Ten principles of good psychiatric prescribing

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Abstract

Psychopharmacology is not the sole province of psychiatrists. General practitioners (GPs) should be familiar with the management of common psychiatric disorders, especially depressive and anxiety disorders, as most people with these disorders are treated in primary care. Hospital physicians encounter many patients for whom psychiatric drugs have been prescribed, partly due to the increased prevalence of anxiety and depressive disorders in individuals with chronic medical disorders and the increased prevalence of diabetes mellitus and cardiovascular disease in people with schizophrenia and bipolar disorder. Psychiatric drugs can cause a wide range of adverse effects that can present to GPs and physicians. This article describes 10 principles of good psychiatric prescribing for the non-specialist.

Keywords Adherence; adverse effects; antidepressants; antipsychotics; drug interactions; drug safety; prescribing; psychopharmacology; SSRIs; teratogenic

Introduction

Pharmacological treatment is an important component of the management of many psychiatric disorders. A meta-analysis concluded that psychiatric drugs were not generally less efficacious than drugs used in treating physical disorders.[1] This article covers key principles in prescribing psychiatric drugs and is aimed at non-psychiatrists, in particular general practitioners and hospital physicians.

Key prescribing principles

Keep prescribing within licence

The non-specialist should ensure that psychiatric drugs are prescribed for licensed indications and within the licensed dose range. Prescribing for unlicensed indications or at above licensed dosages is not necessarily inappropriate, but there needs to be a sensible rationale to support such use and it should usually be recommended by a psychiatrist. Off-licence prescribing should be fully discussed with the patient, who should give informed consent that is documented in the notes.

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Key points

- Keep prescribing within licence
- Ensure the benefit of a medication outweighs the risks
- Start at a low therapeutic dosage and increase gradually
- Ensure a therapeutic trial of sufficient duration
- Avoid unnecessary polypharmacy
- Ensure prescribing is part of a wider treatment plan
- Involve the patient in treatment decisions
- Discuss adverse effects before and during treatment
- Explore adherence regularly
- When terminating treatment, consider withdrawing the drug gradually

Ensure the benefit of a medication outweighs the risks

If a drug is to be prescribed, the likelihood of it leading to improvement, and the clinical benefit of that improvement, should outweigh the risk of any adverse effects. The overall risk–benefit balance for the drug should be more favourable than that expected from no treatment/watchful waiting or alternative drug or psychological treatments. Assessing the risk–benefit balance involves clinical judgement and a knowledge of the evidence base for different treatments, and should take account of the patient's views. Table 1 summarizes some factors that should be considered when selecting a drug.

Start at a low therapeutic dosage and increase gradually

Most psychotropic drugs have a therapeutic dosage range, and it is impossible to predict the dose at which an individual patient will respond. Conversely, most adverse effects become more frequent and severe as the dosage is increased. Doses should be increased gradually, especially in elderly individuals. It is important, however, that following this principle does not inadvertently result in a patient being left permanently on a subtherapeutic dose of medication.

Ensure a therapeutic trial of sufficient duration

Improvement with antidepressant treatment in depressive and anxiety disorders tends to be gradual, and it can take several weeks before a clinically meaningful response occurs. Consequently, treatment should not be stopped prematurely because it is assumed that the drug is ineffective. Conversely, however, if there has been no detectable improvement after 4 weeks of treatment with a therapeutic dosage of an antidepressant, the likelihood of future improvement is low and treatment should be changed.[2]

Factors to consider in choosing the most appropriate medication for an individual

Patient age

- Elderly patients and children/adolescents are more vulnerable to many adverse effects
- In these groups, use lower dosages and slower titrations

Is the patient pregnant or likely to become pregnant? If yes:

- Obtain expert advice
- Avoid drugs that are known teratogens (e.g. lithium, valproate, carbamazepine)
- Choose a drug for which there is evidence of safety in pregnancy
- Consider adverse effects on the fetus and newborn other than teratogenesis
- Consider risk to the newborn if the mother plans to breastfeed while prescribing continues
- Consider risks to the mother and unborn child if psychiatric illness is not treated pharmacologically

Are there coexisting medical disorders?

Consider whether these increase the risk of specific drug adverse effects. In particular, consider:

- Cardiovascular disease
- Epilepsy
- Renal impairment
- Hepatic impairment
- Respiratory problems
- Gastrointestinal disorders including ulcers
- Dementia and cerebrovascular disease

Is there a potential for drug interactions?

- With other prescribed medication
- With over-the-counter medication
- With alcohol
- With illicit drugs

Is the patient at risk of overdose? If yes, consider:

- Prescribing a less toxic drug
- Dispensing in limited quantities
- Asking a relative to give out medication (if the patient agrees)

Is there a history of drug allergies or serious drug adverse effects?

- If yes, avoid these or similar drugs

What are the patient's views about drug treatment?

- In particular, are there specific adverse effects the patient wishes to avoid?

NB: The current Summary of Product Characteristics should be consulted to ensure prescribing is within licence.

Table 1

Avoid unnecessary polypharmacy

The simultaneous use of more than one psychiatric drug from the same British National Formulary class (e.g. two hypnotics, two antidepressants, two antipsychotics) is often termed 'polypharmacy' and should be avoided. In general, polypharmacy does not increase effectiveness but does increase the risk of adverse effects and can lead to drug–drug interactions. The complementary pharmacology of drugs within the same class, and the needs of the patient, occasionally make polypharmacy appropriate (e.g. prescribing a second antipsychotic in a patient with treatment-resistant schizophrenia who has only partially responded to clozapine at an optimal dosage), but these cases are relatively few and will usually be the province of a psychiatrist. A brief period of polypharmacy is appropriate when a cross-taper is used to switch between two drugs in the same class.

