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Debate: Is the long term use of psychiatric drugs harmful?

The controversial topic will be discussed by leading experts at the Maudsley Debate, King's College London

The benefits of psychiatric drugs have been exaggerated and the harms underplayed due to poor trial designs, argues one expert in **The BMJ**. But another expert and a patient contend that the evidence supports the use of these drugs.

More than half a million people aged above 65 years die from the use of psychiatric drugs every year in the Western world and the benefits would need to be "colossal" to justify these "immensely harmful" treatments, argues Peter Gøtzsche, professor and director of the Nordic Cochrane Centre, Denmark.

But benefits are "minimal", he explains, adding that these treatments should "almost exclusively be used in acute situations". New guidelines should support this change as well as widespread withdrawal clinics to help many patients gradually come off these medications.

Benefits have been overemphasised and harms understated, he says, because randomised controlled trials have been biased, not blinded appropriately, have not fully evaluated the effects of these drugs and deaths have gone under reported.

For example, the majority of studies have included patients already using a psychiatric drug and such patients may undergo abstinence and suffer from withdrawal symptoms. As a result, this study design exaggerates benefits and increases harms, and has even driven some patients to suicide, he explains.

Industry funded trials have under reported deaths, he adds, estimating that there have probably been 15 times more suicides among people taking antidepressants than reported by the US Food and Drug Administration (FDA).

He calculates that deaths from three classes of drugs – antipsychotics, benzodiazepines and similar drugs, and antidepressants were responsible for 3693 deaths every year in Denmark. This number corresponds to 539,000 deaths in the United States and European Union combined.

The effects of psychiatric drugs are so small, he says, and that it would be possible to lower current use by 98%. He recommends stopping the use of all antidepressant, ADHD and dementia drugs, and prescribing only 6% of antipsychotics and benzodiazepines.

But Allan H Young, a professor of mood disorders at King's College London, and John Crace, a psychiatric patient, argue that research supports the use of psychiatric drugs which are just as beneficial and efficacious as treatments for other common, complex conditions.

These drugs are needed, they insist, to reduce the long term harms of psychiatric conditions, which are the fifth leading cause of disability worldwide. Most patients suffer from co-existing health conditions, they add, a primary cause of death among this group.

They explain that psychiatric drugs are rigorously examined for efficacy and safety and while the evidence base is “imperfect”, research shows that psychiatric drugs are more beneficial than harmful.

Careful evaluation of these drugs is undertaken before and after regulatory approval, they explain, and that post surveillance after a drug is licensed can include safety of a medication in the general population, which unlike study populations, includes people with varied medical conditions.

Yet concerns persist and many are “overinflated”, they add, and list recent studies supporting the use of lithium, once labelled a "toxic placebo", and antipsychotics, and treatments for mood disorders.

But as with any drug treatment, the harms and benefits need to be evaluated from group data in trials, and be applied to individual patients whose subjective experiences are important to consider, they argue.

[Ends]

Notes to Editors:

The authors are taking part in the 52nd Maudsley debate to be held at King's College London on 13 May.

Personal View: Does long term use of psychiatric drugs cause more harm than good?

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Head To Head Maudsley Debate

Does long term use of psychiatric drugs cause more harm than good?

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Re: Does long term use of psychiatric drugs cause more harm than good?

We are a group of Cochrane editors who are responsible for the Cochrane Reviews that relate to mental health. Like Peter Gøtzsche we are writing in our personal capacity. Cochrane does not, and should not, have an agreed policy on the prescribing of psychotropic medicines.

We recognise that Peter has an important record as a renowned methodologist studying questions of bias, and as a researcher conducting systematic reviews. Therefore his interpretation of the evidence commands respect. However, we are concerned that in this article he steps beyond the accepted role of an independent researcher by appearing to recommend a course of action, and that this could, if acted upon, lead to patient harm.

We agree with Peter that the benefits of psychotropic drugs have long been exaggerated, or that harms (including suicide) have been underestimated. Peter is one of the many researchers that deserve credit for uncovering how the effects of bias, most notably selective outcome reporting, have created this distorted picture. We also agree that such overly optimistic interpretations lead to patient harm.

Despite this we make the following observations:

- The motion of the debate refers to “long term” use of psychiatric drugs, however Peter’s article appears to consider all use. This should have been clarified in the article, and failing to distinguish between short-, medium and long-term use for different types of patients does not facilitate the reader’s understanding.
- Psychotropic drugs and the patients for whom they are prescribed differ widely. Treating them as a homogenous whole is not helpful within such a concise article, given that there will be very different benefits and harms in different populations and with different drugs.
- The central argument Peter makes – that 98% of psychotropic drugs could be stopped without causing harm – is potentially damaging to patient well being, and is not justified within the article. In many cases the citations provided lead either to his own unpublished book or those of others, rather than scientific study reports. Thus it is hard or impossible for the reader to check their veracity.
- The data on suicide related to the use of antidepressants are central to Peter’s argument, and yet the only citation is to his own unpublished book. It is unclear in this section whether the figures presented relate to total suicides in the studies, total suicides in those taking antidepressants, or additional suicides in people taking antidepressants compared with those not taking them. This is an important distinction, and gets to the

heart of how many of these suicides can be attributed to the antidepressants. The same is true for the estimates of total deaths: the data as presented are simply insufficient to justify the confident conclusions and precise estimates reported.

