# BNF 4: CNS - Mental Health Drugs

## Recommendations for the prescribing of Central Nervous System Drugs

| Formulary Key | |
|---|---|
| 1st line formulary choice | Encouraged |
| Alternative formulary choice | On Formulary |
| 2nd line formulary choice | 2nd Line |
| Shared Care (TAG Amber) | Shared Care Agreement |

Local Mental Health Pharmacy Medication Helpline – Norfolk & Suffolk NHS Foundation Trust

Norfolk: Mon to Fri 8.30am-4.30pm - 01603 421212. Mon to Fri 4.30-6pm - 01603 421319

Suffolk: Mon - Fri (exc Bank Holidays) 01473 329141 (leave a message) alternatively email; medicine.info@nsft.nhs.uk

Norfolk and Suffolk NHS Foundation Trust link

## 4.1 Hypnotics and Anxiolytics

### General Prescribing Information

**Treatment of insomnia:** CBT based packages are recommended by BAP (British Association of Psychopharmacology) as first line treatment for chronic insomnia. There is general agreement that when insomnia causes significant personal distress or marked impairment then some form of treatment is appropriate. (ref BAP consensus guideline)

**Treatment for anxiety disorders:** Pharmacological therapies are not recommended as first-line treatments for anxiety disorders due to psychological therapies being associated with a longer duration of effect. Many of the drugs recommended are not licensed for the indications for which they are being used, primarily because the drugs are off patent and licenses have not been applied for. The presence of coexisting depressive symptoms of moderate or greater severity should guide treatment choice towards the prescription of antidepressant drugs rather than benzodiazepines. (ref BAP consensus guideline)

**Insomnia - handy links and guides**

Sleep diary

Sleep hygeine

CKS - Guide to and management of Insomnia — **CKS guide last revised April 2015**

Insomnia assessment guideline

**NICE guidance on zaleplon, zolpidem and zopiclone for insomnia**

| | |
|---|---|
| TA77 guidance | Information for people with insomnia, their families, carers, and the public |

**CSM and BNF prescribing advice - benzodiazepines** — **(CSM and BNF ref)**

Benzodiazepines are indicated for the short term relief (2 to 4 weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short term psychosomatic organic and psychotic illness (recommend secondary care only)

The use of Benzodiazepines to treat short-term "mild" anxiety is inappropriate and unsuitable

Benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress.

**Benzodiazepines - further information and support including Ashton manual available at benzo.org .uk**

Benzodiazepines Learning Module MHRA

This module identifies the most important risks of benzodiazepines in general, outlines factors that contribute to the risks and how the risks can be reduced, identifies important drug interactions of benzodiazepines and the most important hazards of benzodiazepines and informs health professionals how to anticipate, minimise and age the risks.

### 4.1.1 Hypnotics

**Drugs and driving:** the law as of October 2017. Prescription medicines - It's illegal in England and Wales to drive with legal drugs in your body if it impairs your driving. See Gov.uk for a full list of drugs.

**Good Kip Guide** - published by Norfolk and Suffolk NHS Foundation Trust: See Appendix One

Hypnotics should **NOT** be prescribed indiscriminately but only after non-pharmacological methods have failed and where the insomnia is so severe that it is interfering with normal daily life. Routine prescribing is undesirable.

Prescriptions for hypnotics and anxiolytics should **not be routinely available on repeat**. However, there may be a small minority of people who need to be on a small maintenance dose of a benzodiazepine. Examples are people:
– with severe mental health problems under care of a psychiatrist;
– on benzodiazepines for treatment of epilepsy;
– who are seriously or terminally ill.

**Use the lowest effective dose for the shortest period possible. The exact duration will depend on the underlying cause but should not continue for longer than 2 weeks. Up to 4 weeks' use may occasionally be required, but continued use should always be re-assessed after 2 weeks.**

**A patient should only be switched from one hypnotic to another if they experience adverse effects which are considered directly related to a specific hypnotic. This is the only circumstance in which drugs with higher acquisition costs are recommended. Patients who have NOT responded to one hypnotic drug should not be prescribed any of the others.**

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **All hypnotics are licensed for short term use only** | | | | |
| **First line hypnotics after sleep hygiene review** | | | | |
| **ZOPICLONE** | | T: 3.75mg, 7.5mg | **Elderly** : 3.75mg at bedtime<br><br>**Adult over 18 years**: 7.5mg at bedtime. | Elderly / debilitated 3.75mg at bedtime.<br>Longer acting than Zolpidem<br>Useful in patients with poor sleep maintenance and early morning waking.<br>Patients should be advised not to drive or operate machinery the day after treatment until it is established that their performance is unimpaired. (SPC) |
| **ZOLPIDEM** | | T: 5mg, 10mg | **Elderly :** 5mg at bedtime<br><br>**Adult over 18 years:** 10mg at bedtime. | Short acting.<br><br>Useful in patients with sleep onset insomnia and elderly patients.<br>Patients should not drive, operate machinery or work at heights for at least 8 hours after taking Zolpidem. (SPC)<br>No more than 5mg should be prescribed for the **elderly** and those with **liver** impairment. |
| ***Temazepam (not for routine use)*** | | | | |
| **TEMAZEPAM** | | T: 10mg, 20mg<br>L: 10mg/5ml | 10-20mg at bedtime | Avoid use in elderly<br>Should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress and should be prescribed for short periods of time only.<br>**Not cost effective choice** - switch to Zopiclone/ Zolpidem is recommended locally.<br>**DRIVING - see link above for information.**<br>Dosage regimes should not extend beyond 4 weeks (SPC)<br>**Withdrawal from Temazepam (BNF):** Convert to diazepam preferably taken at night. Reduce by 2mg per 2-3 weeks; withdrawal may need to be slower in chronic users and can take up to a year.<br>BNF Guidance to benzodiazepine withdrawal and dose equivalences<br>**1st June 2015** - legislative change to Temazepam. Prescripions must fully comply with the prescription writing requirements for Schedule 3 controlled drugs including. •dose<br>•form<br>•strength (where appropriate)<br>•total quantity of the preparation in both words and figures |
| **Miscellaneous drugs used in insomnia** | | | | |
| **PROMETHAZINE** | | T: 10mg, 25mg<br>L: 5mg/5ml | 25 or 50mg as a single night time dose | Need to encourage alternatives to benzodiazepines and "Z" drugs in primary care **AVALIABLE OTC for self care.** |
| **4.1.1 Melatonin** | | | | |
| Shared Care (TAG Amber status) Circadin Shared Care - Prescribing Information for Circadin® for Sleep Disorders in Children. | | | | |
| **MELATONIN as Circadin ®** | | T: Slow release 2mg | For details of dosing see shared care agreement | Melatonin tablets are non-formulary **(TAG double red)** for licensed indications<br><br>There is no licensed preparation of melatonin available for treatment of sleep disorders in children. Circadin® is a sustained release formulation of melatonin which is prescribable under the shared care agreement. |
| **4.1.2 Anxiolytics and other drugs used in anxiety** | | | | |
| **DIAZEPAM** | | T: 2mg, 5mg<br>L: 2mg/5ml | Anxiety: 2mg three times daily<br>(Elderly 1mg three times daily) | N.B. **Avoid** 10mg tabs as they are more prone to street use - easier to dissolve.<br>Only to be used in Generalised Anxiety Disorder as a **short term** measure during crises. NICE CG113 2011.<br>Should **not** be prescribed for panic disorder as long term outcome is poor. |
| **LORAZEPAM** | | T: 1mg, 2.5mg | Anxiety: 1-4mg daily in divided doses (Elderly or debilitated half adult dose). | |

