Prescribing psychotropic drugs

Recommendations for general practitioners in mental health programmes

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Why these recommendations?

The recommendations that follow should be adapted to each context and programme; expatriate and local psychologists, psychiatrists and general practitioners will have different places and roles to play in every MSF programme having a Mental Health component.

The existence of a Mental Health component implies appropriate psychological care and referral to an identified, available psychiatrist. A specialized psychiatric opinion is recommended for all cases that are complex (acute and chronic psychoses, agitation and confusion – watch out for medical causes) or very severe (suicide risk, major post-traumatic symptoms), and for children with serious disorders.

But general practitioners on MSF teams also have a role in such programmes, and these recommendations are designed to guide them in this work. This document introduces all of the indications that it is essential to know when using psychotropic drugs and caring for patients in serious mental distress.
I. General recommendations

a/ Two key principles for mental health programmes

- No psychotropic medication without psychological support
  While all psychotropic medications are prescribed by physicians, they are only fully effective if they follow from a diagnostic evaluation and are accompanied by psychological support by a psychologist or psychiatrist.
- Drugs are only part of the care needed by those in serious mental distress.
  Anyone experiencing serious mental distress should receive an appropriate psychotropic medication, together with individual psychological support that takes the patient’s specific sociocultural background into account.

Mental suffering – which can manifest itself in various ways, often as somatic complaints that bring the patient in to see a doctor – is normal when a person or social group experiences a tragic event (a natural disaster, for example) or armed conflict. Fortunately, survivors can fall back on family, religious, and community resources to help them overcome – together – the grief, loss, fear, and difficulties in their daily lives.

While individual or group psychological consultations offer the most severely affected real relief, it often takes several weeks of care for the mental pain to gradually diminish.

Prescribing physicians have to believe strongly in the benefits of the psychological care, and should have regular meetings or exchanges with psychologists. In return, psychologists must believe strongly in the benefits of medication for patients with severe symptoms and for their care.

Physicians should always consult MSF’s Essential Drugs guide and/or the specific fact sheets, respect the contraindications, and inform patients of the anticipated effects, the rules for compliance, and any potential side effects (see the drug fact sheets in the appendices).

b/ A few important rules for prescribing psychotropic drugs

- The patient must also be seen by the psychologist (if possible, a joint visit with both the physician and psychologist) for evaluation of his or her complaints, problems, and clinical history. This visit confirms the degree of severity – i.e., the severity of the problem and major personal, family, and social impacts.
  - Do not prescribe psychotropic drugs for anyone under fifteen years of age
  - Do not prescribe psychotropic drugs for complex disorders (including psychoses, or if there is any suicide risk) without immediate psychiatric consultation (or see below, “When there is no psychiatrist”).
  - Beware of any contraindications, especially for pregnant or nursing women.
  - Know what other medications the patient is taking
  - Exercise caution with people over age 65

- Initial prescription: dispense no more than one week’s worth of treatment, and schedule an evaluation with the psychologist. Give clear explanations, including how psychological follow-up will be organized and, if necessary, how the prescription will be continued.
Please complete the prescription form and attach it to the patient’s mental health file, indicating the treatment on the health card, which the patient keeps. Also note any continuation, modification or discontinuation of treatment. This form will be useful to everyone in assessing our actions.
II. Clinical presentations and treatment regimens

a/ Insomnia and somatic complaints

The most common mental suffering-related problems encountered at general practice visits are sleep disorders and somatic complaints with no underlying organic cause.

All patients should receive a thorough clinical examination. Patients should be referred for psychological consultation whenever there are unexplained atypical somatic problems, but without making them feel rejected or misunderstood.

Isolated sleep disorders caused by difficult living conditions should not be treated with diazepam-type tranquilizers, due to the risk of dependence. Sleep disorders can also be caused by pain, which should be treated (treat the cause of the pain and prescribe an analgesic).

In cases of severe, persistent insomnia (lasting more than two weeks), the physician and psychologist should look for associated signs of depression, anxiety and post-traumatic stress disorder (see specific treatments). It’s best to avoid benzodiazepines (like diazepam), and choose one of the following instead:

- **Promethazine 25mg tab**: one to two tabs at bedtime for one week (then reassess to see if problem persists)

  OR

- **Amitriptyline 25 mg tab**: one-half tab at bedtime for one month (contraindicated in people over age 60). If ineffective, increase the dose to 25 mg after a few days.

For patients with somatic complaints having no underlying organic cause, the physician should look for anxiety, depression (diagnosis of “masked depression,” i.e., one that manifests primarily as a somatic problem, is common), and/or post-traumatic stress, and conduct an interview with a view to reassuring patients and sending them to the psychologist. After one or two interviews, the psychologist may decide to send them patient back to the physician.

b/ Anxiety disorders

The patient may express intense fear (including the fear of dying or going crazy), generally associated with physical manifestations such as palpitations, problems breathing, feeling faint, etc.) or a more constant state of anxiety, dizziness or discomfort.

