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Conference paper

AVAILABILITY OF NEW PSYCHIATRIC MEDICATIONS, ESPECIALLY ANTIPSYCHOTICS, IN CONTEXT OF PATIENT RIGHTS AND DESTIGMATIZATION OF PSYCHIATRIC PATIENTS

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INTRODUCTION

Today it is almost unnecessary to insist further on the recognition of importance of mental disorders in terms of the enormous influence they have on every-day quality of life of patients and their families, but also in terms of the significant socioeconomic burden those disorders represent for the community as a whole. It is always easy to use sheer magnitude of a certain health problem and disability that comes as a result of it as justification for urgency and methodical approach in coming up with efficient treatment strategies. When looking just at functional burden, it is important to notice that it was reported by more persons suffering from mental disorders (42%) than by those with chronic medical disorders (24%) (Druss et al. 2009). The overall burden of mental disorders, in this case primarily depression, has started rivaling that of the cardiovascular diseases. Depression ranked third among leading causes of disease burden in 2001 according to Global Burden of Disease Study, with tendency of taking the first place in middle- and high-income countries (Lepine & Briley 2011). Nevertheless, another condition has been perceived by general public to be the face of psychiatry and mental disorders, even if we were to take into account those views that challenge the very concept of mental disorders. Schizophrenia spectrum disorders, because of the abnormal behavior patterns that are often present, have for long time in public perception given the meaning to words like "madness" and "craziness". When compared to that of depression the prevalence of schizophrenia might seem insignificant with lifetime prevalence estimated to be between 0.34% and 1% and annual incidence rate of 10-20 per 100,000 (Goldner et al. 2002). The disorder still carries disproportionate burden to patients and their families, affecting their functioning on many levels. Due to stigmatization brought on by the complex of symptoms patients are often isolated from the community but also from their families. The impact of schizophrenia is no less important for the society as a whole. People with schizophrenia have reduced life expectancy when compared to general population, quality of life of patients and their families is reduced, and the disease is linked to higher unemployment and reduced work productivity, which leads to direct and indirect costs (Rice 1999, Wu et al. 2002, Mangalore & Knapp 2007). Being an immensely burdensome disease, schizophrenia has been compared to chronic medical illnesses and its treatment should therefore be approached with no less seriousness and care. Still, even with the established clear burden of mental disorders, we might ask ourselves if and why health systems are sometimes more reluctant in providing quick access to new psychopharmacs than they are in providing new medications for non-psychiatric conditions.

PSYCHOPHARMACOTHERAPY AND THE RIGHT TO TREATMENT

After introduction of chlorpromazine into clinical practice and the beginning of the modern psychopharmacology during 1950s, the effect that was seen has sometimes been compared to that of the introduction of penicillin (Turner 2007). Application of chlorpromazine and later other antipsychotics led to significant withdrawal of symptoms and improvement in overall functioning, which led to many patients being discharged from hospitals and enabled their return to the community on a scale unimaginable before that. Availability of antipsychotic medications shifted the focus from controlling patients in psychiatric institutions to actually treating schizophrenia and pursuing reintegration in the community. It also challenged and changed the way we were looking at schizophrenia and mental disorders in general, at the same time fueling further research of different treatment options and development of new medications (Kirkby 2005). What followed was the development of newer antipsychotic medications with different receptor profiles, and consequently broadening of the treatment goals to include not just "positive" but other symptom complexes as well. Newer medications helped avoid serious extrapyramidal side-effects of the older generation of drugs and, together with showing superior effects in treating certain patient subgroups, slowly established themselves as first-line treatment (Jukic et al. 2003). However, because newer antipsychotics caused different set of side-effects themselves, their primacy has subsequently been challenged (Geddes et al. 2000, Rosenheck et al. 2007).

One of the major contributions of psychopharmacology revolution of 1950s was that psychotic patients were suddenly perceived as "treatable", and conceptually they went from the realm of "madness" to being integral part of health care systems. Being an integral part of the health system meant they were afforded all the rights of other patients, among which is also the right to be treated under the highest standard of care. Due to the specific nature of their psychopathology, some psychiatric patients, especially psychotic ones, are often not able to fight for their right to get the highest standard of care. Even more, because of, by psychopathology, distorted views of their conditions, some will even actively oppose the treatment. When it comes to talking about cost of the treatment, cost effectiveness, or getting the access to the newest medications, because of everything just mentioned and blocks within the system itself, voices of psychiatric patients are not heard as often as those of other patients. That places both psychiatric patients and the health system in a specific position in which health professionals, especially psychiatrists, have to protect the right of psychiatric patients and enable their access to the state of the art treatment options.

Access to new psychopharmacs could be blocked and rationalized by fear of excessive cost and data from different research that show questionable cost-effectiveness. It was shown that, along with high recurrence rates, within one year 14% of schizophrenia patients are treatment resistant (Lieberman et al. 1999), and over two years 20% to 45% percent respond only partially to medications (Kane 1999). Although early treatment can help reduce burden and cut the cost of the disease, only 13% of the burden is covered by present treatment options, with additional 9% that could be averted by optimizing treatment, leaving three-quarters of the burden not covered by existing interventions (Andrews et al. 2003). However, we have to be careful when using numbers alone, as care for psychiatric patients could never be viewed only through cost-effectiveness. Society has covered costs of psychiatric patients, especially psychotic ones, long before we had effective pharmacologic or psychosocial treatment options, proving that cost-effectiveness cannot be the only determinant of care in mental health. That approach was explained and justified by simple "rule of rescue", by the specific character of the disease and consequently specific resulting burden for the sufferer and society if left untreated, but also by fear of society from psychiatric patients if they are not treated (Musgrove 1999).

