Why do GPs prescribe psychotropic drugs when they would rather provide alternative psychological interventions?

Hypnotics, anxiolytic, and antidepressant drugs are the psychotropic agents most commonly prescribed by GPs. Despite current evidence and guidance, prescribing of these agents is often problematic for GPs and their patients, particularly when drugs are given for an inappropriate indication or for an excessive length of time. A study from France published in this issue,[1] where a quarter of the adult population are on psychotropic drugs, reminds us that, despite national differences in clinical practice, this is an international problem with potentially alarming consequences for adverse outcomes, patient safety, and healthcare costs.

At particular risk is the growing demographic group of older patients who often suffer from multiple morbidities and who are therefore subject to high levels of polypharmacy. Recognition of these alarming trends gives rise to questions about why psychotropic drugs are so often prescribed when other management options might be safer or more effective, why this issue persists despite doctors' (and patients') negative beliefs about drugs, and what might be done about it? Two articles in this issue offer some answers to these questions.[1, 2]

Lasserre and colleagues' used a cross-sectional survey method to study French GPs' opinions about psychotropic prescribing for their older patients. Reducing reliance on psychotropic medication was seen as desirable with possible barriers to implementation being a perception or experience that patients or their carers would refuse alternatives, insufficiently developed services or funding for psychological therapies, and GPs' concerns about the adequacy of their own knowledge or misconceptions about risks associated with stopping these drugs. The solutions offered by participants included better patient education, increased access to psychotherapy (presumably to a range of psychological therapies) or psychiatry, and reinforcement of education for doctors.[1]

On the one hand the study helps to highlight the problem of excessive psychotropic prescribing, with its associated opportunity costs and risk of iatrogenesis, while hinting at solutions and areas for future study. All the same, some of the findings are confusing or incomplete. For example, access to psychiatry was suggested as a solution but conventional psychiatry may be as likely to lead to an increased reliance on pharmacological treatments. Irrespective of their origins, expectations that drugs might be prescribed derive as much from patients as from doctors.[3] Practitioners may assume that the patients expect or do not wish to stop drug treatment even when patients might prefer self care.[4] Such misunderstandings are known to be common[5] and reminiscent of doctors overestimating patients' expectations of antibiotics for sore throat almost three decades ago.[6] These difficulties arise partly from the study design and low response rate; responses were constrained by a questionnaire where a qualitative methodology might have produced a more nuanced understanding of how doctor–patient interactions might lead to psychotropic drug prescriptions rather than psychosocial interventions.

The second study from Bradford, UK, is a qualitative study of patients on long-term antidepressants (over 2 years) and their prescribers.[2] Perhaps unsurprisingly, many of the participating patients and their doctors reported positive attitudes towards initiating and maintaining antidepressant prescribing, even over the longer term. In the real world of general practice, the diagnosis of depression was seen as difficult, the option of drugs easy, and alternative resources scarce or not considered. While social causes of depression were acknowledged these were seen as more difficult to address compared to the ease of reaching out for a prescription pad and offering a pill or weighed against stopping drugs once started.[2]

Both studies implicitly acknowledge a growing sense of unease about the rising tide of prescribing for common mental health problems. The increase may have been fuelled by awareness-raising initiatives for patients and healthcare professionals and the perceived safety of newer drugs;[7,8] which may be true for some agents such as selective serotonin uptake inhibitors, but is less convincing with others, for example, Z-drug hypnotics.[9]

The main messages of the two articles in this issue are different. In the French study, GPs and their patients are increasingly concerned about current prescribing and use of psychotropic medicines at a time when psychological therapies are a viable, but relatively inaccessible alternative. They would prefer to use alternative psychological therapies but for a number of reasons, including those highlighted in the article, are constrained from doing so. In the study from Bradford of long-term antidepressant users and prescribers, both patients and practitioners preferred to continue long-term medication on the basis of their shared platform of perceived satisfaction. Recent evidence on the lack of efficacy of antidepressants for 'milder' forms of depression,[10] national guidance,[11] and education for practitioners may be prompting changes in attitudes for those presenting with new symptoms leading to a more conservative approach to antidepressants prescribing,[12] but for hypnotics there has been little evidence of change in levels of prescribing over the past decade.[13]

The UK is actively promoting greater availability of talking therapies by training more mental health workers in use of cognitive behaviour therapy (CBT) for patients with anxiety and depression and in the context of these two studies the IAPT (Improved Access to Psychological Therapies) program is a significant and positive development.[14] To date, the IAPT strategy has not addressed ways of improving service quality for patients presenting with sleep problems, whether for primary insomnia or in comorbid insomnia related to physical or psychological problems. Psychological treatment for insomnia with cognitive behavioural therapy for insomnia (CBT-I)[15] is a specific area that needs to be addressed and a quality improvement project is currently under way to establish how this can be incorporated into routine general practice.[16]

The reality facing GPs is that they see many distressed patients every day who need more than drugs or CBT.[17] They also need someone to listen, understand, empathise, and respond to their problem in a caring and effective way and in discussion with their doctors they want choices:[18,19] most need practical help, support, and counselling from their GP; others opt for talking therapies from a therapist or counsellor; and some have tried talking treatments but found that they did not get on with the treatment or therapist, or that it made them feel worse, and choose to try antidepressants instead. Many require a combination of help, support, and treatment.

Everyone who is suffering from a mental health problem, whatever their age, sex, race, religion, or circumstances has a right to expect the highest quality care that the NHS can provide. Encouragingly, recent evidence suggests that many GPs are trying to work with their patients to manage distress in a more effective, safe, and compassionate way.[12,20] We need to support patients and their doctors with resources to respond effectively and individually in a timely way to personal distress. Further work needs to be done to develop the resources to help primary care teams and their patients to access and implement alternatives to pharmacological interventions for distress.[17]

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