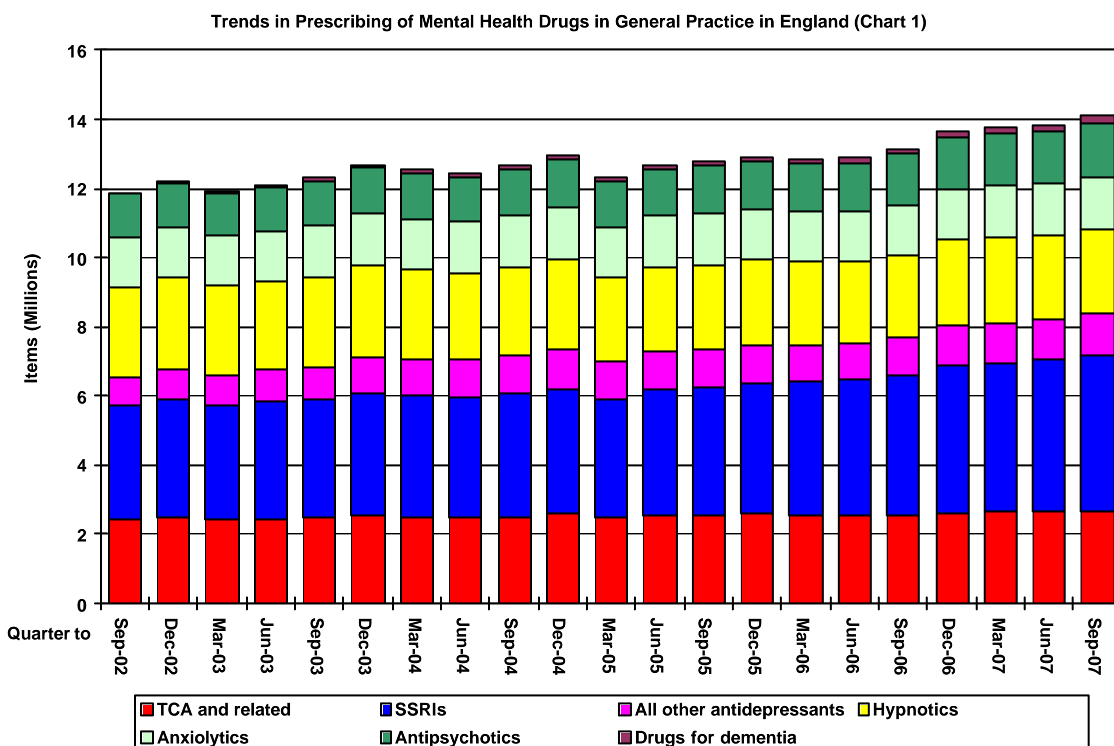
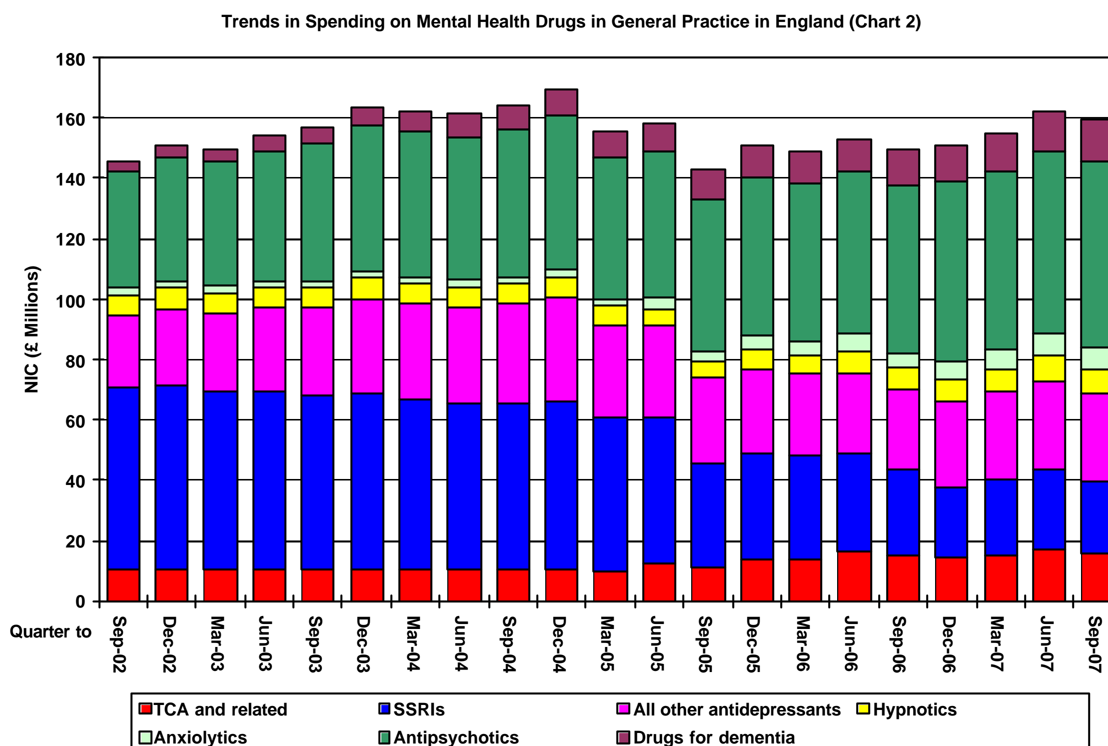
The 10-year reform programme for mental health started in 1999 with the publication of the National Service Framework, and has seen over 700 new mental health teams established in the community offering home treatment, early intervention or intensive support.[1] Chart 1 shows the increase in prescribing of antidepressants and atypical antipsychotics over the last 5 years. The cost of antidepressants (chart 2) has fallen due to price decreases in selective serotonin re-uptake inhibitors (SSRIs). There has been a 20-fold increase in the use of modern anti-psychotic drugs in the last 10 years.[1]