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|---|---|---|---|---|
| **Miscellaneous drugs used in anxiety** | | | | |
| **SSRIs** | | | | |
| | | | For full details of dosing for SSRIs in anxiety see BNF Sertraline first line see below | NICE CG113 notes that SSRIs should be used first line for Generalised Anxiety Disorder. Consider Sertraline. |
| **SERTRALINE** | | T: 50mg, 100mg | Social anxiety disorder (BNF) **ADULT over 18 years,** initially 25 mg daily for 1 week, then increased to 50 mg daily, then increased in steps of 50 mg at intervals of at least 1 week if required, increase only if response is partial and if drug is tolerated; maximum 200 mg per day. | |
| **VENLAFAXINE** | | M/R: 37.5mg, 75mg, 150mg, 225mg | **Use modified release preparations.** **Generalised anxiety disorder ADULT over 18 years,** 75 mg once daily, increased if necessary up to 225 mg once daily, dose to be increased at intervals of at least 2 weeks; maximum 225 mg per day. | SNRI - as an alternative to SSRI is not tolerated and no other SSRI is appropriate for the patient as per NICE CG113 (2011)<br>Take with food.<br>Reduce dose in moderate renal impairment.<br>At initiation and all dose increases - monitor BP at 4 and 8 weeks - cease therapy or reduce dose if BP consistently raised.<br><br>Contraindicated if high risk of serious cardiac arrythmia or uncontrolled hypertension. |
| | | | **Social anxiety disorder ADULT over 18 years,** 75 mg once daily, there is no evidence of greater efficacy at higher doses, increased if necessary up to 225 mg once daily, dose to be increased if necessary at intervals of at least 2 weeks; maximum 225 mg per day. | Venlafaxine is associated with a higher risk of withdrawal effects compared with other antidepressants due to short half life - mean disposition half life venlafaxine 5 hours and metabolite 11 hours respectively. |
| **Other Miscellaneous drugs used in anxiety** | | | | |
| **PROPRANOLOL** | | T: 10mg, 40mg | 40mg once daily increased to a maximum of 40mg three times daily | Used to reduce autonomic symptoms such as palpitation, and tremor. Use in patients with predominately somatic symptoms. |
| **PREGABALIN** | | C: 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg | Initially 150 mg daily in 2–3 divided doses, then increased in steps of 150 mg daily if required, dose to be increased at 7 day intervals, increased if necessary up to 600 mg daily in 2–3 divided doses. | Consultant should recommend but GP can take responsibility for all scripts.<br>NICE CG113 notes that pregabalin is 3rd line if SSRI or SNRI is not tolerated.<br>Public Health Advice for prescribers on the risk of the misuse of pregabalin and gabapentin - NHS England. |
| **BUSPIRONE** | | T: 5mg, 10mg | Initially 5mg two to three times per day. Dosage may be increased every 2-3 days. Usual therapeutic dose is 15-30mg daily in divided doses. Max dose is 60mg per day. | Buspirone is better suited for benzodiazepine-naive patients, especially if "on-demand" relief of anxiety is not a major therapeutic goal.<br>**Buspirone remains Double Red for Augmentation of an antidepressant - as per NICE CG 90 - Do Not Do** |

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## Local prescribing messages and available resources for antipsychotic prescribing

***For drugs used in Dementia treatment please see 4.11 Drugs for Dementia Formulary***

**Psychosis and Schizophrenia**

CKS - managing Psychosis and Schizophrenia — Last revised February 2015

Psychosis and schizophrenia in adults: treatment and management | Guidance and guidelines | NICE CG 178

Patients with schizophrenia should have physical health monitoring (including cardiovascular disease risk assessment) at least once per year.