If these problems are very severe, unrelieved by one or two reassurance sessions or simple breathing/relaxation techniques, and experienced as disabling by the patient and his family, the physician can offer one of the following (on a short-term basis, and only one at a time):

- **Diazepam 5 mg tab**: 5 to 10 mg PO, as either a single dose or a maximum six-day course of treatment. For severe anxiety attacks, diazepam can also be administered intramuscularly: one 10-mg ampoule, to be repeated after one hour if needed.

  OR

- **Promethazine 25mg tab** PO: one to two tabs daily for a few days. Less risk of dependence, very well-tolerated

**Caution!** These drugs are sedating, so the patient needs to be warned not to drive. Reassess with the psychologist after a few days, and recommend gradual reduction.
For anxiety that is persistent, severe, and disabling, or for recurring panic attacks, it’s better to use an SSRI-type antidepressant (like paroxetine), which is also appropriate for this indication (see severe depressive disorders below).

c/ Severe depressive disorders

In a painful life situation, grief- and loss-related sadness is a normal reaction. It will gradually fade, thanks to family and community support. For severe situations, psychological help should be offered in order to give the patient relief and prevent exacerbations.

While no drug will enable them to “forget their pain,” medication can help reduce the painful and disabling symptoms (fatigue, insomnia, loss of appetite, loss of desire, etc.). Despite psychological help, some people will have very severe depression that prevents them from functioning normally in their family relationships and daily activities, continuously for more than two weeks:

- severe, persistent insomnia, early waking in particular
- significant fatigue, making it difficult to carry out daily tasks
- withdrawal and lack of interest, which can prevent psychotherapeutic follow-up
- loss of appetite and weight loss
- irritability, relationship problems, concentration problems
- guilt feelings, a desire to die, even suicidal ideation
- mental anguish from the time they wake up.

These patients should be offered an antidepressant, with an explanation of how it will work, unpleasant side effects that may occur, and the duration of treatment needed to maintain its efficacy (see the drug fact sheets in the appendices).

Clear information promotes good treatment compliance.

The prescribing physician should encourage follow-up by the psychologists: no treatment can work miracles.

- The antidepressant should be combined with promethazine 25 mg tab at night for the first few days, in case of insomnia or significant anxiety; this can be continued for the first few weeks if anxiety persists.

- A single antidepressant:
  - Paroxetine 20mg tab: one tablet at night (if available, this is the SSRI to use), increasing to two tabs (40 mg), if necessary, after one month of treatment.

  If unavailable:
  - Fluoxetine 20mg tab: the only SSRI currently available in the Essential Drugs guide, this should be used with caution if the patient also has severe anxiety or is immobilized (wounded patients).
OR

• Amitriptyline 25mg tab: one and then two tabs at night, increasing gradually to 100/150 mg (contraindicated in people over age 60, due to cardiac and other risks); sedating and anxiolytic.

OR

• Clomipramine 25mg tab: same dosage and contraindications as amitriptyline, but much less anxiolytic; should be taken in the morning.

Note

➤ The patient must understand that this treatment needs to be continued for at least three to six months (especially if it’s working). The antidepressant effects aren’t immediate (two to three weeks), but the anxiety relief may be more rapid. Note, however, that there is a risk of increased anxiety during the first three weeks, especially with fluoxetine and clomipramine.

➤ The patient should be seen by the physician each week early in treatment (for evaluation of tolerance, and then efficacy), and also by the psychologist, who will provide psychotherapeutic follow-up over the following months.

➤ If there is a risk of suicide, a major disorder, or one that does not improve at all after three weeks of treatment, the patient should be referred to a psychiatrist. Be careful with tricyclic antidepressants; because the prescribed dose is very close to the lethal dose (do not give the patient more than one week’s worth of medication, especially in the beginning).

➤ The medication should always be stopped gradually, reducing the dose over a period of at least two weeks (half-dose, then every other day). Warn the patient of the risk of problems (common) from stopping abruptly.

➤ Beware of depression caused by organic problems or exacerbated by drug treatment.

d/ Post-traumatic disorders

During natural disasters and armed conflict, civilian populations witness horrible things, and some people may have terrifying confrontations with death. People are affected collectively, but such tragic moments slowly become painful memories.

“Mental distress, in its varied forms, is a normal reaction to abnormal events.” This message is aimed at raising awareness in psychosocial programmes, and while useful for the first few weeks, it should not lead us to neglect the many people (10%) – both adults and children – who are going to come in with severe problems that won’t go away without psychological help.