Depression
Approximately 5 to 10% of people seen in primary care have major depression, however this is only diagnosed in about 50% of cases.[2] Most cases of major depression seen in general practice are mild. NICE recommends that patients with mild depression who do not want intervention or, in the opinion of a healthcare professional may recover without intervention, should undergo a further assessment, normally within 2 weeks ('watchful waiting').[3] Cognitive behavioural therapy (CBT) can be useful in patients with mild or moderate depression, and exercise or guided self-help can help patients with milder depression. CBT delivered via an interactive computer programme is also an option for some patients.[4] The optimal duration of computerised CBT will vary among individuals: for mild and moderate depression, brief CBT of between 6 to 8 sessions over 10 to 12 weeks is usual. For moderate to severe depression, the duration is typically in the range of 16 to 20 sessions over 6 to 9 months.[4] Randomised controlled trials (RCTs) indicate that for many diagnostic groups around 50% of individuals with depression experience clinically important improvement with CBT, which is similar to outcomes achieved with antidepressant drugs.[3]

Antidepressant drug use in mild depression is not routinely indicated because the risk-benefit ratio is poor and the placebo response rate in mild depression is high.[3] Antidepressants are considered suitable for treating moderate to severe depression; the choice of drug will reflect patient preference and past treatment experience.[3] Some individuals will show a good response to a particular drug, however, across the population there is very little difference observed in efficacy between antidepressants.[2] SSRIs are slightly better tolerated than tricylic antidepressants (TCAs) but they both produce different types of side effects. NICE recommends SSRIs for first line use (fluoxetine and citalopram are considered reasonable choices).[3] Careful monitoring of symptoms, side effects and suicide risk (particularly in those under 30 years old) should be routinely undertaken especially when initiating antidepressant medication.[3] The highest risk in overdose is with TCAs (with the exception of lofepramine). Venlafaxine is more dangerous in overdose than other equally effective drugs recommended for routine use in primary care such as SSRIs.[3] Before prescribing venlafaxine the following should be considered: the increased likelihood of patients stopping treatment due to side effects; its higher cost; and the presence of pre-existing hypertension, which should be controlled in line with the current NICE Hypertension Guideline.[3] Venlafaxine and TCAs (with the exception of lofepramine) should not be prescribed for patients with a high risk of serious cardiac arrhythmias and/or recent myocardial infarction.