**Antipsychotic prescribing - MHRA's new learning package available at:**

MHRA antipsychotics e-learning module

The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug including:

- Metabolic (e.g. weight gain and diabetes) Patients treated with any atypical antipsychotic, should be monitored for symptoms of hyperglycaemia (such as polydipsia, polyuria, polyphagia and weakness) and patients with diabetes mellitus should be monitored regularly for worsening of glucose control.
- Extrapyramidal (e.g. akathisia, dyskinesia and dystonia)
- Cardiovascular (e.g. prolonging the QT interval)
- Hormonal (e.g. raising serum prolactin levels)
- Other (e.g. unpleasant subjective experiences)

Suggested Guidance on Monitoring Drugs in Primary Care

**Extrapyramidal effects and withdrawal syndrome have been reported occasionally in the neonate when antipsychotic drugs are taken during the third trimester of pregnancy. Following maternal use of antipsychotic drugs in the third trimester, neonates should be monitored for symptoms including agitation, hypertonia, hypotonia, tremor, drowsiness, feeding problems, and respiratory distress.**

**It is advisable to monitor prolactin concentration at the start of therapy, at 6 months, and then yearly. Patients taking antipsychotic drugs not normally associated with symptomatic hyperprolactinaemia should be considered for prolactin monitoring if they show symptoms of hyperprolactinaemia (such as breast enlargement and galactorrhoea).**

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **RISPERIDONE** | | T: 500 micrograms, 1mg, 2mg, 4mg, 6mg<br>L: 1mg/ml (expensive preparation) | See BNF | Risperidone is indicated for the management of schizophrenia, moderate to severe episodes of manic behaviour in patients with bipolar disorder. Short term use (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions where there is a risk to self or others. In aggressive behaviour in very specific patients.<br>**Prescribe generically**<br>Note: Risk of Diabetes Mellitus. Check blood glucose annually. |
| **ARIPIPRAZOLE** | | T: 5mg, 10mg, 15mg, 30mg<br>T orodisp:10mg and 15mg<br>L: 1mg/ml | See BNF | GP prescribing following consultant initiation / recommendation<br>NICE TA292<br>NICE TA213<br>NICE CG155 |
| **AMISULPRIDE** | | T: 50mg, 100mg, 200mg, 400mg<br>L: 100mg/ml (expensive preparation) | See BNF | Please **don't** prescribe 400mg tablets as not cost effective option. |
| **OLANZAPINE** | | T: 2.5mg, 5mg, 7.5mg & 10mg<br>Oral Disp Tabs: 5mg, 10mg & 15mg | See BNF | Consultant should prescribe for an initial period of **one month.**<br>Caution : risk of metabolic syndrome |
| **QUETIAPINE** | | T immediate release: 25mg, 100mg, 150mg, 200mg & 300mg. | See BNF | Consultant should prescribe for an initial period of **one month.**<br>Avoid use in elderly<br>**Modified Release** may be prescribed on the recommendation of specialist due to intolerance (e.g. due to severe sedation affecting functionality or postural hypotension / dizziness with increased risk of falls). USE most cost effective brand available. |

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| **HALOPERIDOL** | | C: 500 micrograms<br>T: 1.5mg, 5mg, 10mg, 20mg<br>L: 1mg/ml, 2mg/ml | See BNF<br>BNF limit for oral haloperidol is now **20mg** a day | Reduce dose in elderly<br>Contraindicated with drugs which prolong the QT interval (see Appendix Two) |
| **TRIFLUOPERAZINE** | | T: 1mg, 5mg<br>L: 1mg/5ml, 5mg/5ml | See BNF | Reduce dose in the elderly : usually quarter to half. |
| **SULPIRIDE** | | T: 200mg | Adult and child over 14 years: 200-400mg twice daily. | Please prescribe as 200mg tablets as most cost effective strength. |
| **FLUPENTIXOL** | | T: 3mg | Initially 3-9mg twice daily adjusted according to response max. 18mg daily | Reduce dose in the elderly : usually quarter to half. |
| **ZUCLOPENTHIXOL** | | T: 2mg, 10mg, 25mg | Initially 20-30mg daily in divided doses. Max 150mg if necessary.. Maintenance dose 20-50mg daily and max single dose is 40mg. | Reduce dose in the elderly : usually quarter to half. |
| **CHLORPROMAZINE** | | T: 25mg, 50mg, 100mg<br>L: 25mg/5ml, 100mg/5ml | See BNF | Owing to the risk of contact sensitisation, pharmacist, nurses, and other health workers shold avoid direct contact with chlorpromazine; tablets should not be crushed and solutions should be handled with care<br>As photosensitisation may occur with higher doses, patients should avoid direct sunlight. |
| **ONLY as part of Early Intervention Treatment Pathway for schizophrenia only** | | | | |
| **LURASIDONE - Lutada ®** ▼ | | **T: film coated** 18.75mg, 37mg, 74mg | Dose as per specialist. | TAG status Green (GP prescribable following consultant initiation)<br>NSFT trust specialists to ensure **4 weeks oral Lurasidone is provided to those over 18 years requiring treatment for schizophrenia before requesting GP to take over prescribing**. A letter will be produced in line with the Early Intervention Treatment Pathway when developed.<br>Grapefruit juice should be avoided during treatment with lurasidone |
| **Red Hospital Only Prescribing** | | | | |
| **CLOZAPINE** | | Clozapine must **not** be prescribed in primary care. It is "RED" (Hospital only) prescribing - hospitals are also responsible for the safety monitoring. **GPs are responsible for the annual health check.**<br>Suggested monitoring of drugs in primary care<br>Clozapine **MUST** be recorded on GP Clinical systems to ensure all healthcare professionals are aware it is being prescribed.<br>When a new patient is initiated on clozapine it is the responsibility of the initiating prescriber to inform the GP so that it can be added to the GP clinical system<br>Caution - smoking cessation may cause up to 50% increase in Clozapine levels<br>Caution - constipation is likely with Clozapine - please ensure adequate laxative use to prevent faecal impaction and potential bowel rupture. | | |
| **Hospital only DEPOT injections and ORAL formulations - Safety consideration** | | | | |
| Hospital only Depot and oral products - Please ensure that all healthcare professionals involved in the individual's care are made aware of secondary care specialist prescribing of depot injections or oral products for psychosis and related conditions. Best practice would be to add this item to the patient's drug list and an additional note made to alert the community pharmacist that this is for specialist use or community psychiatric nurse use only. The item should be noted as not for order via community pharmacy to prevent provision to the patient via FP10. | | | | |

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Norfolk and Suffolk NHS Foundation Trust link

