The PACT Centre Pages report on prescribing of drugs used in mental health, issued to general practitioners in November 2003, is reproduced here for readers with an interest in patterns and trends of prescribing.

Mental health problems affect 1 in 4 people during the course of a lifetime and are more frequent in women than men. The most common problems are depression and anxiety. Around 90% of mental health care is provided solely by primary care. Chart 1 demonstrates the increase in prescribing of drugs in primary care to treat mental health problems and clearly shows the rise in prescribing of antidepressants and atypical antipsychotics. These two groups of drugs are also driving the increased expenditure (chart 2). The burden of mental health problems in England has a high cost with around £12 billion attributed to lost employment and productivity. Over 91 million working days are lost to mental ill health every year, half of these days lost are due to anxiety and stress conditions.[1]

The National Service Framework (NSF) for Mental Health[2] sets national standards for tackling mental illness in adults up to the age of 65. One of the key features of the framework is care of mental health patients at a local level and the integration of specialist services, including social care, when individuals can not be managed in primary care alone. Part of the NSF for Older People addresses the mental health needs of people aged over 65, particularly those with dementia and depression.[3] Key interventions cover prevention, care and treatment for older people with mental health problems including promoting good mental health and access to specialist care.

Depression

At some point in their life 1 in 6 people will experience depression, it is most common in people aged 25-44 years.[1] Major depression ranges from mild to moderate, up to severe. In moderate to severe depression choice of therapy should take into account past treatment experience, patient preference and whether simpler interventions have been beneficial. Tricyclic antidepressants (TCAs) or selective serotonin re-uptake inhibitors (SSRIs) are both suitable for first line use. No clinically significant differences in efficacy between these two drug classes have been found.[4] Lower rates of withdrawal due to side effects have been observed with SSRIs compared to TCAs among primary care patients.[5] For a small number of people, there may be an increase in suicidal thoughts and behaviour in the early stages of treatment with any antidepressant, including SSRIs.[6] The Committee on Safety of Medicines (CSM) advises that neither paroxetine nor venlafaxine should be used in children and adolescents under the age of 18 years to treat depression due to an increased risk of harmful outcomes, including suicidal behaviour. The CSM also offers specific advice on the use of St John's wort since evidence of its benefit is limited. Non-drug treatment such as cognitive behavioural therapy is also effective for depression.
A major depressive episode is classed as 'mild' when symptoms only just fulfill the threshold criteria for diagnosis and the patient has minimal functional

impairment. In the initial treatment of mild depression in primary care an immediate antidepressant prescription may not be justified, there is little trial evidence that convincingly demonstrates benefit. A supportive 'watchful waiting' approach would be a reasonable first line option.[7]

Anxiety and insomnia

Anxiety disorders include panic attacks, phobias and generalised anxiety disorder (GAD). Benzodiazepines are indicated for the short-term (2 - 4 week) treatment of anxiety which is severe, disabling and causing unacceptable distress to an individual. Using benzodiazepines to treat short-term mild anxiety should be avoided. Talking treatments, such as cognitive behavioural therapy, are useful to deal with anxieties. If long-term treatment is required for GAD, an antidepressant licensed for this disorder could be tried. Hypnotic use should be reserved for short courses and the underlying cause of the insomnia established and treated first where possible. The newer hypnotics (zaleplon, zopiclone and zolpidem) are only licensed for short-term use; there is some evidence of dependence with these drugs in long-term use. Prescribing rates for drugs acting on benzodiazepine receptors is a Commission for Health Improvement (CHI) PCT performance indicator. The rationale for this indicator is to keep prescribing of these drugs to a minimum; the indicator should reflect a fall in prescribing over time.

Schizophrenia

About 1 in 100 people will have one episode of schizophrenia, and two-thirds of these will go on to have further episodes.[1] The antipsychotic drugs are separated into two groups, typical and atypical, by their extrapyramidal side effects (EPS) profile, elevation of prolactin, efficacy in individuals who are resistant to treatment and efficacy against negative symptoms. Overall the atypical drugs are better tolerated than the typicals, although there are other adverse effects such as weight gain, hyperglycaemia and occasional diabetes associated atypicals. A recent meta-analysis investigated all randomised controlled trials (RCTs) comparing new generation atypical antipsychotics to low-potency (equivalent to or less potent than chlorpromazine) conventional drugs.[8] Only clozapine demonstrated significantly fewer EPS and higher efficacy than low-potency conventional drugs. The new generation drugs as a group were moderately more efficacious than the low-potency antipsychotics. A Health Technology Assessment comparing the clinical and cost effectiveness of atypicals to typicals and placebo demonstrated similar results.[9] The conclusions are based on limited evidence, therefore research involving large numbers of people, comparisons of atypicals to each other and greater assessment of the EPS associated with atypicals would be beneficial.