Anxiety and insomnia
Generalised anxiety disorder (GAD) and panic disorder are common anxiety disorders and can often go unrecognised and untreated. The use of any of the following alone or in combination is suitable for the immediate management of GAD: CBT, benzodiazepines, sedating antihistamines, self-help and problem solving.[5] Benzodiazepines should not be used to treat short term 'mild' anxiety and they should be used for only 2 to 4 weeks if anxiety is severe, disabling or subjecting the individual to unacceptable distress. Psychological therapy, self-help and antidepressant treatment are suitable interventions in panic disorder.[5]

Treatment of insomnia should be non-pharmacological in the first instance. The Committee on Safety of Medicines (CSM) advice is that benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress. There is still widespread sedative hypnotic use in the elderly population despite the risk-benefit relationship being unknown. A meta-analysis of 24 studies included 2,417 patients aged 60 or over with insomnia with pharmacological treatment being treated for at least 5 consecutive nights.[6] Number-needed-to-treat was derived from 4 studies where patients reported any improvement in sleep quality compared with no improvement or a worsening in sleep quality. On this basis the number of patients who need to be treated with a sedative for one patient to have an improvement in sleep quality is 13. The number needed to harm for sedative hypnotics compared to placebo is 6 on the basis of adverse event reporting in 16 studies.[6]

Dementia
Dementia is a progressive and largely irreversible clinical syndrome that is characterised by widespread impairment of mental function.[7] Some or all of the following features can occur: memory loss, language impairment, disorientation, changes in personality, difficulties with activities of daily living, self-neglect, psychiatric symptoms (e.g. apathy, depression or psychosis) and out-of-character behaviour (e.g. aggression, sleep disturbance or disinhibited sexual behaviour, the latter is not typically the presenting

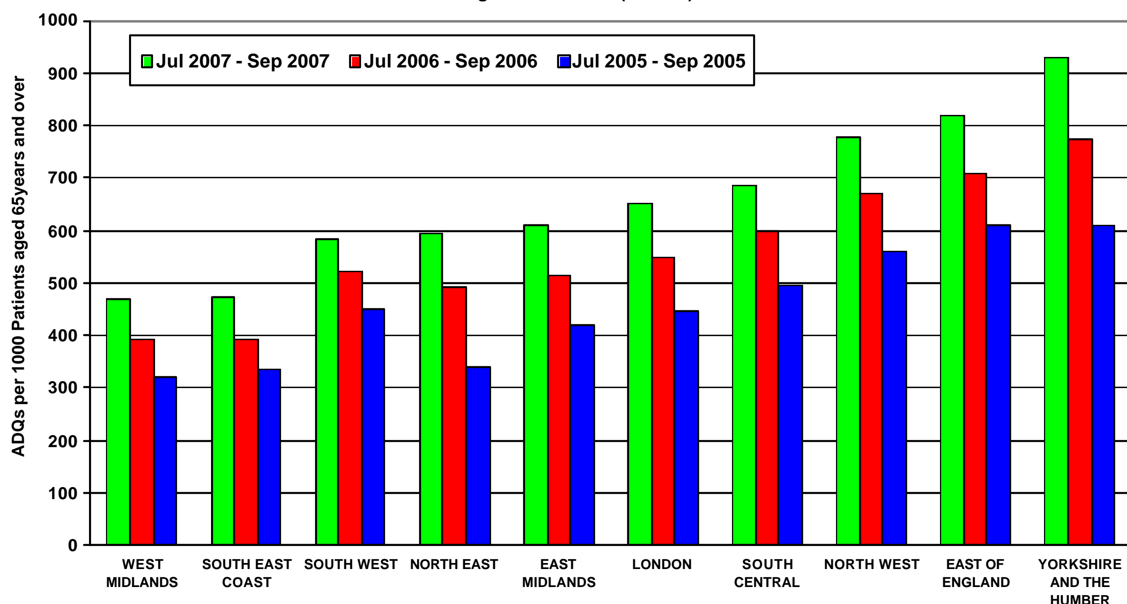
feature of dementia).[7] NICE recommends that general population screening for dementia should not be undertaken. Review of modifiable risk factors in dementia (e.g. smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) should be carried out in middle-aged and older people. A UK study suggests that 1.3% of the English population have dementia and incidence data suggest that 0.3% of the population, or 148,000 people, are diagnosed with dementia each year.[8] Prescribing of drugs to treat dementia in primary care varies two-fold across PCTs (Chart 3) and has increased by 43% over the last 3 years. This variation may reflect differences in local delivery of dementia services between primary and secondary care.

