Current Issues with Medicines used to treat Mental Disorders

AMHP training: January 2018

"L'imagination est plus importante que le savoir"

Albert Einstein

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Discussion

What do you think are the most important problems currently . . .

concerning the use of medicines to treat mental disorders?

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Outline

- Brain physiology & pharmacology
- Good practice in the use of medicines
  - Anxiety
  - Depression
  - Bipolar disorder
  - Schizophrenia & Psychosis
- Iatrogenic disease in SMI
- Treatment adherence in SMI & crisis in mental health services
- Individualising treatment
  - Patient choice & information

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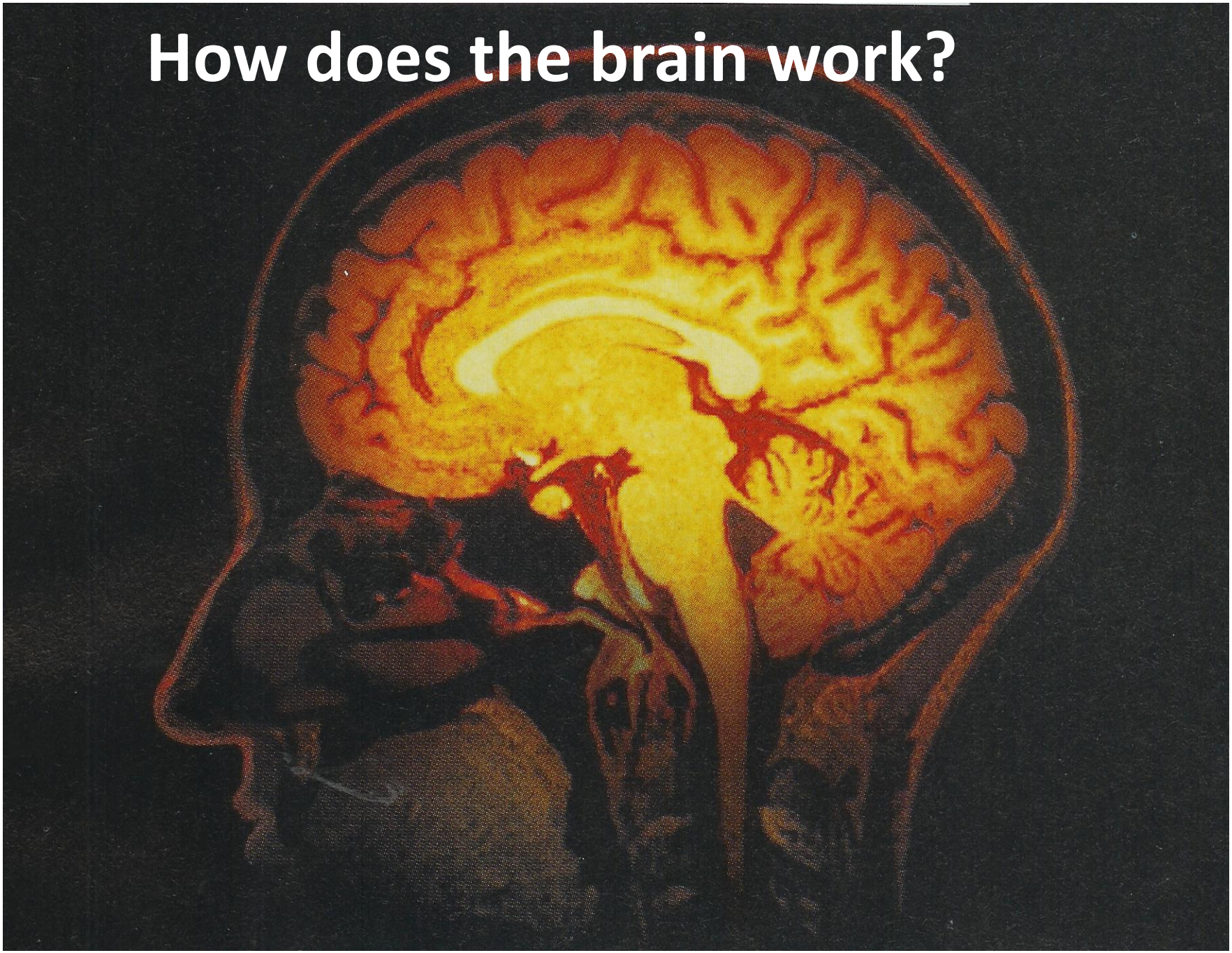
How does the brain work?



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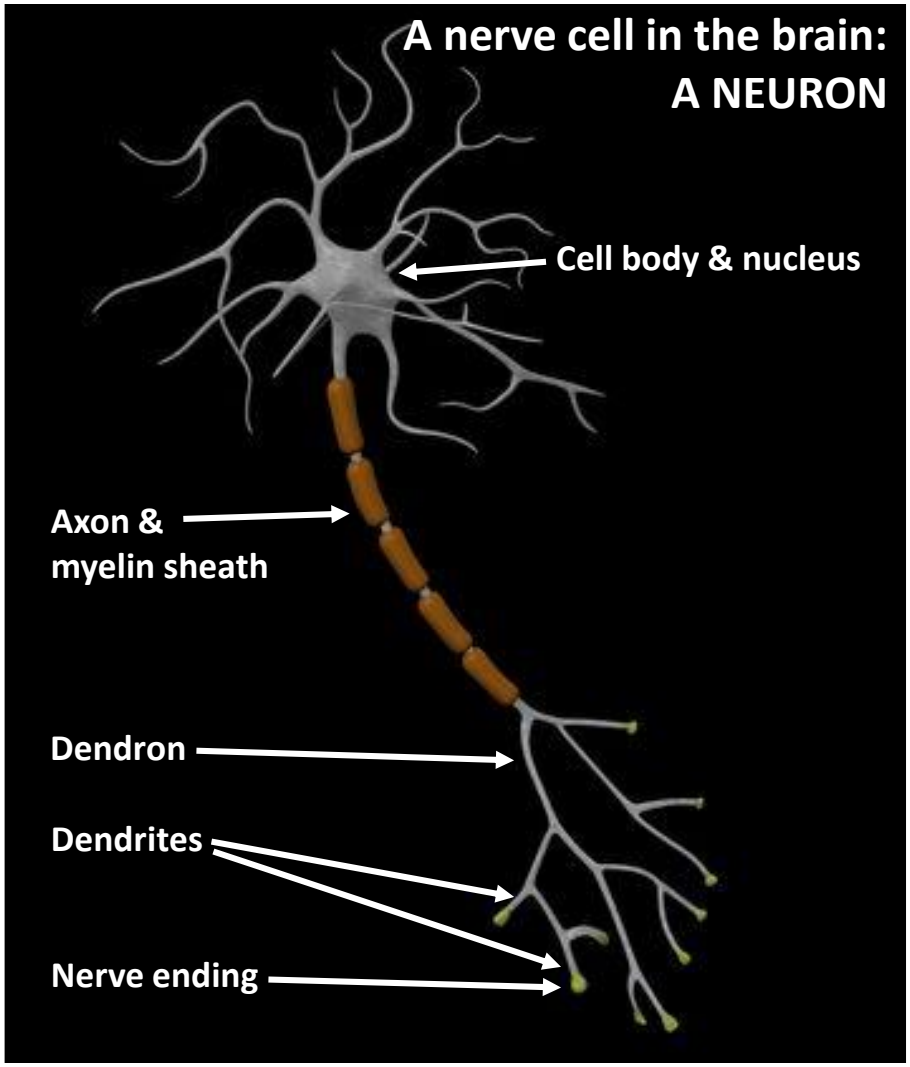
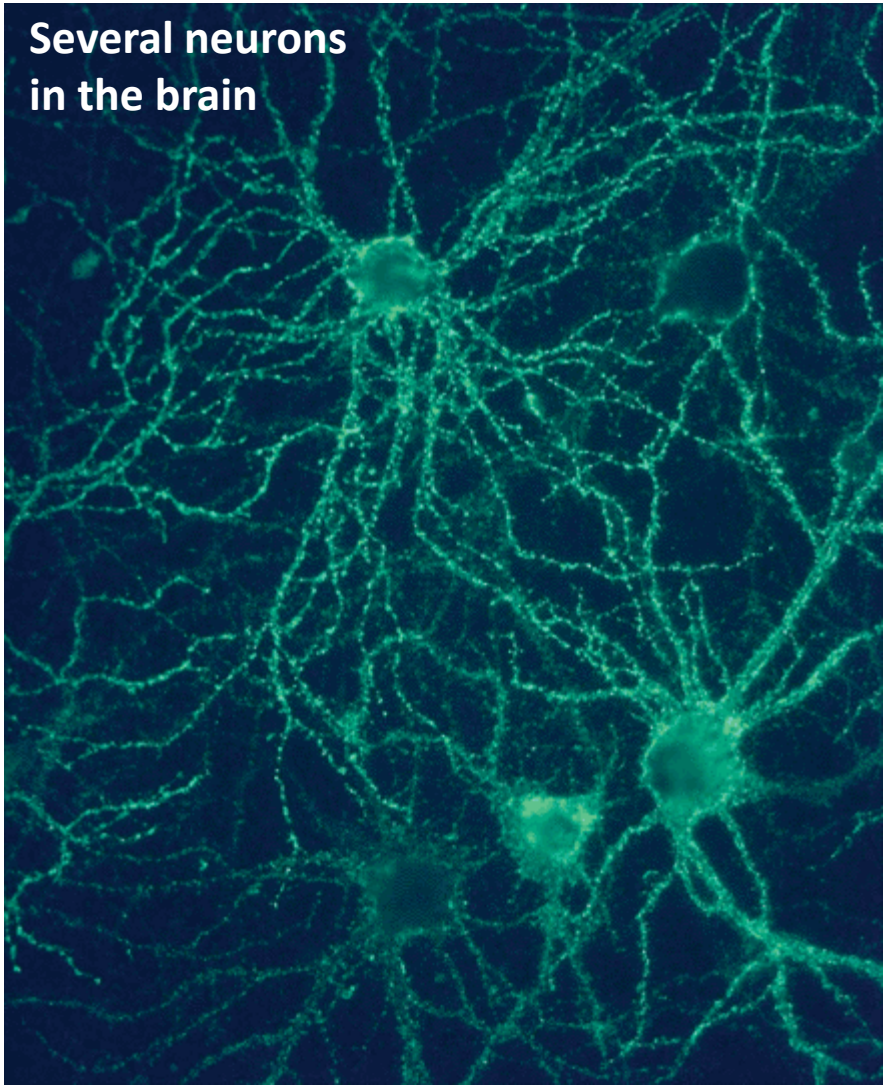


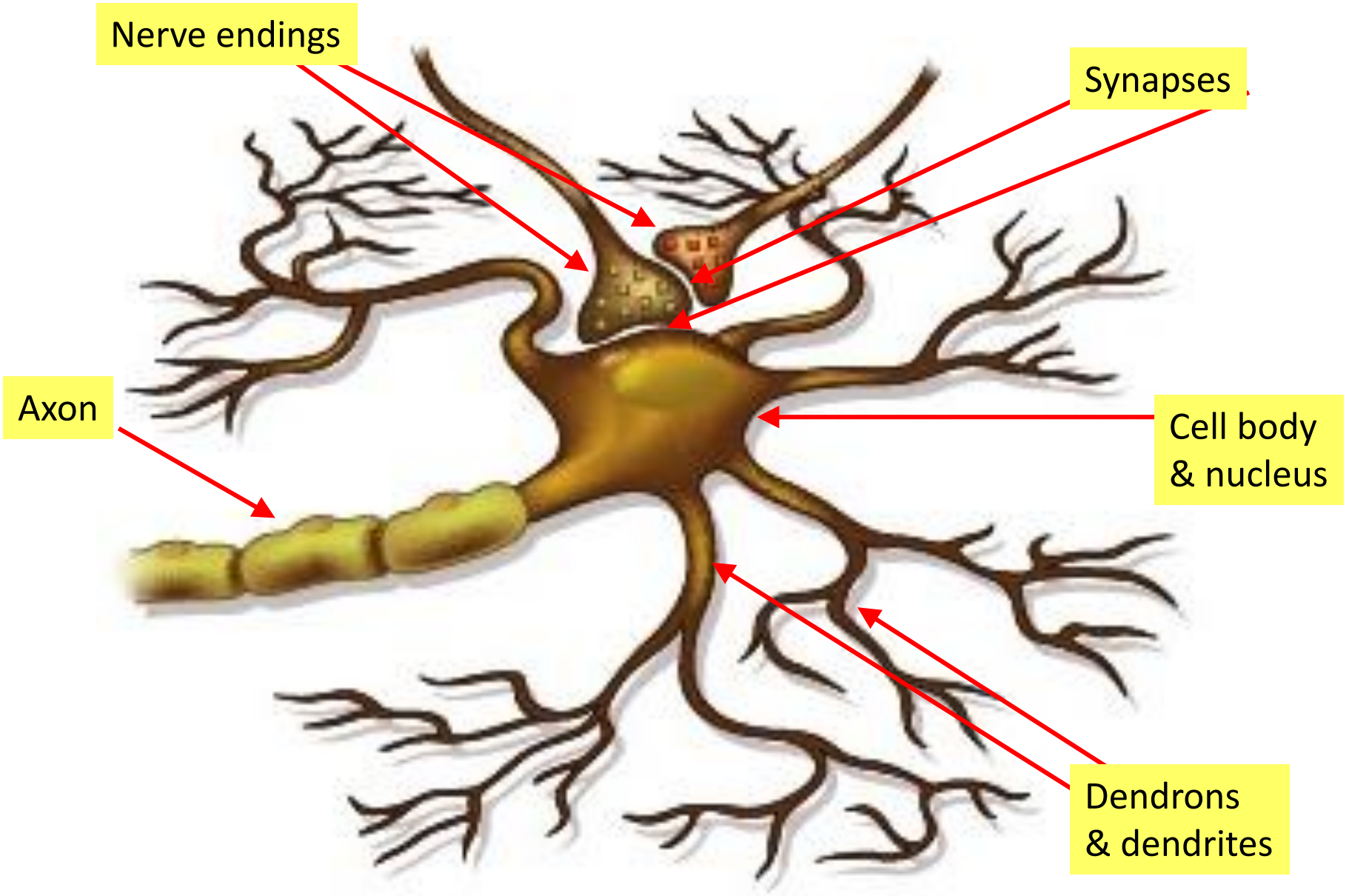
The neuron is the fundamental cellular unit of the nervous system



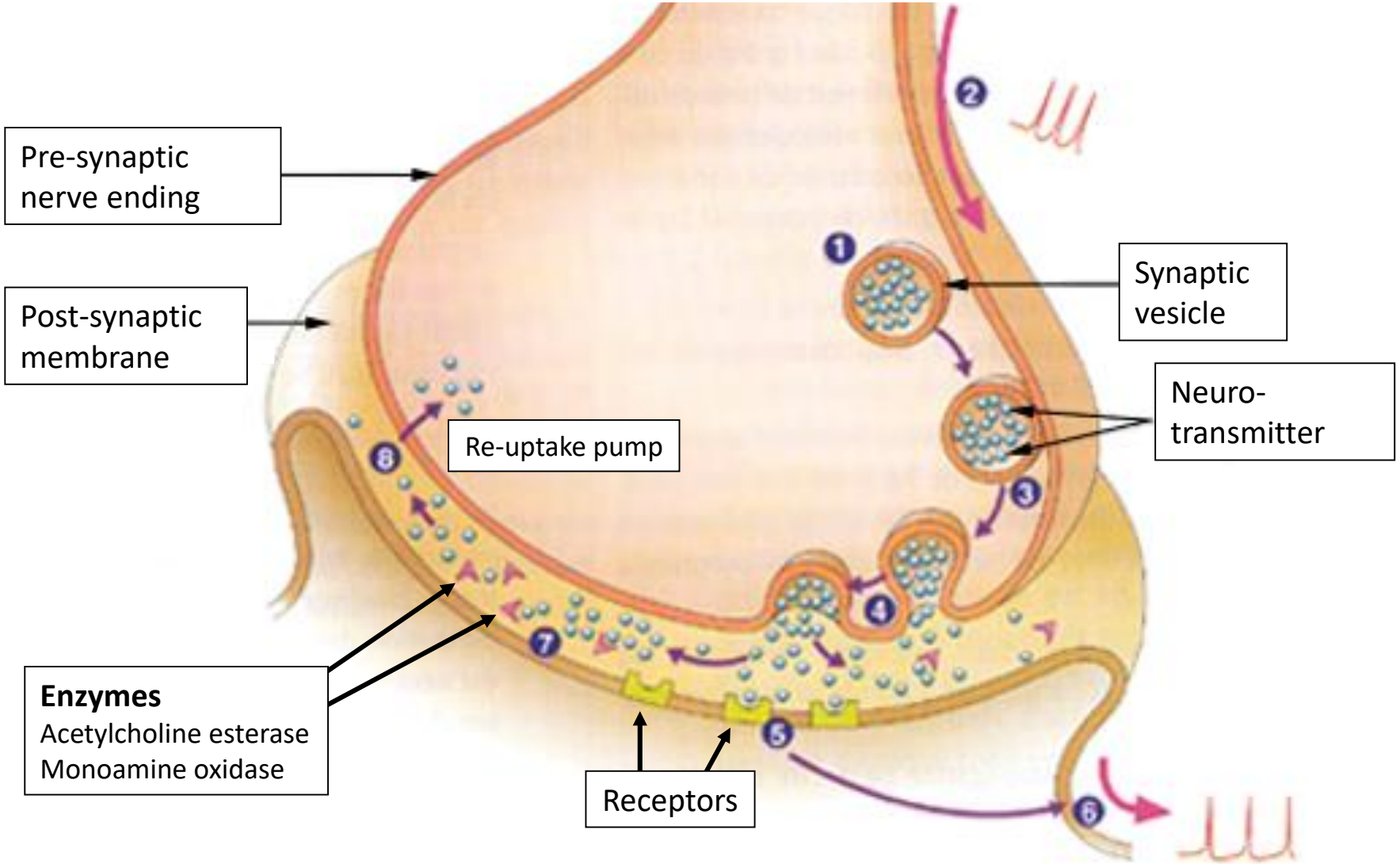
Brain: 100 billion individual neurons plus neuroglia (support cells)

Neurones transmit electrical impulses which are generated by neuro-transmitters

The Synapse


Nerve endings
Synapses
Axon
Cell body
& nucleus
Dendrons
& dendrites

Release of chemical messengers "Neuro-transmitters"



Neurotransmitters

Dopamine

Reward / Mood
Psychosis
Movement
Hormonal

Gamma-amino butyric acid (GABA)

Inhibitory
Anxiety
Sleep

Serotonin (5-hydroxy-tryptamine 5-HT)

Mood
Anxiety / sleep
Linked with Dopamine
Movement
Physical functions

Glutamate

Excitatory
Mood
Thinking processes
Negative symptoms
Psychosis

Acetyl Choline

Memory
Movement
Physical functions

Noradrenaline (US Norepinephrine)

Mood
Anxiety

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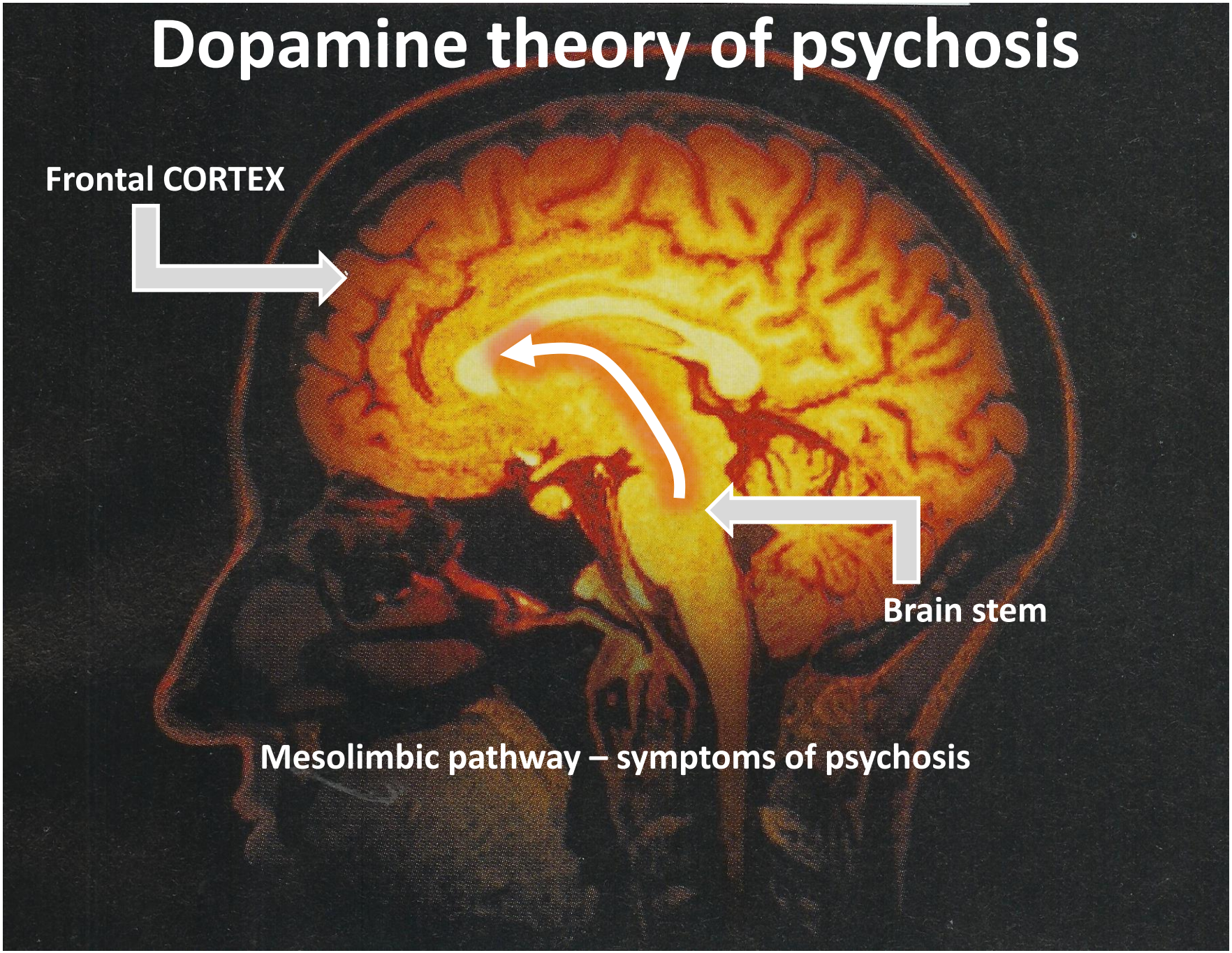
Dopamine theory of psychosis



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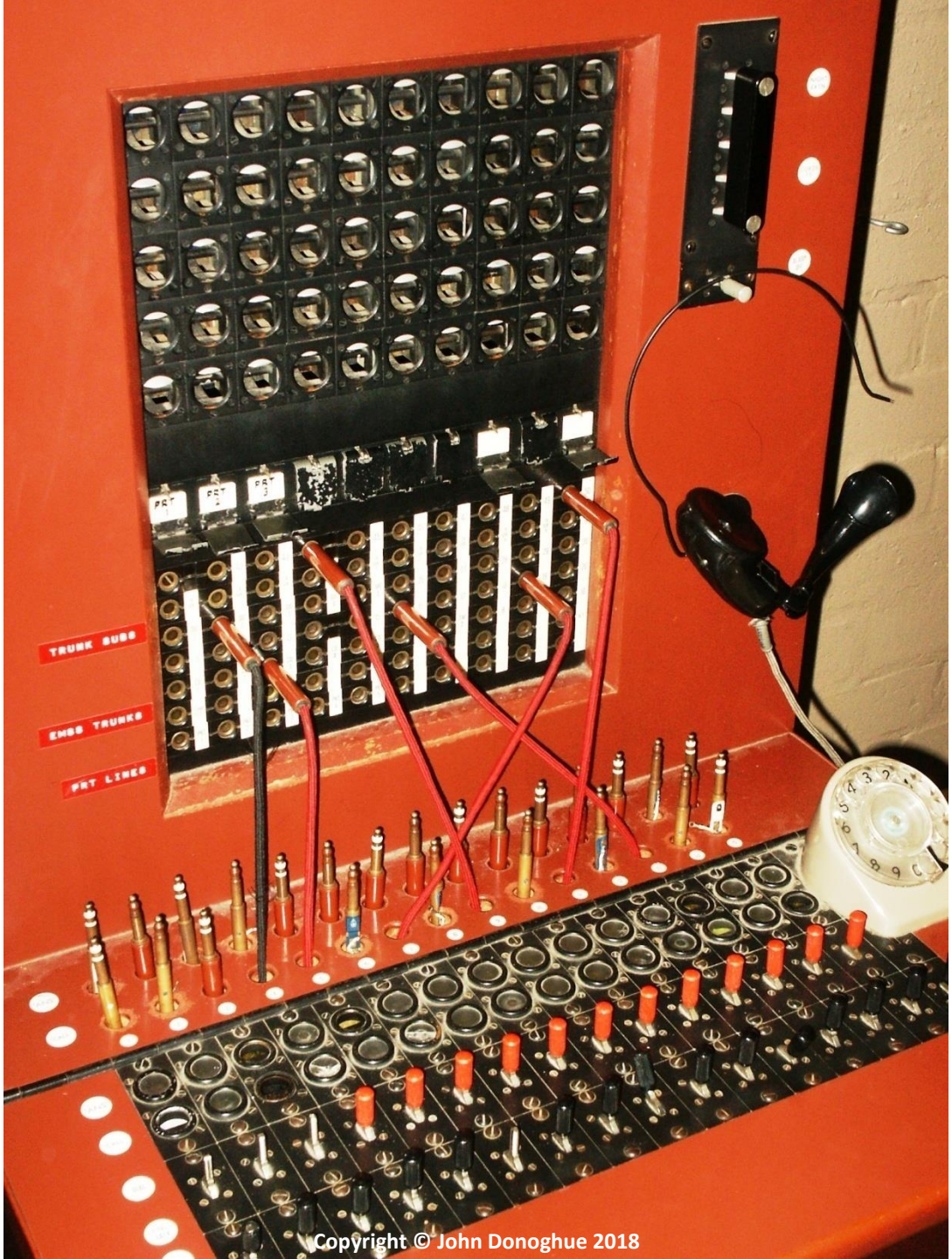