## 4.2.3 Drugs used for mania and hypomania

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **Bipolar Disorder** | | | | |
| Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care NICE CG185<br>CKS link for managing bipolar disorder<br>UKMi - NICE Bites Bipolar Disorder 2014 | | | | Last revised September 2017 |
| **LITHIUM CARBONATE (tablets)** | | **Priadel:**<br>M/R T: 200mg, 400mg<br>**Camcolit:**<br>T: I/R 250mg (Bioequivalent to Camcolit - rebranded), 400mg M/R<br>**Liskonum:** 450mg M/R tablet | See BNF and prescribe by brand. | Specialist advice only<br>Register patients with lithium database 01603 421212 or link for further info<br>Knowledge Anglia Lithium Database Information<br>**Requires monitoring**<br>Suggested monitoring of drugs in primary care |
| **LITHIUM CITRATE (liquids)** | | **Li-liquid (two strengths)**<br>**Yellow liquid:** 509mg/5ml (=200mg lithium tablets)<br>**Orange liquid:** 1018mg/5ml (=400mg of lithium tablet)<br>**Pridel liquid:** 520mg/5ml (=204mg of lithium tablet)<br>**Not interchangeable with the tablet form - please prescribe with caution. If considering due to swallowing difficulty please reassess for ongoing need.** | | Interactions – See BNF<br>**Lithium toxicity** is made worse by sodium depletion, therefore concurrent use of diuretics (particularly thiazides) is hazardous and should be avoided.<br>**Caution** with ACE and NSAID use - up to a 4 fold increase in serum levels can occur with concomitant use.<br>**Caution:** co-prescribing with soluble analgesics may cause altered serum levels. Full dose soluble analgesia contains approximately 8g Na+. Care also with raft forming indigestions remedies as these may also contain high levels of Na+ at full dose. See BNF for the sodium content of individual products.<br>Note: Preparations vary widely in bioavailability. Changing the preparation requires the same precautions as initiation of treatment.<br>Patients should be advised not to change their diet drastically without first consulting their doctor. |
| **OLANZAPINE** | | T: 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg<br>ODT: 5mg, 10mg, 15mg, 20mg | Prevention of recurrence of manic episode, initially 10mg once daily, or continue at same dose if receiving treatment for manic episode.<br>Adjust in all cases if necessary within range of 5—20mg daily. | Olanzapine can be used for the long-term management of bipolar disorder in patients whose manic episode responded to olanzapine therapy. It can be given either as monotherapy, or in combination with lithium or valproate if the patient has frequent relapses or continuing functional impairment. |
| **QUETIAPINE** | | T: 25mg, 100mg, 150mg, 200mg, 300mg | Manic episode, 100mg on day 1, 200mg on day 2, 300mg on day 3 and 400mg on day 4. All in two divided doses. Then titrate according to response, usually 400—800mg daily; range 200—800mg daily.<br>Maintenance, 300—800mg daily in two divided doses. | XL formulations are **non-formulary** |
| **ARIPIPRAZOLE** | | T: 5mg, 10mg, 15mg, 30mg<br>ODT: 10mg, 15mg | Manic episodes: **Adults:**15mg once daily; max 30mg daily. Continue on same dose for preventing recurrence of manic episodes.<br>**Adolescents aged 13-18:** usual maintenance dose of 10mg once daily. Max duration 12 weeks. | NICE TA292<br>TAG recommendation: Consultant/Specialist should recommend, but GP can take responsibility for all scripts. Usually initiated in secondary care. |

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|---|---|---|---|---|
| **SODIUM VALPROATE** |  | T: 100mg, 200mg, 500mg<br>M/R tablets: 200mg, 300mg, 500mg<br>M/R capsules: 150mg, 300mg<br>L: 200mg/5ml<br><br>Other formulations e.g. Episenta granules, Epilim Chronosphere | Initially (as slow release) 500mg/day increased according to response to 1-2g daily | Contraindicated in pregnancy - causes reduced folate levels. Adequate contraception should be advised during treatment.<br>Drug safety Update January 2015 - Medicines related to valproate: risk of abnormal pregnancy outcomes.<br>Prescribing with specialist advice only |
| **VALPROATE SEMI-SODIUM** |  | T : 250mg, 500mg | Initially 750mg daily in 2-3 divided doses, increased according to response to 1-2g daily | Contraindicated in pregnancy - causes reduced folate levels. Adequate contraception should be advised during treatment.<br>Drug safety Update January 2015 - Medicines related to valproate: risk of abnormal pregnancy outcomes.<br>Prescribing with specialist advice only |
| **Bipolar depression** | | | | |
| **LAMOTRIGINE** |  | T: 25mg, 50mg, 100mg & 200mg<br><br>Disp T: 2mg, 5mg, 25mg & 100mg | Dose titration is complex and depends upon concomitant medication | Specialist advice only. GPs may continue treatment following initiation and recommendation by a Specialist. TAG recommendation Green (Suitable for GPs to prescribe following specialist initiation) Only for use in Bipolar depression - see GP Prescribing Guidance below.<br>Lamotrigine for Bipolar Depression GP Prescribing Guidance: Lamotrigine for Bipolar Depression |
| | | | | Patients should receive at least 2 weeks supply of medication following discharge from hospital. |
| **CARBAMAZEPINE** |  | T: 100mg, 200mg, 400mg<br><br>M/R tablets: 200mg, 400mg<br>Liquid: 100mg/5ml | See BNF and prescribe by brand. | |

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## 4.3 Anti-Depressant Drugs

CKS link for the management of depression — Last revised October 2015

Depression in adults: recognition and management NICE CG90

Depression in children and young people: identification and management NICE CG28

**MHRA guidance and learning module on SSRIs**

MHRA - Selective Serotonin reuptake inhibitors (SSRIs) e-learning module

MHRA Guidance - Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs): use and safety Published 18 December 2014

