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DON'T RESTRICT ACCESS TO PSYCHIATRIC MEDICATIONS

By Michael B. Friedman

Psychiatric medications are not the only critical component of recovery from serious mental illnesses or serious emotional disturbances, and for some people they are not a critical element at all; but, for most people with severe and prolonged mental health illnesses, they are certainly one of the three or four necessary conditions for living a satisfying life in the community. Sadly, access to psychiatric medications for people who rely on Medicaid is now under attack in several states around the country, including New York State. Sadly, too, the attack on access to medications has not risen to the top of the agendas of many mental health advocates. Of course, we have many fires to fight so as to be able to continue to provide people with the mental health services they need to lead decent lives in the community. But isn't it obvious that if the people for whom we are fighting do not get access to the medications that work for them, little else we do will matter very much?

It is easy enough to understand why state governments, which are experiencing rapid growth of Medicaid expenditures, want to limit access to medications. The cost of pharmaceuticals (although a relatively small proportion of overall Medicaid spending) is the fastest growing element of Medicaid cost. By creating "preferred drug lists" which favor the use of one or two drugs from the same drug class, they are able to negotiate volume discounts and other financial benefits, thus reducing the overall cost of drugs.

It is important, of course, to find ways to reduce spending in these economically trying times—so long as it can be done without depriving people of the services that are critical to their well-being. The question is whether drug costs can be reduced without depriving people of access to the medications they need.

It seems clear to me that the creation of a preferred drug list which restricts access to certain medications prescribed by a physician invites disaster—even if a procedure is created to appeal and to get exceptions made.

Appeals processes are often difficult, arbitrary, and time-consuming—designed in fact to discourage appeals even when they are medically appropriate. People on Medicaid should be able to get the medications their physicians believe are most appropriate without running a bureaucratic obstacle course. It makes no sense to require a physician to prescribe a medication he or she believes will be ineffective just because it is on a state's preferred list. A physician's judgment about what is likely to be the most effective drug should be questioned only if there is good reason to believe that the physician is making an error in medical judgment. In such a case it should be up to the state to appeal to the physician to use a more appropriate drug rather than to force a physician to appeal an arbitrary list.

It is critical to be clear that there are sound clinical reasons for a physician to choose one drug rather than another, even if they are drugs from the same family including:

- history of response to medications
- avoiding the risk of precipitating a crisis by changing medication
- combinations of symptoms
- side-effects

For people with severe mental illnesses, it is also important to prescribe medications which patients will agree to take. Lack of willingness to take psychiatric medications (usually referred to as lack of "compliance") is the source of a great many relapses as well as periods of very low quality of life for people with severe and recurrent mental illnesses. Physicians must have the freedom to prescribe medications that the patients will agree to take

Finally, it is important to keep in mind that very rapid progress is now being made regarding psychiatric medications. New drugs, generally with fewer side-effects, are introduced frequently. In theory the state's preferred list could be updated every time a new drug is introduced. But given the nature of bureaucracy and the goal to save money by negotiating quantity discounts, how likely is it that the new drugs will get on the preferred list rapidly? Those of us who have been advocates for high quality care for people with serious mental illnesses remember all too well the battle we had to wage in New York State a few years ago to get chlozapine approved for Medicaid payment—even though it was a drug—albeit an expensive drug—with clear benefits over other medications. As the experience with chlozapine makes clear, states are likely put the need to hold down costs ahead of the needs of people with serious mental illnesses.

For all of these reasons, I oppose the establishment of "preferred drug lists", have made it a top priority for my mental health advocacy, and hope that more and more advocates will make it a top priority too. As I said at the beginning, if people with serious mental illnesses do not get access to the medications that work for them, little else will matter.

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