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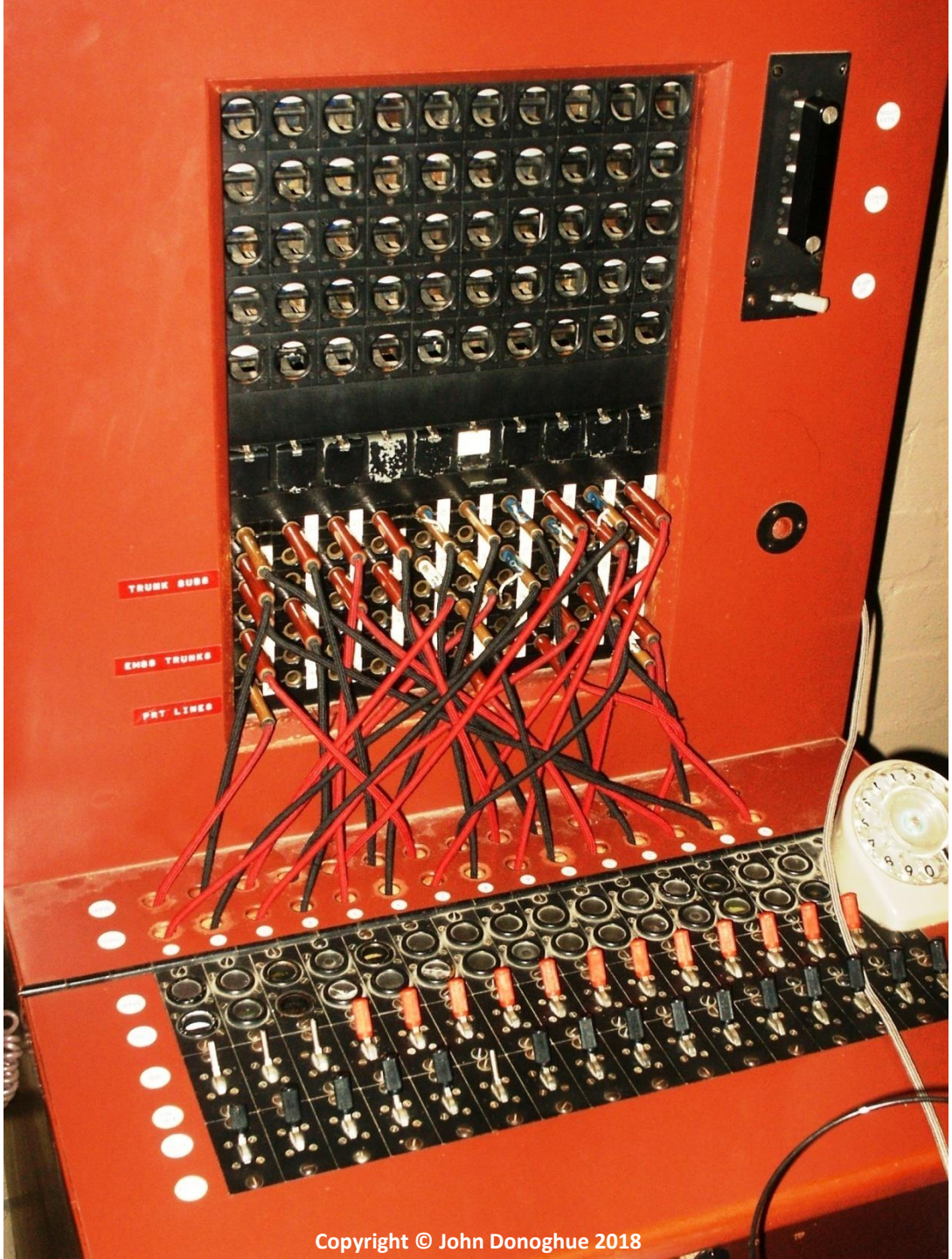

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Actions of psychotropic medicines

- Increase the availability of a neurotransmitter in the synapse
  - Inhibit re-uptake pump (most antidepressants)
  - Prevent enzymatic degradation (treatments for Alzheimer's disease & MAOI antidepressants)
- Modify the action of a receptor
  - Benzodiazepines
- Activate a receptor
  - Aripiprazole
- Block a receptor
  - Antipsychotics

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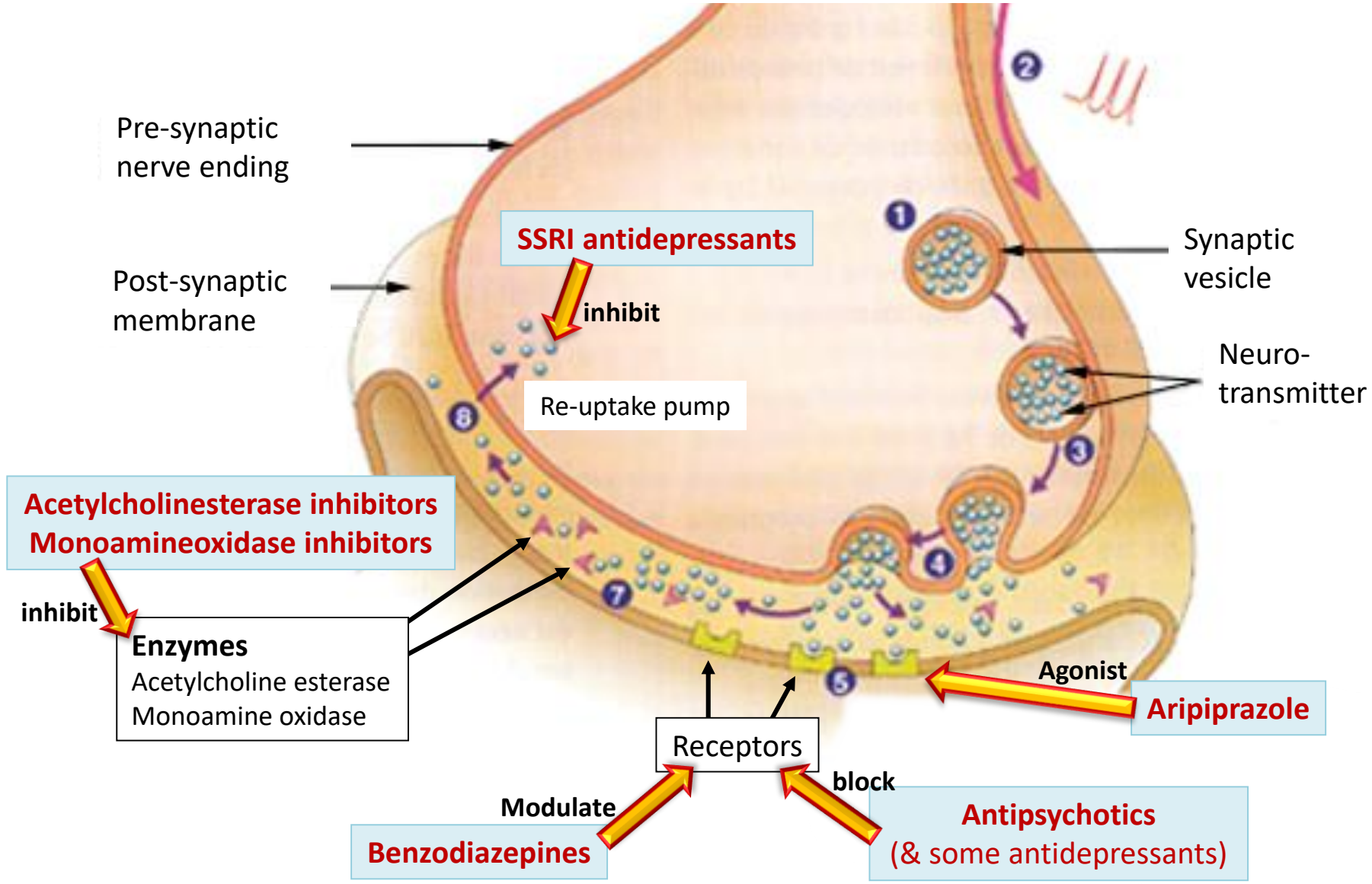
Examples of modes of action of psychotropic medicines



Blocking receptors causes adverse effects

Dopamine

Movement disorders

Increased prolactin

Sexual dysfunction

Gamma-amino butyric acid (GABA)

Anxiety

Sleep disturbance

Serotonin (5-hydroxy-tryptamine 5-HT)

Complex: many sub-types of 5-HT receptors with different functions

BUT

Improves some movement disorders

Acetyl Choline

Impairs thinking & memory

Physical side effects

BUT

Improves some movement disorders

Histamine

Sedation

Weight gain

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General principles

- Most medicines used in psychiatry suppress symptoms – they do not "cure" the condition
- When medicines are stopped, symptoms often return – it's usually just a matter of time
- Not everybody responds well to every medicine
- **All medicines have side effects**
- The key is to find a balance between a meaningful improvement in symptoms and side effects

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Psychotropic Medicines

Treatments for anxiety & insomnia

Anxiolytics

Hypnotics

Minor tranquillisers

Treatments for depression (& OCD)

Antidepressants

Treatments for ADHD

Stimulants

Treatments for dementia

Cognitive enhancers

Treatments for bipolar disorder

Antipsychotics &

Mood stabilisers

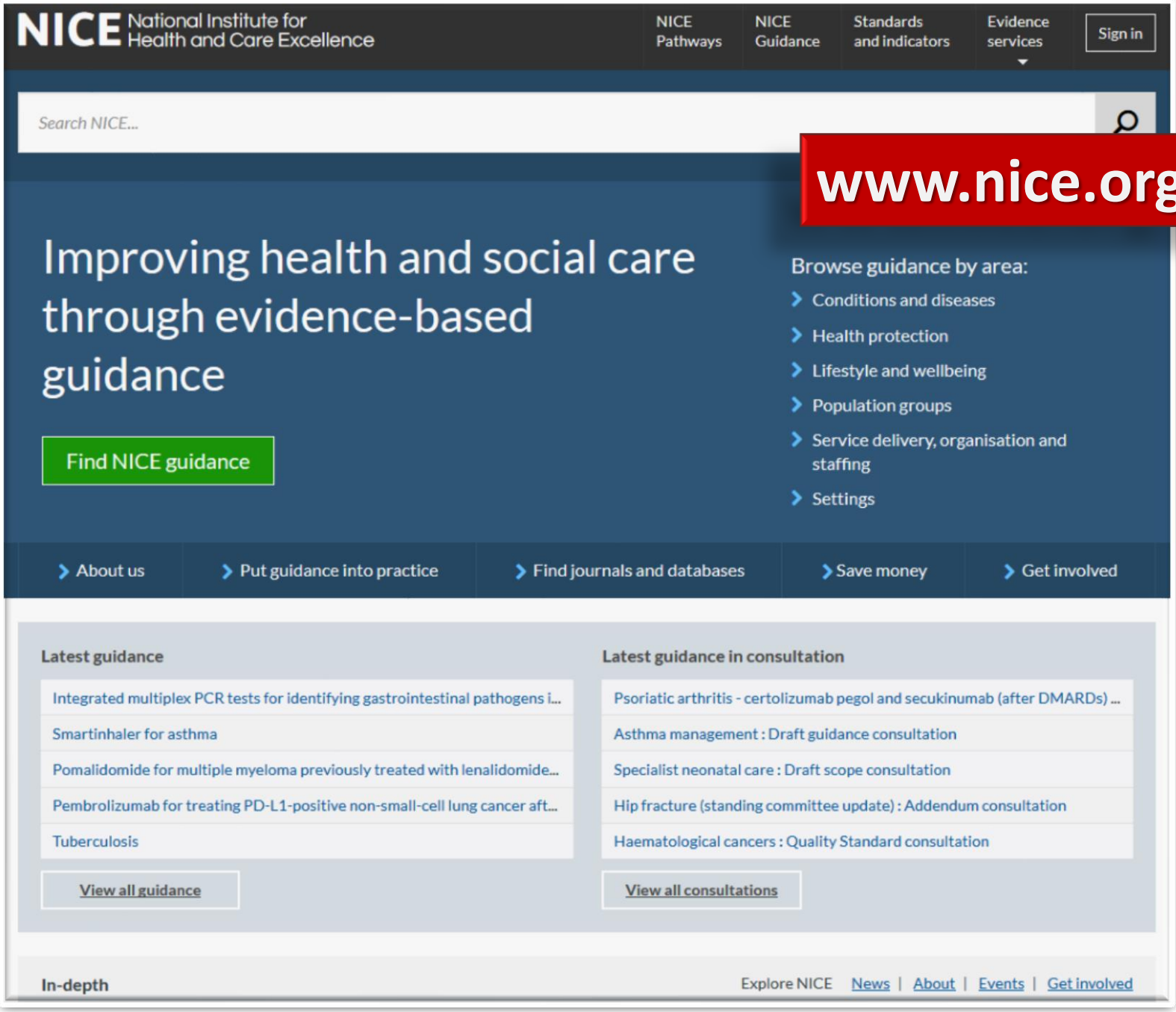
Treatments for psychosis

Antipsychotics

Neuroleptics

Major tranquillisers

Treatments for alcoholism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NICE Pathways
NICE Guidance
Standards and indicators
Evidence services
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Improving health and social care through evidence-based guidance
Find NICE guidance
Browse guidance by area:
Conditions and diseases
Health protection
Lifestyle and wellbeing
Population groups
Service delivery, organisation and staffing
Settings
About us
Put guidance into practice
Find journals and databases
Save money
Get involved
Latest guidance
Integrated multiplex PCR tests for identifying gastrointestinal pathogens i...
Smartinhaler for asthma
Pomalidomide for multiple myeloma previously treated with lenalidomide...
Pembrolizumab for treating PD-L1-positive non-small-cell lung cancer aft...
Tuberculosis
View all guidance
Latest guidance in consultation
Psoriatic arthritis - certolizumab pegol and secukinumab (after DMARDs) ...
Asthma management : Draft guidance consultation
Specialist neonatal care : Draft scope consultation
Hip fracture (standing committee update) : Addendum consultation
Haematological cancers : Quality Standard consultation
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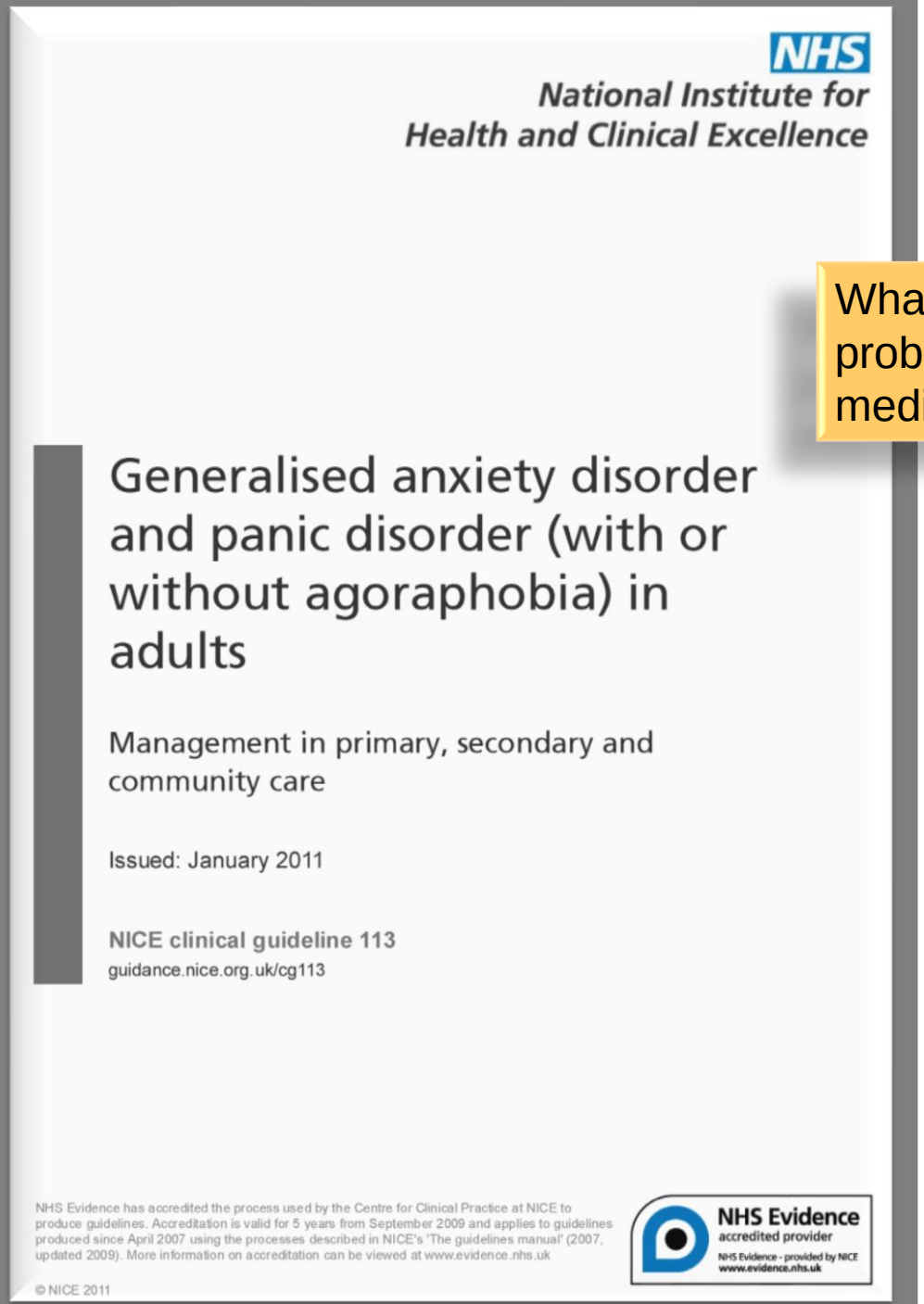

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What do you think are the most important problems currently concerning the use of medicines to treat anxiety?

Stepped care approach

Focus of the intervention	Nature of the intervention
STEP 4: Complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment	Choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment
STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care	Low-intensity psychological interventions: individual non-facilitated self-help*, individual guided self-help and psychoeducational groups
STEP 1: All known and suspected presentations of GAD	Identification and assessment; education about GAD and treatment options; active monitoring

NICE Clinical Guideline 113, 2011

GAD & Panic Disorder: Drug treatment

1.2.22 If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions. **[new 2011]**

1.2.23 If sertraline is ineffective, offer an alternative SSRI or a serotonin–noradrenaline reuptake inhibitor (SNRI), taking into account the following factors:

- tendency to produce a withdrawal syndrome (especially with paroxetine and venlafaxine)
- the side-effect profile and the potential for drug interactions
- the risk of suicide and likelihood of toxicity in overdose (especially with venlafaxine)

1.2.24 If the person cannot tolerate SSRIs or SNRIs, consider offering pregabalin. **[new 2011]**

NICE Clinical Guideline 113, 2011

GAD & Panic Disorder: Drug treatment

1.2.25 Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the 'British national formulary' on the use of a benzodiazepine in this context. **[new 2011]**

1.2.26 Do not offer an antipsychotic for the treatment of GAD in primary care. **[new 2011]**

NICE Clinical Guideline 113, 2011

Medicines used to treat anxiety

Questions?

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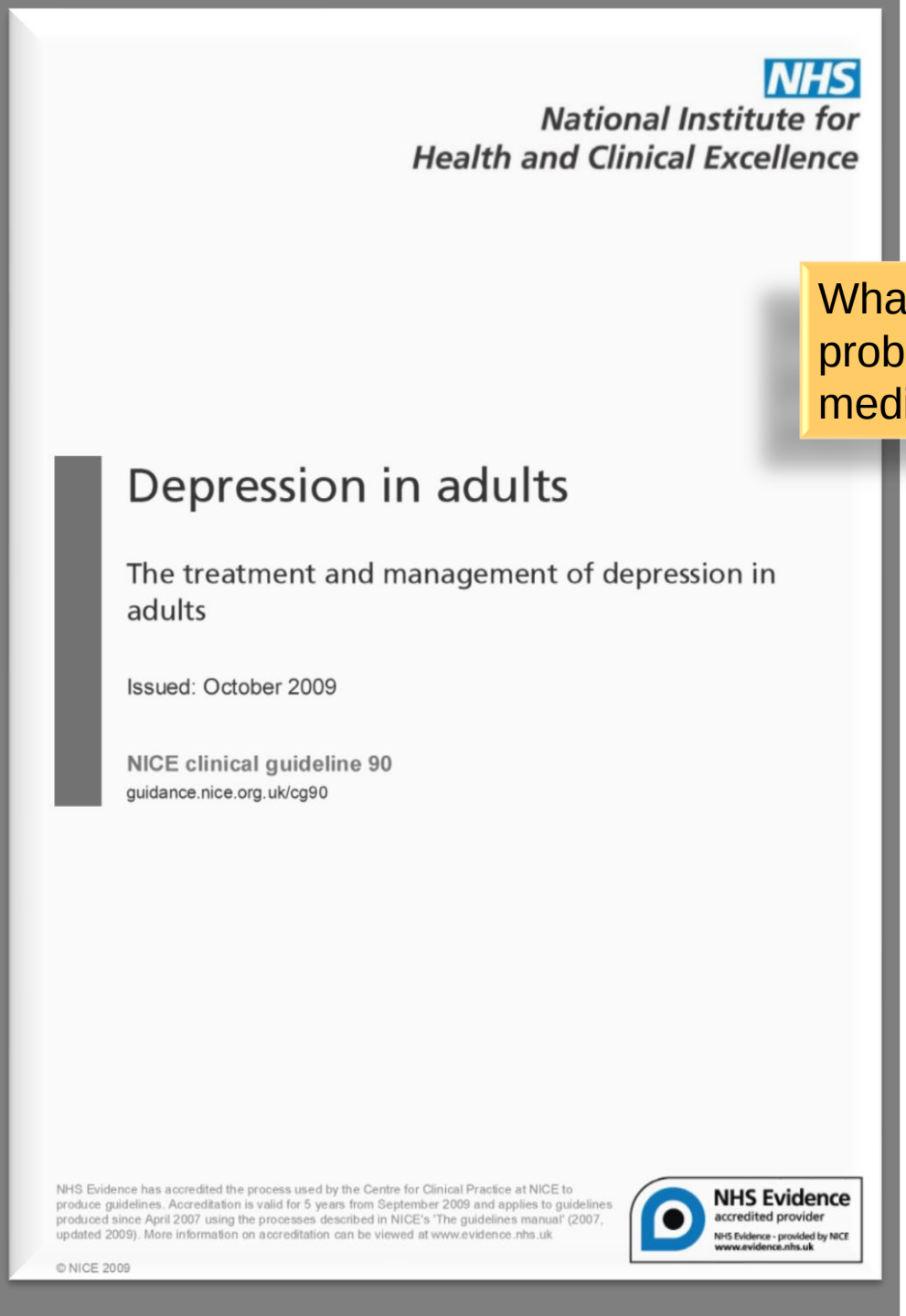

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What do you think are the most important problems currently concerning the use of medicines to treat depression?

NB. Depression guideline update Expected March 2018

Focus of the intervention	Nature of the intervention	
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions	**Primary Care**
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions	**At least 80% of cases**
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[a] and referral for further assessment and interventions	
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care	**Specialist Care**

NHS Evidence has accredited the process used by the Centre for Clinical Practice at NICE to produce guidelines. Accreditation is valid for 5 years from September 2009 and applies to guidelines produced since April 2007 using the processes described in NICE's 'The guidelines manual' (2007, updated 2009). More information on accreditation can be viewed at www.evidence.nhs.uk

NHS Evidence accredited provider
NHS Evidence - provided by NICE
www.evidence.nhs.uk

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NICE: antidepressant treatment

- In moderate depression, antidepressant medication should be routinely offered to all patients before psychological interventions
- Common concerns about taking medication should be addressed

NICE Clinical Guideline 90, 2009

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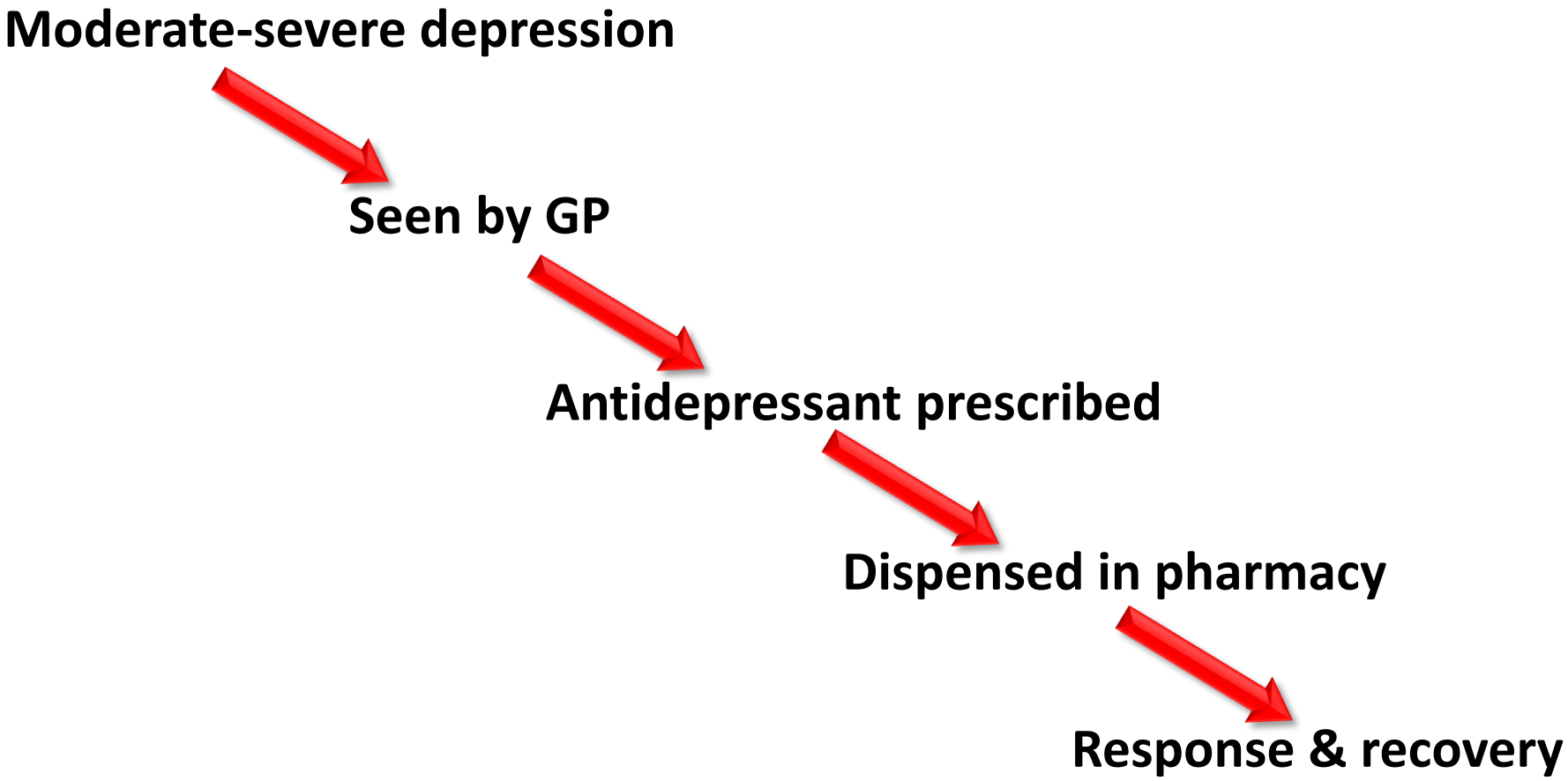
Antidepressants

Similar efficacy

- 60-70% response in clinical trials
- 25-30% placebo effect
- All take 2-4 weeks to act – longer in elderly
- Continue for 12 months after remission of symptoms

- **TCA** tricyclic antidepressant
- **MAOI** monoamineoxidase inhibitor
- **RIMA** reversible inhibitor of monamineoxidase-A
- **SSRIs** selective serotonin reuptake inhibitor
- **SNRI** serotonin & noradrenaline reuptake inhibitor
- **NARI** noradrenaline reuptake inhibitor
- **NASSA**
- **Others**

Typical patient pathway?