- In the Cochrane Review cited (tricyclic antidepressants versus active placebo), Peter merely states that the “review did not find any meaningful effect”. This over simplifies the findings of the review, which is now substantially out of date, identified scarce and heterogeneous data from old studies and led the authors to describe their findings as uncertain or “tentative”.

In summary, we are concerned that the picture painted by Professor Gøtzsche may be a partial one, and that the extreme recommendations he makes based on his interpretation of the published research are inappropriate, and insufficiently justified by the scientific literature presented, to guide decision making in practice or health policy.

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Re: Does long term use of psychiatric drugs cause more harm than good?

Four of my Cochrane colleagues, the editor-in-chief and the editors responsible for reviews of antidepressants, antipsychotics and ADHD drugs, agree with me that the benefits of psychotropic drugs are exaggerated and the harms (including suicide) underestimated (1).

They are concerned, however, that my recommendation that we only need 2% of the drugs we currently use (1,2) could lead to patient harm. As they didn't explain how, this is a remarkably evidence-free postulate, particularly considering that I documented that psychiatric drugs kill more than half a million people every year in the United States and Europe (1,2). My recommendations would lead to healthier and more long lived populations and would spare tens of millions of people from becoming mentally crippled (2).

The Cochrane editors say that my recommendations are based on inappropriate interpretation of the published research and lament that some of my references are to my upcoming book. As they haven't read my book, they cannot know whether my interpretation of the science is appropriate. My book is evidence-based and has hundreds of relevant references.

The Cochrane editors are concerned that I step "beyond the accepted role of an independent researcher by appearing to recommend a course of action." I disagree vehemently. When doctors see harm on a massive scale, they have a duty to inform the public about it, and if they can suggest a solution, it is even better. It appears to me that by their non-evidence based attack on the messenger, the Cochrane editors protect psychiatry's guild interests rather than the patients.

The Cochrane editors say they cannot see what my estimates for total deaths and suicides refer to. However, I did use the term excess deaths (1). I also made the suicides clear: "there are likely to have been 15 times more suicides among people taking antidepressants than reported by the FDA" (1). I have several references for this estimate in my book and the studies are remarkably consistent (2). Here is one revealing observation (2). Thomas Laughren was responsible for the FDA's huge meta-analysis of the randomised trials, which reported only 5 suicides in 52,960 patients on SSRIs, or one per 10,000 (3). Five years earlier, Laughren reported on 22 suicides in 22,062 patients randomised to antidepressants using FDA data, which is 10 per 10,000 (4), or 10 times as many as he reported five years later! There were only 2 suicides in 8,692 patients on placebo (4), which Laughren interpreted thus: "There is obviously no suggestion of an excess suicide risk in placebo-treated patients." No, but why didn't Laughren comment on the fact that flies in the face, namely that there were four times as many suicides on antidepressants as on placebo, which was statistically significant ($P = 0.03$, my calculation)? When Laughren left the FDA, he established the Laughren Psychopharm Consulting with himself as director to help the drug industry with getting their drugs approved (2).

What I get out of the colossal underreporting is that SSRIs likely increase suicides in all ages. It is remarkable that it is so subjective how many suicides there are and also that several major drug companies have cheated with their reporting of suicides and suicide attempts (2). I doubt SSRIs are safe at any age, and they kill very many elderly patients by falls and hip fractures (2,6).

In contrast to what the Cochrane editors say, the Cochrane review of tricyclic antidepressants versus an active placebo containing atropine is not substantially out of date (7). It is from 2004, but according to Cochrane routines that doesn't make it out of date if no new relevant trials have been published, which is highly unlikely. The newest of the 9 included trials is from 1984. The drug industry doesn't use active placebos because then the whole world could see that the emperor has no clothes. It is also misleading when the editors say that the authors described their findings cautiously. Evidence-based medicine is about using the best available evidence, and this review is the most reliable evidence we have about the effect of antidepressant drugs (1,2). It didn't find any effect (1,2).

My interpretation of the science is shared by the patients who disagree strongly with the psychiatrists about psychiatric drugs, which they intensely dislike (2). It is telling that in meta-analyses of depression trials, both in children and in adults, the psychiatrists found effect sizes between 0.25 and 0.29 whereas there was no effect when the patients were asked (effect sizes 0.05 and 0.06) (2,8-10).

Surveys are similarly revealing. Although the psychiatrists deny it is a problem (2), about half the patients on antidepressants feel that the drugs change their personality (11,12). And in a large survey of 2,031 citizens from 1995, people thought that antidepressants, antipsychotics, electroshock and admission to a psychiatric ward were more often harmful than beneficial (13).

So whom should we believe? The psychiatrists who are often on industry payroll and know that if they report favourable results, they will be asked again? Or the patients?

The Cochrane editors think that my recommendations are extreme. I write about being extreme in my book: "Usually, people who are extreme are few in number but in this case, it is the vast majority of psychiatrists that are extreme. It is truly extreme that psychiatrists have built their specialty on a number of myths, lies and highly flawed research, which have harmed our nations to the extent we have seen. Marcia Angell [previously editor-in-chief of the New England Journal of Medicine] has noted that psychiatrists should consider that other medical specialists, unlike psychiatrists, would be very reluctant to offer long-term symptomatic treatment without knowing what lies behind the symptoms, e.g. if a patient suffers from nausea or headache" (2).

Stopping psychiatric drugs abruptly is dangerous, as it can lead to suicide and homicide because of withdrawal akathisia (2). We need widespread withdrawal clinics because many patients have become dependent on psychiatric drugs, including antidepressants, and need help to stop taking them slowly and safely (1).

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