**Switching or withdrawing antidepressants**

Switching and Withdrawing Antidepressants MIMs Online

**Additional useful information**

Specialist Pharmacy Services - Q&As on antidepressants

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **First Line - SSRIs after non-pharmacological approach accessed through Norfolk and Waveney Wellbeing Service** | | | | |
| **Relevant Medicines Q&As for SSRIs** | | | | |
| **What is the risk of gastrointestinal bleeding associated with selective serotonin reuptake inhibitors (SSRIs)?** | | | | |
| If an SSRI is required in a patient at high risk of an upper GI bleed (including elderly patients also taking NSAIDs or aspirin or those on multiple drugs which can cause bleeding), consider the use of a gastro-protective agent. Studies have shown the use of acid suppressing drugs, e.g. PPIs, to be protective against upper GI bleeds in patients receiving single-therapy SSRI or combined NSAID and SSRI treatment. Paracetamol should be considered as an alternative to an NSAID in patients who are taking SSRIs. | | | | |
| **If antidepressant-induced hyponatraemia has been diagnosed, how should the depression be treated?** | | | | |
| Most antidepressants are associated with hyponatraemia, with the highest risk being with SSRIs and lowest risk being with mirtazapine. | | | | |
| **What is serotonin syndrome and which medicines cause it?** | | | | |
| **CITALOPRAM** | | **T:** 10mg, 20mg, 40mg | 20mg daily (morning) | Restrictions on the maximum daily doses of citalopram: 40 mg for adults; 20 mg for patients older than 65 years; and 20 mg for those with hepatic impairment. |
| | | **Liquid:** 40mg/ml (1drop=2mg), 4 drops (8mg) ≡ 10mg tablet | The **liquid MUST** be prescribed in number of drops **NOT in millilitres**. | Contraindicated in patients with known prolonged QT interval or congenital long QT, AND contraindicated with other medicines known to prolong QT interval. |
| | | | | See appendix 2. |
| | | | Citalopram hydrochloride base in the liquid is more potent than the hydrobromide salt in tablets. | Caution in patients at higher risk of Torsades de Pointes. |
| | | | | Half life: 36 hours |
| **SERTRALINE** | | **T:** 50mg,100mg | 50mg daily initially, increasing gradually to a max of 200mg daily if | Half life: 26 hours so beware of discontinuation symptoms |
| **FLUOXETINE** | | **C:** 20mg, 60mg | 20mg daily in the morning increased according to response to 60mg daily | When used in a 60mg dose prescribe 3 x 20mg capsules which is the most cost effective option. |
| | | **Liquid:** 20mg/5ml | | Half life: up to two weeks for the active metabolites. |
| | | **Dispersible tablets S/F**: 20mg (can be halved) | | Avoid giving at night as can cause sleep disturbance |
| **ESCITALOPRAM** | | **T:** 5mg and 10mg | Start at 10 mg daily, increased if necessary to 20mg/day. For panic disorder start at 5mg daily for 7/7 then increased to 10-20mg daily. | Half life: 36 hours |
| | | | | Take in the morning to avoid sleep disturbance |
| **PAROXETINE** | | **T:** 20mg, 30mg<br>**L:** 10mg/5ml | Doses for depression use 20-50mg daily. Start at 10mg daily in panic disorder to minimise exacerbation of symptoms. | Take in the morning to avoid sleep disturbance |
| *If failure to respond to dose escalation consider switching to another SSRI or other antidepressant.(NICE 2009)* | | | | |
| *Caution: withdrawal effects may occur with abrupt discontinuation of an SSRI and have been reported more commonly in SSRIs with a shorter half life. The symptoms usually last for one to two weeks. Switching to an SSRI with a longer half life before gradually tapering may be of benefit.* | | | | |

## *Second Line - other antidepressant drugs*

*NaSSa - Noradrenaline and Specific Serotonin antidepressant. TCA - Tricyclic Antidepressant. RIMA - Reversible Inhibitor of Monoamine A. SMS - Serotonin Modulator and Stimulator*

| | | | | |
|---|---|---|---|---|
| **MIRTAZAPINE (NaSSa)** | | **T:** 15mg, 30mg, 45mg | Initially 15mg to 30mg at bedtime, increased up to 45mg daily if necessary | Orodispersible tablets are the most cost effective option. |
| | | | | Causes sedation during initial treatment. Starting at 30mg nocte will cause less sedation. |
| | | | | Half life 20-40 hours |
| **VENLAFAXINE (OTHER)** | | **T:** 37.5mg, 75mg | **Depression:** Initially 75mg daily in two divided doses, increased slowly at intervals of two weeks; for dose titration use the standard release tablets. | Take with food |
| | | **XL Tablets:** 37.5mg, 75mg, 150mg, 225mg | | Reduce dose in moderate renal impairment. |
| | | **XL Capsules**: 75mg, 150mg | (Maximum 300mg daily unless under specialist supervision) | Caution in patients with established cardiac disease. Possibility of arrhythmias and increased. Consider ECG for anyone wit the possibility of heart disease. |
| | | | | At initiation and all dose increases - Monitor BP at 4 and 8 weeks - cease therapy or reduce dose if BP consistently raised. |
| | | | | Therapeutic Drug Monitoring Guide |
| | | | | For **S/R preparations** please prescribe as XL tablets or as cost effective branded generic capsules. |
| | | | | Venlafaxine is associated with a higher risk of withdrawal effects compared with other antidepressants due to short half life - mean disposition half life venlafaxine 5 hours and metabolite 11 hours respectively. |
| **LOFEPRAMINE (TCA)** | | **T:** 70mg | 140-210mg daily in divided doses | Elderly may respond to lower doses |
| | | **L:** 70mg/5ml | | Due to lower risks in overdose NICE recommends Lofepramine as the tricyclic of choice. |
| **AMITRIPTYLINE (TCA)** | | **T:** 10mg, 25mg, 50mg | Starting dose 75mg daily at night or in divided doses. Doses 125mg-150mg required to effectively treat depression. | Use lower dose if 2D6 slow metaboliser. Use lower doses in the elderly. |
| | | **L:** 10mg/5ml, 25mg/5ml, 50mg/5ml | | |
| **DULOXETINE (OTHER)** | | **GR Caps:** 30mg, 60mg | 60mg dailly | Take in the morning to avoid sleep disturbance |
| | | | | 4th line for depression, 3rd line for adults over 65. |
| **CLOMIPRAMINE (TCA)** | | **C:** 10mg, 25mg, 50mg | Start at 10mg at bedtime, increased to 125-150mg/day for depression, max 250mg /day. **Elderly:** max dose is 75mg daily. | Use a lower dose in 2D6 slow metabolisers. Is highly serotinergic. At higher doses 150mg –300mg/day monitor ECG. |
| **IMIPRAMINE (TCA)** | | **T:** 10mg, 25mg, 50mg | Start at 75mg daily in divided doses increased slowly up to 200mg according to response | Up to 150mg can me taken as a single bedtime dose. |
| | | **L:** 25mg/5ml | **Elderly:** use lower doses starting at 10mg daily up to 50mg max. | Less sedative than amitriptyline. |
| **MOCLOBEMIDE (RIMA)** | | **T:** 150mg, 300mg | **Depression:** 150-600mg daily in a divided dose after food. | No MAOi dietary restrictions as such but avoid large amounts of tyramine containing foods or |
| **TRAZODONE (TCA related)** | | **T:** 150mg | **Depression:** Start at 150mg daily in divided doses up to 600mg daily according to need. | Has hypnotic properties due to highly sedative antihistaminergic action. |
| | | **C:** 50mg, 100mg | **Anxiety:** start at 75mg daily increased to a maximum dose of 300mg daily. | Take after food to reduce peak blood levels. |
| | | **L:** 50mg/5ml | | |

