

Medications Used In Psychiatric Practice

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What's new?

Not very much!
(at least in the context of
occupational health)

Schizophrenia

Clozapine

Atypicals:

Olanzapine

Quetiapine

Risperidone

Amisulpiride

Occupational Health

The big challenges

- Depression
 - Anxiety
 - PTSD
 - Alcohol
 - ?Somatisation
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Depression

- ❑ CBT – effective, but only in mild to moderate cases.
 - ❑ Antidepressants – unfortunately none are more effective than the tricyclics introduced in the 1950s. Modern antidepressants are more tolerable (in some people). They are certainly safer in overdose compared with older drugs.
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Antidepressants

General Principles

- ❑ All take about 3 weeks to start working and about 3 months to have full effect
 - ❑ No single antidepressant is better than any other, but different drugs may be tolerated by individuals differently
 - ❑ The ability to tolerate an antidepressant in adequate dosage is crucial
 - ❑ If the patient is not getting better, or if their progress has stalled – then something needs to change.
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Antidepressants

(what to do if they don't work)

- ❑ Is the patient taking them in the correct dose? (Some patients may be fast metabolisers and need more than the BNF recommended maximum)
 - ❑ Switch to a different group
SSRI > TCA > MAOI
 - ❑ Augmentation
 - L-Tryptophan
 - Lithium
 - 2nd antidepressant
 - Thyroxine
 - (CBT)
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Depression

Remember – if somebody is off work for > 6 months the chances off getting them back to an active role rapidly decline.

Early intervention and vigorous, enthusiastic treatment is essential.

Antidepressants in Common Use

□ SSRI s

Fluoxetine

Sertraline

Cipramil (Escitalopram)

□ TCAs

Dosulepin (Dothiepine)

Amitryptylene

Lofepramine

□ MAOI s

Phenelzine

Anxiety

- Anxiety is depression until proven otherwise!
 - CBT may be very effective
 - Anxiety and disaffection are common bed-fellows
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Anxiety

Drug Treatments

- Excluding antidepressants, any drug that effectively treats anxiety is potentially addictive – including alcohol
 - Antidepressants
 - Anxiolytics
 benzodiazepines
 - Antiepileptics gabapentine
 pregabalin
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PTSD

- ❑ Mild to moderate – avoid drugs if possible – use trauma focused CBT or EMDR – preferably combined with exposure.
 - ❑ Co-morbidity with anxiety and depression is almost inevitable – use antidepressants and/or short term anxiolytics or hypnotics as appropriate
 - ❑ In severe cases low dose antipsychotics – Olanzapine or Quetiapine – may help to lower arousal levels and enable psychological treatment to be tolerated.
 - ❑ ? Beta blockers as a preventative
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Alcohol

General Principles

- You will not find them unless you look for them!
 - When you do find them, it isn't necessarily a crisis.
 - Once you have identified a significant problem do not let go – insist on regular, unrelenting follow-up – preferably with monitoring of gamma GT.
 - Have a clear policy as to what is a disciplinary matter and what is a medical matter.
 - Watch out for co-morbidity with PTSD.
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Alcohol (Drug Treatment)

Detox

prevent fits – chlordiazepoxide

prevent nerve damage – Vit B
Co strong

Reduce craving - ?Acamprosate

Prevent relapse – follow-up ?Antabuse

Alcohol

- If co-morbid with depression/anxiety – get rid of the alcohol first
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Somatisation

- Chronic fatigue (ME)
 - Fibromyalgia
 - Gulf war syndrome
 - Agent orange!
 - Effort syndrome
 - DAH (disordered action of the heart)
 - Neurasthenia
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Somatisation (possible treatments)

- CBT
 - Graded exercise
 - Antidepressants (MAOIs may have a particular role)
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