PCT Prescribing Report Oct - Dec 2007

Drugs used in Mental Health – Prescribing Guidance and Discussion Points

Discussion Points

1. Does your PCT promote access to non-drug therapies for treatment of mild and moderate depression? Can practices in your PCT refer patients with depression for appropriate non-drug therapies as described in NICE guidelines?
2. Is your PCT monitoring routine prescribing of antidepressants for mild depression? Does your PCT encourage practices to review patients who are regularly prescribed antidepressant therapy?
3. Does your PCT ensure practices have robust protocols for monitoring the physical health of people with mental health problems, especially those with severe and enduring mental illness?
4. Is your PCT monitoring the use of hypnotics and anxiolytics? Do you commission any form of psychological support for patients as an alternative to drug treatment?
5. What is the trend in prescribing of drugs for dementia in your PCT? Is your PCT reviewing the implementation of the NICE guideline and NICE technology appraisal within primary and secondary care?

- Over 700 new mental health teams have been established to provide specialised services to the community since the 10-year reform programme for mental health commenced in 1999 with the publication of the National Service Framework.
- New staff include over 900 primary care workers with training to deliver basic psychological therapies.
- Since 1997 the suicide rate has fallen by 7.4% (around 350 deaths per year) towards a target of a 20% reduction by 2010.
- The total planned reported investment in mental health services in 2006/2007 was £4.99 billion.
- Figure 1 shows the increase in prescribing of antidepressants and antipsychotics over the last 5 years; prescription items for antidepressant drugs have increased by 28% to 8.4 million items per quarter. There has been a 20-fold increase in the use of atypical antipsychotic drugs in the last 10 years (based on items dispensed in the community – source Prescription Cost Analysis).
- Figure 2 shows that cost has fallen in the last 5 years due to price decreases in selective serotonin re-uptake inhibitors (SSRIs).

Figure 1: Trends in Prescribing of Mental Health Drugs in General Practice in England

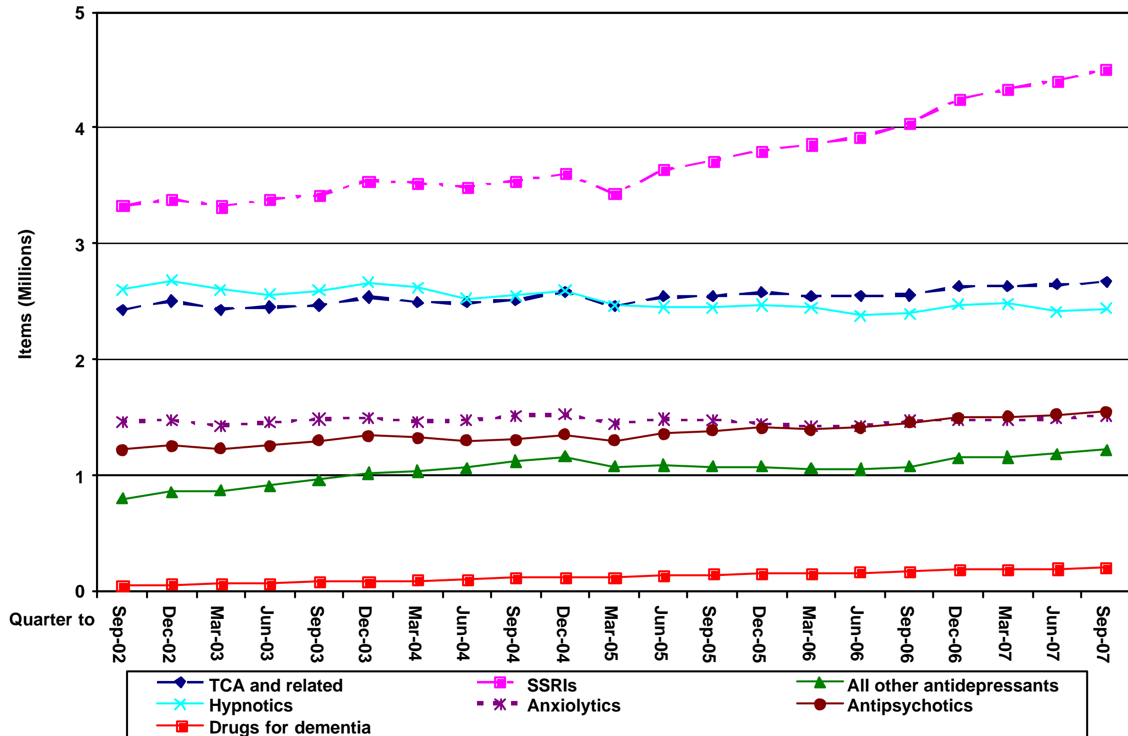
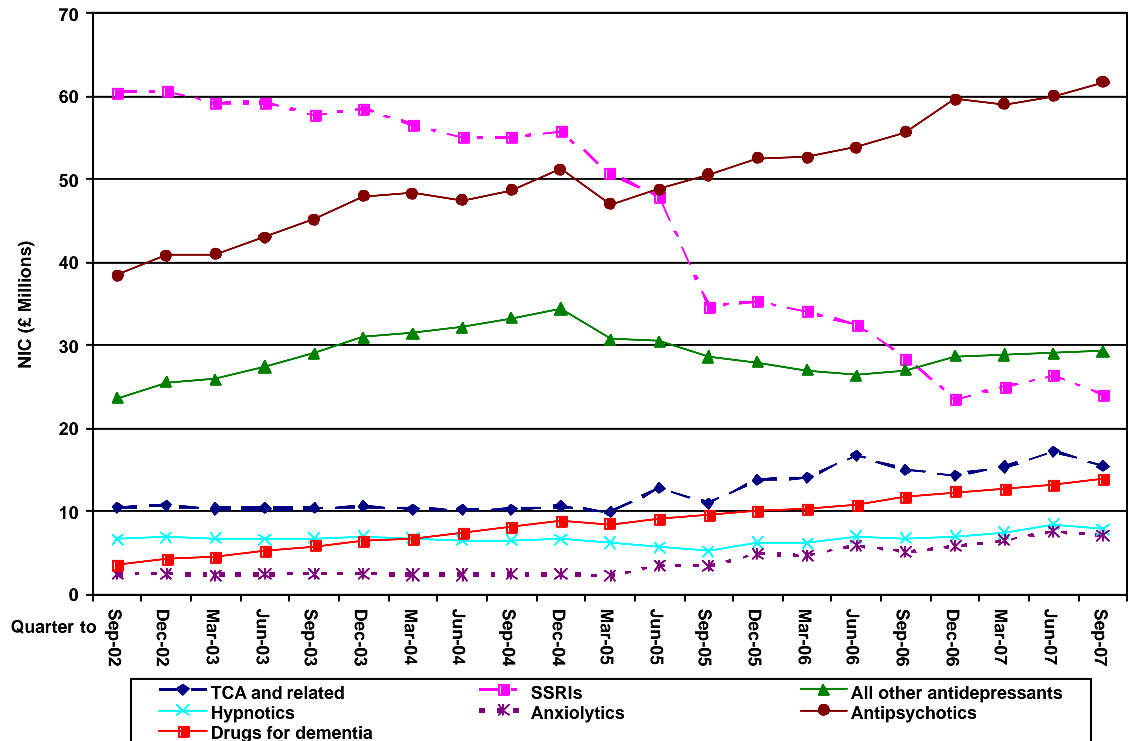