ANTIPSYCHOTICS AND STIGMA

Even if only inadvertently, we are always confronted with the problem of psychiatric patients being specific in eyes of the public, especially psychotic patients, which raises the questions of stigmatization in the community and within the health care system, as well as what role antipsychotics might play in terms of that stigmatization. Today public is exposed to different activities aimed at exposing myths about mental disorders and demystifying its nature, course and treatment, but we are still faced with certain degree of apprehension, discomfort and misunderstanding when people come face to face with those suffering from mental disorders, again especially if they are face to face with someone suffering from schizophrenia spectrum disorders. That fact bears numerous implications for lives of patients and their families, and we should be vigilant to prevent it affecting treatment of those people. Although serious questions have been asked whether cost-effectiveness of treating some chronic physical diseases of similar impact would show any significant difference from that of schizophrenia (Andrews et al. 2003), we are still left with the feeling of psychiatric patients being looked differently regardless of the disease descriptors. That means that cost of treatment for those patients might be perceived to be greater than that of treatment for physical diseases, disregarding the objective indicators, which could compromise the availability of newest medications and treatment options for this patient population within the health care system. Based on that, availability of newest psychotropic medications in a health care system, compared to availability of other new medications, could be viewed as an indirect indicator of the level of stigmatization of psychiatric patients within the same system. It is again worth pointing out that psychiatric patients are often less visible or active when it comes to pursuing their rights in ensuring the access to newest medications, which places health care professional in special position.

Papers looking at the link between antipsychotics and stigmatization are scarce, and existing research is mostly focused on exploring stigmatizing effect of antipsychotics due to their different side-effects or on the fact that even the simple act of taking psychiatric medications can be seen as disease disclosure and foster the perception of person being a psychiatric patient. Antipsychotics cause different adverse effects, but patients complain of the effect to their social life and functionality, along with showing similar drug attitudes, regardless of whether they're taking classical or atypical antipsychotics (Freudenreich et al. 2004). It might be difficult correctly distinguishing the stigmatizing effect of the disease itself and various symptom complexes from stigmatization caused by taking antipsychotics (Sajatovic & Jenkins 2007). It would be easy to imagine how, after medications start working and cause withdrawal of symptoms, clinical presentation of the disease becomes secondary in terms of stigmatization, while undesirable social reaction and adverse effects perpetuate the stigma. This might give rise to notions of "stigma despite recovery" (Jenkins & Carpenter-Song 2005, Novak & Svab 2009). Because of the stigma caused by side-effects patients reported work-related problems and the feeling of discrimination, which led to them discontinuing treatment (Novak & Švab 2009).

Taking everything into account it is important to be careful when reaching conclusions. As impressed as we might be by stigmatization caused by antipsychotics, we must note that stigma was there before the medications. Even with all the imperfections, antipsychotics do the job they were supposed to do, they reduce symptoms of schizophrenia and other psychotic disorders. As important as education and dispelling myths might be, reduction of symptoms of the disease is still the best way to remove the stigma. The overall feeling might be that patients see only negative aspects of taking drugs, but they will also express positive perceptions of their medications, recognizing their stabilizing effects, especially when they compare their present state with inadequate functioning during a psychotic episode (Noguchi 2008). Positive perception is inevitably linked to reduction of subjectively uncomfortable symptoms like anxiety, fear, confusion, irritability. Patients whose remission reached the stage of return to satisfactory social functioning were more likely to view their medications positively, recognizing their pivotal role, and were more likely to accept taking medications as part of their daily routine (Noguchi 2008).

CONCLUSION

Burden of mental disorders is clear, comparable to that of certain physical diseases, and reduces quality of life of patients and their caregivers, but also affects the society as a whole. Mental disorders and especially schizophrenia spectrum disorders, with their specific complex of symptoms and significant resulting disability, carry the added weight of stigma that should not be ignored even when talking about accessibility to newest treatment options and interventions. Availability of newest psychiatric medications through health care system, compared to availability of newest medications for physical diseases with similar burden, could be used as an indicator of stigma of mental disorders in that same system. Health care professionals and health care system in general should be mindful of that stigma and aid psychiatric patients in securing adequate access to newest medications and treatment options, not allowing their treatment to be perceived as less important in any aspect.

When exploring links between psychiatric medications, especially antipsychotics, and stigmatization, it is easy to focus only on adverse events and public's possible negative perception of those who take psychiatric medications, thus seeing only stigmatizing effects of these drugs. However, by reducing symptoms antipsychotics primarily fight stigma of the disease and enable social reintegration of patients. The fact that significant part of burden of schizophrenia is not averted by presently available treatment options and interventions, shows us there is a huge unmet need, and that can be addressed adequately only if patients and mental health care professionals get unrestricted access to newest medications and treatment options.

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