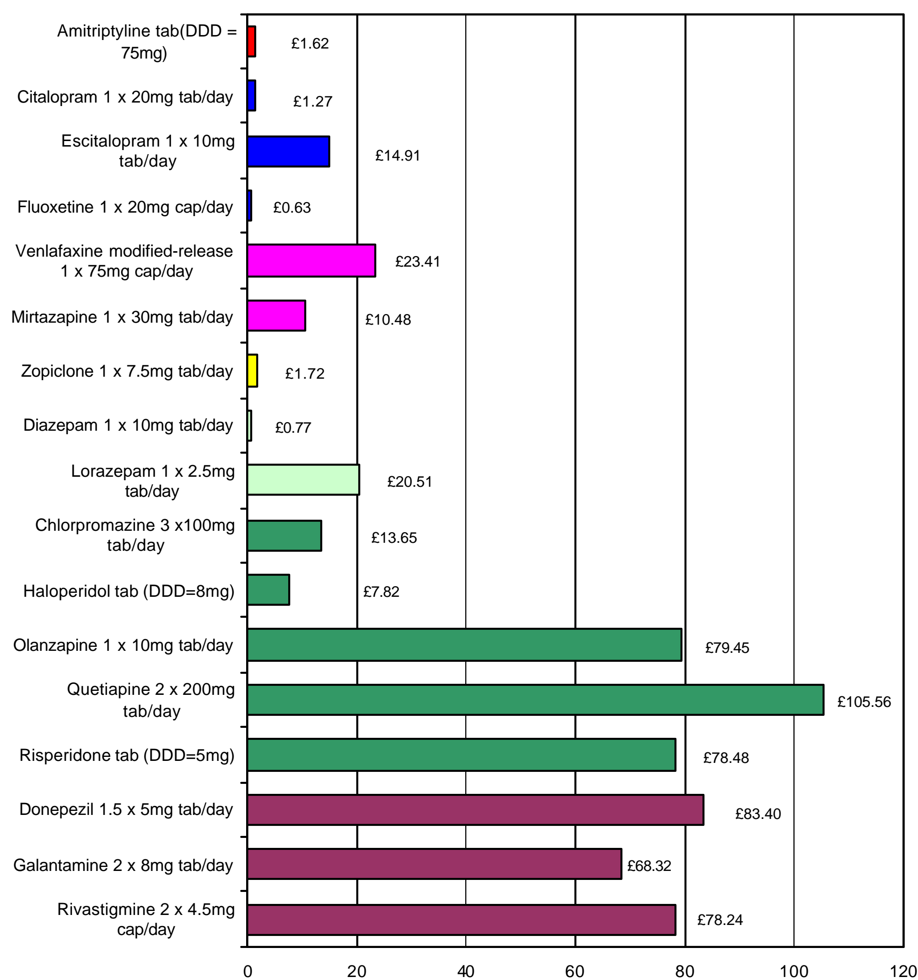
People who are diagnosed with mild to moderate dementia should be offered the opportunity to participate in a structured group cognitive stimulation programme irrespective of drug treatment for cognitive symptoms. For moderate Alzheimer's disease (Mini Mental State Examination (MMSE) score of 10-20 points), NICE recommends that drug treatment with donepezil, rivastigmine or galantamine can be considered but should only be started by a specialist in dementia care.[7] The least expensive drug should be used to start therapy but an alternative should be considered if the adverse event profile, concordance, comorbidity, possible drug interaction or dose profiles suggest this is not appropriate. Review of the MMSE score and global, functional and behavioural assessment should be carried out every 6 months. Memantine should not be used in people with moderately severe Alzheimer's disease except as part of well designed clinical studies.[7] NICE's recommendations have been subject to legal challenge but this has been unsuccessful.