The National Institute for Clinical Excellence (NICE) guidance[10] recommends that an oral atypical antipsychotic drug is considered for prescription in the following circumstances:

- an individual is newly diagnosed with schizophrenia

- an individual's symptoms are adequately controlled on a typical antipsychotic but he or she is experiencing unacceptable side effects
- an individual is in relapse but has previously experienced unsatisfactory management or unacceptable side effects with typical antipsychotic drugs.

Prescribing of atypical antipsychotics as a proportion of all antipsychotics prescribed is also a CHI PCT performance indicator. Below average for this indicator is prescribing of atypicals at less than 43.5% of all antipsychotics, above average is 54.6% and over.

Dementia

Dementia (one of the main forms of which is Alzheimer's disease) affects around 670,000 people in the UK with 10-20% of people over 80 years being affected.[1] NICE guidance is available on the use of donepezil, rivastigmine and galantamine for the treatment of mild and moderate Alzheimer's disease.[11] NICE recommend the use of these drugs when people who have been examined using the mini mental state examination (MMSE) have a score of 12 points or above. Treatment should only be initiated by a specialist after assessment in a specialist clinic. Memantine is a new drug for the treatment of moderate to severe Alzheimer's disease. A recent RCT compared 181 patients (mean age 76 years) receiving memantine or placebo.[12] The MMSE score was not a primary efficacy variable in this trial but was measured (mean base line score <8). In a subgroup analysis of patients with moderate Alzheimer's (MMSE score 10 – 14) and severe Alzheimer's (MMSE score <10) there appeared to be greater benefit for memantine over to placebo. However limitations of this study included a dropout rate of 28% for the total study population.

Prescribing Data

Prescription items for antidepressant drugs have increased by 51% over the last 5 years to 6.7 million items, cost has increased by 45% to £97 million. SSRIs account for half of all prescribing of antidepressant drugs and 61% of cost. Prescribing of SSRIs has increased by 86% in the last five years whereas cost has only risen by 16%. Around 1 million items per quarter are now prescribed for both fluoxetine and citalopram with costs of £10.3 million and £19.3 million respectively. Prescribing of paroxetine increased steadily reaching 968,000 items in the quarter to December 01 but has since decreased to 733,000 items, quarter to June 03. Prescribing of tricyclic and related antidepressants has remained static over the last five years at 2.5 million items per quarter (36% of all antidepressant prescribing and 11% of cost). The majority of other antidepressant prescribing is for venlafaxine with 620,000 items (9%) and £21.8 million (23%), quarter to June 03.

Prescribing of anxiolytics has remained constant over the last 5 years (1.5 million items, quarter to June 03) however cost has doubled (£2.4 million). Diazepam is the most frequently prescribed anxiolytic (1.1 million items, £1.1 million cost per quarter). Hypnotic prescribing has also shown little change over the last 5 years (2.6 million items, £6.6 million per quarter). Temazepam is the most frequently

prescribed hypnotic with 961,000 items (37%) and £1.3 million (20%) cost, quarter to June 03. Use of zopiclone has increased to 34% (860’000) of all hypnotic items and 51% (£3.4 million) of cost.

Atypical antipsychotics account for 56% (703,000 items) of all antipsychotic prescribing but 94% (£40.4 million) of cost. Risperidone is the most frequently prescribed atypical (325,000 items and £11.8 million, quarter to June 03) closely followed by olanzapine (279,000 items and £22.4 million). Chlorpromazine is the most commonly prescribed typical with 173,000 items costing £340,000 per quarter.

Prescribing of drugs to treat dementia has increased 7 fold in the last 3 years reaching 68’500 items at a cost of £5.2 million, quarter to June 03. This is due to increased prescribing of donepezil (50,000 items costing almost £4 million per quarter) and the introduction of galantamine and rivastigmine. Almost half of all PCTs spend £1 to £49 per 1,000 Prescribing Units (PUs) on drugs for dementia, however a few PCTs spend over £200 per 1,000 PUs demonstrating a wide variation.

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Summary

- TCAs and SSRIs are both effective first line treatments for major depression however SSRIs are generally better tolerated.

- The newer hypnotic drugs (zopiclone, zaleplon and zolpidem) are only licensed for short-term (2 - 4 weeks) use.

- In a recent meta-analysis comparing atypical antipsychotics to low-potency conventional drugs, only clozapine demonstrated significantly fewer extrapyramidal side effects and higher efficacy.

- NICE guidance recommends that an oral atypical antipsychotic drug is considered for prescription in people newly diagnosed with schizophrenia or where an individual has experienced unacceptable side effects with a typical antipsychotic.

- Treatment for Alzheimer's disease should be initiated by a specialist where patients score 12 points or above on the mini mental state examination.