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BMJ

RESEARCH

1993-2005

Explaining the rise in antidepressant prescribing: a descriptive study using the general practice research database

Michael Moore, senior lecturer,[1]
A Mullee, director, research des
professor of primary medical ca

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[2]Public Health Sciences and Medical Statistics, University of Southampton, Southampton SO16 6YD
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Correspondence to: Michael Moore
mvm198@soton.ac.uk

Cite this as: *BMJ* 2009;339:b3999
doi:10.1136/bmj.b3999

ABSTRACT

Objective To explore the reasons b
increase in antidepressant prescrib
Kingdom.

Design Detailed retrospective anal
practitioner consultations and anti
prescribing.

Data source Data were obtained fro
research database, which contains
records of over 3 million patients r
Data were extracted for all new inc
depression between 1993 and 200

Review methods Detailed analysis
consultations and antidepressant
restricted to 170 practices that wer
the full duration of the study.

Results In total, 189 851 people w
practice research database experie
episode of depression between 19
150 825 (79.4%) received a prescr
antidepressants in the first year of
proportion remained stable across
examined. The incidence of new ca
in young women but fell slightly in
overall incidence increased then d
7.83 cases per 1000 patient years
2005, women: 15.83 cases per 10
1993 to 10.06 in 2005). Antidepre
nearly doubled during the study pe
number of prescriptions issued pe
from 2.8 in 1993 to 5.6 in 2004. Th
antidepressant prescriptions were
treatment or as intermittent treatm
multiple episodes of depression.

Conclusions The rise in antidepres
mainly explained by small changes
patients receiving long term treatm
guidelines have focused on antide
appropriate targeting of antidepressants. To address the
costly rise in antidepressant prescribing, future research
and guidance needs to concentrate on appropriate long

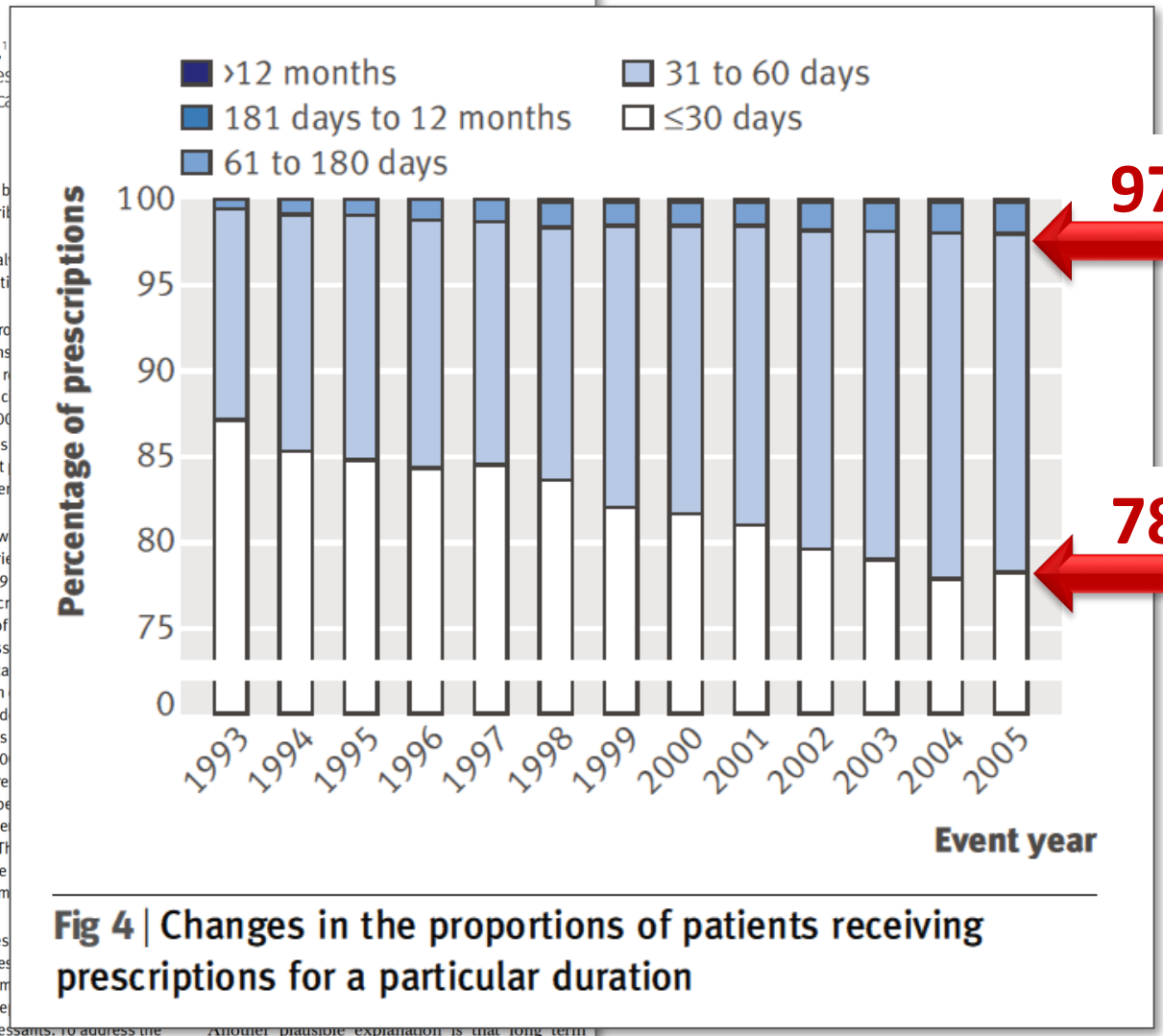
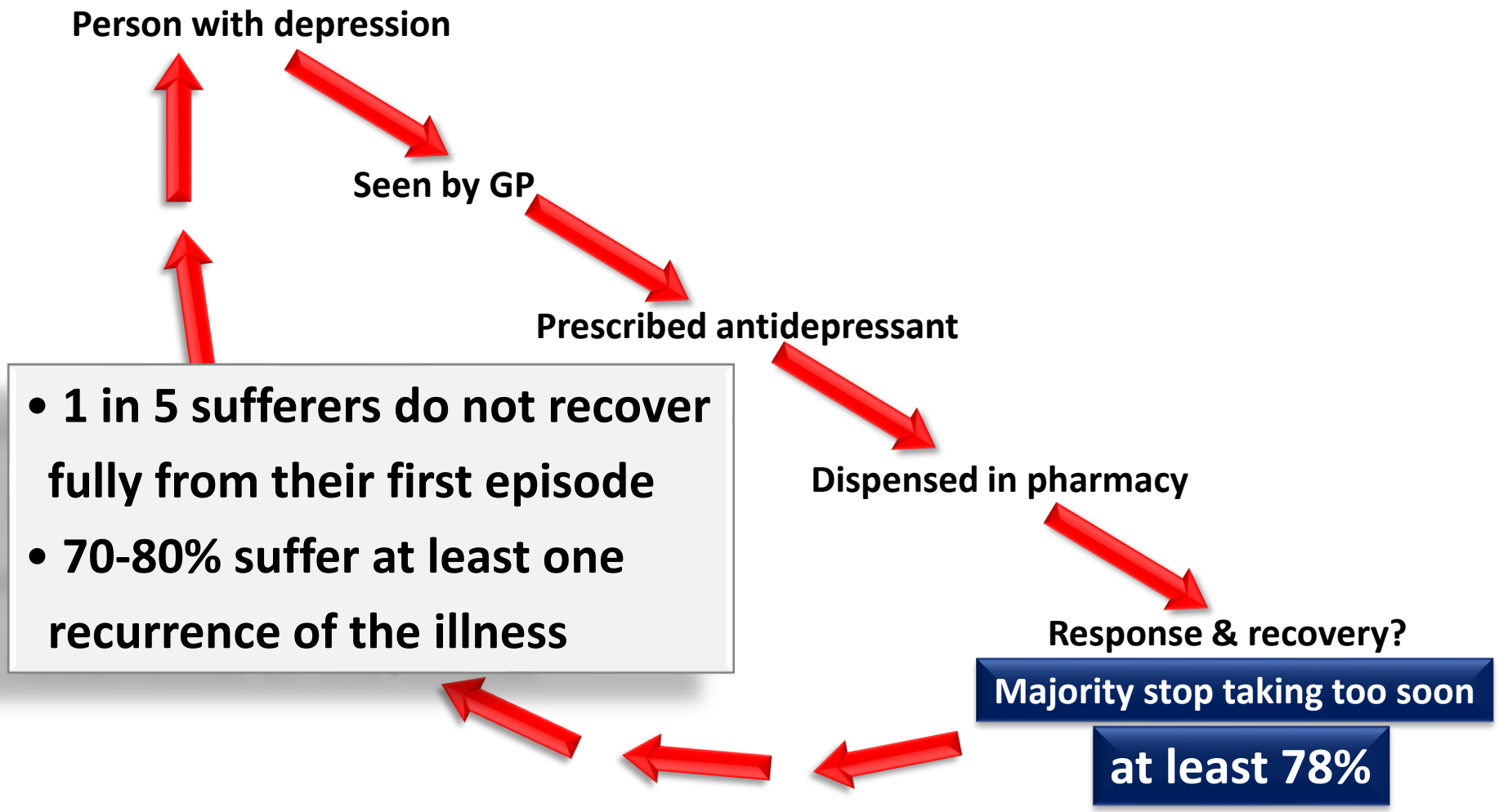


Fig 4 | Changes in the proportions of patients receiving prescriptions for a particular duration

Another plausible explanation is that long term repeat prescribing of antidepressants has increased in recent years. A cross sectional survey of general

Typical patient pathway?



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NICE: antidepressant treatment

When an antidepressant is to be prescribed in routine care, it should be a **selective serotonin reuptake inhibitor (SSRI)**, because SSRIs are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects

NICE Clinical Guideline 90, 2009

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Failure to respond to antidepressant

- **Check**
  - Adherence / side effects
  - Single AD has lower risk of side effects than combination treatments
- **Switch** to alternative AD
  - Same class?
  - Change class?
  - **NOT** dosulepin

- **Augment** with
  - Lithium
  - Antipsychotic
    - 2nd generation only
    - Quetiapine most effective
  - Antidepressant
    - Mirtazapine
    - Extreme care with TCAs + SSRIs
    - **NEVER** SSRI + MAOI

NICE Clinical Guideline 90, 2009

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Violent/self-harming behaviour?

- Mixed evidence that SSRI antidepressants may induce / worsen violent or self-harming behaviours
- May be linked to side effect - Akathisia
- Rare
- Reported most frequently with fluoxetine (Prozac)

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Discontinuation symptoms

Have been reported with nearly ALL antidepressants

- SSRI & other antidepressants
  - Paroxetine & venlafaxine cause most problems
  - Fluoxetine causes least problems
- Tricyclic antidepressants
  - All known to cause discontinuation symptoms

- Vary depending on:
  - Antidepressant
  - Length of time
  - Rapidity of discontinuation
- Most symptoms mild & transient
- Managed by slow withdrawal of treatment

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Antidepressants and dependence

- Discontinuation symptoms are **NOT** the same as dependence

- No desire to continue taking drug
- No compulsion to increase use
- No tolerance to drug develops
- No neglect of other activities / interests
- No desire to persist despite evidence of harmful consequences

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Medicines used to treat depression

Questions?

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What do you think are the most important problems currently concerning the use of medicines to treat bipolar disorder?

Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care

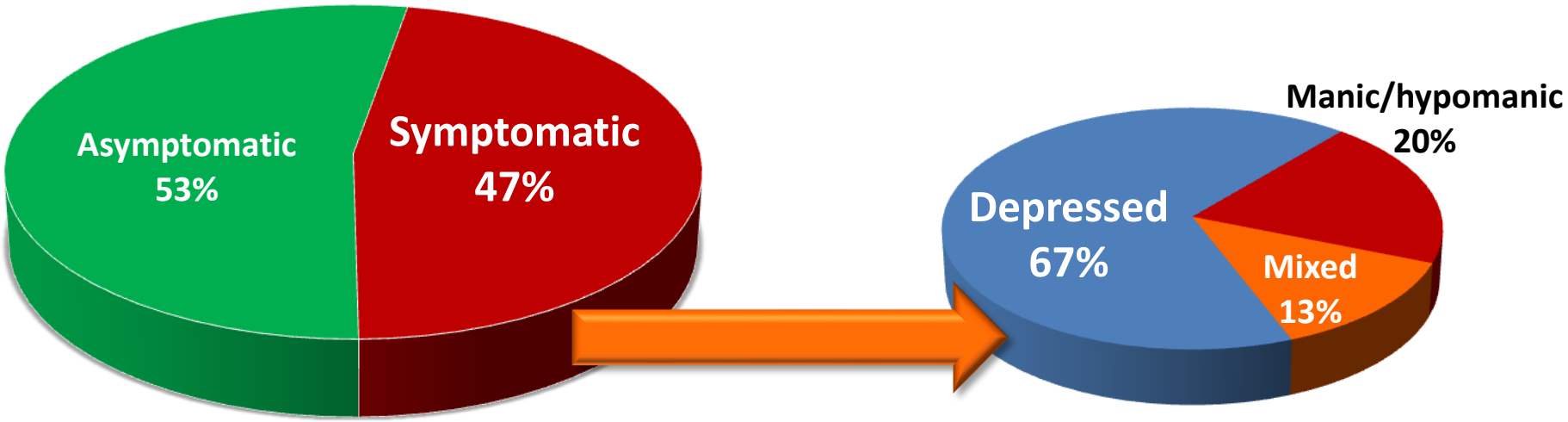
Issued: September 2014 last modified: April 2015

NICE clinical guideline 185

guidance.nice.org.uk/cg185

Long-term symptomatic status

Bipolar-1



Judd LL, Akiskal HS, Schettler PJ et al.
The long-term natural history of the weekly symptomatic status of Bipolar I Disorder
Arch Gen Psychiatry 2002;59:530-37

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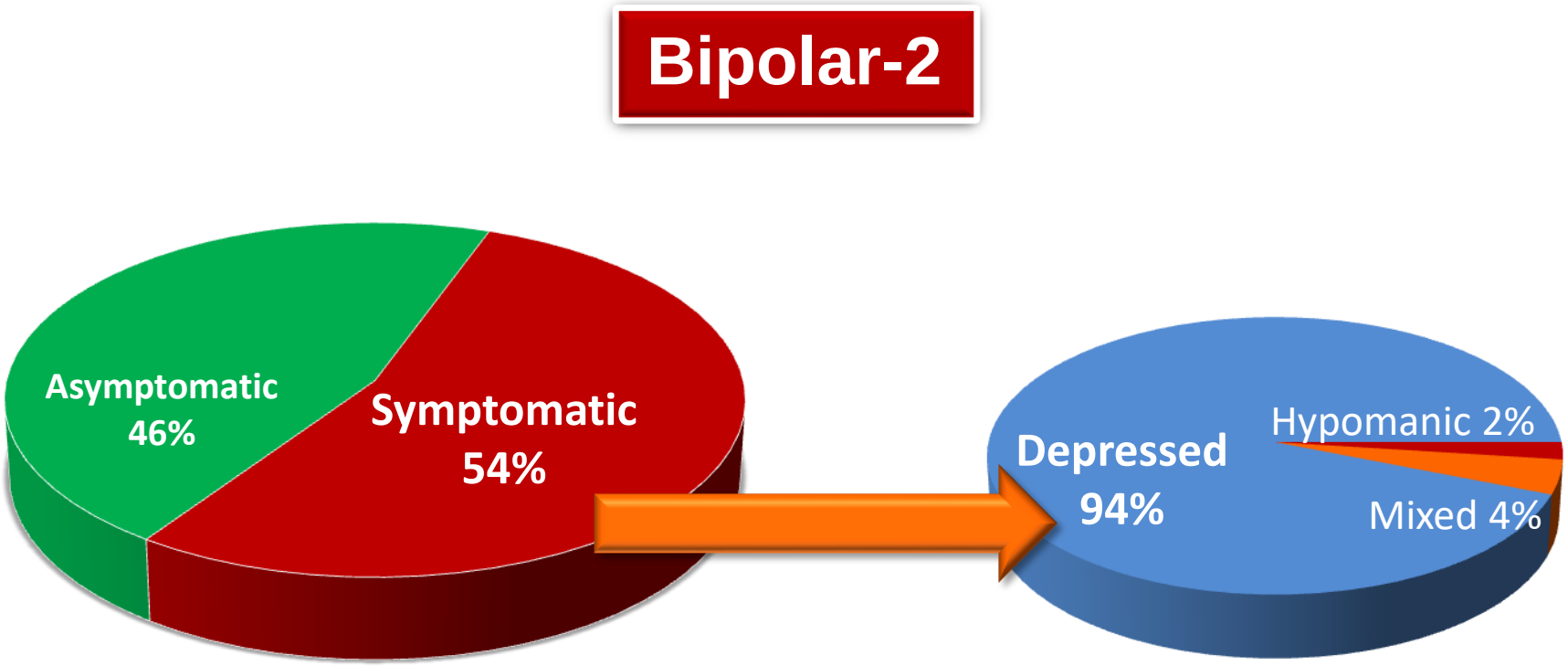
Long-term symptomatic status



Judd LL, Akiskal HS, Schettler PJ et al.
A prospective investigation of the natural history of the long-term weekly symptomatic status of Bipolar II Disorder
Arch Gen Psychiatry 2003;60:261-269

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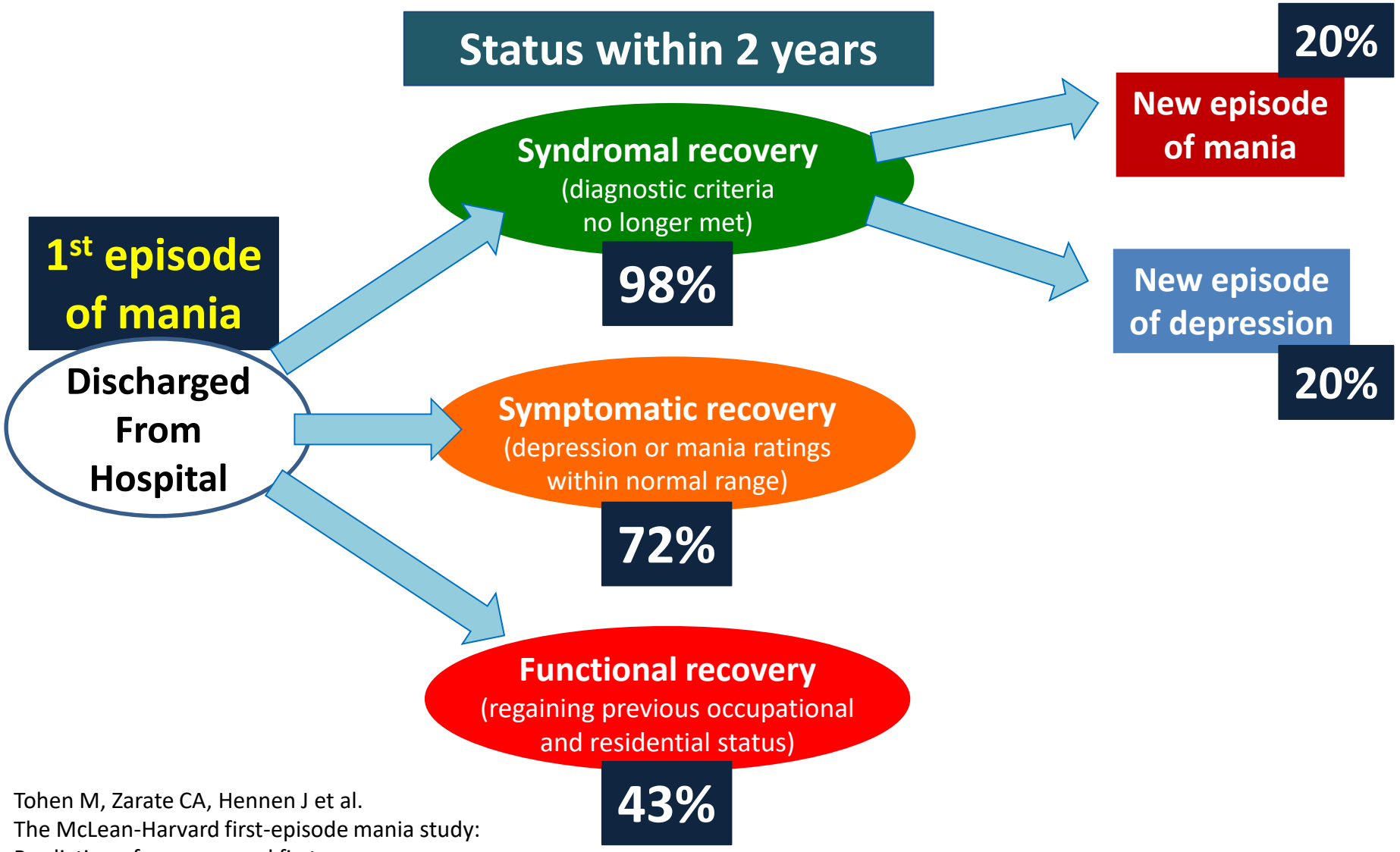
Outcomes after first episode of mania



Tohen M, Zarate CA, Hennen J et al.
The McLean-Harvard first-episode mania study:
Prediction of recovery and first recurrence.
Am J Psychiatry 2003;160:2099-2107

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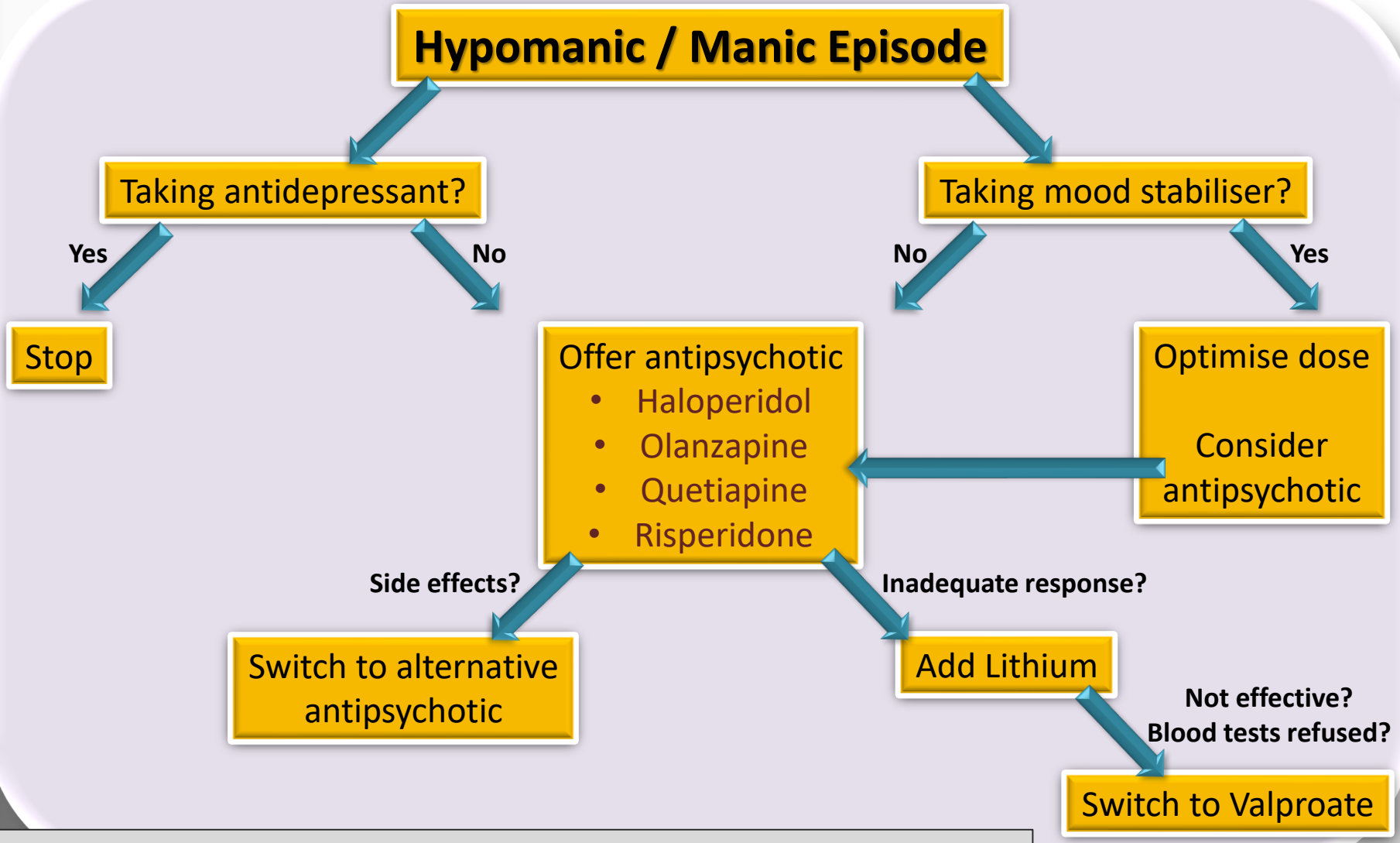

Notes:

1. Haloperidol & Risperidone not recommended for long-term use
2. Aripiprazole not mentioned

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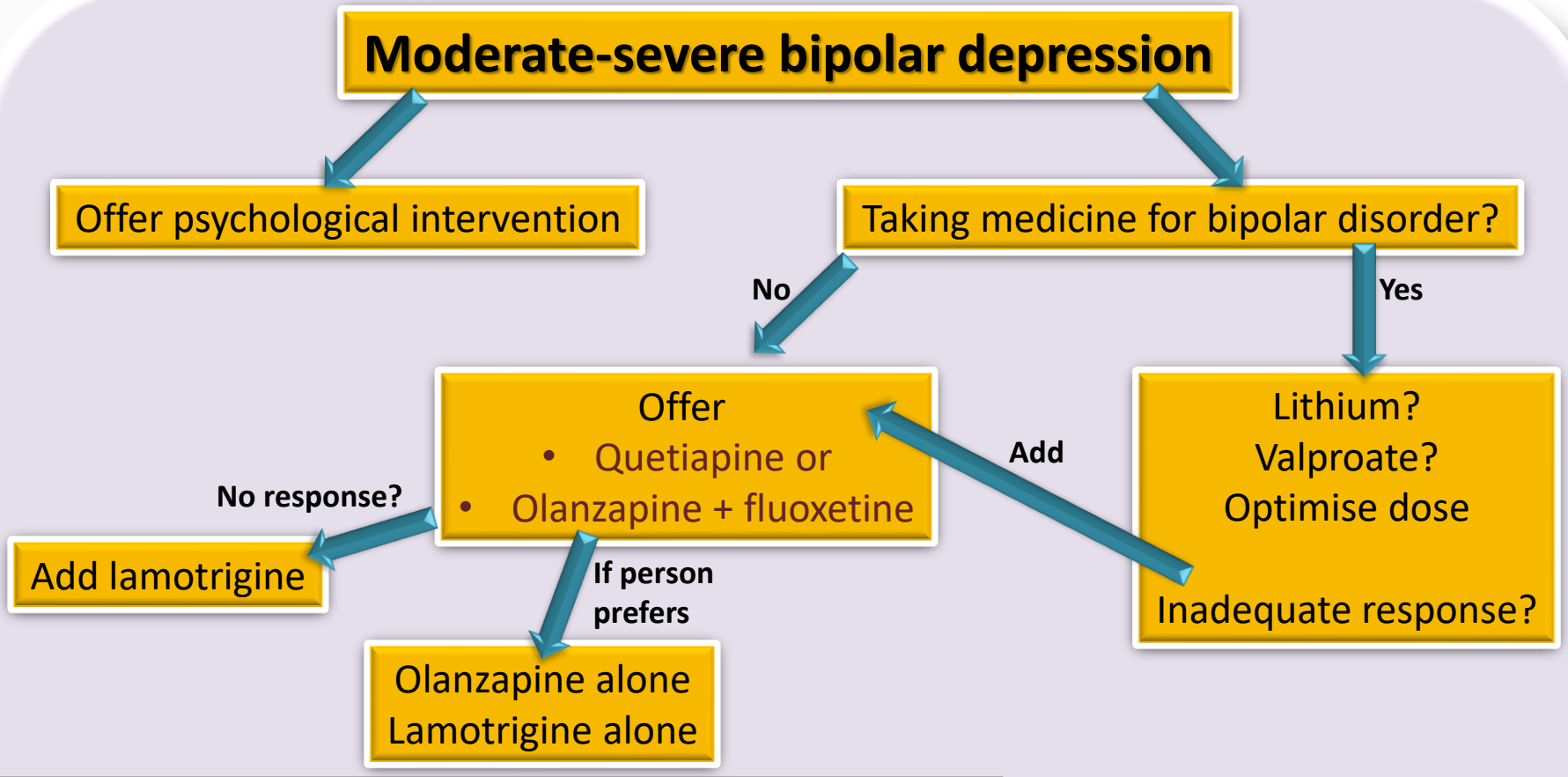

Notes:

1. Olanzapine-Fluoxetine combination not licensed in UK
2. Evidence for benefit of Olanzapine alone is weak
3. Evidence for benefit of Lamotrigine is weak
4. Lamotrigine not licensed for this indication in the UK
5. Evidence for benefit of Lithium in bipolar depression is weak
6. **Best evidence is for Quetiapine as monotherapy**

Managing bipolar disorder in adults in the longer term in secondary care

Pharmacological interventions

- Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder and:
  - if lithium is ineffective, consider adding valproate[6]
  - if lithium is poorly tolerated, or is not suitable (for example, because the person does not agree to routine blood monitoring), consider valproate or olanzapine[7] instead or, if it has been effective during an episode of mania or bipolar depression, quetiapine.

