WHAT INFLUENCES HAVE LED TO INCREASED PRESCRIBING OF PSYCHOTROPIC DRUGS?

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The treatment of psychiatric disorders has been revolutionised during the past 20 years by the introduction of new and effective psychotropic drugs. These drugs have increased the involvement of general practitioners in the treatment of such disorders. Meanwhile concepts and criticism of their use have changed in recent years.

Trends in psychotropic drug prescribing

Psychotropic drugs currently account for just under one in five of all prescriptions dispensed by chemists under the National Health Service. They form the largest single group of drugs prescribed in terms of both number of prescriptions and cost. In 1971, 47·8 million prescriptions for psychotropic drugs were dispensed by NHS pharmacists in England and Wales.

These prescriptions, issued by general practitioners, represent about 3,000 million tablets or capsules, about 60 million every week. Overall from 1961 to 1971 there was a 48·8 per cent increase in prescriptions for these drugs. Analysis shows that 41 per cent of psychotropic drugs dispensed in 1971 were hypnotics, 38 per cent tranquillisers, 15 per cent antidepressants and six per cent stimulants and appetite suppressants.

From 1965 to 1971 there was a 32 per cent decrease in the prescribing of barbiturate hypnotics and a 43 per cent decrease in the prescribing of stimulants and appetite suppressants. The prescribing of non-barbiturate hypnotics increased by 166 per cent, tranquillisers by 70 per cent and antidepressants by 103 per cent.

Three proprietary minor tranquillisers: ' Librium ' (chlordiazepoxide), ' Valium ' (diazepam) and ' Mogadon ' (nitrazepam) made a significant contribution to the overall increase in psychotropic drug prescribing. These drugs are benzodiazepines, produce similar effects, and are manufactured and marketed by the same company.

This information suggests both distinctive trends in the type of psychotropic drug prescribed and a steady increase in their prescription. What influences then have led to their increased use: doctors, patients, the pharmaceutical industry or government? All are dependent on each other. In accounting for each influence, the other influences must be considered in order to make the trends intelligible.

Doctors

Major tranquillisers and antidepressant drugs represent important advances in psychopharmaco-therapeutics. If used responsibly and appropriately they are effective in relieving the psychotic or depressed patient of symptoms which interfere with his capacity to cope with his everyday existence. The efficacy of some of them is an obvious cause for their increased use, although many of them appear to be prescribed without sufficient indication, in inadequate dosage and for too short a time to be of any real therapeutic value.

However, the increased prescribing of minor tranquillisers and some hypnotics is much more difficult to explain, particularly in the absence of any data from randomised clinical trials about their efficacy. Admittedly the benzodiazepine drugs are reasonably free from abuse potential and are safe when taken in overdose. But are such criteria sufficient to explain the issuing of about 15 million prescriptions in 1971?

Further, many prescribed preparations do not represent any advance in efficacy.

Some are combination products and others are slow-release preparations. Most contain standard drugs in various strengths and mixtures.

The contemporary trend of increasing prescription of psychotropic drugs suggests that doctors are using these drugs in order to accomplish the regulation of personal and interpersonal processes. As Lennard states, " When a physician prescribes a drug for the control or solution or both of personal problems of living, he does more than merely relieve the discomfort caused by the problem. He simultaneously communicates a model for an acceptable and useful way of dealing with personal and interpersonal problems."

Should the implications of this model and its long-term effects concern us? Few would question the selected use of psychotropic drugs, but many must question the widespread use of some of them, particularly the hypnotics, minor tranquillisers and appetite suppressants. Admittedly, it is difficult to assess current needs for mental health, yet in society today insomnia, anxiety, and depression are common symptoms of stress. Many patients with such symptoms are now prescribed psychotropic drugs and we must ask whether this is appropriate therapy.