Traumatized people relive their experiences over and over again, can’t control their thoughts and emotions, and remain stuck on the events, which revisit them without warning as “flashbacks.” There is no before or after. The experiences are extremely frightening and cause secondary problems; people withdraw, their behaviour changes, they stop fulfilling their family and social roles, and passing time only makes things worse. Children can have specific problems that severely impede their development.

These post-traumatic disorders can be characterized, schematically, by three types of psychological responses, usually seen in combination:

➤ traumatic re-experiencing (intrusive thoughts related to the event, flashbacks, nightmares, repetitive play in children, etc.);
- avoidance behaviours with regard to places, situations, and people associated with the traumatic events. Some may resort to alcohol and drugs to keep painful thoughts at bay;
- hypervigilance (state of alert, panic attacks, palpitations, headaches, generalized physical pain, etc.).

Quite often, these problems are associated with depressive symptoms and with a change in usual behaviours and attachments. Bereavement issues are often intermixed.

Generalized physical pain is the common manifestation of the psychic exhaustion that comes from traumatic re-experiencing or the fear of it.

These problems often appear after a few-week latency period following the traumatic event.

- Psychological care is recommended for all of these people, in order to reduce their suffering, the disabling symptoms, and the resulting family and social handicaps.
- While severe post-traumatic disorders can be relieved with psychotropic medication, which is aimed at reducing the associated symptoms (anxiety, depression, and insomnia), they require psychotherapeutic care, above all.

For severe, disabling problems, see the recommended treatments for insomnia, anxiety (see promethazine, above), and especially depression.

The standard treatment is paroxetine 20 mg tab PO, for patients with obsessive thoughts and/or pronounced hypervigilance, in particular. If the treatment is helping, it is important to continue it for at least six months.

N.B.

- Stupor (and, more rarely, confusion) can also be a post-traumatic disorder, because it is a reaction to the events experienced. It is not an uncommon feature, and a psychiatric consult is needed very quickly. Physicians should be especially careful to check for a possible organic cause.
- Similarly, some patients exhibit acute delusional states, which may be more or less noisy and expressive, but which indicate severe disorganization. They require immediate medical care while awaiting psychiatric evaluation. These people, probably more than anyone, need close psychological care.
- These disorders require psychiatric consultation and/or follow-up, appropriate antipsychotic medication (see specific points), and psychological care involving the family.
III. Specific points

a/ Psychiatric disorders due to organic disease

When presented with acute psychiatric disorders, and in particular those that are confusional in nature, it is essential to look for associated clinical signs (fever, etc.) and go over the medical history and the history of the present disorder as carefully as possible in order to rule out an organic cause.

Confusional state: characterized by recent, abrupt or more gradual onset (exacerbation), with concentration and memory problems, decreased consciousness, temporal and spatial disorientation, and fluctuation during the course of the day, associated or not with agitation, delusional ideas and behaviour disorders.

Beware of the particular case of delirium tremens in alcohol-dependent patients undergoing abrupt withdrawal. Always think about an organic (neurological or metabolic) cause when there are visual hallucinations.

Mnemonic DIVINE MD TEST\(^1\)

<table>
<thead>
<tr>
<th>Letter</th>
<th>Medical causes of psychiatric disorders to rule out</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Drugs and medications (corticosteroids, etc.)</td>
</tr>
<tr>
<td>I</td>
<td>Infectious Diseases: meningitis, cerebral malaria, encephalitis, septicaemia, AIDS, syphilis, etc.</td>
</tr>
<tr>
<td>V</td>
<td>Vascular diseases: stroke, subarachnoid haemorrhage, etc.</td>
</tr>
<tr>
<td>I</td>
<td>Inflammatory or Immunological disorders</td>
</tr>
<tr>
<td>N</td>
<td>Nutritional disorders (avitaminoses, etc.) or withdrawal (from alcohol or sedative-hypnotics)</td>
</tr>
<tr>
<td>E</td>
<td>Endocrine disorders: hyper- or hypothyroid, Cushing’s disease, etc.</td>
</tr>
<tr>
<td>M</td>
<td>Metabolic disorders: electrolyte disorders, hyper- and hypoglycaemia, hepatic or renal failure encephalopathy, etc.</td>
</tr>
<tr>
<td>D</td>
<td>Degenerative/demyelinating diseases (neurological symptoms)</td>
</tr>
<tr>
<td>T</td>
<td>Traumatic: Epidural and subdural hematoma (specific signs of trauma)</td>
</tr>
<tr>
<td>E</td>
<td>Epilepsy: aura, convulsion, and post critic disorders</td>
</tr>
<tr>
<td>S</td>
<td>Structural disorders, elevated intracranial pressure, etc.</td>
</tr>
<tr>
<td>T</td>
<td>Toxins /heavy metal poisoning (presentation depends on causative agent)</td>
</tr>
</tbody>
</table>

\(^1\) Adapted from Khouzam, Tan, Gill (2007). Handbook of Emergency Psychiatry. Mosby, Elsevier
When there is no psychiatrist

Referral for psychiatric care is an issue at all mental health programmes: how to provide mental health care without sending away those who are most ill? (While admittedly a small number (3%), they will inevitably come in.)