## *Third Line - other antidepressant drugs*

| | | | | |
|---|---|---|---|---|
| **VORTIOXETINE (SMS)** ▼ | | **T:** 5mg, 10mg, 20mg | Starting dose 10mg daily, adjust to 5-20mg daily **Elderly**: The lowest effective dose of 5 mg vortioxetine once daily should always be used as the starting dose in patients ≥ 65 years of age. Caution is advised when treating patients ≥ 65 years of age with doses higher than 10 mg vortioxetine once daily for which data are limited. (SPC) | **Approved by NICE as 3rd line option antidepressant for treating major depressive episodes in adults whose condition has responded inadequately to two antidepressants within the current episode, in accordance with NICE TA367.** |
| | | | | Metabolised by CYP2D6 so may require dose adjustments with concomitant medication |

# BNF 4: CNS - Mental Health Drugs

## Recommendations for the prescribing of Central Nervous System Drugs

**Formulary Key**

| | |
|---|---|
| 1st line formulary choice | Encouraged |
| Alternative formulary choice | On Formulary |
| 2nd line formulary choice | 2nd Line |
| Shared Care (TAG Amber) | Shared Care Agreement |

Local Mental Health Pharmacy Medication Helpline – Norfolk & Suffolk NHS Foundation Trust

Norfolk: Mon to Fri 8.30am-4.30pm - 01603 421212. Mon to Fri 4.30-6pm - 01603 421319

Suffolk: Mon - Fri (exc Bank Holidays) 01473 329141 (leave a message) alternatively email; medicine.info@nsft.nhs.uk

Norfolk and Suffolk NHS Foundation Trust link

## 4.4 CNS Stimulants and drugs used for attention deficit hyperactivity disorder

Atomoxetine for ADHD and related disorders in Children & Adolescents

Stimulants are indicated for the treatment of Attention Deficit/Hyperactivity Disorder (ADHD) in children aged 6 years of age and over as part of a comprehensive treatment programme where remedial measures alone prove insufficient.

Treatments for Adults with ADHD (relating to Specialist Services provided by NSFT, commissioned by Central and West Norfolk CCGs)

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **First Line** | | | | |
| **METHYLPHENIDATE**<br><br>Prescribe by bioequivalent brand - for cost effective choices see Shared Care Agreement | | **Tablets:** 5mg, 10mg & 20mg<br>**M/R Capsules**:10mg, 20mg &30mg<br>**S/R Capsules:** 10mg, 20mg, 30mg, 40mg<br>**S/R Tablets:** 18mg, 36mg<br>**S/R Tablets:** 18mg, 36mg, 54mg<br>**S/R Tablets:** 18mg, 27mg, 36mg | See BNF<br><br>**Use cost effective choice** | **Prescribe by Brand :** Medikinet ® or Ritalin ®<br>**Prescribe by Brand :** Equasym XL®<br>**Prescribe by Brand :** Medikinet XL®<br>**Prescribe by Brand**: Xenidate XL®<br>**Prescribe by Brand :** Matoride XL ®<br>**Prescribe by Brand :** Delmosart ® |
| **ATOMOXETINE** | | **C :** 10mg, 18mg, 25mg, 40mg, 60mg, 80mg & 100mg. | See BNF | **Prescribe by Brand:** Strattera®<br>**GP monitoring responsibility:** 6-monthly monitoring of height, weight, BP & pulse is advised for all treated with CNS stimulants for ADHD. |
| | | | **MHRA Nov 2011** - Contraindications - atomoxetine should not be used in patients with:<br>Severe cardiovascular or cerebrovascular disorders in which clinical deterioration would be expected with increases in blood pressure or heart rate that could be clinically important (e.g. 15–20 mm Hg in BP or 20 bts / min in HR). Refer to the manufacturer's SPC. | |
| **Dexamfetamine and lisdexamfetamine may be used to treat ADHD in children aged six years and over in whom methylphenidate and atomoxetine have not been successful or are not clinically indicated.** | | | | |
| **DEXAMFETAMINE** | | **T:** 5mg | See BNF | |
| **LISDEXAMFETAMINE - Elvanse ▼** | | **C:** 30mg, 50mg, 70mg | See BNF | **Prescribe by Brand:** Elvanse ® |

# BNF 4: CNS - Mental Health Drugs

## Recommendations for the prescribing of Central Nervous System Drugs

**Formulary Key**

| | |
|---|---|
| 1st line formulary choice | Encouraged |
| Alternative formulary choice | On Formulary |
| 2nd line formulary choice | 2nd Line |
| Shared Care (TAG Amber) | Shared Care Agreement |

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Norfolk and Suffolk NHS Foundation Trust link

## 4.10 Drugs used in substance dependence - to be used on accordance with local shared care and/or as part of a public health commissioned service.