It appears that symptomatic therapy has increased and this may be related amongst other things to changes in the patterns of disease. As morbidity and mortality from infectious diseases and physical deprivation decrease, so social and mental problems have become exposed. It seems from work on the changing patterns of disease, particularly emotional disorders, that common conditions now have an insidious onset and episodic course. Many patients with such disorders will present what appear as ' minor ' symptoms over time and yet attendances will be frequent. It is with such patients that recourse to ' symptom ' therapy may occur, especially the use of psychotropic drugs. This is all the more important as there is no evidence that general practitioners are seeing more patients. On the contrary there is some evidence that during the past decade the number of patient-doctor contacts have remained the same or decreased (Royal College of General Practitioners (1970). *Reports from General Practice No. 13, Present State and Future Needs of General Practice*).

In addition to a suspected increase in symptomatic therapy there is evidence that the number of patients on psychotropic drugs increases with age and this is in part due to an increasing number of patients on long-term drug therapy (Adams *et al.*, 1966; Johnson and Clift, 1968; Balint *et al.*, 1970; Parish, 1971).

There is also a relationship between long-term psychotropic drug-taking and indirect methods of obtaining repeat prescriptions, i.e. without seeing the doctor (Parish, 1971; Balint *et al.*, 1970; Dunnell and Cartwright, 1972). Some practices fail to keep records of prescriptions issued and others do not record repeat prescriptions. Further the general completeness of prescription data is often deficient (Parish, 1971; Dawes, 1972). In taking drugs of dependence patients will seldom complain of ' reliance.' They will try to obtain further supplies by indirect methods if possible.

Thus the increasing use of psychotropic drugs with advancing age, the ease of obtaining repeat prescriptions and the increasing numbers of long-term drug takers contributes to the annual increase in psychotropic drug prescriptions.

Most doctors in practice today have had no formal training in learning to manage the burden of mental disorders and common anxieties which exist in the community. Further, currently marketed psychotropic drugs were either unknown or unavailable when more than half the general practitioners of this country were receiving their training in medical schools. Rapid advances in pharmacology and therapeutics outdate much of what has been taught soon after graduation. Yet medical schools do not appear to recognise their responsibility in this field.

On entering general practice the young doctor, knowingly or unknowingly, becomes the critical link between manufacturer and patient. He becomes a key figure in drug

marketing strategy. He must be able to choose from a very large number of competitive products which are often duplicated. He must deal with a large amount of advice on drug prescribing, biased and unbiased, from medical representatives, advertisements and other forms of sales promotion. Against all these pressures it is assumed that he has the training, time and experience to evaluate the evidence available and to make a rational and responsible selection.

Admittedly, in recent years there has been a rapid expansion of the facilities available to general practitioners for postgraduate medical education. For example, during the 1970–71 academic year, 55,587 attendances were made by 16,195 doctors at 2,349 grant-aided courses. But there were only 27 programmes devoted to therapeutics attended by 672 doctors. Attendances numbered 3,645 at 341 recognised courses yet only four of these courses were devoted to therapeutics at which 164 doctors were present. *Therapeutics is still neglected as a subject.*

Patients

This century has seen swings of fashion for various psychotropic drug ' treatments.' In the 1930s bromides gave way to barbiturates and sedation became acceptable and expected under exposure to stressful situations. This continued up to the late 1940s, when the ' pep ' pill became fashionable; the 1950s was the decade of ' pep.'

Towards the end of the 1950s the word ' sedative ' was beginning to lose its mystique and the term ' tranquilliser' was substituted. This proved an immediate success and the 1960s was the decade of the tranquillisers.

However, during this period a ' new ' disorder became recognised and labelled—that of ' depression '. This coincided with the introduction of antidepressant drugs and slowly by the end of the 1960s these drugs started to compete for status with the successful tranquillisers. The beginning of the 1970s has seen the introduction of drugs with combined anti-anxiety and antidepressive ' properties ' and it will be interesting to observe a further change of fashion.

It appears that as one drug falls ' out of fashion ' it is quickly replaced by a ' new ' drug which, on introduction, is widely acclaimed and prescribed. Subsequent experience leads from initial optimism to more cautious appraisals and the realisation that the ' new ' drug shares some of the disadvantages of the drug it has replaced and may also be shown in the course of time to possess additional ones.