Patients with non-cognitive symptoms and behaviour that challenges should only be considered for medication if there is severe distress and/or agitation or an immediate risk of harm to the person with dementia or others. Currently in the UK no drugs are licensed specifically for behavioural changes and psychological symptoms in dementia, however, antipsychotic treatment has been used in people with dementia for psychotic symptoms and also for agitation and aggression.[9] Due to increased risk of cerebrovascular adverse events the CSM advised in 2004 that risperidone and olanzapine should not be used for the treatment of behavioural symptoms of dementia. Treatment with an antipsychotic drug might be appropriate but only when specific conditions have been met e.g. target symptoms have been identified and co-morbid conditions considered. Both conventional and atypical antipsychotics are similarly effective but with different unwanted side effect profiles.[9]

Schizophrenia

Symptoms of schizophrenia include delusions, hallucinations, thought disorder and changes in affect. People with schizophrenia have a lower life expectancy than the general population and are more likely to die from coronary heart disease.[10] The newer atypical antipsychotics are usually better tolerated than typicals because they are less likely to cause parkinsonian side effects.[10] The CATIE study suggests there is little to choose in terms of overall effectiveness between the atypical antipsychotics studied (olanzapine, quetiapine, risperidone, ziprasidone (not available in the UK)), and the typical antipsychotic perphenazine.[11] All antipsychotics were associated with high rates of intolerable side effects and failure to control symptoms. Olanzapine appeared to be the most effective atypical agent (higher doses were used than the UK licensed dose range) but its benefits were limited by unacceptable weight gain and metabolic effects.





Prices based on Drug Tariff February 2008. Dose based on WHO DDDs where possible, otherwise BNF stated dose. The WHO DDD is a unit of measurement based on the assumed average maintenance dose in adults. It may not necessarily reflect the actual dose used.

Prescribing Data (reporting quarter = July-September 2007, index quarter = July-September 2002)
Prescriptions for antidepressant drugs have increased by 28% over the last 5 years to 8.4 million items, whereas cost has decreased by 27% to £69 million. SSRIs account for 54% of all antidepressant drug items and 35% of the cost. Prescribing of SSRIs has increased by 36% in the last 5 years whereas cost has fallen by 60%, mainly due to patent expiries. The most commonly prescribed SSRI is citalopram (2 million items, £7.1 million per quarter). Fluoxetine prescribing stands at 1.3 million items and costs at £4.6 million. Prescribing of tricyclic and related antidepressants has risen by 10% to 2.7 million items while cost has risen by 48% to £15.4 million over the last 5 years. TCAs account for 32% of all antidepressant prescribing and 22% of the cost. Amitriptyline is the most commonly prescribed TCA (1.6 million items, costing £4.9 million per quarter). Some of these prescriptions will be for indications such as neuropathic pain. The majority of other antidepressant prescribing is for venlafaxine and mirtazapine (558,000 items and 511,000 items, £19.2 million and £7.3 million respectively).

Prescribing of anxiolytics has remained stable over the last 5 years at 1.5 million items per quarter whereas cost has risen almost three-fold to £7.1 million. Diazepam is the most commonly prescribed anxiolytic (1.2 million items). The cost of prescribing diazepam has more than doubled in the last 5 years to £2.3 million. Hypnotic prescribing has remained fairly constant at 2.4 million while cost has increased by 18% to £7.9 million. Zopiclone is now the most frequently prescribed hypnotic at 1.1 million items (£2.9 million), followed by temazepam (794,000 items, £1.5 million).

Atypical antipsychotics account for 69% (1.1 million) of all antipsychotic items but 95% (£58.5 million) of cost. Olanzapine is the most commonly prescribed atypical (385,000 items, £26.6 million), followed by quetiapine (282,000 items, £14.6 million). Chlorpromazine is the most frequently prescribed typical drug (128,000 items, £911,000). Prescribing of drugs to treat dementia has more than quadrupled in the last 5 years reaching 203,000 items per quarter (£13.9 million). Donepezil accounts for 66% of prescribing (135,000 items) and two thirds of cost (£9.5 million).