    Discuss with the person the possible benefits and risks of each drug for them.

Notes:

1. Evidence of benefit with Lithium treatment is **strong**
2. Evidence of benefit with Valproate alone is weak
3. Evidence of benefit with Olanzapine is **strong BUT causes metabolic disease**
4. Evidence of benefit with Quetiapine is **strong**
5. Evidence of benefit with Aripiprazole is **strong but not mentioned even though low risk of metabolic disease**

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Medicines licensed in UK for the treatment of bipolar disorder

Drug	Treatment of acute episodes		Prevention of recurrence		
	Manic episode	Depressive episode	Manic episode	Depressive episode	Mixed episode
ANTIPSYCHOTICS					
ARIPIPRAZOLE	☑	☒	☑	☒	☒
OLANZAPINE	☑	☒	☑	☒	☒
RISPERIDONE	☑	☒	☒	☒	☒
QUETIAPINE	☑	☑	☑	☑	☑
MOOD STABILISERS					
LITHIUM	☑	☒	☑	☒	☑
VALPROATE	☑	☒	☑	☒	☑
LAMOTRIGINE	☒	☒	☒	☑	☒

Information for Abilify®, Zyprexa®, Risperdal®, Seroquel® *, Seroquel XL®
obtained from Electronic Medicines Compendium www.medicines.org.uk/EMC/

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Medicines used to treat bipolar disorder

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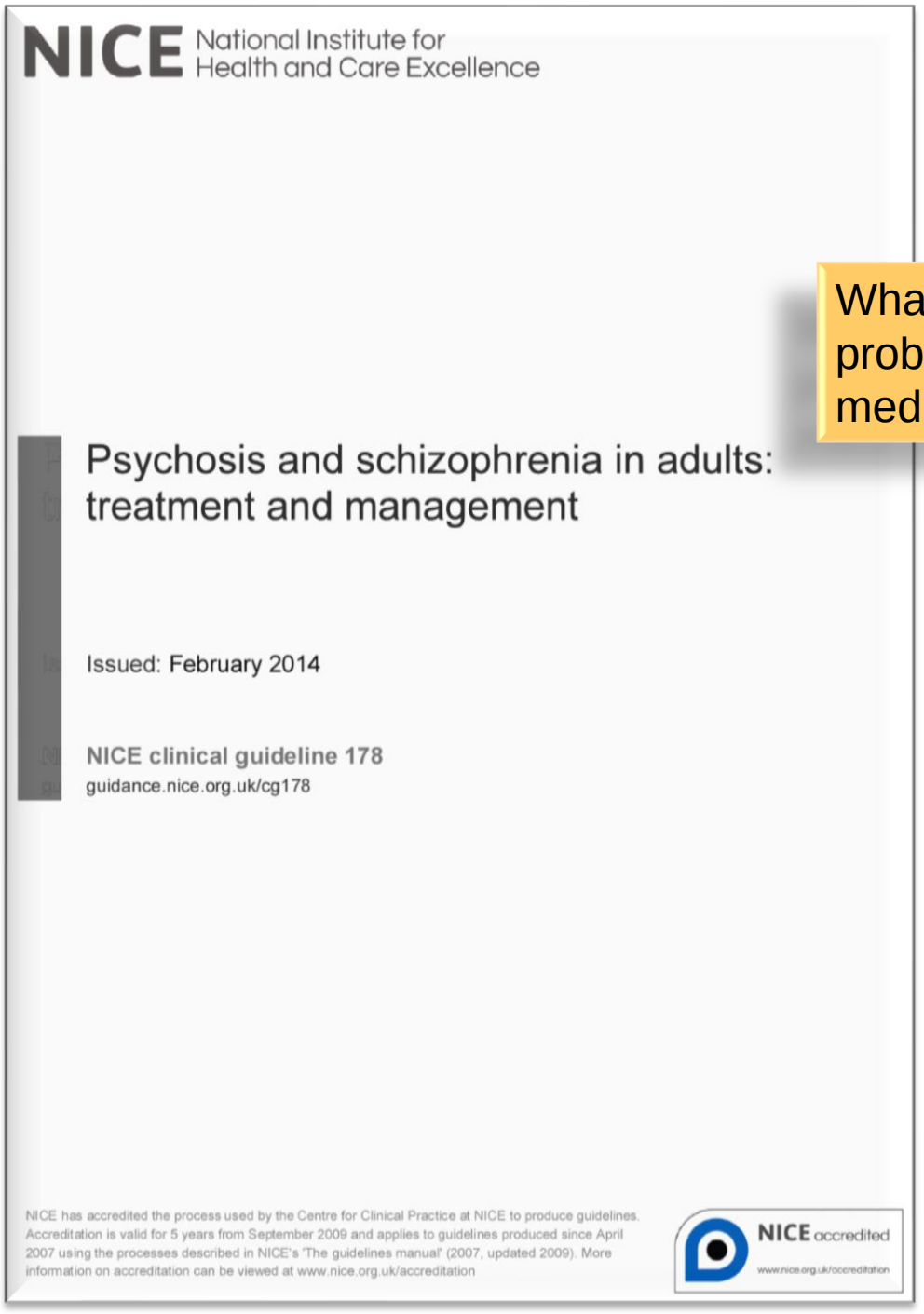

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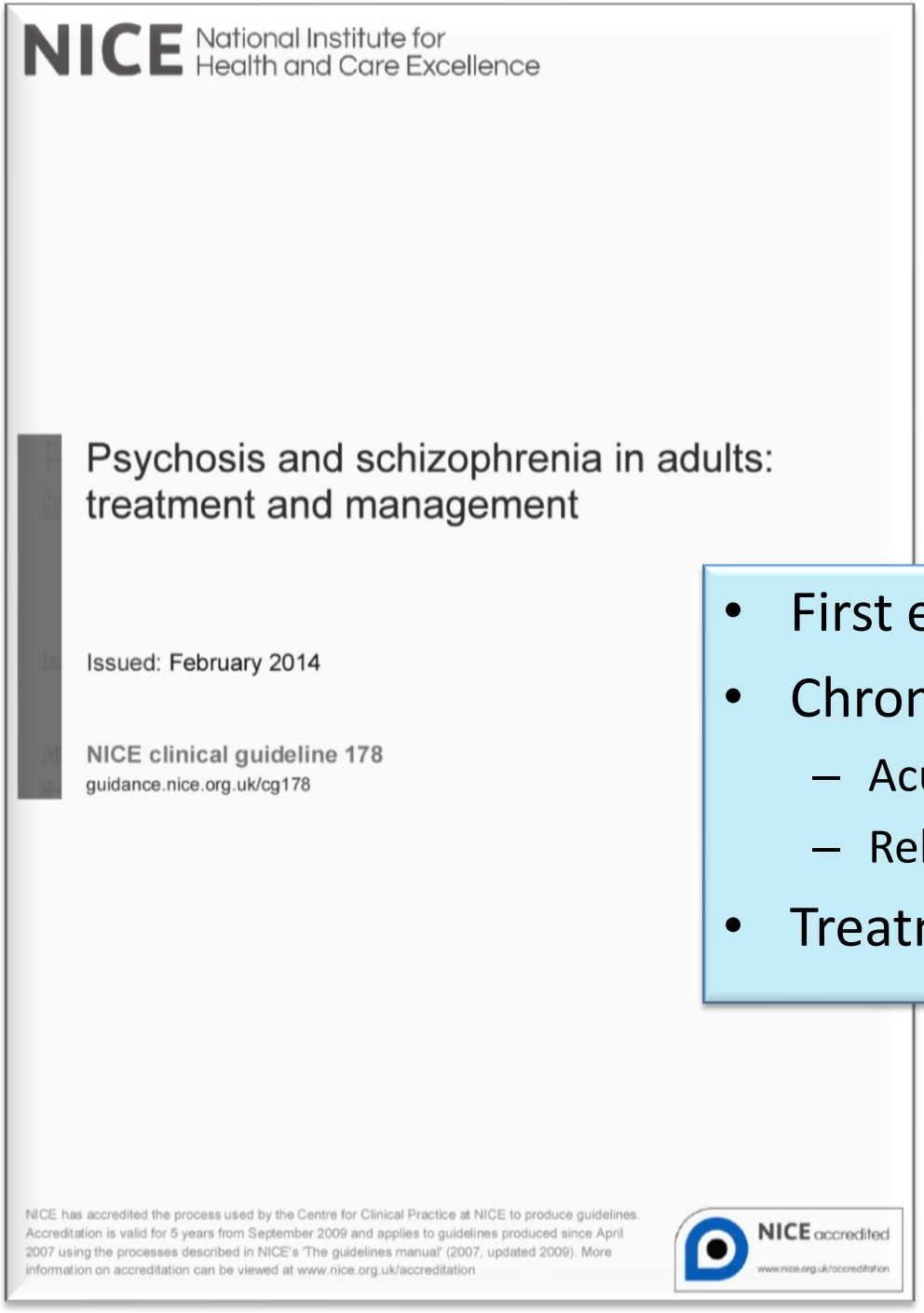
What do you think are the most important problems currently concerning the use of medicines to treat schizophrenia?



www.nice.org.uk

- First episodes of schizophrenia
- Chronic schizophrenia
  - Acute psychotic episode
  - Relapse prevention
- Treatment-resistant schizophrenia

NICE Guideline 2014

First episode of schizophrenia

1.3.4 Treatment options

1.3.4.1 For people with first episode psychosis offer:

- oral antipsychotic medication in conjunction with
- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

NICE Clinical Guideline 178, 2014

NICE Guideline 2014

Psychotic episode in chronic schizophrenia

1.4.2.1 For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer:

- oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with
- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

1.4.3 Pharmacological interventions

1.4.3.1 For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication. **[2009; amended 2014]**

NICE Clinical Guideline 178, 2014

NICE Guideline 2014

Preventing relapse in chronic schizophrenia

1.5.5 Pharmacological interventions

1.5.5.1 The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). **[2009]**

1.5.5.2 Do not use targeted, intermittent dosage maintenance strategies3 routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity. **[2009]**

1.5.5.3 Consider offering depot /long-acting injectable antipsychotic medication to people with psychosis or schizophrenia:

- who would prefer such treatment after an acute episode
- where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan. **[2009]**

NICE Clinical Guideline 178, 2014

NICE Guideline 2014

Treatment-resistant schizophrenia

1.5.7.2 Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic.

NICE Clinical Guideline 178, 2014

Clozapine

- Only medicine shown to be effective in refractory schizophrenia
- Risk of dangerous adverse effect limits use
- Regular testing of WBC count is mandatory
- High risk of severe relapse if discontinued abruptly

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Antipsychotics

- **First generation (Typical)**
  - Chlorpromazine
  - Haloperidol
  - Trifluoperazine
  - Flupentixol
  - Zuclopenthixol
  - Fluphenazine
  - Sulpiride
  - Etc
- **Second generation (Atypical)**
  - Amisulpride
  - Aripiprazole
  - Clozapine
  - Olanzapine
  - Paliperidone
  - Quetiapine
  - Risperidone
  - Lurasidone NEW!

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Differences between FGAs & SGAs

- **Efficacy?**
  - No clinically important differences **EXCEPT CLOZAPINE**
- **Side effects?**
  - SGAs **less likely** to cause movement disorders
    - Esp Aripiprazole, Clozapine, Quetiapine

    No different from placebo
  - Some SGAs **less likely** to cause prolactin-related adverse effects
    - Aripiprazole
    - Clozapine
    - Quetiapine

    No different from placebo
  - Some SGAs **MORE LIKELY** to cause weight and metabolic problems
    - Clozapine
    - Olanzapine

    Lowest risk of weight gain:
    FGA – Haloperidol
    SGA - Aripiprazole & Lurasidone
- **Other?**
  - FGAs cheaper

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Medicines used to treat schizophrenia

Questions?

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Outline

- Brain physiology & pharmacology
- Good practice in the use of medicines
  - Anxiety
  - Depression
  - Bipolar disorder
  - Schizophrenia & Psychosis
- Iatrogenic disease in SMI
- Treatment adherence in SMI & crisis in mental health services
- Individualising treatment
  - Patient choice & information

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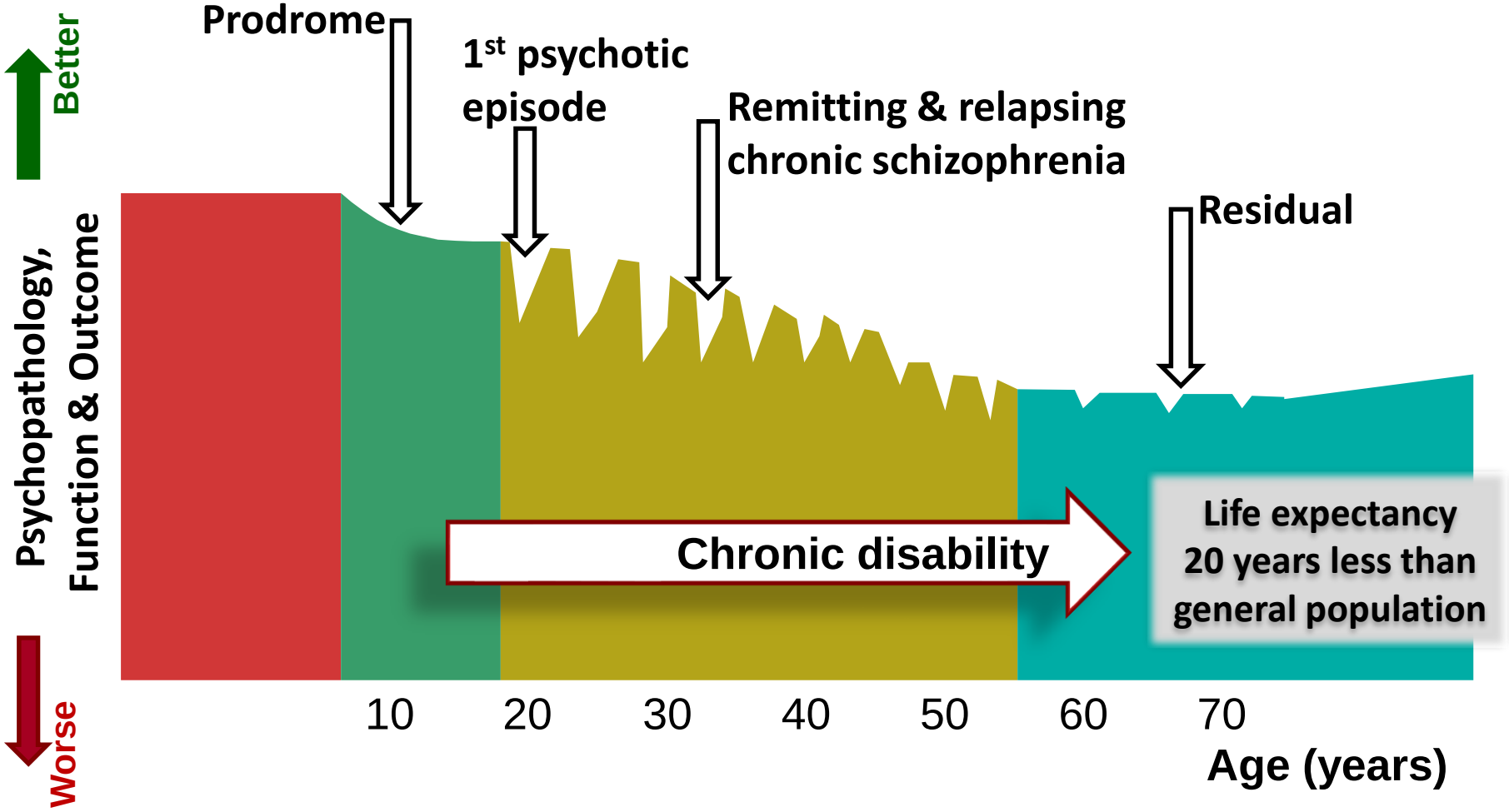
General course of schizophrenia



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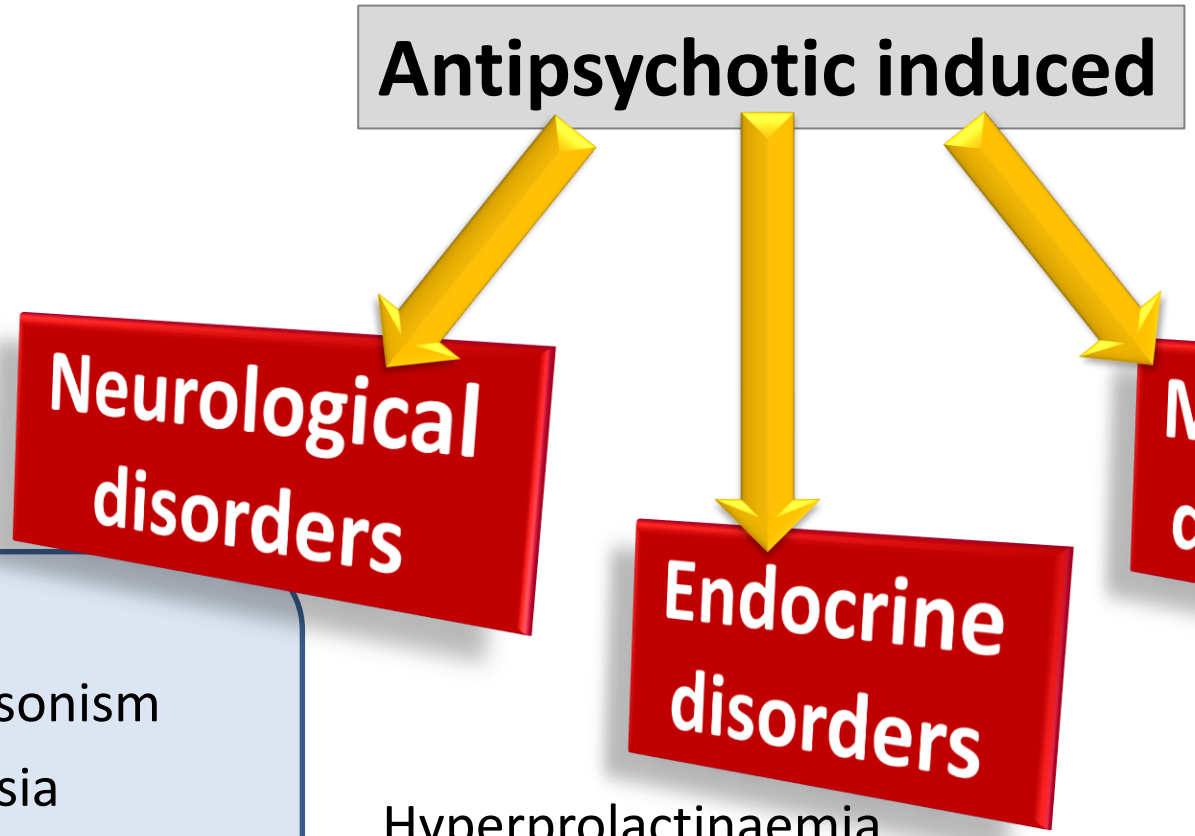
Antipsychotics & Iatrogenic Disease



EPS:

Parkinsonism

Akathisia

Dystonia

Tardive dyskinesia

Hyperprolactinaemia

Sexual dysfunction

Osteoporosis

Breast cancer

Obesity

Type 2 diabetes

Dyslipidaemia

Hypertension

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Sexual dysfunction: the secret side effect?

50% of patients 'never or infrequently' discuss sexual functioning with their mental healthcare providers

62.5% of men and 38.5% of women felt that their medication was causing sexual side effects

80% of women with sexual side effects never discuss sexual dysfunction with their mental healthcare providers

41.7% of men and 15.4% of women admitted stopping their medications because of sexual side effects

Rosenberg K, Bleiberg K, Koscis J, et al
A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance.
J of Sex and Marital Therapy, 2003;29:289–296

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Osteoporosis

Effects on bone mineral density:

- Premature bone loss in both women and men

Haddad PM, Wieck A. Drugs 2004;64:2291-314

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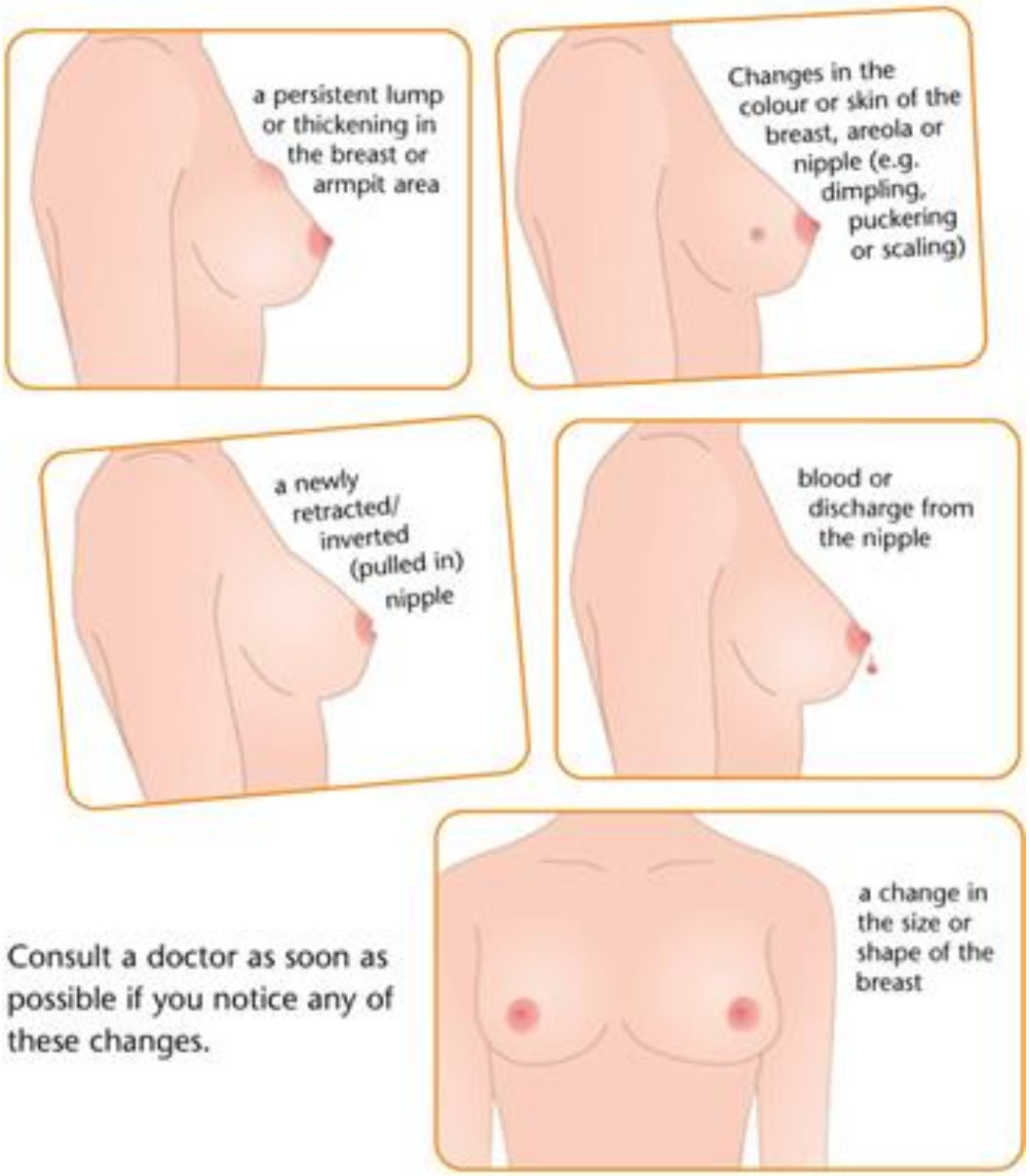
Breast Cancer



- **Use of antipsychotics associated with increased risk of breast cancer[1]**
- **Excess mortality from breast cancer reported in female schizophrenic patients[2]**

1. Wang PS, Walker AM, Tsuang MT, et al. Arch Gen Psych. 2002;59:1147-54
2. Harris EC, Barraclough B. Br J Psychiatry 1998;173:11-53

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Growing awareness of need to improve metabolic health in severe mental illness

- Life expectancy for individuals with schizophrenia is 20% less than that of the general population
- Increased morbidity
  - Medical illnesses
  - Psychiatric comorbidities
- CV morbidity & mortality is a growing concern
- Decreased access to care
- Poverty
- Limited insight

Barnett AH et al. J Psychopharmacol OnlineFirst, published on April 19, 2007 as doi:10.1177/0269881106075509

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A Systematic Review of Mortality in Schizophrenia

Is the Differential Mortality Gap Worsening Over Time?