Prescribing ' fashions ' influence patients' expectations which subsequently determine the ' fashions ' of society. Sometimes society demands a particular drug therapy, e.g. oral contraceptives and, at other times, it may show concern about the use of drugs, e.g. amphetamines. However, both the medical profession and society are exposed to the influences of the pharmaceutical industries who appear to be " redefining and relabelling as medical problems calling for drug intervention, a wide range of human behaviour which, in the past, has been viewed as falling within the bounds of the normal trials and tribulations of human existence" (Lennard *et al.*, 1971). Much evidence for Lennard's observations can be found in drug advertisements to doctors, particularly those about minor tranquillisers. Normal problems and conflicts of status change, marital relationships, social relationships and so on are re-labelled as medical-psychiatric problems and as such are described in sales promotion literature as suitable indications for the use of these drugs.

Pharmaceutical industry

The Association of British Parmaceutical Industries (ABPI) has 109 member companies and they account for 95 per cent of the sales of human and veterinary prescription medicines. Seventy of these are large international research-based companies operating in the United Kingdom and responsible for the majority of ethical product sales.

The value of sales in the principal markets in 1970 were: £163 million from the NHS; £140 million from exports and £96 million from sales of household medicines. The cost of the total NHS in England for 1969–70 was £1,651 million of which about ten per cent (£163 million) went on executive-council pharmaceutical services. The proportion has remained fairly stable over the past decade and represents about one half of one per cent of the gross national income. Research and development expenditure by the British Pharmaceutical Industries was £22 million in 1970 (ABPI *Annual Report*, 1970).

The Association maintains an active and continuous programme of public relations. Outside the industry it circulates the *ABPI News* and in 1970 distributed such publications as *Medicines that protect us* and *The Pharmaceutical Industry and the Nation's Health*. The Association is also seeking ways of ensuring that medical students are likewise aware of the availability of information of this kind. It makes full use of press and broadcasting and provides a speaker's service to Rotary clubs and business groups.

It organises symposia, and in May, 1968, established a Medical-Pharmaceutical Forum comprising as founder members 13 Royal Colleges and ' other eminent organisations of the medical profession.' It also supports the Office of Health Economics (OHE) which publishes a series of papers about health problems, special studies and early diagnosis (ABPI *Annual Report*, 1970).

The Association is therefore active in the fields of industry, government, news-media and professions. Thus, when it is also taken into consideration that clinical trials of drugs are sponsored and that ' official ' journals rely heavily upon revenue obtained from drug advertising, it is difficult to determine how unbiased assessment of a drug is possible, particularly under the pressures of day-to-day clinical practice.

Sales promotion in the pharmaceutical industry has two functions: one is the directly commercial one of selling each firm's products and the other that of informing doctors about new medicines and developments in therapeutics.

It is estimated that British and foreign firms operating in the United Kingdom spend about 14 per cent of their gross income from sales of NHS products on promotion of sales. This is less than in other European countries and the United States where it is estimated to be 20 per cent of gross sales of ethical products (OHE, 1972).

Mailings of drug notices and advertisements are numerous and all the most widely read professional journals carry advertisements of pharmaceutical products. In addition there are many journals and newspapers with controlled circulation (including drug compendia such as *MIMS*), sent free to prescribing doctors and supported entirely by drug advertising.

Medical representatives

However, medical representatives remain the best and most effective means of producing a sale or prescription. They have a two-way role, not only do they inform doctors about their firm's products, but they also feed back information to the company about the doctors and their responses to these products. In addition to visiting general practitioners they also visit hospital consultants and retail pharmacists.

There are about 3,500 medical representatives in the field (about one to every seven general-practitioner principals) backed by sales and market research departments which employ medical advisers and use market research companies to carry out field work on doctors' prescribing and attitudes.

The typical medical representative is highly trained. He undergoes a three-month initial training programme and then one week's refresher course each year. He attends major sales meetings quarterly which usually last about two days. Each month he

meets members of his senior sales staff and colleagues for follow-up basic discussions on the marketing of his firm's products.

At the end of each quarter he is briefed and supplied with data and literature for the following quarter's sales promotion drive. This includes market information on the firm's products and competitors, market strategy, application of this strategy, detailed plans and special advertising schedules. He is told about the journals in which his firm's products will be advertised and he is given data prepared by various market research companies.