**Better patient outcomes are obtained when prescribing forms part of a programme including psychosocial support**

Adult Drug and Alcohol Services in Norfolk: Change Grow Live (CGL)

### 4.10.1 Alcohol dependence

CKS link to Alcohol Problem Drinking (updated 2018)

Before considering treatment use an alcohol use screening test to assess the patient's risk from drinking alcohol.

**NICE CG 115** Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence - Feb 2011 (reviewed 2015)

1.3.1.5 NICE CG 115- All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff.

1.3.1.7 NICE CG 115 - Give information and support on the value and availability and help to access community support networks and self-help groups

| Drug | | Formulations | Dose | Notes |
|---|---|---|---|---|
| **ACAMPROSATE**<br>**NOT TO BE PRESCRIBED IN PRIMARY CARE.** | | **GR T:** 333mg | Adults 18-65 years: | Maintenance of abstinence in alcohol-dependent patients. |
| | | | Body-weight 60kg and over 666mg 3 times daily: body weight less than 60kg, 666mg at breakfast, 333mg at midday and 333mg at night. | It should be initiated as soon as possible after abstinence is achieved and continued for up to 6 months or longer for those benefitting from the drug. Evidence suggests the intended actions of acamprosate are maintained over **1 year** but not beyond. Treatment should be maintained if the patient has a temporary relapse but **STOPPED** if the patient returns to regular or excessive drinking that persists 4-6 weeks after starting treatment. |
| | | | | Assess efficacy regularly |
| **DISULFIRAM**<br>**NOT TO BE PRESCRIBED IN PRIMARY CARE.** | | **T:** 200mg | Adult: 200mg daily, increased if necessary up to 500mg daily | Adjunct in treatment of chronic alcohol dependence (under specialist supervision) |
| | | | | Patients should not have ingested alcohol 24 hours before starting disulfiram. |
| | | | | No longer than six months treatment without review. |
| | | | | LFTs should be repeated every month for the first 2 months of treatment |
| **NALTREXONE** | | **T:** 50mg | Specialist alcohol services will initiate medication and provide dose regime. See shared care agreement. | Naltrexone can be used as an adjunctive prophylactic therapy in the maintenance of detoxified, formerly alcohol-dependent patients, where there is risk of relapse into alcohol use and the patient has made an informed choice to take the medication. |
| | | | | Naltrexone should be stopped if drinking persists 4 - 6 weeks after starting the drug. |
| | | | | Patients should be reviewed at least monthly for the first 6 months and subsequently at reduced intervals if the drug is considered to be effective and continued. |
| | | | | Shared Care Agreement: Naltrexone for Abstinence in Alcohol Use Disorder |
| **Do not prescribe on FP10 until available via Public Health Commissioned Service** | | | | |
| **NALMEFENE - NICE TA 325 Selincro ®**<br>**NOT TO BE PRESCRIBED IN PRIMARY CARE.** | | **T:**18mg | This will only be funded through Public Health. | NICE TA 325 - An option for reducing alcohol consumption, for people with alcohol dependence who have a high drinking risk level without physical withdrawal symptoms and who do not require immediate detoxification. Should only be prescribed in conjunction with continuous psychosocial support and be initiated only in patients who continue to have a high drinking risk level 2 weeks after initial assessment. |

## Detoxification

**Dexotification from alcohol: Thiamine 100mg TDS and Vitamin B Co strong tablets (2 tablets three times daily) may be prescribed for the prevention of Wernicke's Encephalopathy for six weeks. Patients who resume drinking or continue to drink and are at risk of malnourishment should be given oral thiamine indefinately.**

## 4.10.2 Nicotine dependence

Smoking and Drug Interactions UKMi Nov 2017

**First Line**

Nicotine replacement therapy (NRT) is normally used first line as monotherapy. Choice should be based on simplicity of the product and cost. Prescribing for two weeks at a time is encouraged as this will prevent waste and encourage a face to face review. The patient must be motivated to quit. Prescribing of NRT to those who continue to smoke is not supported. (NICE PH Smoking Cessation)

NICE Public Health Guidance Smoking cessation services - updated Nov 2103

| | | | | |
|---|---|---|---|---|
| Nicotine patches | | all strengths 16 hour and 24 hour | See BNF | |
| Nicotine gum | | 2mg & 4mg | See BNF | |
| Nicotine lozenges | | 1mg, 2mg & 4mg | See BNF | |
| Nicotine sublingual tablets | | 2mg & 4mg | See BNF | |
| Nicotine inhalator | | | See BNF | |
| Nicotine nasal spray | | 0.5mg/ spray | See BNF | |
| Nicotine oral spray | | 1mg/ spray | See BNF | |
| **Second Line** | | | | |
| **BUPROPION** | | **T:** 150mg | See BNF - duration normally 7 - 9 weeks | Many contra-indications and side effects.<br>Not first line treatment<br>When prescribed by other healthcare professionals ensure it is added to the GP clinical system<br>**MHRA** -Prescribers are reminded that buproprion is contraindicated in patients with previous or current seizure disorder. Bupropion carries a 1 in 1000 risk of causing seizures. |
| **VARENCILINE - Champix** ◖▼ | | **T:** 500 micrograms, 1mg | See BNF - recommended for 2 - 4 weeks initially. | It should be prescribed ONLY as part of a Level 3 programme which includes behavioural support.<br>**MHRA/ CHM advice**: Patients should be advised to discontinue treatment and seek prompt medical advice if they develop agitation, depressed mood, or suicidal thoughts.<br>GP prescribable after Consultant/specialist recommendation where the specialist is a Smoking Cessation Adviser (Level 2 or 3). |