Figure 2: Trends in Spending on Mental Health Drugs in General Practice in England



Most cases of depression seen in general practice are mild. Approximately 5 to 10% of people seen in primary care have major depression. One of the main policy priorities identified in the 2007 report by the National Director for Mental Health (Mental Health Ten Years On: Progress on Mental Health Care Reform) is to expand the availability of evidence-based psychological therapies, especially cognitive behavioural therapy. Use of antidepressant drugs in mild depression is not routinely indicated because the risk-benefit ratio is poor. Randomised controlled trials show that approximately 50% of individuals with depression experience clinically important improvement with cognitive behavioural therapy alone, which is similar to outcomes achieved with antidepressant drugs. However, evidence also exists that there is little clinically important difference in outcomes between antidepressants and placebo. SSRIs are recommended by NICE as suitable first line antidepressants. PCTs can encourage prescribers to take account of cost-effectiveness when selecting an SSRI. There is considerable variation in cost between SSRIs that are still in patent and those that are now available as generics, for example citalopram and fluoxetine.

NICE has published a clinical guideline on the management of anxiety disorders, which highlights the role of psychological therapies. Commissioners therefore need to ensure appropriate access to psychological therapies. SSRIs are the recommended first line drug therapy in most anxiety disorders. The Government has recently announced additional targeted funding in the Comprehensive Spending Review (CSR07) to begin national roll-out of new local psychological therapies services. A total of £173 million will have been allocated by 2010/11. This will enable PCTs to implement the NICE guidelines for people suffering from depression and/or anxiety disorders. The ultimate aim is a service for each PCT. The national guidelines for the Improving Access to Psychological Therapies programme have recently been published (February 2008). Strategic Health Authorities will need to engage with potential local training providers and develop plans for tender completion by April 2008, to begin training in September 2008. SHAs will need to select PCTs to become IAPT sites by April 2008, to introduce IAPT services in tandem with the commencement of training places in September 2008.

Benzodiazepine drugs should not normally be used beyond 2 to 4 weeks for the relief of severe anxiety or insomnia. Prescribing of these drugs has only decreased slightly in the last 5 years, which suggests that some patients remain on long-term treatment. There is relatively widespread sedative hypnotic use in the elderly population. NICE has recommended that because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorter-acting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed. Zopiclone is the most frequently prescribed hypnotic (1.1 million items, quarter to September 2007) and it is less expensive than zaleplon, zolpidem and most of the benzodiazepine drugs.

Overall, dementia affects around 5% of people aged over 65 years, rising to 20% of those over 80 years. Prescribing of drugs to treat dementia varies two-

fold across PCTs (this may reflect different patterns of service provision between primary and secondary care), and has increased by 43% over the last 3 years. A costing report is available which looks at the resource impact of implementing the NICE and Social Care Institute for Excellence guidance on dementia in England. Patients who are suffering from dementia should undergo a review of modifiable risk factors in dementia (e.g. smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol). 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. Acetylcholinesterase inhibitors should only be started by a specialist in dementia care for patients with moderate dementia; their use can also be continued for patients with mild dementia who were already taking these drugs before the NICE guidance was issued.

People with schizophrenia have a lower life expectancy than the general population and are more likely to die from coronary heart disease (50 to 75% versus 33%). The newer atypical antipsychotics are usually better tolerated than typicals because of a decrease in parkinsonian side effects; however, some of the atypical agents are more commonly associated with weight gain and diabetes. Atypical antipsychotics account for 69% of all antipsychotic prescribing (1.1 million items per quarter) but 95% (£58.5 million) of cost. There is still significant use of antipsychotics for a range of other disorders including anxiety, behavioural and personality disorders despite a lack of robust evidence of benefit in these disorders.

Sources of further information

1. Information on prescribing for the PCT is available using ePACT.net and the Prescribing Toolkit.
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10. Drug and Therapeutics Bulletin. How safe are antipsychotics in dementia? DTB 2007; 45: 81-85
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