He sorts his doctors into various categories, such as 'innovators,' 'receptives' and so on. When visiting general practitioners he may discuss the prescribing of local consultants and when visiting retail pharmacists he may discuss prescribing of local general practitioners. He distributes small gifts and samples and organises local lunches, dinners and film shows at which the firm's products are displayed.

Educational services

Pharmaceutical companies also organise postgraduate meetings at national and regional level. They help to meet the cost of printing programmes, reports and invitations for hospital and general-practitioner functions. These activities have increased in recent years and although some companies provide excellent educational services it ought not to be forgotten that drug firms are in business to sell drugs and many of these 'educational facilities' are referred to by the industry as 'below the line.'

Sales promotion

Sales promotion unquestionably plays a major part in inducing doctors to prescribe new products and it is therefore an important feature in the competition between the various companies to sell their products. Market research by these companies is highly sophisticated and a recent seminar on the marketing of pharmaceutical products gives some indication of the levels of study.

For example there were papers on: An experiment in typography; Evaluating the physician productivity classifications through the use of syndicated audit services; Segmentation of doctors—a case study; Segmentation of doctors' types; The development of a technique for measuring the reactions of general practitioners to marketing prices and journal advertisements; Advertising, promotion and medical detailing; Measuring the determinants of prescribing behaviour amongst doctors; A simulation model of doctors' prescribing; The differing promotional requirements of consultants, hospital doctors and general practitioners (ESOMAR, 1970).

As Sainsbury (1965) stated, "In view of the large sums which companies spend on promotion it is apparent that they believe it has a considerable effect upon doctors' prescribing." What the Sainsbury Committee did not report on was the cost of market research in addition to sales promotion.

Drug companies at present are the main source of therapeutic information and are responsible for the diffusion of this information to the prescribing doctor. To bring a new product to his notice now requires all the skills of contemporary marketing and it is therefore reasonable to hypothesise that sales promotion exercises the greatest influence upon new drug innovation and adoption.

Government

Throughout the existence of the National Health Service there has been a widely held opinion that in some degree the service was being abused by patients. It is often suggested that the ready availability of drugs and services has created the increased demand.

If the existence of the National Health Service did play as large a part in prescribing

as some claim, then it could be predicted that in countries where there is no National Health Service the prescribing rates might be less. Information about prescribing in other countries suggests otherwise. Parry (1968) presented evidence from two surveys of national samples which suggest that about one of four US adults used one or more kinds of psychotropic drugs. Nearly half the US population reported the use of psychotropic drugs at some time. According to Parry the cumulative use of tranquillisers over a decade has shown a steady increase—from about seven per cent of the population in 1957 to about 27 per cent of the population in 1967. A further report from the US (Freyhan, 1971) indicates that one third of adults in the US are prescribed tranquillisers each year and that the prescribing of psychotropic drugs has doubled during the past four years.

In Sweden too, the prescribing of such drugs has increased threefold in the past ten years (Westherholm, 1971). Also in 1971 Cooperstock and Sims found that prescriptions for psychotropic drugs accounted for one in four of all prescriptions dispensed in a Canadian non-hospitalised population.

These and other data show no evidence to support the suggestion that the National Health Service is responsible for the escalation in psychotropic drug prescribing. Rather there appear to be international influences, not the least of which is sales promotion by the international pharmaceutical industries.

In terms of human welfare, drugs impose important responsibilities on the pharmaceutical industry and upon government. These responsibilities go well beyond the accountability of expenditure of public funds.

The cost of a nation's ill health can be measured in terms of morbidity rates, mortality rates, duration of illness, time off work, loss of production, cost of National Insurance benefits, cost of hospitalisation and many other indices.

The cost of the pharmaceutical services is therefore a small fraction of the overall expenditure involved in the process of caring yet because this cost is easily identifiable, it has been subjected to much investigation and legislation. These have resulted in directing the Department of Health and Social Security's measures towards economic prescribing. Since public money is involved, the Government would be accused of failing to carry out its duty if it did not try to identify and investigate these factors, even though some will argue that the total economic benefit from the ' therapeutic revolution ' far exceeds its cost.