Sukanta Saha, MSc, MCN; David Chant, PhD; John McGrath, MD, PhD, FRANZCP

Standardised Mortality Ratio (SMR) is high

- All causes of death: 2.98
- Cardiovascular disease: 2.01

SMR = (observed number of deaths / expected number of deaths)

Context: Despite improvement
vices in recent decades, it is uncl
mortality in schizophrenia has c

Objective: To explore the distri
mortality ratios (SMRs) for peop

Data Sources: Broad search
MEDLINE, PsychINFO, Web of Science, and Google Scholar to identify all studies that investigated mortality in schizophrenia, published between January 1, 1980, and January 31, 2006. References were also identified from review articles, reference lists, and communication with authors.

Study Selection: Population-based studies that reported primary data on deaths in people with schizophrenia.

Data Extraction: Operationalized criteria were used to extract key study features and mortality data.

Data Synthesis: We examined the distribution of SMRs

est SMR (12.86); however, most of the major causes-of-death categories were found to be elevated in people with schizophrenia. The SMRs for all-cause mortality have increased during recent decades ($P = .03$).

Conclusions: With respect to mortality, a substantial gap exists between the health of people with schizophrenia and the general community. This differential mortality gap has worsened in recent decades. In light of the potential for second-generation antipsychotic medications to further adversely influence mortality rates in the decades to come, optimizing the general health of people with schizophrenia warrants urgent attention.

Arch Gen Psychiatry. 2007;64(10):1123-1131

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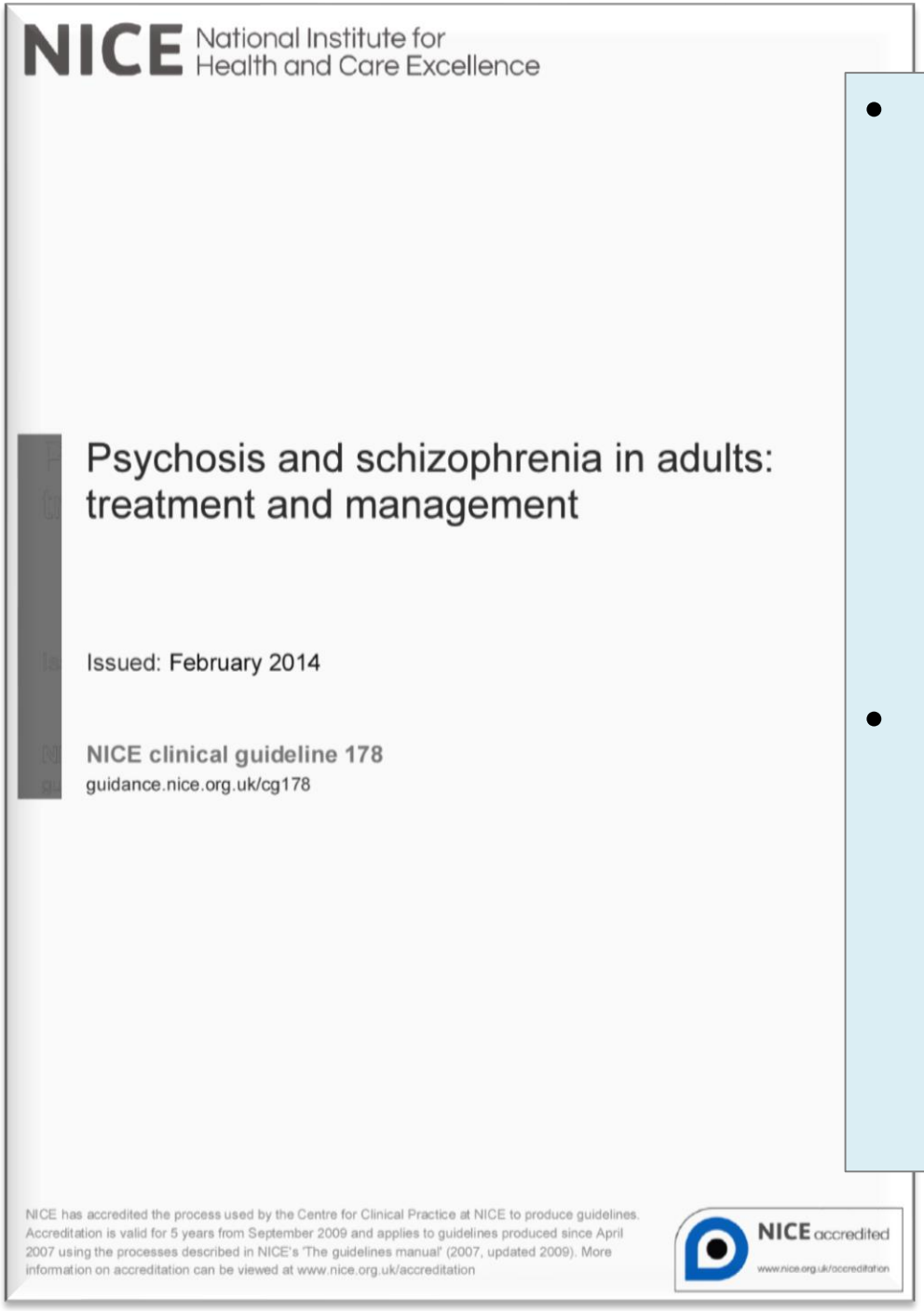
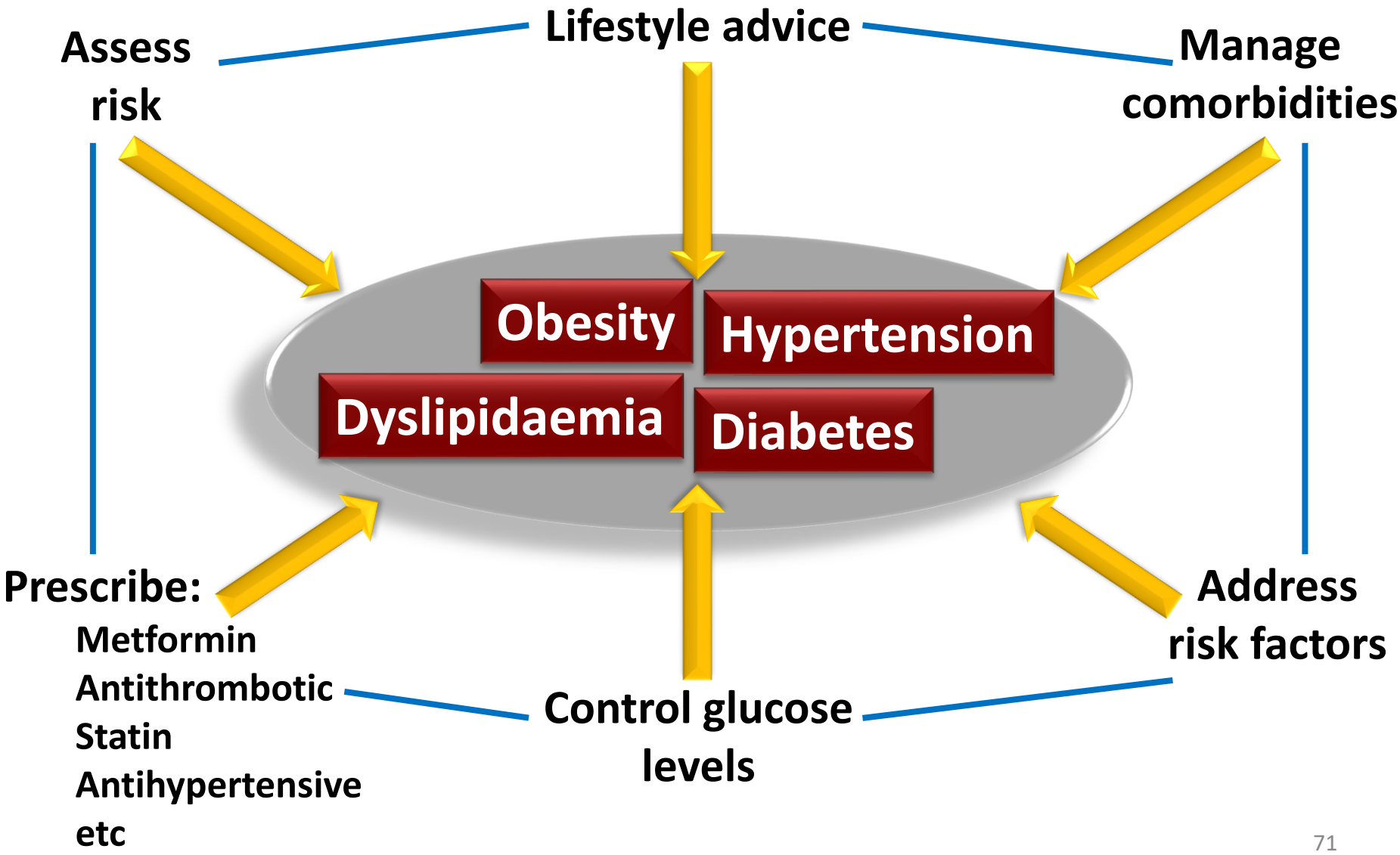


- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually
- Follow various NICE Guidelines for cardiovascular disease
  - Obesity
  - Type 2 Diabetes
  - Dyslipidaemia
  - Hypertension

Patients with schizophrenia have complex metabolic health needs



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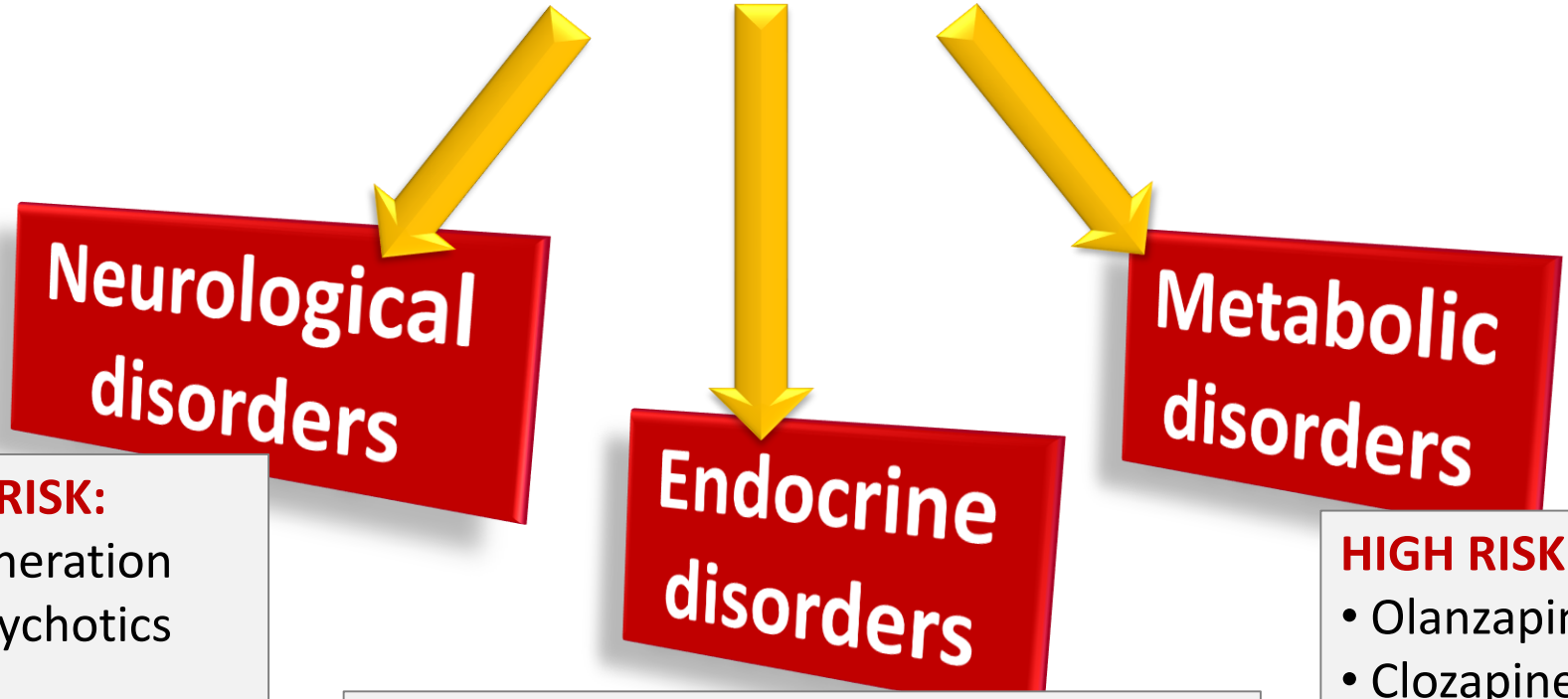
Antipsychotics & Iatrogenic Disease



HIGH RISK:
1st generation antipsychotics

Lower risk:
2nd generation antipsychotics

HIGH RISK:
1st generation antipsychotics and some 2nd generation antipsychotics
- Amisulpride, Risperidone, Paliperidone

Low risk:
- Aripiprazole, Lurasidone, Quetiapine

HIGH RISK:
- Olanzapine
- Clozapine

Low risk:
- Aripiprazole
- Lurasidone
- Haloperidol

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Medicines & iatrogenic disease

Questions?

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Outline

- Brain physiology & pharmacology
- Good practice in the use of medicines
  - Anxiety
  - Depression
  - Bipolar disorder
  - Schizophrenia & Psychosis
- Iatrogenic disease in SMI
- Treatment adherence in SMI & crisis in mental health services
- Individualising treatment
  - Patient choice & information

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October 2013

CommunityCare
Inspiring excellence in social care

Home | Adults | Children | Mental Health | Workforce | Jobs

You are in: Home > Patients at risk as 'unsafe' mental health services reach crisis point

Patients at risk as 'unsafe' mental health services reach crisis point

Community Care investigation prompts minister to pledge to end "institutional bias against mental health" in NHS

by **Andy McNicoll** on October 16, 2013 in **Mental Health**, **Mental Health Act**

Image: Rex Features/Phaney

135

Mental health crisis services in England are "unsafe" and delivering substandard care to acutely unwell adults and children, an investigation by Community Care and BBC News has revealed.

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16 October 2013 Last updated at 00:15

Share

England's mental health services 'in crisis'

By Michael Buchanan
BBC News

The mental health service in England is in crisis and unsafe, says one of the country's leading psychiatrists.

Dr Martin Baggaley, medical director of the South London and Maudsley NHS Trust, spoke out as an investigation by BBC News and **Community Care** magazine reveals more than 1,500 mental health beds have closed in recent years.

Many trusts have all their beds filled.

Care Minister Norman Lamb said the current situation was "unacceptable" and provision must improve.

Care Minister Norman Lamb; "I know there are problems and I am absolutely determined that we address them"

While there was a drive to treat more people in the community, he said beds must be available when patients needed them.

System 'inefficient, unsafe'

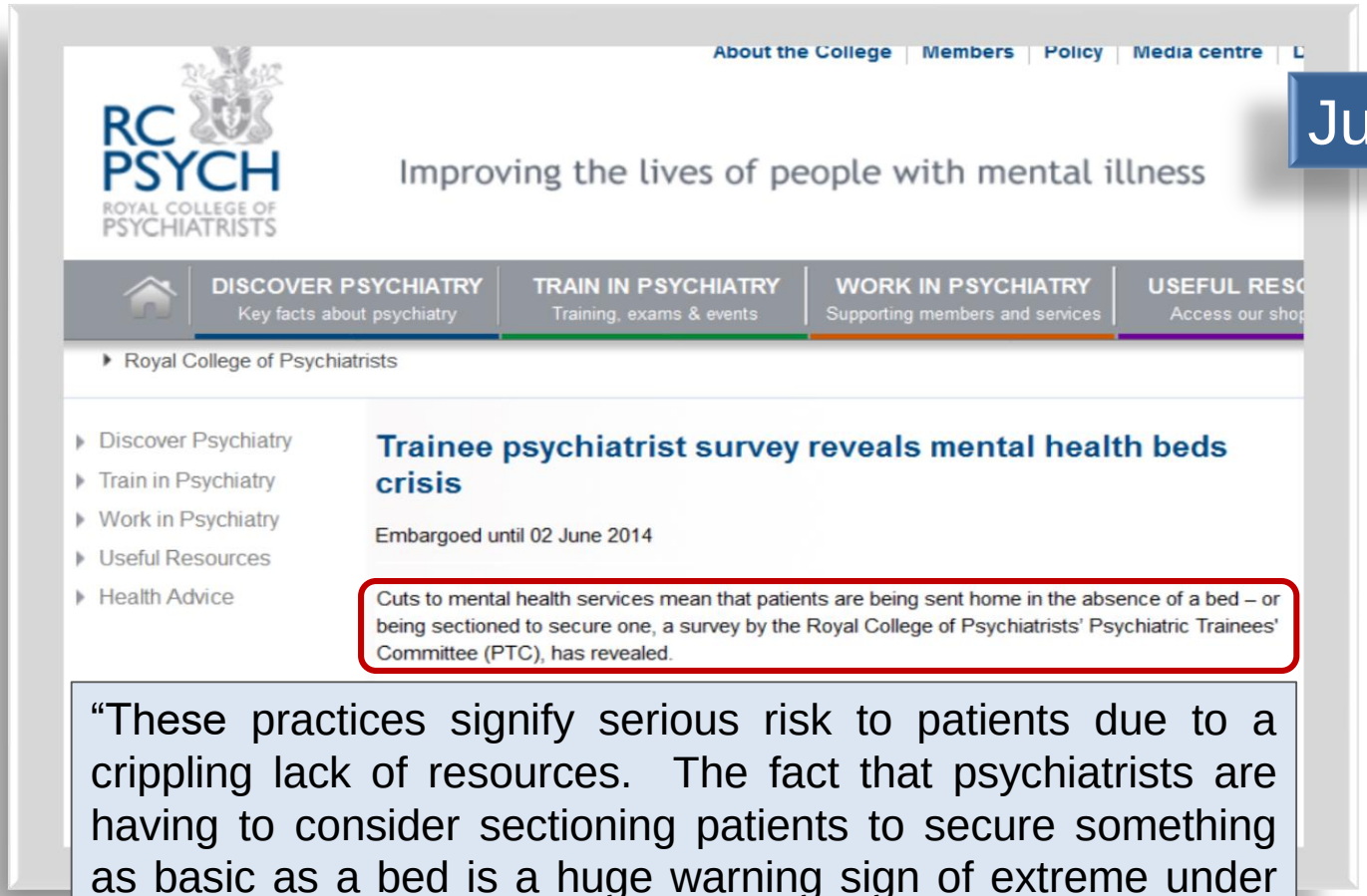
Freedom of Information requests were sent to 53 of England's 58 mental health trusts, by BBC News and Community Care, and 46 trusts replied.

The figures show that a minimum of 1,711 mental health beds have been closed since April 2011, including 277 between April and August 2013.

Related Stories

- **Cost of policing mental illness**
- **Warning over mentally ill in cells**
- **Mental health bed closures referred**

June 2014



"These practices signify serious risk to patients due to a crippling lack of resources. The fact that psychiatrists are having to consider sectioning patients to secure something as basic as a bed is a huge warning sign of extreme under provision."

The King's Fund

Ideas that change health care

November 2015

Briefing

Mental health under pressure

- Funding for mental health services has been cut in recent years. Our analysis shows that around 40 per cent of mental health trusts experienced reductions in income in 2013/14 and 2014/15.
- There is widespread evidence of poor-quality care. Only 14 per cent of patients say that they received appropriate care in a crisis, and there has been an increase in the number of patients who report a poor experience of community mental health care.
- Bed occupancy in inpatient facilities is frequently well above recommended levels, with community services, in particular crisis resolution and home treatment teams, often unable to provide sufficient levels of support to compensate for reductions in beds. This is having a negative impact on safety and quality of care.
- The lack of available beds is leading to high numbers of out-of-area placements for inpatients. Out-of-area placements are costly, have a detrimental impact on the experience of patients and are associated with an increased risk of suicide.

February 2016

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NEWS

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Health

Mental health beds search 'a scandal'

9 February 2016 | Health

The practice of sending mentally ill adults in England long distance care is unacceptable and must end, a report by experts says.

Mental health

Mental health patients 'should not have to travel across England for beds'

Independent commission lists ways psychiatric services must improve, and notes funding lag behind physical health

James Meikle

Tuesday 9 February 2016 00.01 GMT

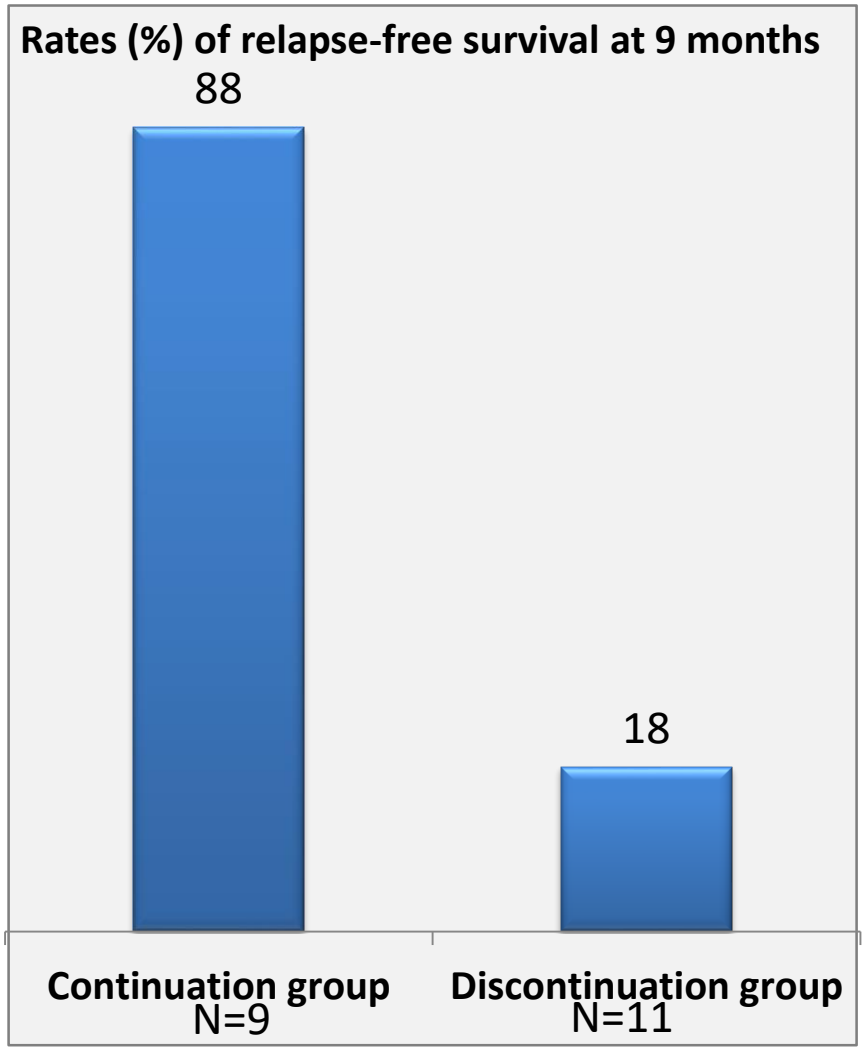
theguardian website of the year

Save for later

Lack of funding for some mental health services in England is putting vulnerable people, including children, at risk, the report says. Photograph: Alamy

Antipsychotic discontinuation in 1st episode schizophrenia leads to rapid relapse

- Patients stable for 1 year after recovery from first episode of schizophrenia or schizoaffective disorder
- Randomly assigned to continue antipsychotic or gradual withdrawal
- Primary outcome:
  - Relapse-free survival at 9 months
- Study terminated prematurely for ethical reasons



Boonstra G, Burger H, Grobbee DE, Kahn RS
Antipsychotic prophylaxis is needed after remission from a first psychotic episode in schizophrenia patients: results from an aborted randomised trial.
Int J Psychiatr Clin Pract 2011; 15: 128-34

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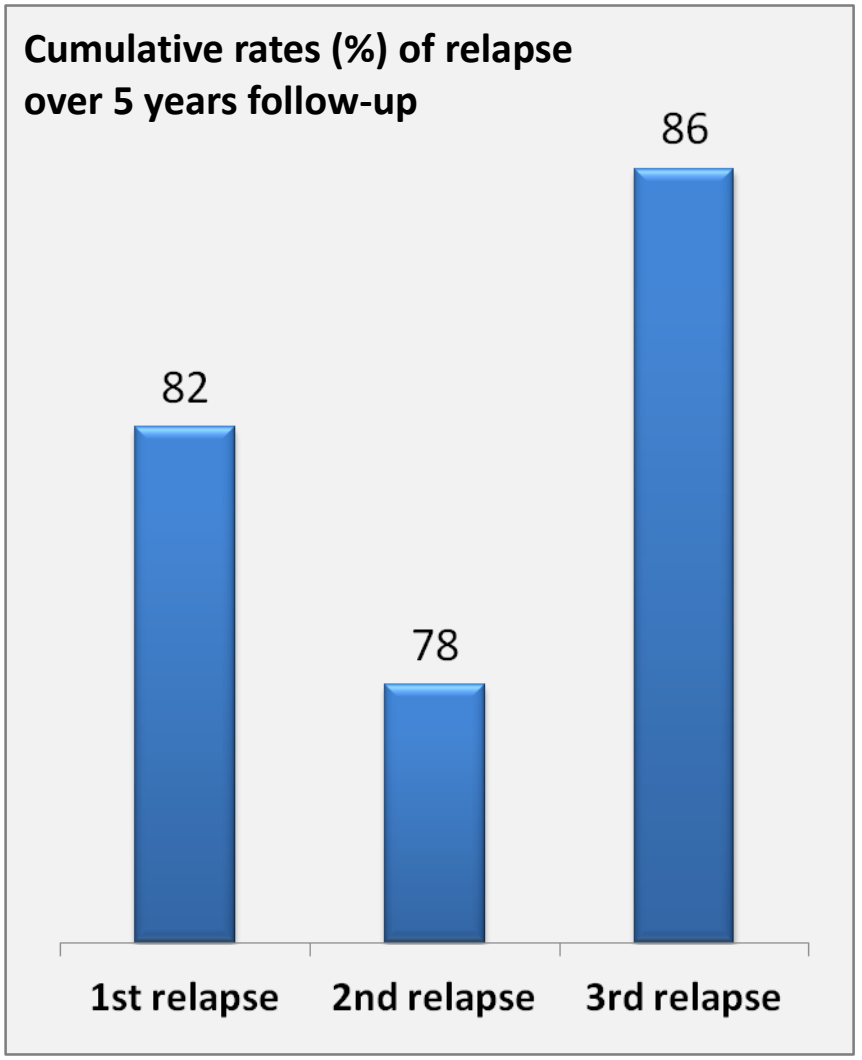
Stopping antipsychotics in 1st episode schizophrenia leads to high rates of relapse