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2. National Prescribing Centre. Depression – Data Focussed Commentary. www.npci.org.uk
3. NICE. Depression (amended): Management of depression in primary and secondary care. Clinical Guideline 23 (amended); April 2007
4. NICE. Computerised cognitive behaviour therapy for depression and anxiety. Technology Appraisal 97. February 2006
5. NICE. Anxiety (amended): Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. Clinical Guideline 22 (amended); April 2007
6. Glass J, Lanctot K L, Herrmann N, Sproule B A, Busto U E. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. BMJ 2005; 331: 1169 -1175
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8. NICE. Dementia. Costing Report. Implementing NICE SCIE guidance in England. November 2006.
9. Drug and Therapeutics Bulletin. How safe are antipsychotics in dementia? DTB 2007; 45: 81-85
10. National Prescribing Centre. Schizophrenia – Data Focussed Commentary. www.npci.org.uk
11. National Prescribing Centre. Antipsychotics in schizophrenia: a message from CATIE. MeReC Extra No.23 July 2006

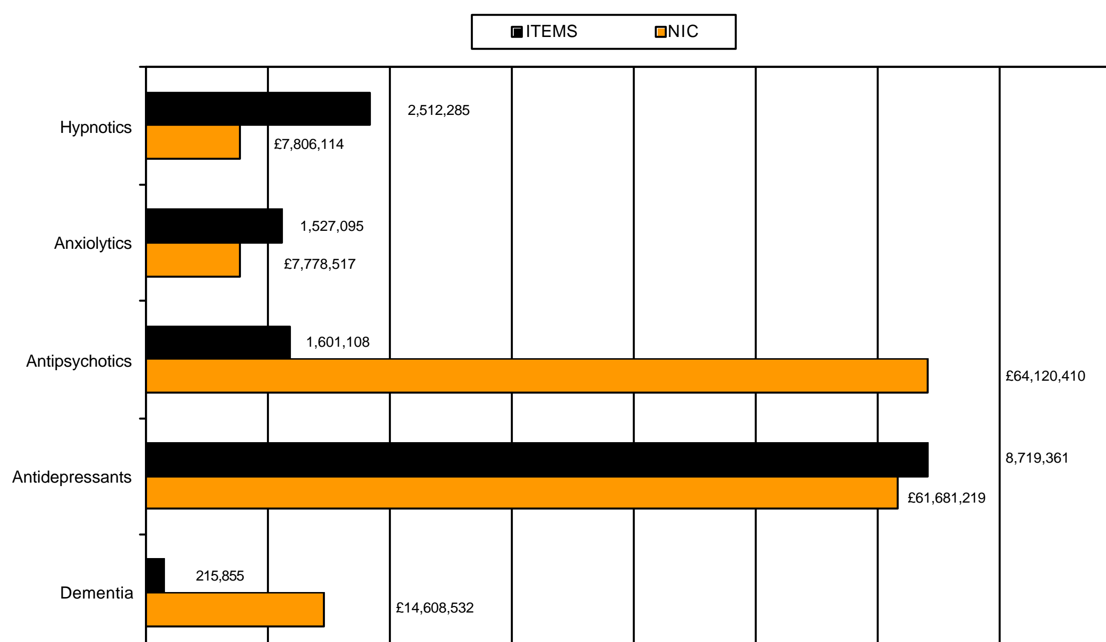
Summary

- Patients with mild depression should not normally be prescribed antidepressant medication. Computerised cognitive behavioural therapy, exercise or guided self-help may be beneficial in mild depression. Patients who do not want intervention should undergo a further assessment, normally within 2 weeks.

- An SSRI is a suitable first line choice for moderate to severe depression. Individual drug choice should take into account risk of side effects, patient preference, previous treatment experience and suicide risk.

- Patients with mild to moderate dementia should be given the opportunity to participate in a group cognitive stimulation programme.

- Treatment for moderate Alzheimer's disease should start with the least expensive drug and should only be initiated by a specialist in dementia care.



Quarter to Dec 07

National

	ITEMS/1000 PUs	NIC/1000 PUs
Tricyclic and related antidepressant drugs	39.09	£185.18
Selective serotonin re-uptake inhibitors	65.89	£254.99
Mirtazapine	7.66	£105.51
Venlafaxine	8.15	£282.86
All other antidepressants	2.16	£41.36