Government attempts to control costs

The Department of Health and Social Security attempts to control and restrain costs and general practitioners' prescribing by four main procedures:

(*i*) *Controls on drugs prescribed*

Under the National Health Insurance Scheme which was introduced in 1912 doctors were precluded from prescribing preparations which were not drugs and a *National Formulary* was issued to them. Since 1948, much of the action taken to control the cost of drugs to the NHS has been based on measures adopted under this earlier scheme. Most of these measures are aimed at persuading doctors to prescribe standard preparations and various Standing Joint Committees have been in operation since 1948 to advise on the classification of proprietary preparations.

(*ii*) *Controls on an individual doctor's prescribing*

The prescribing investigation research unit of the Department identifies high cost prescribers. The arbitary definition of high cost for this purpose is an average cost per person of 1·25 times the average for all doctors in the executive council area in which the doctor practises.

If a doctor is found to be a high-cost prescriber he is selected for further investigation of his prescribing costs. These analyses are examined by a Senior Medical Officer (SMO) and if he considers that the analysis suggests matters that merit discussion from a medical point of view, a Regional Medical Officer (RMO) is asked to visit the doctor informally. About 1,500 of these detailed analyses are prepared each year and in 1970 regional medical officers undertook 4,768 informal prescribing visits.

If the doctor continues to be a high cost prescriber he is again visited on an informal basis by an SMO and if after these steps the doctor continues to prescribe in excess of what appears to be reasonable for the treatment of his patients, he is visited formally by an SMO who may refer the doctor to the local medical committee of the executive council in which he practises.

If the committee finds that excessive prescribing has occurred, subject to the doctor's right of appeal, the Department may direct the executive council to withhold an appropriate amount of remuneration. On average, less than five such cases in England and Wales are investigated by local medical committees each year. The number has dropped markedly in the past few years.

(*iii*) *Informative publications*

Throughout the period of the NHS a number of publications have been distributed by the Department. These include the *British National Formulary* (published jointly by the British Medical Association and the Pharmaceutical Press); *Prescribers' Journal*, (an 'independent' journal compiled by a representative committee of management supported by an advisory panel drawn from medical schools, The Royal College of General Practitioners, the Pharmaceutical Society and the Department of Health and Social Security); lists of approved drugs; histograms on comparative costs; drug tariffs and executive council notes.

(*iv*) *Controls and restraints on prices*

The cost of medicines has been a matter of concern since the very early days of the National Health Service and Ministers have been conscious of a need to ensure that prices are no higher than is fair and reasonable. Attempts have been made to control the price of drugs and to restrain the cost of prescriptions by the introduction of prescription charges.

(*a*) *The price of drugs.* Negotiations between the Department and the industry have included various voluntary price regulation schemes. Compulsory powers for regulating prices have also been enacted and Acts related to patents have been applied in an endeavour to secure medicines at the lowest prices consistent with the patentees deriving a reasonable advantage from their patent rights. These patent rights last up to 16 years.

(*b*) *Prescription charges.* When the NHS was inaugurated in 1948 there was no charge for prescriptions issued to NHS patients. In 1952 the Government decided to exercise powers given under the NHS (Amendment) Act, 1949 (Section 16) to impose charges for prescriptions issued under general pharmaceutical services. The object of the charges was not only to reduce the net cost to the Exchequer directly by the amount of the charges paid by patients, but also indirectly to 'discourage demands on doctors for remedies which patients might reasonably be expected to buy for themselves.'

A shilling charge was introduced in June 1952 in respect of each NHS prescription form dispensed, regardless of the number of prescription items on the form. On 1 December 1956, a shilling became payable on each item supplied irrespective of the number of prescription items per form. In March 1961 this was increased to two shillings per item. This charge remained until February 1965 when all charges were abolished.

In June 1968 a charge of two shillings and six pence was introduced per item with exemptions for children aged under 15 years, patients aged 65 or over, pregnant women and certain approved chronic illnesses or disabilities. The item charge was increased to four shillings (20p) in April 1971.