- 5-year follow-up study after initial recovery from first episode of schizophrenia or schizoaffective disorder
- Discontinuation of antipsychotic medication increased risk of relapse almost 5-fold



Robinson D, Woerner MG, Alvir JMJ et al.
Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder
Arch Gen Psychiatry 1999;56:241-47

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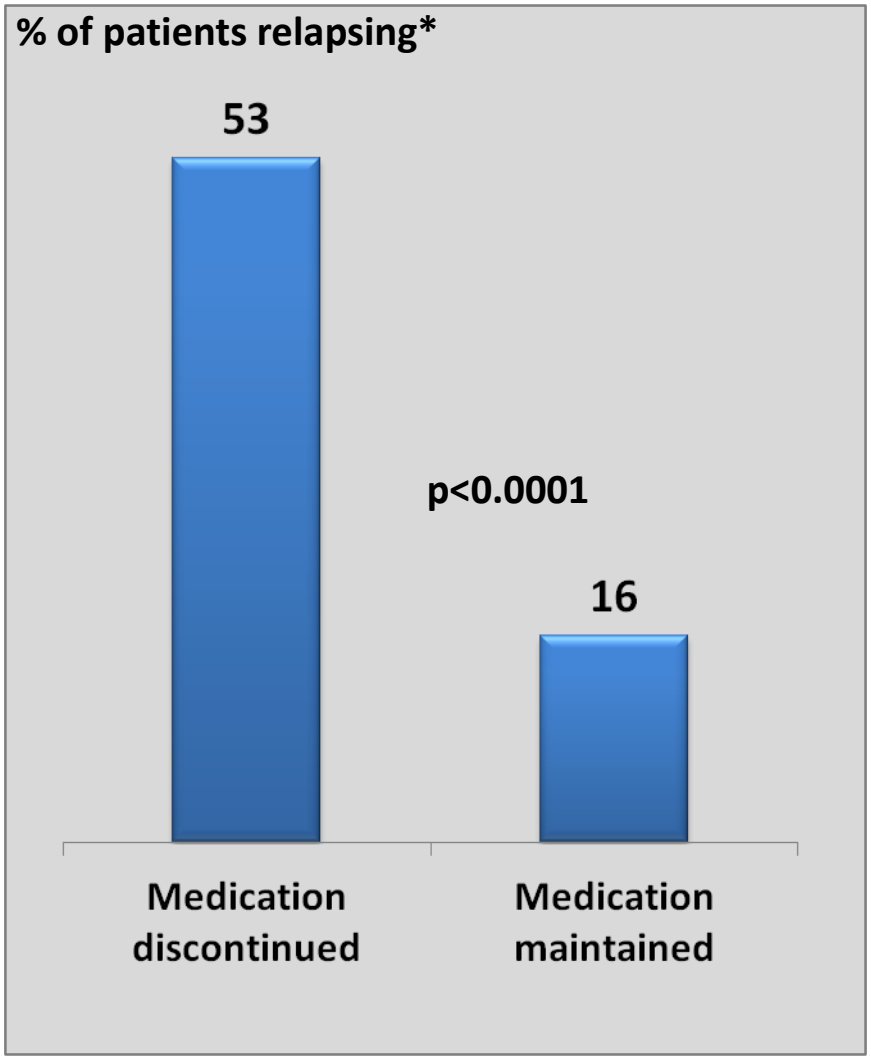
Chronic schizophrenia: Poor adherence leads to high relapse rates

- Pooled analysis of 66 studies with 4365 patients with chronic schizophrenia
- Relapse rates over 10 month period



*** Data from 29 of the 66 studies where there were matched withdrawal and treatment maintenance groups**

Gilbert PL, Harris MJ, McAdams LA, Jeste DV.
Neuroleptic withdrawal in schizophrenic patients:
a review of the literature.
Archives of General Psychiatry 1995;52:173-88

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Poor adherence in schizophrenia: a large and persistent problem

Systematic review of literature

- 39 studies from 1980 onwards
  - 10 retrospective, 15 cross-sectional, 14 prospective
- Mean duration of illness 9-24 years
- Range of adherence measures
- *"Taking medication as prescribed at least 75% of the time"*

49.5% of patients non-adherent

Lacro JP, Dunn LB, Dolder CR et al.
Prevalence of and risk factors for medication non-adherence in patients with schizophrenia: a comprehensive review of recent literature.
J Clin Psychiatry 2002;63:892-909

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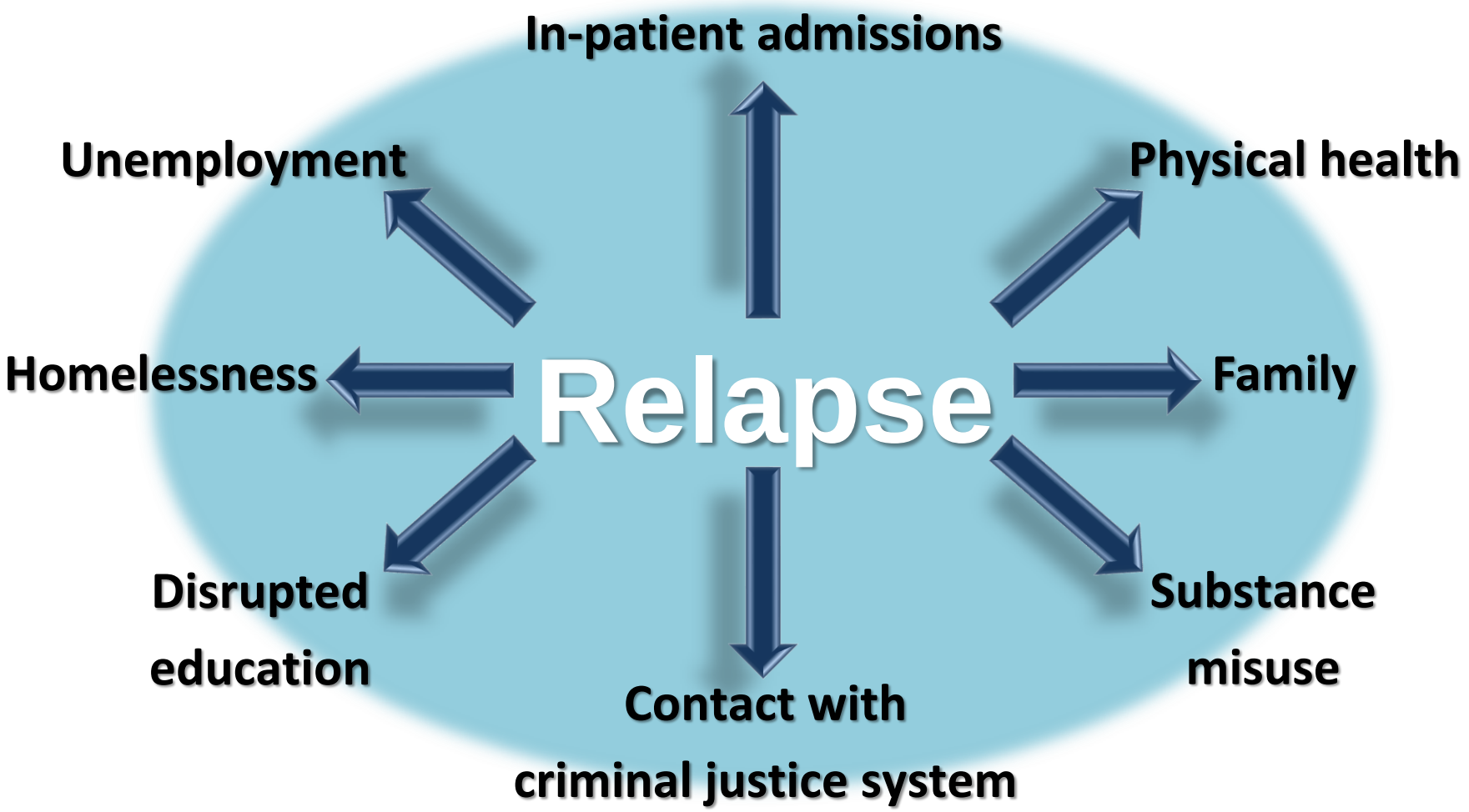
What is the impact of relapse?



Andrew A, Knapp M, McCrone P et al. Effective interventions in schizophrenia: the economic case Report for the Schizophrenia Commission. London, LSE & PSSRU, November 2012

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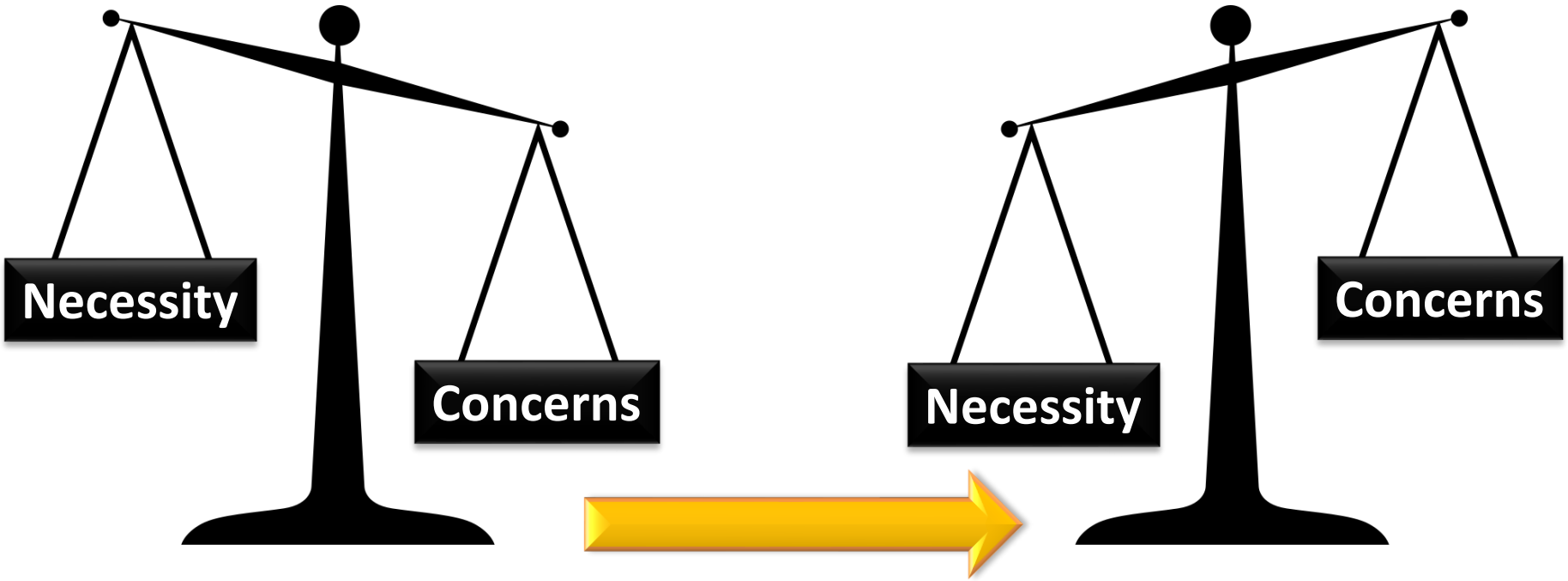
Necessity / Concerns model for understanding adherence

Necessity = understanding and accepting necessity of treatment

Concerns = concerns about accepting treatment



= poor adherence

= improved adherence

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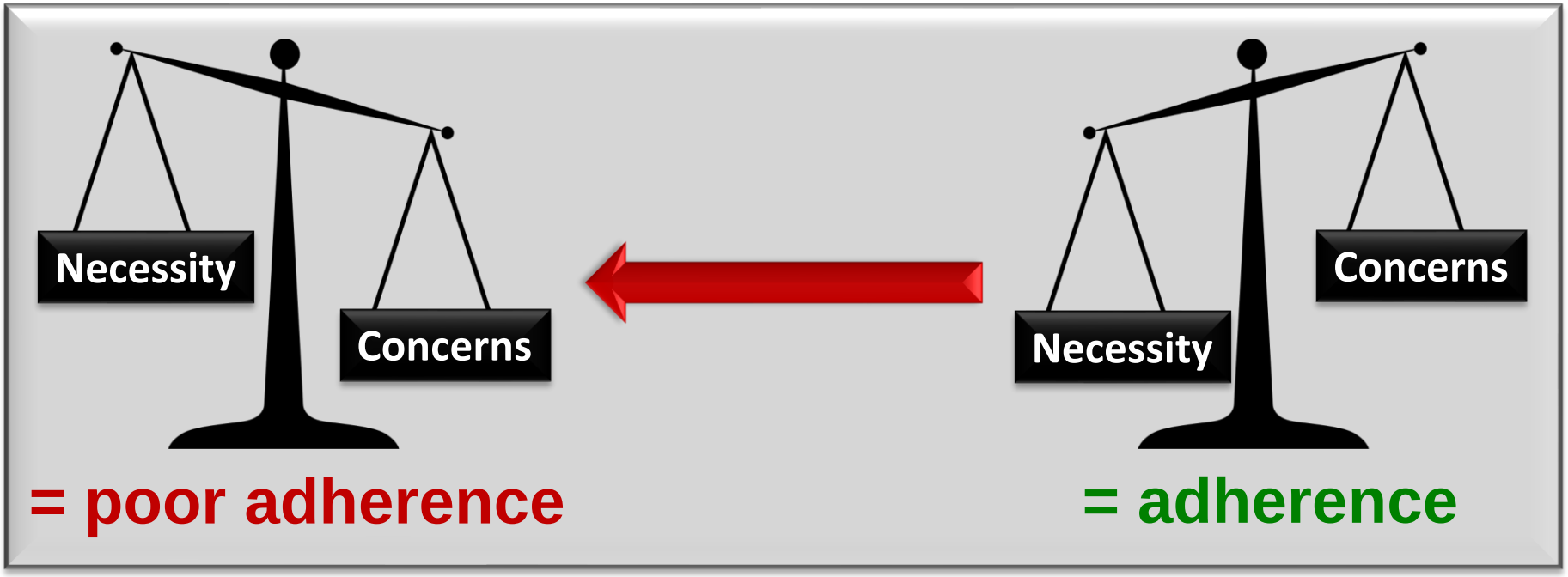
Is poor adherence always irrational?

- How rational / careful is prescribing?
- How seriously are side effects taken?
- How often do patients make informed choices?
- How often are patients involved in decisions?



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Treatment adherence & relapse

Questions?

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Outline

- Brain physiology & pharmacology
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  - Anxiety
  - Depression
  - Bipolar disorder
  - Schizophrenia & Psychosis
- Iatrogenic disease in SMI
- Treatment adherence in SMI & crisis in mental health services
- Individualising treatment
  - Patient choice & information

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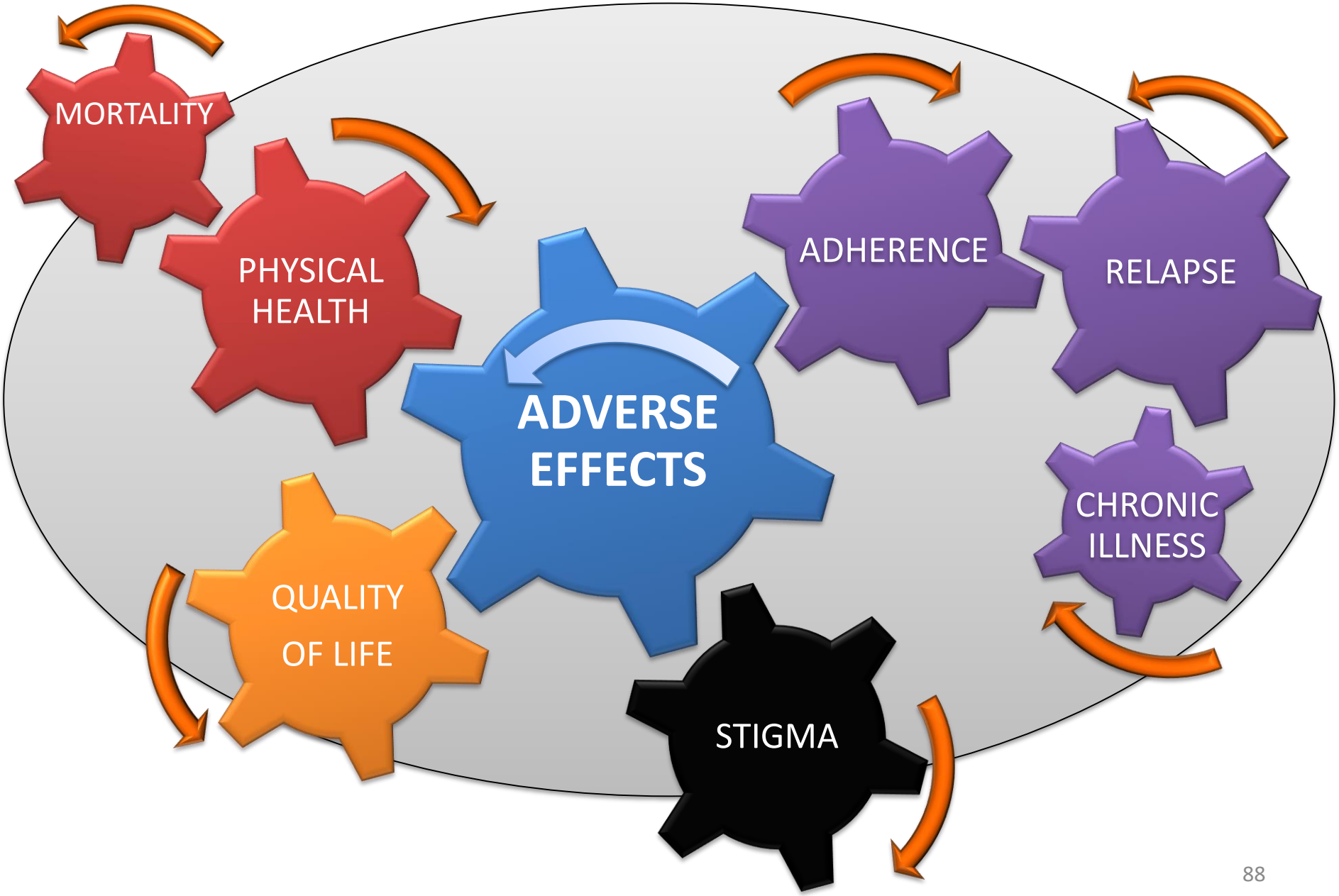
Adverse effects have a pervasive impact



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Individualising antipsychotic treatment

Antipsychotic
Oral?
LAI?

Which side-effects does the patient most want to **avoid**?

Which treatments are **least** likely to cause these side-effects?

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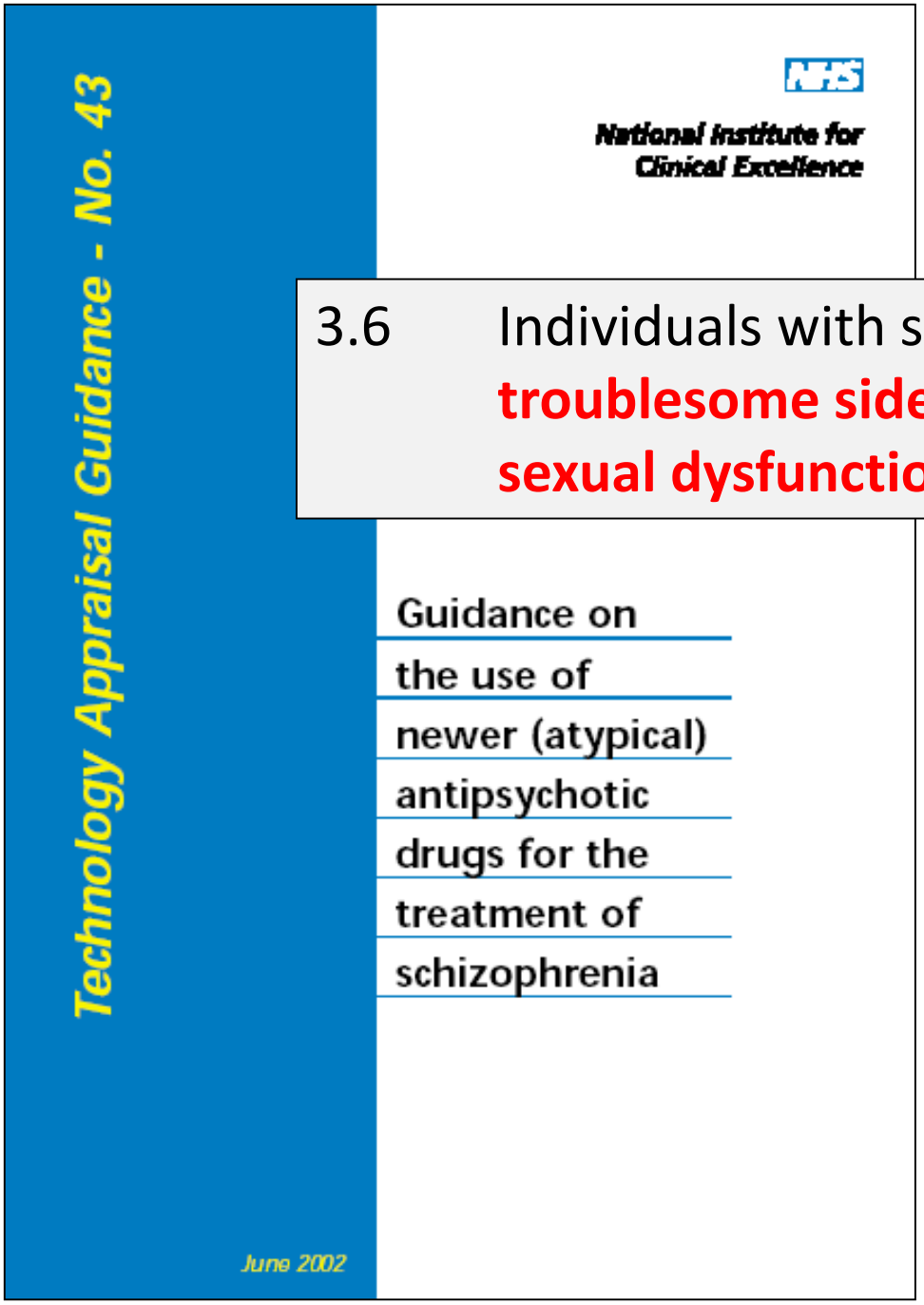
www.nice.org.uk



3.6 Individuals with schizophrenia consider **the most troublesome side effects** to be **EPS, weight gain, sexual dysfunction and sedation.**

The most common side effects of 2nd-generation antipsychotics

- EPS
- Weight gain
- Raised prolactin & sexual dysfunction
- Daytime sleepiness

- Nausea
- Stomach upset
- Type 2 Diabetes
- Vomiting
- Constipation
- Insomnia
- Dizziness
- Dry mouth

SPCs for amisulpride, aripiprazole, olanzapine, quetiapine & risperidone
http://www.medicines.org.uk/emc/ accessed 13.02.13

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Which side effects would a teenage male most like to avoid?

- EPS
- Weight gain
- Raised prolactin & sexual dysfunction
- Daytime sleepiness

- Nausea
- Stomach upset
- Type 2 Diabetes
- Vomiting
- Constipation
- Insomnia
- Dizziness
- Dry mouth

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Which side effects would a woman aged 30 most like to avoid?

- EPS
- Weight gain
- Raised prolactin & sexual dysfunction
- Daytime sleepiness

- Nausea
- Stomach upset
- Type 2 Diabetes
- Vomiting
- Constipation
- Insomnia
- Dizziness
- Dry mouth

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Which side effects would an overweight, middle-aged Asian man most like to avoid?

- EPS
- Weight gain
- Raised prolactin & sexual dysfunction
- Daytime sleepiness

- Nausea
- Stomach upset
- Type 2 Diabetes
- Vomiting
- Constipation
- Insomnia
- Dizziness
- Dry mouth

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Which side effects would you personally most like to avoid?

