

Advice on Clinical Use of Antipsychotic Drugs

This document is intended as general advice regarding the prescription of antipsychotic drugs in Primary Care. It assumes that appropriate diagnosis has been made in accordance with ICD-10 criteria. It cannot cover all situations and is not relevant to situations where specialist advice has been given that, for specific clinical reasons, may suggest prescribing outside the usually suggested situations or doses.

Where use of 'high doses' is referred to, this should be taken to mean doses above the usual BNF limits. Though such use is unlicensed, in certain situations it is supported by a body of professional opinion. If more than one antipsychotic drug is being prescribed then the 'percentage method' is used to decide what may be a 'high dose' of the combined drugs (i.e. the dose as percentage of maximum of each drug is added together and if over 100% then this is 'high dose' use).

Psychotic Illness

The institution of an antipsychotic in a patient with psychosis for the first time should preferably be decided by a psychiatrist or by a general practitioner with some specific training/experience in psychiatry. The NICE guideline for Schizophrenia advises that choice of drug should be in consultation with the patient, particularly in relation to known adverse effects. Patients should be commenced on the lowest appropriate dose and a single antipsychotic should be used. Such patients should be referred quickly to an appropriate mental health team.

After the acute episode patients should be informed of the high risk of relapse if medication is stopped before 1-2 years. Patients with a known diagnosis who have relapsed should have the reasons for this reviewed. An increase in dose of their existing medication may be required but attention to stressors is also very important. Consider re-referral to secondary care if there is:

- poor treatment response
- non-adherence to medication
- intolerable side effects from medication
- comorbid substance misuse
- risk to the person or others

There is no evidence that use of 'high dose' antipsychotics or more than one antipsychotic confers any additional clinical benefit in the majority of patients. However, there are certain situations, particularly in relation to treatment resistant patients, where a carefully monitored trial of such approaches is appropriate. This should only be under the supervision of a Consultant Psychiatrist.

Bipolar Disorder

Antipsychotic drugs are appropriate for the management of acute mania and hypomania and can be used in prophylaxis. The advice above for Psychosis should apply. The majority of patients will not require long-term prescription of an antipsychotic. A mood stabiliser (anticonvulsant or lithium) will usually be adequate for long-term prophylaxis. Patients requiring long-term treatment with both a mood stabiliser and an antipsychotic should be under review by a Mental Health Team until an appropriate period of stability has been established (which for most cases will probably be a minimum of 2 years).

Evidence is not clear regarding the management of an episode of depression in the context of bipolar disorder. Some recent evidence suggests that quetiapine may be of value in this situation. However, any evidence of relapse in a patient with bipolar disorder should prompt a request for early review by mental health services.

Unipolar Depression

Low doses of antipsychotic drugs can be useful for the management of agitation in patients with an episode of depressive disorder. Clinical trials also indicate that patients with psychotic
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depression require treatment with both an antidepressant and an antipsychotic. There is evidence in favour of augmentation of antidepressants with an atypical antipsychotic in cases of treatment resistant depression.

In older patients with depression, who may frequently present with agitation, the dose must be kept as low as possible and greater caution is required.

Anxiety Disorder

In general the NICE guidelines do not recommend the use of antipsychotic drugs in the management of anxiety disorders. None of the available drugs have a licence for this indication. However, there have been positive clinical trials with some first and second generation drugs. NICE does suggest consideration of quetiapine and risperidone for some patients with severe OCD.

If used, this should generally be at low doses. Patients with anxiety may be discharged from secondary care on low doses of antipsychotics. However, it may be appropriate after a period of time to seek specialist advice regarding continuation of such treatment.

Dementia

Routine use of antipsychotics is not recommended in dementia and such use is unlicensed.

For severe psychotic symptoms associated with dementia an antipsychotic may be considered. For severe behavioural disturbance causing severe distress or a risk of harm, not responsive to other approaches, an antipsychotic may be considered. Treatment in these situations should not be for longer than 6-12 weeks unless clear reasons are documented and there is regular review. In all cases risk-benefit considerations are important in particular in relation to extrapyramidal side-effects, cardiovascular and cerebrovascular risks (stroke/transient ischaemic

episodes). Antipsychotics are contra-indicated in Lewy Body Dementia.

Personality Disorders

NICE does not give any guidance on use of antipsychotics in people with a personality disorder. A recent Cochrane Review suggests limited evidence for benefits in Borderline Personality Disorder. It may be appropriate to consider a trial of an antipsychotic but such should follow assessment by a secondary care mental health team. Some may benefit from long-term treatment but, as for anxiety disorders, it may be appropriate after a period of time to seek specialist advice regarding continuation of such treatment.