Discussion

Drugs are developed, manufactured, promoted and supplied by the pharmaceutical industry; they are prescribed by doctors; dispensed by pharmacists; consumed by patients and through the National Health Service they are paid for by the taxpayer. The Department of Health and Social Security acts for the Government in attempting to control the cost to the National Health Service of the pharmaceutical services.

Each agency is interdependent and the critical link between them is the prescribing doctor, for it is he who ' puts pen to paper.' He is the final common pathway of patients' expectations, society's demands, industry's promotion, pharmacists' livelihood and the Government's concern.

The pharmaceutical industry exercises all the skills of contemporary marketing and although many would criticise the ' standards ' of some of its methods, has not the medical profession received what it has deserved? The standards of many non-subscribed journals and newspapers, mailed literature and ' hand-outs ' are very low.

Further, is it not surprising how highly receptive to the idea of payment some general practitioners are? For token re-imbursements they seem to co-operate with any market research company who cares to masquerade under a quasi-scientific name. If the prescribing doctor were more discerning in his demands would not the industry improve its methods to meet these demands?

The pharmaceutical industry is responsible for the way its products are promoted and in so doing it oftens defines and re-defines indications for the use of drugs and so, not only has the industry influenced treatment, it has influenced diagnosis. It is possible to argue that the cost of these treatments is high, profits are high, that there are restrictive practices, that patents last too long and that there is much duplication of product marketing.

It is also possible to argue that unbiased therapeutic data are difficult to obtain and that the prescribing doctor is a ' manipulated ' agent between producer and consumer. Yet the doctor at the point in the patient-doctor transaction when he issues a prescription is acting of his ' own volition.' If his training has been insufficient to equip him for this role then does not the responsibility lie with his ' educators ' and not, as it does at present, with the pharmaceutical industry? What of the future? The profession, industry, government, pharmacists, politicians and patients should start continuing discussions in order to develop rational policies and responsible prescribing. But this is unlikely to happen until patients are made more aware of rational therapy and become more critical of drug treatments.

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DISCUSSION

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There has been too much talk about labels and not enough about people. General practice is about people and it is our duty as general practitioners to discharge our care of people with compassion. To do this we must relieve pain and suffering, which involves us in the responsible use of drugs. Mental symptoms are just as painful as physical symptoms. Therefore, it is just as rational to use psychotropic drugs to relieve these symptoms as it is to prescribe analgesics for physical pain. Provided of course, that we realise we are only relieving symptoms and not curing the disorder.

However, if we are helping our patients to cope with their everyday existence, then we are right to do this; we are right to provide sleep for the patient who cannot sleep, we are right to calm the tense and lift the depressed. We are right when we rid the patient's mind of distressing feelings. We are right to use drugs to produce these effects, because we stop the patient suffering and we also help his relatives. Having done these things, we must then not forget to treat the patient, we must not forget that our treatment is purely symptomatic. We must, therefore, offer support, encouragement and understanding. We must help the patient once his symptoms are lifted to rationalise his situation and help him, if we can, to sort himself out.

We must, however, know our limitations and if we are unable to understand the complexities of psychological illness, then we can still offer the patient relief from his mental pains. We must understand that in most cases we cannot alter the unalterable, but does this preclude us from the judicious use of drugs? However, in the use of drugs, we must be responsible, we must give the most appropriate drug, in appropriate dosage for an appropriate length of time. We must use the safest and most effective drug we know; this demands detailed knowledge.

Some of the drugs we use are highly effective in relieving mental suffering, particularly the antidepressants and neuroleptics. Unfortunately, these drugs are not always used when they should be and often they are not used appropriately. Other psychotropic drugs, often of unproven value in relieving undefined disorders, are prescribed liberally and over long periods of time to patients who may not benefit from such therapy. These drugs produce dependence and are often taken long after the initial episode of mental stress is passed. It is in the prescribing of these drugs that many doctors appear irresponsible and yet it is difficult to criticise them because of the pressures applied to them to prescribe such drugs. In 1971, in order to make patients feel happy, keep calm, sleep or slim, about 3,000,000,000 tablets or capsules of psychotropic drugs were prescribed by general practitioners in England and Wales. It is time therefore,