- EPS
- Weight gain
- Raised prolactin & sexual dysfunction
- Daytime sleepiness

- Nausea
- Stomach upset
- Type 2 Diabetes
- Vomiting
- Constipation
- Insomnia
- Dizziness
- Dry mouth

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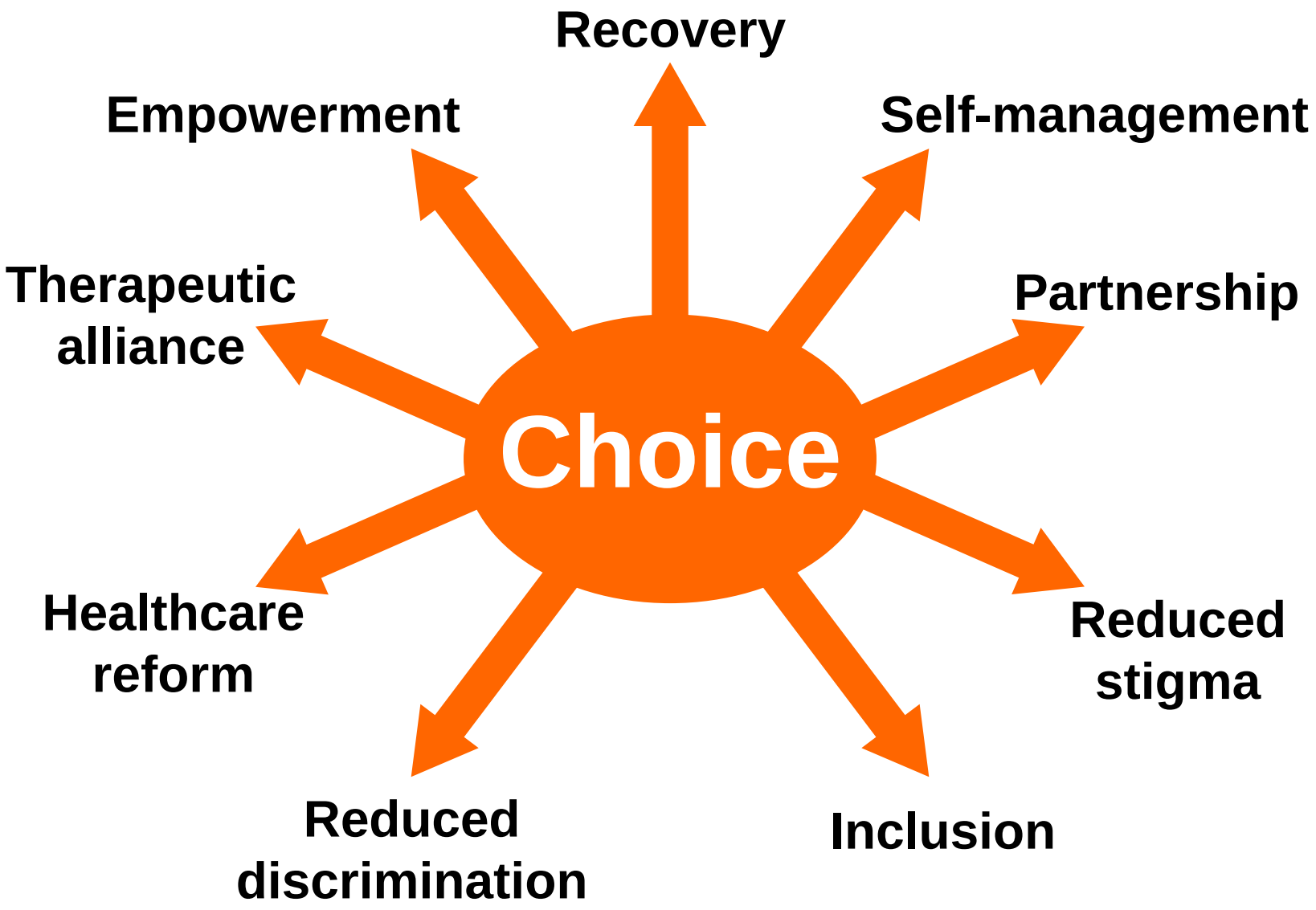

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Modern Standards and Service M

Mental Health

Executive Summary

Building on the Be

Choice, Responsiveness and Equity in the NHS

December 2003

DH Department of Health

HM Government

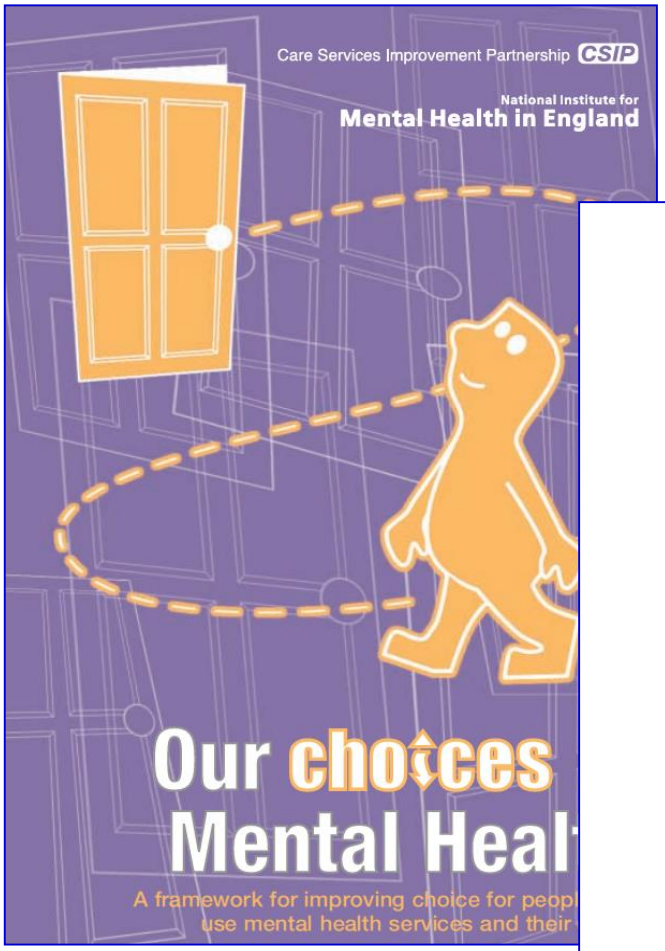
DH Department of Health

NHS

Creating a Patient-led NHS

Delivering the NHS Improvement Plan

DH Department of Health


Care Services Improvement Partnership CSIP
National Institute for
Mental Health in England
Our choices
Mental Heal
A framework for improving choice for peop
use mental health services and their

NHS
THE NHS
CONSTITUTION
the NHS belongs to us all
for Engl
21 January 2

Equity and excellence:
Liberating the
NHS
DH Department of Health

2010

Equity and excellence:

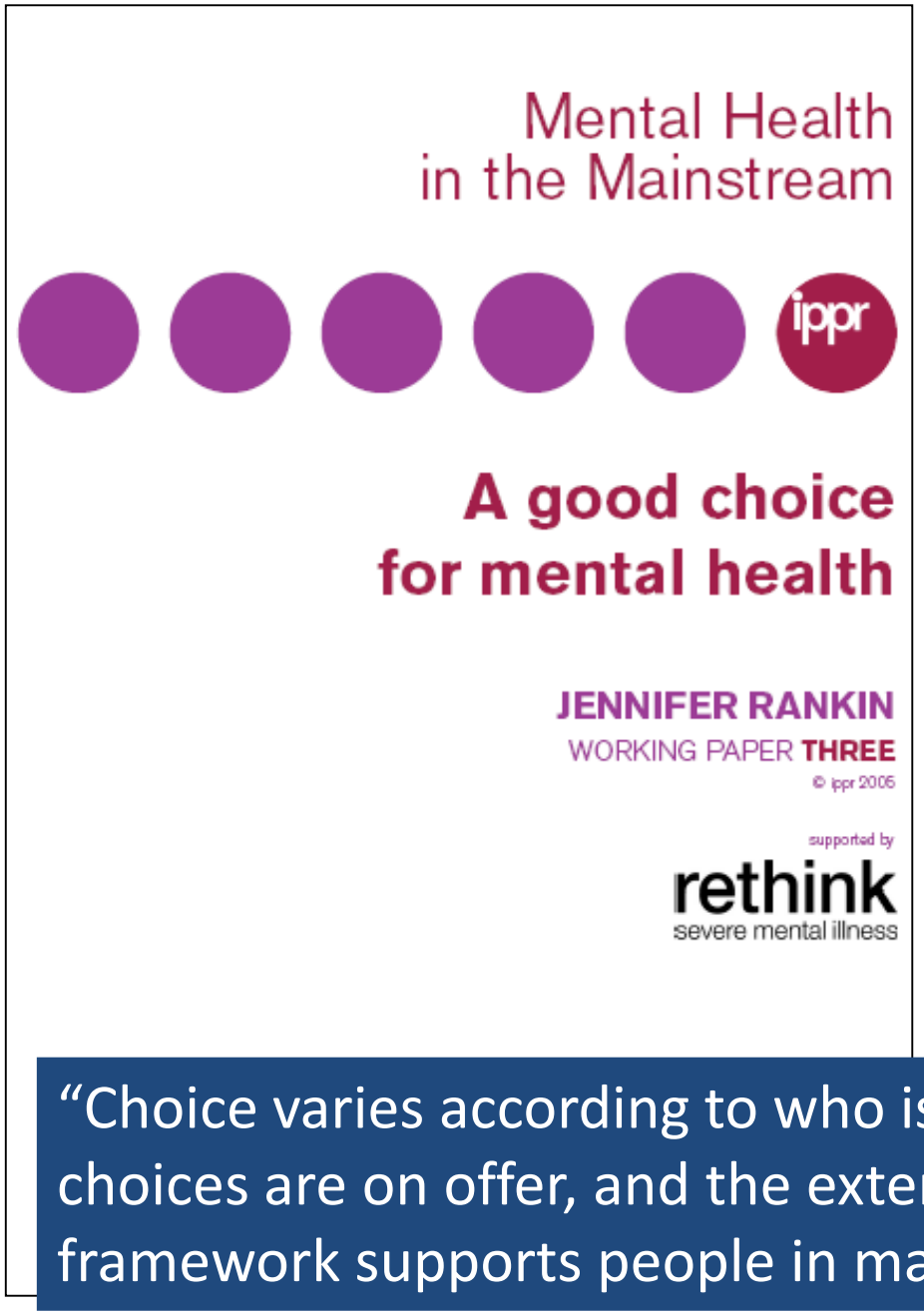
Putting patients and public first

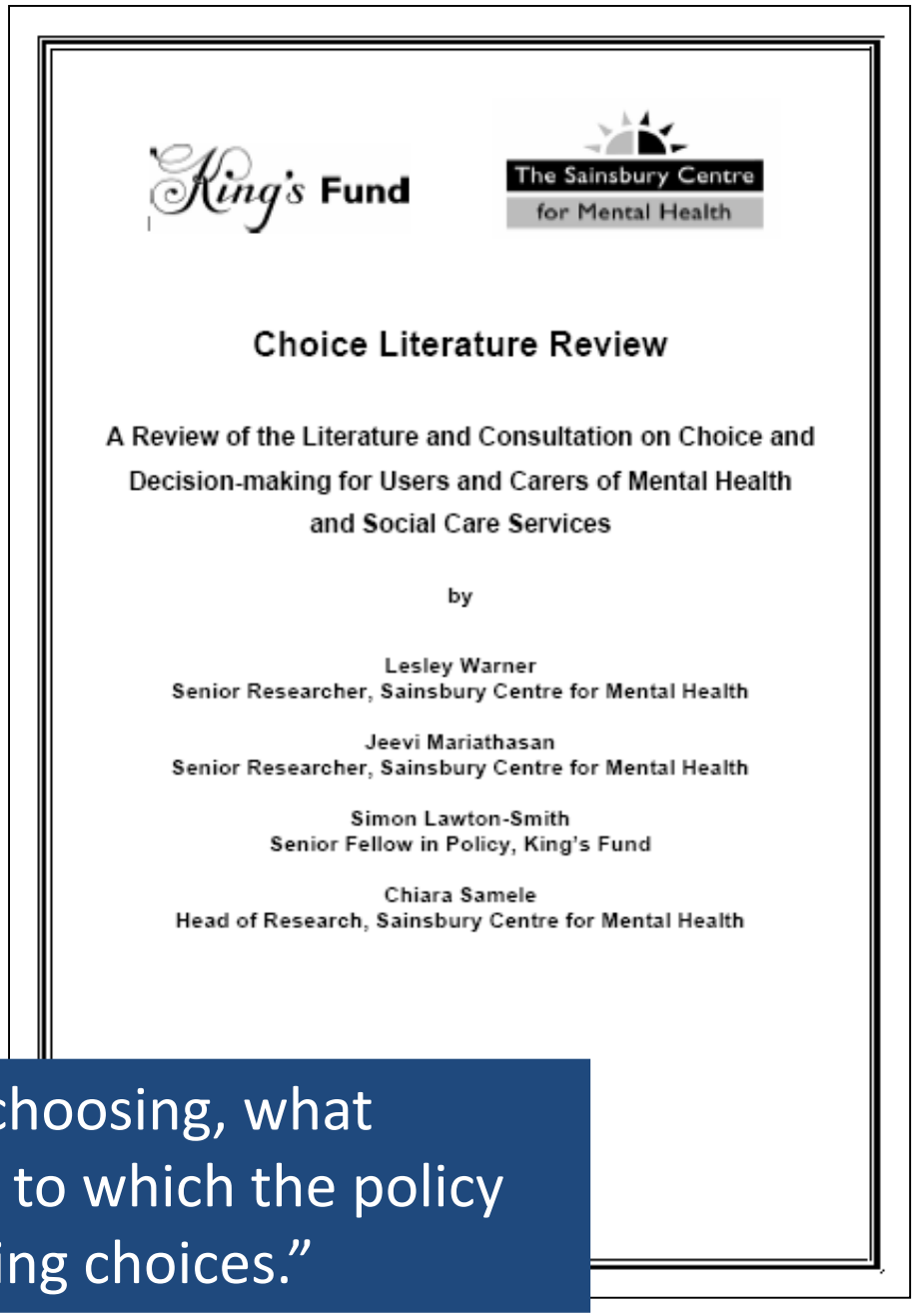
4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

   a. Shared decision-making will become the norm: *no decision about me without me*.

   b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

   c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.





"Choice varies according to who is choosing, what choices are on offer, and the extent to which the policy framework supports people in making choices."

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Barriers to Choice

- Lack of capacity of services to offer Choice including
  - an apparent lack of a range of treatment options and
  - restrictions on local service provision that make choices meaningless
- Lack of support from health professionals including
  - a reluctance to support service users to make choices that might differ from their own
  - a reluctance to involve carers in decisions about treatment or care

Warner, L., Mariathasan, J., Lawton-Smith, S. & Samele, C. Choice Literature Review. London: The Sainsbury Centre for Mental Health and King's Fund 2006.

Rankin, J. A good choice for mental health: mental health in the mainstream; Working paper 3. London: Institute for Public Policy Research 2005.

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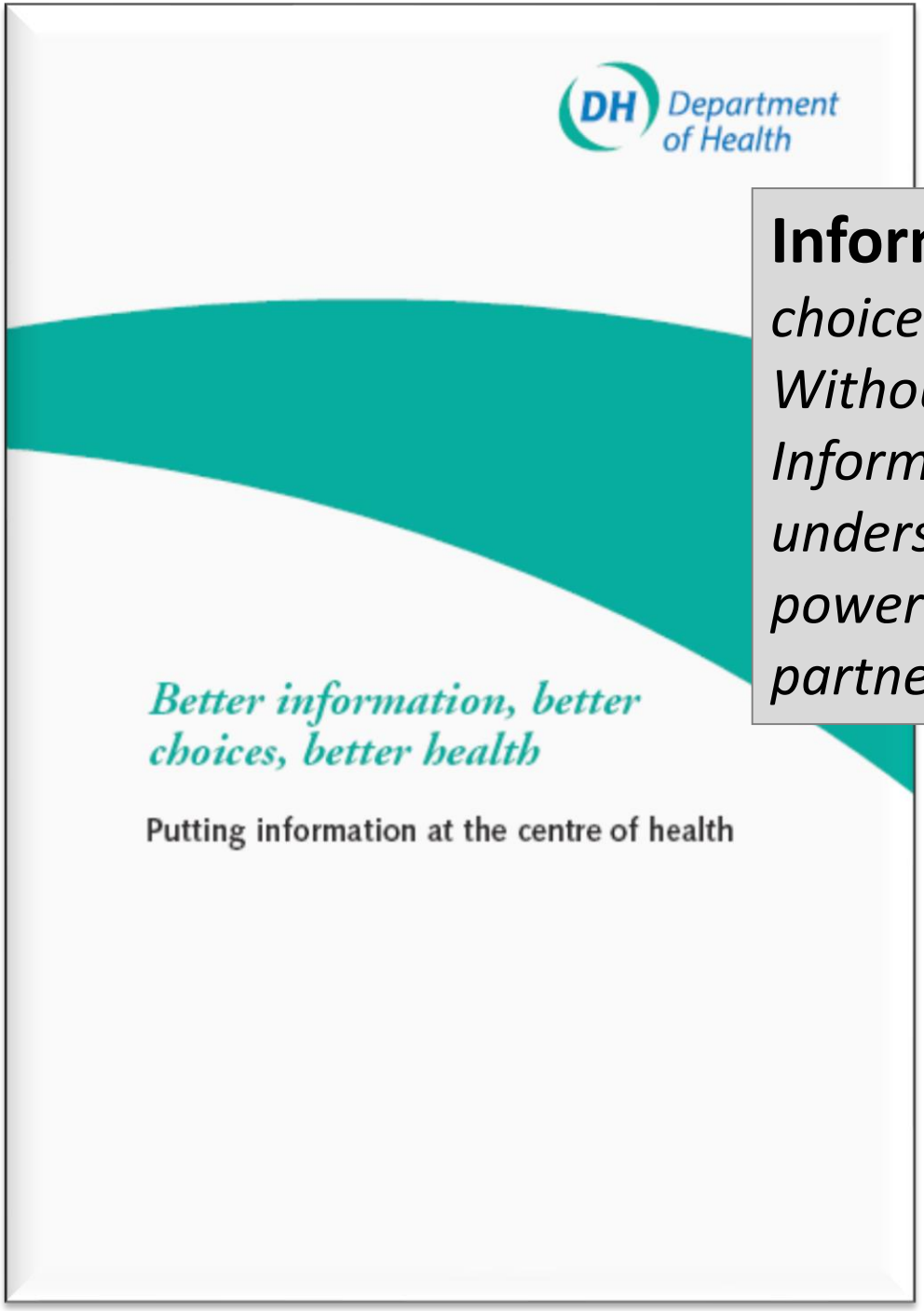

Information *". . . is fundamental to choice and making informed decisions. Without information there is no choice. Information helps knowledge and understanding. It gives patients the power and confidence to engage as partners with their health service."*

2009

NHS

THE NHS CONSTITUTION

the NHS belongs to us all

for England
21 January 2009

- The right to make choices about NHS care.
- The right to be involved in discussions and decisions about healthcare, and to be given information to enable users to do this.
- The right to accept or refuse the treatment that is offered, and not to be given any treatment unless valid consent has been obtained.
- The right to be given information about any proposed treatment in advance, including any significant risks and any alternative treatments, and the risks involved in doing nothing.

Minimum information required for informed choice – including informed consent

- Effects of treatment vs no treatment
- How likely is it to work?
- How does it compare with other options?
- Risks associated with poor adherence to treatment

Where can this information be found?

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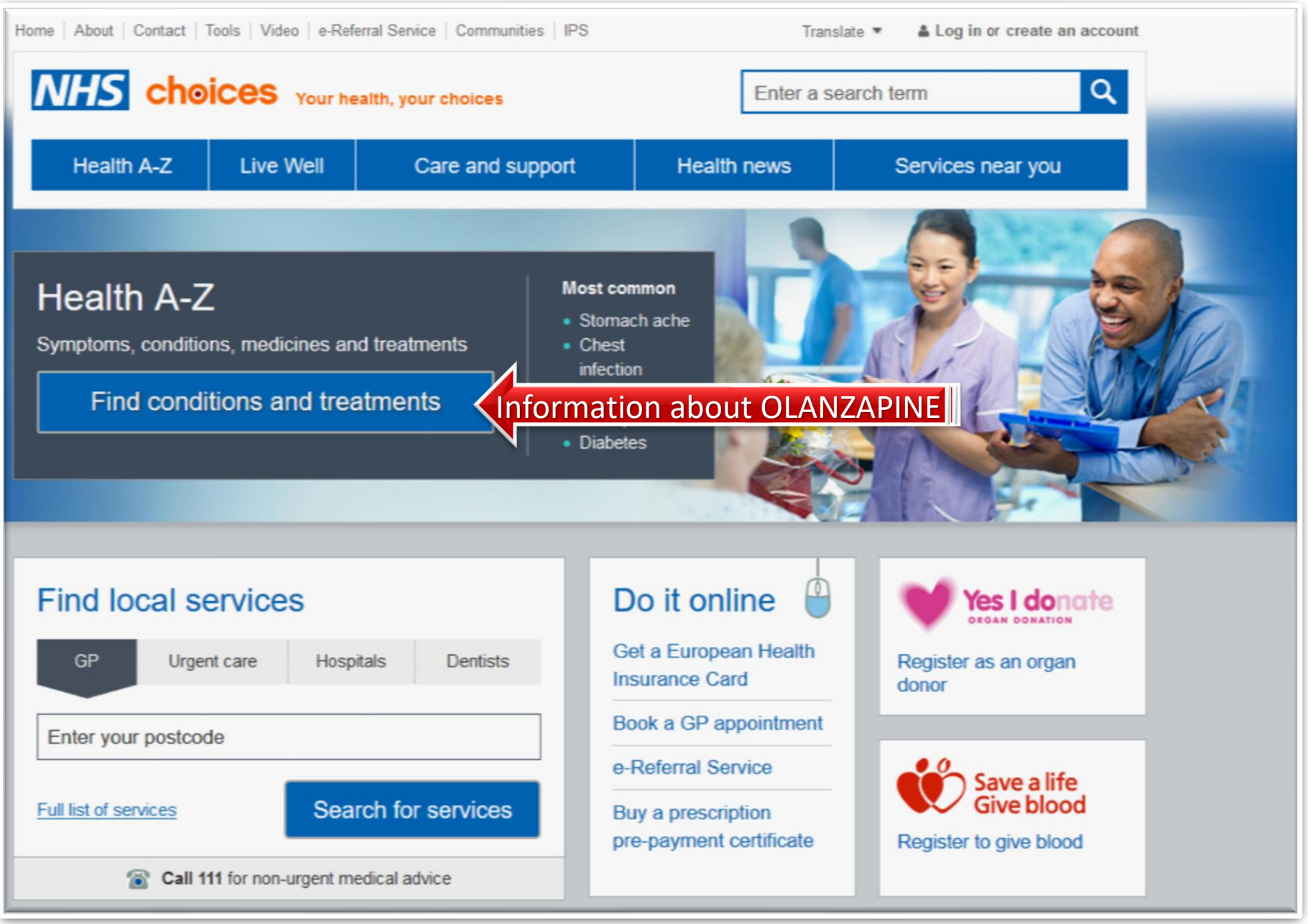

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accessed 14.01.17

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Health A-Z - Conditions and treatments starting with O

Browse by index

A B C D E F G H I J K L M N **O** P Q R S T U V W X Y Z 0-9

Ob

Obesity

Find weight loss support services

Weight loss

Obesity continued...

Weight loss surgery

Obsessive compulsive disorder

Obstructive sleep apnoea

Oc

Occupational therapy

OCD (obsessive compulsive disorder)

Ocular cancer

Ocular migraine

Od

Odour, imaginary

Oe

Oedema

Oesophageal atresia and tracheoesophageal fistula

Oesophageal cancer

http://www.nhs.uk
accessed 14.01.17

Click here

Search results for 'olanzapine'

11 search results found

Medicines information links
Medicines information advice

Psychosis - Treatment
Read about treating psychosis. Treatment for psychosis involves a combination of antipsychotic medicines, psychological therapies, and social support.

What are side effects? - Health questions
Side effects are unwanted symptoms caused by medical treatment. They're also called

Sorry, the Medicines A-Z page you are looking for is no longer available

The A-Z directory of medicines information is no longer published by NHS Choices. You may find the following links useful:

- Information on medicines from Medicines.org.uk
- Information on treatments and conditions from NHS Choices

To report a suspected medicine side effect, use the Yellow Card scheme:

- Report medicine side effects

Page last reviewed: 29/09/2015
Next review due: 29/09/2017

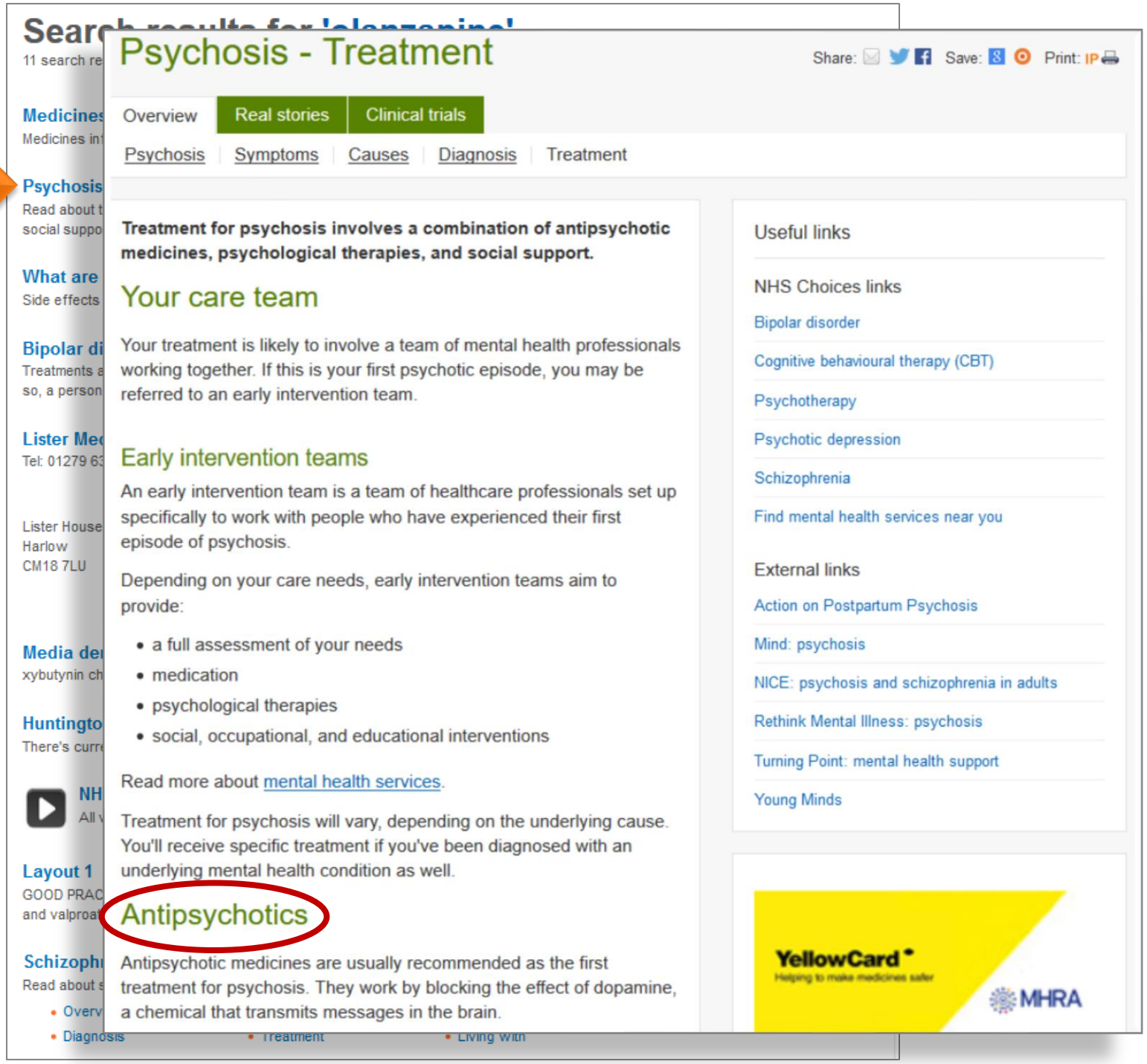
NHS VIDEOS | All videsos in the catalog
All videos in the catalog presented in a non paged way to allow the GSA to crawl them.

Layout 1
GOOD PRACTICE OBSERVED. • Lithium, **Olanzapine** and Valproate are considered for long-term treatment. • ... 2. Lithium, **olanzapine** and valproate should be considered for long-term treatment of bipolar disorder.

Schizophrenia
Read about schizophrenia, a long-term mental health condition that causes a range of different psychological symptoms.