## 4.10.3 Opioid Dependence

**Some useful links**

NICE CG 51: Drug misuse in over 16s: psychosocial interventions 2007 (updated 2016)

NICE CG 52 - Drug misuse in over 16s: opioid detoxification 2007 (updated 2014)

Drug Misuse and dependence - UK guidelines on clinical management 2017

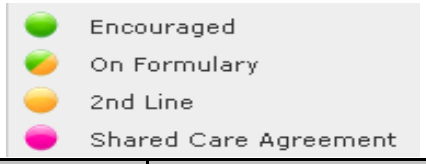
Royal College of General Practitioners - Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care 2011

**Initiated via specialist services**

# BNF Chapter 4.11 Drugs for Dementia

**Formulary Key**

1st line formulary choice
ternative formulary choice
2nd line formulary choice
Shared Care (TAG Amber)




| Drug | | | Dose | Notes |
|---|---|---|---|---|
| **Acetyl-cholinesterase Inhibitors** | | | | |
| Primary Care Guidance - Managing behavioural problems in people with dementia - Guidance for GPs on the use of antipsychotics for behavioural problems in people with dementia. | | | | |
| Key Message Bulletin 29: Antipsychotics in dementia | | | | |
| Donepezil, galanatmine and rivastigmine can be used for treatment of mild to moderate Alzheimers disease as per NICE TA217 | | | | |
| Shared care is supported where a specialist should prescribe for an initial period of four months - see TAG Guidance | | | | |
| **For advice on prescribing for patients with swallowing difficulties, contact ARDEN &GEM CSU Prescribing and Medicines Optimisation Team : 01603 257000** | | | | |
| Shared Care Prescribing Information - Donepezil, Galantamine, Rivastigmine and Memantine for the treatment of Alzheimer's disease and dementia with Lewy Bodies (DLB) | | | | |
| **First line choice** | | | | |
| **Donepezil** | | **T:** 5mg, 10mg | 5mg once daily at bedtime, increased to 10mg after one month if necessary | Mild to moderate dementia in Alzheimers disease. |
| **Second line choice** | | | | |
| **Galantamine** | | **T:** 8mg, 12mg | 4mg twice daily for 4 weeks increased to 8mg twice daily for 4 weeks; maintenance 8-12mg twice daily | Mild to moderate dementia in Alzheimers disease. |
| | | **MR Cap:** 8mg, 16mg, 24mg | 8mg once daily for 4 weeks increased to 16mg once daily for 4 weeks, maintenance 16mg - 24mg daily | Prescribe by cost effective brand. |
| **Rivastigmine** | | **C:** 1.5mg, 3mg, 4.5mg, 6mg | 1.5mg twice daily, increased in steps of 1.5mg twice daily at intervals of at least 2 weeks; usual range 3-6mg twice daily | Mild to moderate dementia in Alzheimers disease or in Parkinson's disease. |
| | | **Patch:** 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr | | **Note - high cost formulation. ONLY for patients with swallowing difficulties.** |
| **Glutamate Receptor Antagonists** | | | | |
| Memantine may be used as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer's disease as per NICE TA217 | | | | |
| A shared care agreement exists where by a specialist should prescribe for an initial period of 7 to 8 weeks until 2nd review - see Shared Care Prescribing Information: Memantine for Alzheimer's Disease | | | | |
| **Memantine** | | **T:** 10mg, 20mg | 5mg once daily, increased in steps of 5mg at weekly intervals to max. 20mg daily | Moderate to severe dementia in Alzheimers disease |
| Combination treatment with memantine and an acetylcholinesterase inhibitor is not recommended (NICE TA217) | | | | |
| Guidance for general practice on assessing and treating dementia in primary care can be found at http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf | | | | |

## Appendix One

# Good kip guide

Norfolk and Suffolk NHS
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- Avoid alcohol and caffeine containing drinks (e.g. tea, coffee, cola) within two hours of bedtime. They will affect your sleep.
- If you are not asleep within half an hour, then get up and do something relaxing.
- Avoid daytime naps, be more active during the day.
- A warm bath a few hours before bedtime may help you feel sleepy.
- Avoid doing excessive physical or mental activity near bedtime.
- Make sure the bedroom is warm and comfortable. Avoid extremes of noise, light and temperature.
- Go to bed and get up at a regular time, regardless of how much sleep you've had.
- Make sure your bed is associated with sleep. For example, don't watch TV, eat or talk on the telephone in bed.
- Avoid smoking late at night. Nicotine is a stimulant and can keep you awake.

There are many good reasons for not sleeping well. These can inlude getting older, medical and emotional problems, unhelpful surroundings and disrupted sleep routines.

Sleep varies between people. There is no 'right' amount of sleep.

It is also possible to think you have a sleep problem when in fact you are still getting enough sleep but it is different from what you expect.

**BE PATIENT** - sleep problems are very common. It can take many weeks to develop new sleep habits.

Produced by Pharmacy Dept. NSFT - December 2103. GFX3235

## Appendix Two

Some drugs associated with QT prolongation (list not exhaustive):

Credible meds: has regularly updated lists of drugs which prolong QT interval. Free to use but requires registration for printable lists. Seach for single drugs is free https://www.crediblemeds.org/index.php

### Antibiotics

- Azithromycin
- Clarithromycin
- Erythromycin
- Metronidazole (with alcohol)
- Moxifloxan

### Antifungals

- Fluconazole (in cirrhosis)
- Ketoconazole

### Antivirals

- Nelfinavir

### Antimalarials

- Chloroquine
- Mefloquine

### Anaesthetics

- Halothane

### Antiarrhythmics

- Disopyramide
- Procainamide
- Quinidine
- Amiodarone
- Sotalol

### Antidepressants

- Amitriptyline
- Clomipramine
- Dosulepin
- Doxepin
- Imipramine
- Lofepramine

### Antipsychotics

- Risperidone
- Fluphenazine
- Haloperidol
- Clozapine
- Pimozide
- Chlorpromazine

### Others

- Methadone