Ensure prescribing is part of a wider treatment plan

Pharmacological treatment should be accompanied by social and psychological treatment approaches, although the complexity of these can vary greatly. At its simplest, this can include assisting the patient to identify and manage stressors and reduce excess alcohol consumption. Psychological treatment includes the supporting and trusting professional relationship with the treating doctor and other clinicians, and extends to cognitive behavioural treatment and other psychological therapies.

Involve the patient in treatment decisions

Where possible, the patient should be involved in selecting a medication and given several options. Clinicians have an important role in providing information, and it is important that they dispel any misconceptions the patient has. Depending on the psychiatric disorder and its severity, patient choice can also include psychological treatment as an alternative, or adjunct, to drug treatment, or the option of no drug treatment and a period of watchful waiting. Adherence and patient satisfaction tend to be better when patients are involved in treatment decisions.

Discuss adverse effects before and during treatment

Psychotropic drugs can cause a wide range of adverse effects encompassing all bodily systems.[3] Adverse effects are clinically important as they can cause suffering, impair quality of life, stigmatize patients and lead to non-adherence with medication that can result in relapse of the underlying psychiatric disorder.[3] Common adverse effects, as well as rare but serious ones, should be discussed with a patient before starting a medication.

At subsequent consultations, it is important that the clinician enquires about adverse effects rather than simply waiting for the patient to volunteer information. For antipsychotics, which can cause a wide range of adverse effects, the use of an adverse effect checklist can help to ensure a systematic approach to monitoring. Depending on the prescribed medication, symptom enquiry may need to be supplemented by examination and blood tests. For example, monitoring body mass index and blood glucose and lipid levels is recommended during treatment with antipsychotics. If adverse effects are detected, their impact on the patient should be explored and options for treatment discussed. Some can be managed by simple lifestyle changes (e.g. sipping water if a drug causes a dry mouth), but others may require a dosage reduction or a switch to an alternative medication with less propensity to cause the particular adverse effect. Some adverse effects may require treatment in their own right (e.g. a statin may be used to treat raised cholesterol).

Explore adherence regularly

Poor adherence with psychotropic drugs, as with drugs used in general medicine, is common but often covert and a frequent reason for apparent non-response.[4] In addition to discussing adverse effects with patients and involving the patient in treatment decisions, the clinician should try to understand the patient's beliefs and concerns about their illness and

medication so that potential barriers to adherence can be identified and tackled.[4]

When terminating treatment, consider withdrawing the drug gradually

When psychiatric drugs have been prescribed for 4 weeks or longer and are to be stopped, with no plan to switch to another drug in that class, it is best to taper the drug down over several weeks rather than to stop it abruptly. This is to decrease the likelihood of discontinuation or withdrawal symptoms. These terms refer to a wide variety of symptoms that can occur within a few days of stopping a drug and can be understood in terms of pharmacological 'rebound'.[5] Withdrawal symptoms are well recognized with benzodiazepines, antipsychotics and antidepressants. If a patient is switching from one drug to another in the same class (e.g. from one selective serotonin reuptake inhibitor to another), it is usually possible to switch directly without tapering the first drug as the common pharmacology of the two drugs makes the occurrence of withdrawal symptoms unlikely.[5] ◆

KEY REFERENCES

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TEST YOURSELF

To test your knowledge based on the article you have just read, please complete the questions below. The answers can be found at the end of the issue or online here.

Question 1

A 50-year-old man attended the accident and emergency department complaining of slurred speech and a marked tremor of his hands. He had had bipolar disorder, well controlled on lithium, for some years. He drank 38 units of alcohol each week. He had recently started taking ibuprofen for arthritic pain. On examination, he was unsteady but there were no focal neurological signs.

What is the most likely explanation of his symptoms?

A Stroke
B Lithium toxicity
C Lithium-induced hypothyroidism
D Relapse of depression
E Alcohol withdrawal symptoms

Question 2

A 35-year-old woman presented with a moderate depressive illness, and a joint decision was made by her and her doctor to commence treatment with a selective serotonin reuptake inhibitor.

What best describes the amount of information about potential adverse effects that should be provided in the consultation?

A Discuss all adverse effects with her
B Avoid a discussion of adverse effects as a depressed person may react negatively to the information
C Tell the patient to read up on side adverse on the internet
D Explain the most common adverse effects
E Only highlight extremely serious adverse effects

Question 3

A 66-year-old man had a depressive illness that had led to him being absent from work on sick leave, losing interest in a wide range of activities and frequently being tearful. He had been treated with the selective serotonin reuptake inhibitor (SSRI) citalopram 20 mg daily for 4 weeks without any response. Compliance seemed satisfactory, and there were no underlying chronic difficulties.

Which treatment option is most appropriate given the circumstances?

A Continue treatment with the same dose of citalopram for a further 4 weeks
B Increase the dose of citalopram to 40 mg daily
C Switch the citalopram to an alternative antidepressant such as sertraline
D Combine the citalopram with another SSRI so he is treated with two SSRIs in combination
E Consider he has 'treatment-resistant depression' and that further pharmacological treatment is not appropriate