- Overview
- Symptoms
- Causes
- Diagnosis
- Treatment
- Living with

http://www.nhs.uk
accessed 14.01.17



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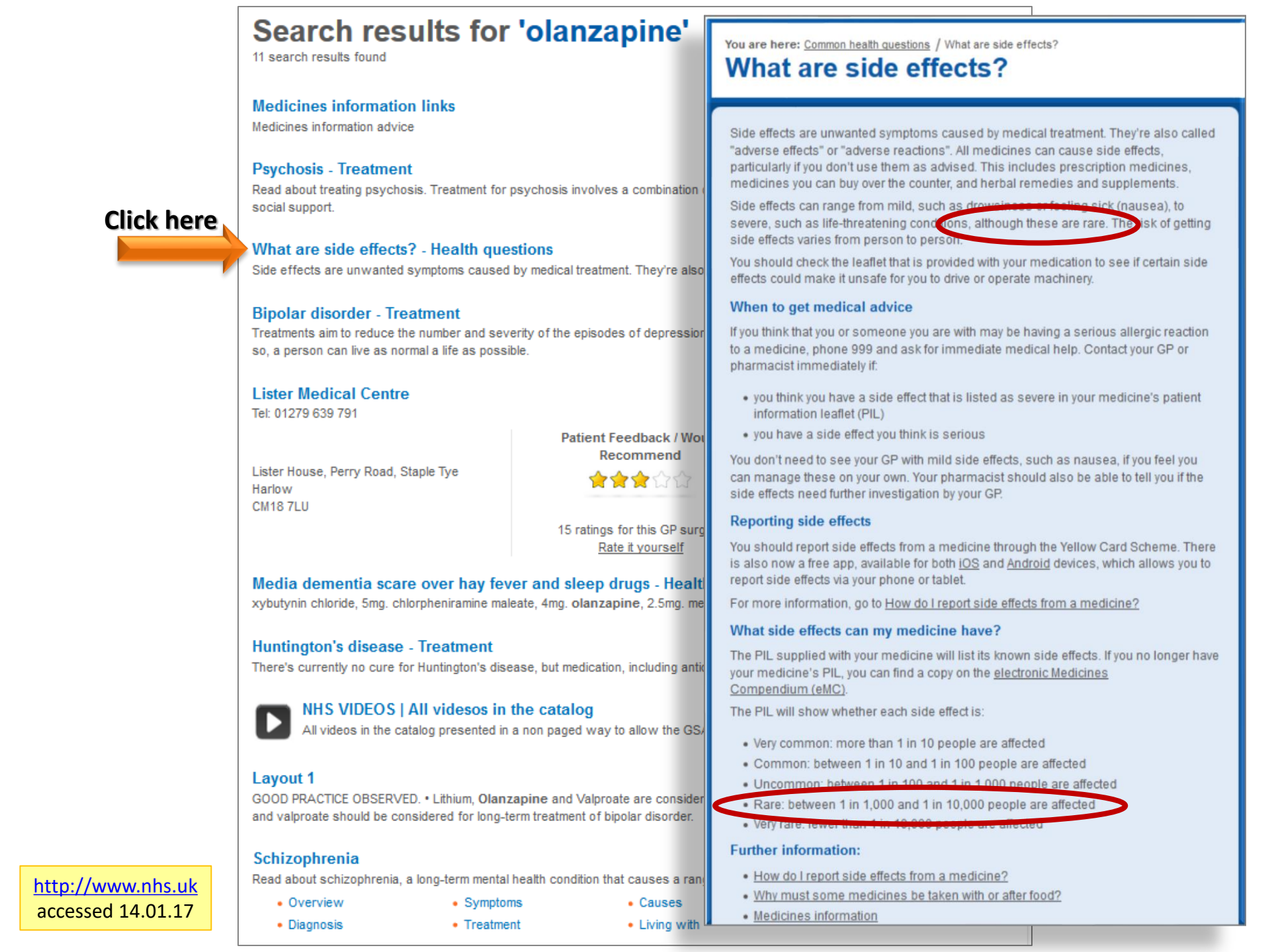

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Antipsychotics

Antipsychotic medicines are usually recommen
treatment for psychosis. They work by blocking
a chemical that transmits messages in the brai

However, they're not suitable or effective for ev
can affect people differently. In particular, antips
monitored closely in people who also have epil
causes seizures or fits.

People who have cardiovascular disease – con
heart, blood vessels, or circulation, such as hea
closely monitored.

Antipsychotics can usually reduce feelings of a
of use, but they may take several days or week
symptoms, such as hallucinations or delusional

Antipsychotics can be taken by mouth (orally) o
There are several slow-release antipsychotics,
one injection every two to six weeks.

Side effects

Antipsychotics can have side effects, although not everyone will experience them and their severity will differ from person to person.

Side effects can include:

- drowsiness
- shaking and trembling
- weight gain
- restlessness
- muscle twitches and spasms – where your muscles shorten tightly and painfully
- blurred vision
- dizziness
- constipation
- loss of sex drive (libido)
- dry mouth

Tell your GP or mental health worker if you have side effects that are becoming particularly troublesome. There may be an alternative antipsychotic medicine you can take that causes less side effects.

Never stop taking medication prescribed for you unless advised to do so by a qualified healthcare professional responsible for your care.

Suddenly stopping prescription medication could trigger a return of your symptoms (relapse). When it's time for you to stop taking your medication, it will be done gradually.

http://www.nhs.uk
accessed 14.01.17

Only the best medication.

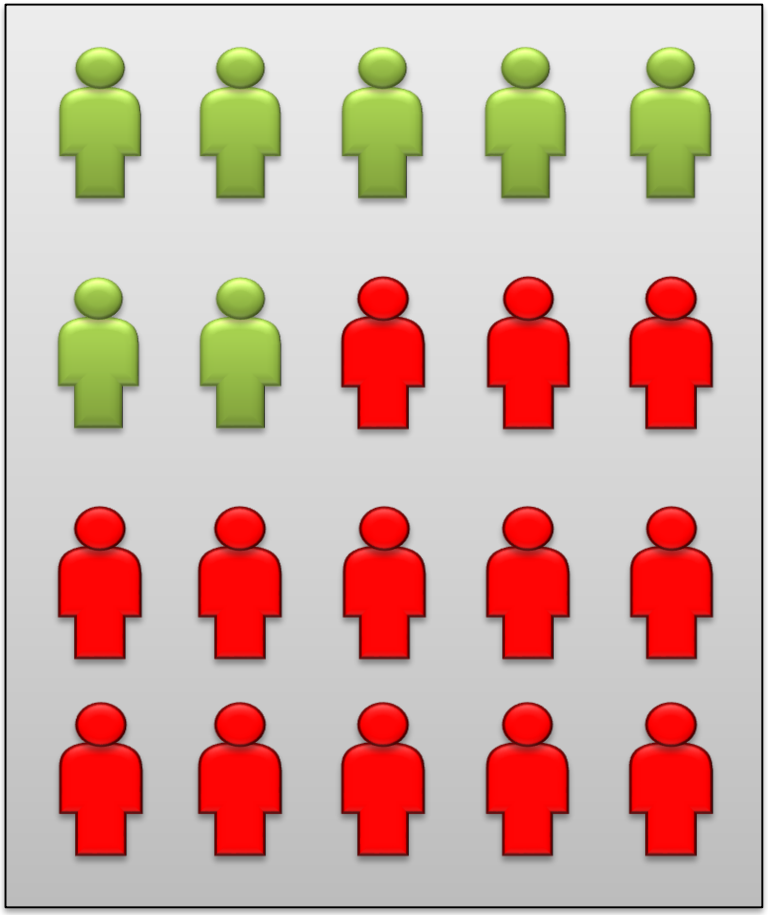
Your guide to antipsychotic and mood stabiliser medication

Drug	Sedation	Weight gain	Extra-pyramidal	Anti-cholinergic	Hypotension	Prolactin elevation
Amisulpride	–	+	+	–	–	+++
Aripiprazole	–	+/–	+/–	–	–	–
Asenapine	–	+/–	+/–	–	–	+/–
Benperidol	+	+	+++	+	+	+++
Bifeprunox	–	+/–	+/–	–	–	–
Chlorpromazine	+++	++	++	++	+++	+++
Clozapine	+++	+++	–	+++	+++	–
Flupentixol	+	++	++	++	+	+++
Fluphenazine	+	+	+++	++	+	+++
Haloperidol	+	+	+++	+	+	+++
Iloperidone	–	++	+	–	+	–
Loxapine	++	+	+++	+	++	+++
Olanzapine	++	+++	+/–	+	+	+
Perphenazine	+	+	+++	+	+	+++
Pimozide	+	+	+	+	+	+++
Pipotiazine	++	++	++	++	++	+++
Promazine	+++	++	+	++	++	++
Quetiapine	++	++	–	+	++	–
Risperidone	+	++	+	+	++	+++
Sertindole	–	+	–	–	+++	+/–
Sulpiride	–	+	+	–	–	+++
Trifluoperazine	+	+	+++	+/–	+	+++
Ziprasidone	+	+/–	+/–	–	+	+/–
Zotepine	+++	++	+	+	++	+++
Zuclopenthixol	++	++	++	++	+	+++

Key +++ High incidence/severity ++ Moderate + Low – Very low

Side effects of Olanzapine in people with schizophrenia

Weight gain



Name of side effect

Weight gain

What this means

Putting on so much weight that it can affect your health

What are the chances of getting this side effect?

Two-thirds of people who take Olanzapine for longer than 6 months get this side effect

gets the side effect

doesn't get the side effect

Source: FDA prescribing information December 2012

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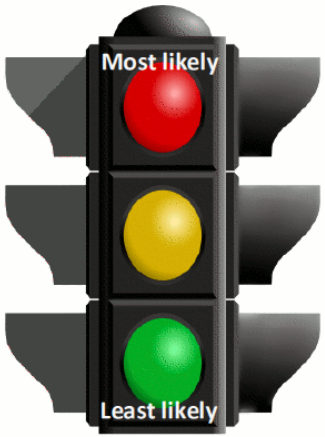
Side effects of medicines used in the treatment of schizophrenia

Name of side-effect	**WEIGHT GAIN**
What this means	Eating more and putting on weight. There is a risk of becoming obese. This means putting on so much weight it can damage your health. It can affect your heart, give you high blood pressure or increase the risk of getting diabetes.
What can be done about it?	If only a little weight is gained, don't worry. A diet with lots of fresh fruit and vegetables plus keeping active and getting regular exercise helps to keep weight under control. Exercise doesn't need to be strenuous or involve going to a gym. Walking briskly—for 30 minutes 3 times a week—has real health benefits. If this doesn't help, and weight gain is a problem, you can ask to see a dietician for advice.

What medicines are likely to cause this side effect?



CLOZAPINE, OLANZAPINE

AMISULPRIDE, QUETIAPINE, RISPERIDONE

ARIPIPRAZOLE

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Sources of Information about medicines

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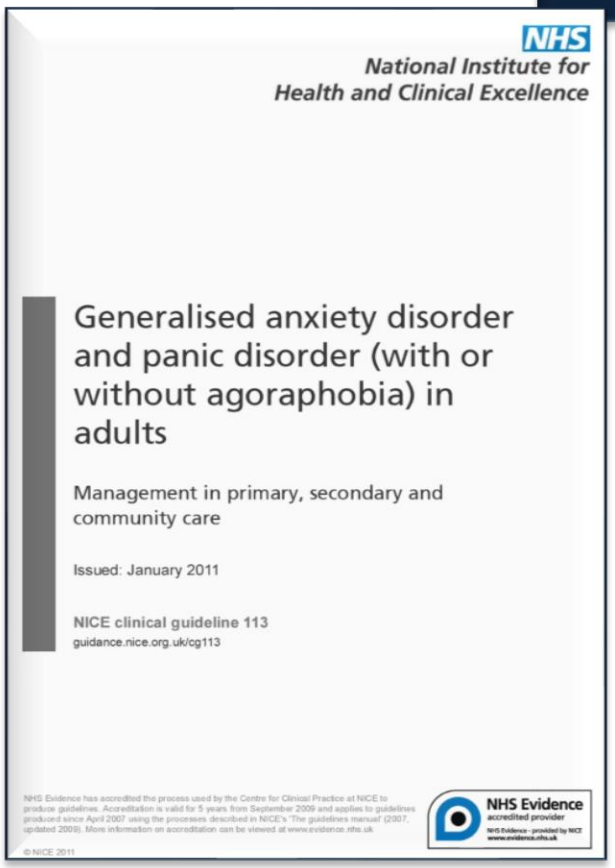
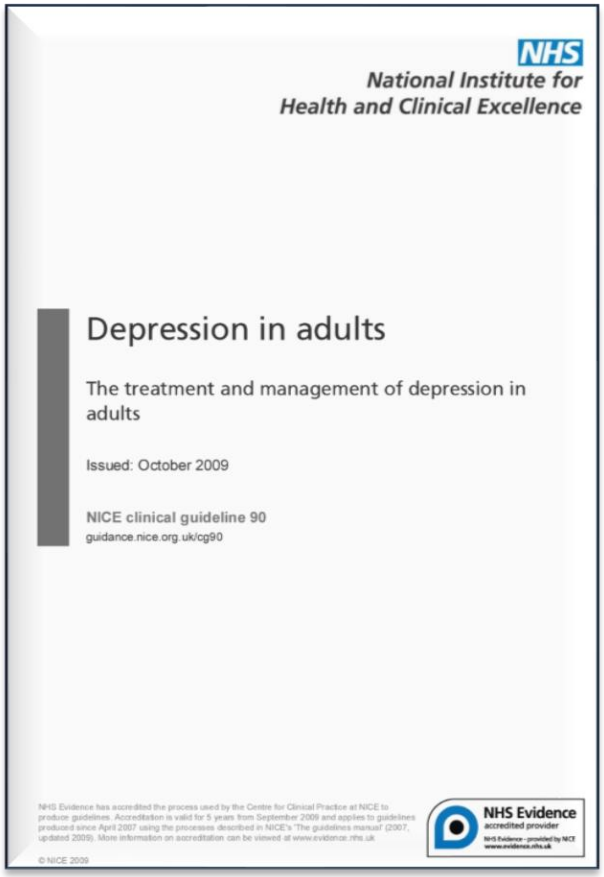
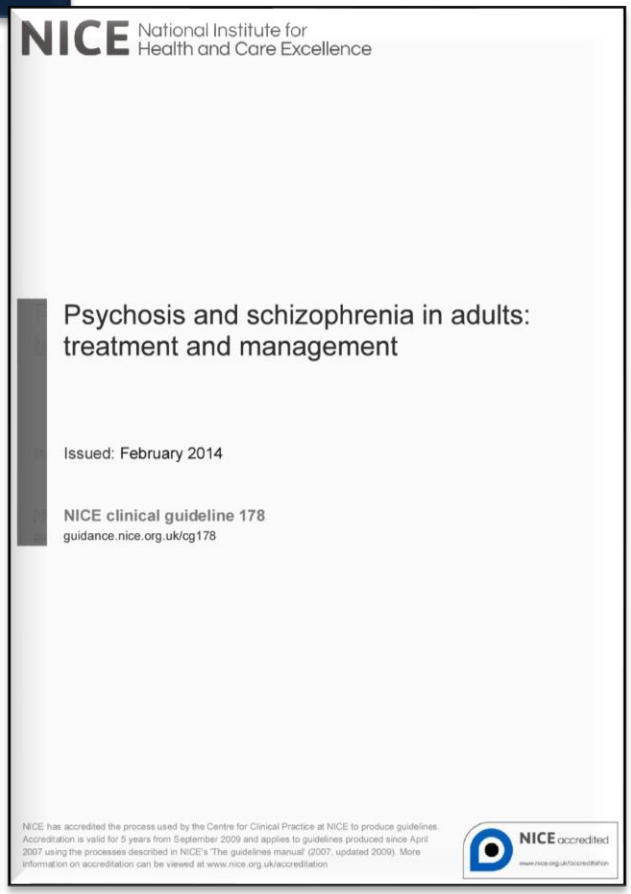
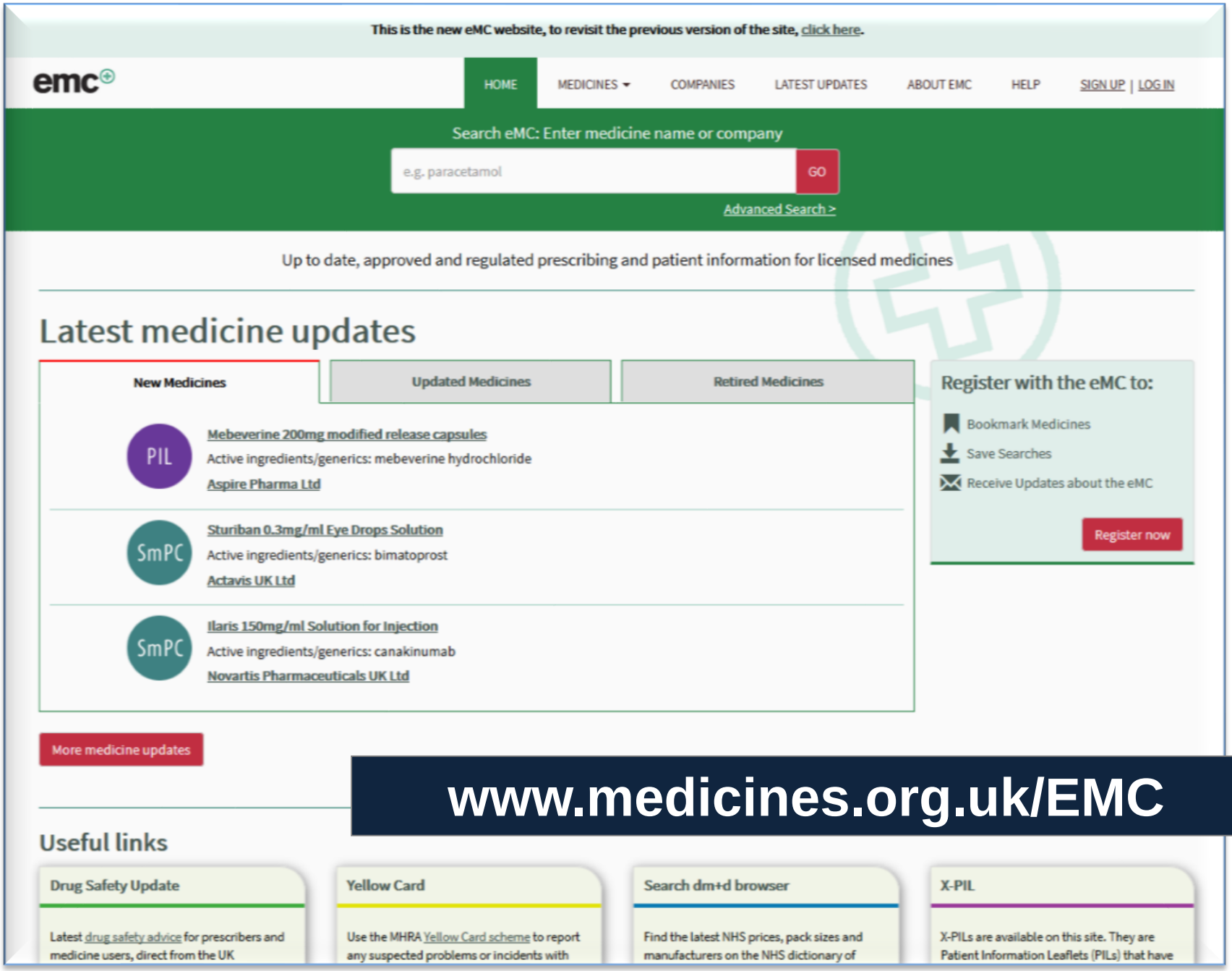
www.nice.org.uk





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Up to date, approved and regulated prescribing and patient information for licensed medicines
Latest medicine updates
New Medicines
Updated Medicines
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Mebeverine 200mg modified release capsules
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Sturiban 0.3mg/ml Eye Drops Solution
Active ingredients/generics: bimatoprost
Actavis UK Ltd
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Ilaris 150mg/ml Solution for Injection
Active ingredients/generics: canakinumab
Novartis Pharmaceuticals UK Ltd
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Bookmark Medicines
Save Searches
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More medicine updates
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Useful links
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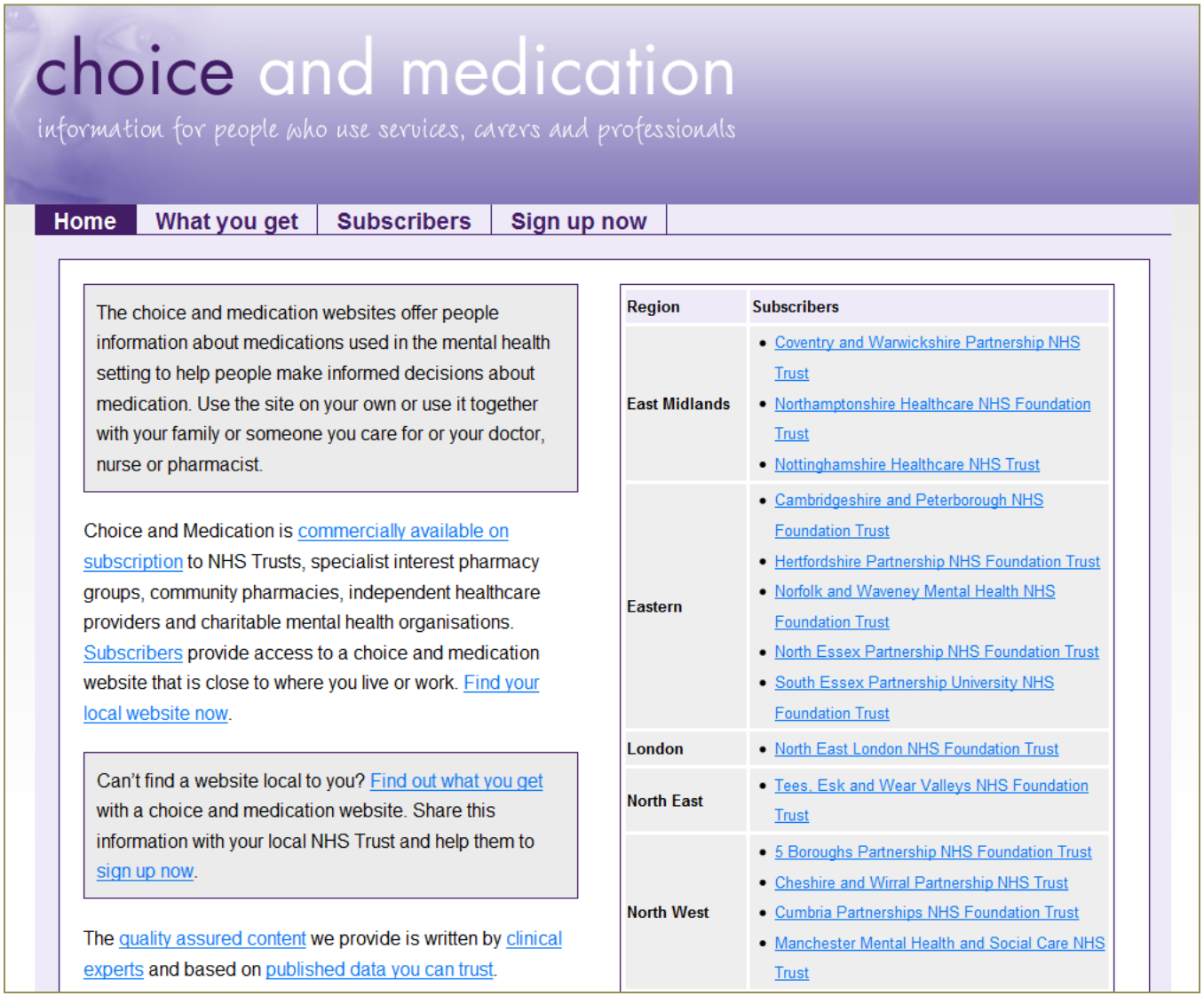
Latest drug safety advice for prescribers and medicine users, direct from the UK
Yellow Card
Use the MHRA Yellow Card scheme to report any suspected problems or incidents with
Search dm+d browser
Find the latest NHS prices, pack sizes and manufacturers on the NHS dictionary of
X-PIL
X-PILs are available on this site. They are Patient Information Leaflets (PILs) that have



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Books › **"physicians desk reference"**

Showing 1 - 12 of 738 Results

1.

Physicians' Desk Reference 2010 (Library/Hospital Version) by PDR (Physicians' Desk Reference) Staff (**Hardc**

Buy new: ~~£57.00~~ **£54.15**

10 new from £44.54 8 used from £9.25

Get it by **Tuesday, Mar 1** if you order in the next **7 hours** and choose express delivery.

Only 5 left in stock - order soon.

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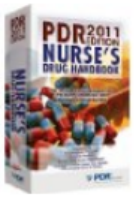
2.

2011 PDR Pharmacopoeia Pocket Dosing Guide (Physicians' Desk Reference Pharmacopoeia Pocket Dosing

Buy new: **£8.99**

Available for pre-order. This item will be released on 25 March 2011.

Eligible for **FREE** Super Saver Delivery.

3. 

PDR Nurse's Drug Handbook 2011 (Physicians' Desk Reference Nurse's Drug Handbook) by PDR (Physicians'

Buy new: ~~£33.99~~ **£32.29**

2 new from £32.29

Available for pre-order. This item will be released on 7 March 2011.

Eligible for **FREE** Super Saver Delivery.

4.

2011 PDR Electronic Library on CD-ROM by PDR (Physicians' Desk Reference) Staff (**CD-ROM** - 1 Mar 2011)

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1 in 5 people in the UK suffer from Depression..

"You're not alone!"

DepressionAlliance

"We work to relieve and to prevent this treatable condition by providing information and support services."

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justgiving

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In the News..

A great Christmas song to help raise funds for DA

An award-winning song by Jamie Hawkins (Jimmer) - release date: 12th December

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DepressionAlliance

Employment and Wellbeing

DA launches new Employment and Wellbeing project.

Read more >

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What is Depression?

Depression can have many effects on a persons life. Find out what Depression is and how it can affect your life.
Learn More >

Living with Depression

Find out what Depression is and how it can affect your life.
Learn More >

How we can Help

Find out how Depression Alliance can assist people affected by depression and anxiety, through a range of services.
Learn More >

Get Involved

If you feel that you have some set time which you could devote to a particular task to help Depression Alliance.
Click for More >

Depression Alliance would love to offer you the chance to both raise some money and improve your fitness by taking part in the London 10K run. The event is taking place on Sunday 10th July 2011, and starts at 9.45am. Can you raise £100 and run (or walk) 10K? If the answer is yes why not take part and see the sights of London.

For more information please email simon@depressionalliance.org

Request an Information Pack

information@depressionalliance.org

0845 123 23 20

Which treatment is right for you?

Visit a new online resource that gives information on symptons, treatments and helps you make decisions on the best treament for you.

whatyoushouldknow.depression-alliance.co.uk

DepressionAlliance

In an emergency it is possible to visit your local Accident and Emergency department and ask to see the duty psychiatrist. NHS Direct

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Patient choice & information

Questions?

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Summary

- Brain physiology & pharmacology ☑
- Good practice in the use of medicines ☑
  - Anxiety
  - Depression
  - Bipolar disorder
  - Schizophrenia & Psychosis
- Iatrogenic disease in SMI ☑
- Treatment adherence in SMI & crisis in mental health services ☑
- Individualising treatment ☑
  - Patient choice & information

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Questions, Discussion & Evaluation

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Thank you

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