adult is likely to be at greater risk as a result. If the risk is high, then of course confidentiality would have to be breached.

The reason this petition was brought was the tragic death by suicide of Annette Mackenzie's daughter, Britney. The central issue was that of informed consent and the prescribing of powerful anti-anxiety drugs at first consultation. Even if Britney had not been prescribed them at first consultation but had returned for further consultations, the risks of tak-

ing the drugs would have been the same. The risks of the drugs have to be properly communicated to patients of whatever age and at whatever stage of the consultation process they happen to be prescribed. it is assumed that the prescribing doctor will be aware of those risks but perhaps we should not take that for granted. Was Britney informed that propranolol has been associated with many suicides? Did the trainee GP in question know that this was the case? Had Britney been informed that this was one of the risks associated with this particular drug, perhaps she would have been better placed to understand what was happening to her. Instead, the outcome was that the trainee GP had acted as any other doctor would do in similar circumstances. This surely does not bode well for other young patients seeking help for anxiety or depression. An information sheet would ensure that any known risks are presented and presented consistently. Written consent would ensure that there is documentary evidence that the process of informed consent has indeed taken place and this would protect the prescribing doctor in the event of a subsequent death or other adverse event.