Failing to respond to an acute psychiatric situation, when a general practitioner can offer treatment, is detrimental to the person who is ill. Yet immediate psychiatric consultation and referral isn’t always possible. Assistance from the medical coordinator then becomes essential (he or she will seek support from the medical department psychiatric expert). Psychologists are crucial in this situation, because they have to provide reassurance, vigilance, and containment, and be available to the patient and his family.

1– Mental patients suffering from chronic psychoses:

- People with longstanding disorders who have never received antipsychotic medications: if there are no serious problems, don’t start treatment if follow-up isn’t possible.
- Agitation, requests for help from the patient’s family, behaviour problems leading to physical disputes: antipsychotic medication is needed, but should be combined with family counselling to resolve the dispute.
- People whose care has been interrupted by events (disaster, displacement, etc.): resume previous antipsychotic medication (or equivalent available at MSF). The patient and his family need medical and psychological support until referral systems are functioning again.
- Drug treatment includes an antipsychotic, if necessary combined with an anxiolytic and an agent to counteract the extrapyramidal side effects:
  - **Risperidone** 2 to 6 mg daily (increase gradually);
  - Failing that, **haloperidol** 5 to 10 mg daily, combined with **Biperiden** 2 mg, one to three times a day in case of extrapyramidal side effects;
  - or /and **chlorpromazine 25mg tabs**: 50 to 150 mg daily in three doses (more sedating than haloperidol, and can be combined with it);
  - At the start of treatment, feel free to add **diazepam 5 mg** two to three tabs daily, because it usually takes a few days until improvement is noted.

An injectable drug is preferable if the patient is very agitated, reassuring contact is impossible, or there are behavioural problems (violence and resistance), but you must attempt to obtain the patient’s consent.

- Feel free to use both:
  - **Haloperidol injection**: one 5-mg ampoule IM. Note that this is an oily, immiscible product; prepare in a second syringe if combining with:
  - **Diazepam injection**: one 10-mg ampoule IM

If necessary, repeat the combination one to two hours later.

- Another possibility is **Chlorpromazine injection**: one 25-mg ampoule IM (or 50 mg, maximum 100 mg per day), alone or in combination with haloperidol (more sedating). Switch to the oral route as soon as possible, monitoring for extrapyramidal symptoms to counteract (see **biperiden**).
N.B.

Cultural beliefs around the history of the illness need to be considered and respected, and the national psychologists play a central role in this understanding. It's usually the patient's family that has asked for help from western medicine, often after having exhausted traditional therapeutic resources. The patients and their families should get simple, clear explanations on the treatment being proposed (medications and situation-appropriate psychosocial support).

These are medications that have to be taken for long periods.

Uncertainty about medium-term follow-up is no excuse for not treating in the short-term, because patients and their families get a real benefit while the treatment lasts.

2– Acute psychotic disorders

For recent onset delusional and/or behavioural disorders, after all potential medical causes have been ruled out (see above), the treatment should combine medication and follow-up, by a psychologist, for the patient and his family.

- Don’t forget that acute delusional states can be the manifestation of an underlying depressive breakdown and/or of a reactive disorder following a traumatic event. Stupor and mutism with or without resistance are not uncommon.

- In other cases, and whatever the context, these disorders may mark the start of a chronic psychotic disorder. Only time will tell, but early psychiatric help and adherence to treatment are decisive factors for subsequent prognosis.

- These complex disorders require specialized care, but only rarely hospitalization in a unit for chronic patients. It is preferable to keep the patient in their family and community setting, with the closest possible outpatient follow-up.

The antipsychotic treatment is the same as for chronic psychoses:

- **Risperidone 2 to 6 mg daily**
  
  If unavailable

- **Haloperidol 5 to 10 mg daily**
  
  or/and

- **Chlorpromazine 25 mg tab**: 50 to 150 mg in three doses (sedating)

  Start with a low dose and increase if necessary.

In the beginning, add an anxiolytic (**diazepam** 5 to 10 mg).

The side effects (more common with haloperidol) can be countered by reducing the dose and prescribing the counteractive treatment, **biperiden 2 mg tab**: one to three tabs per day.

- Three months of treatment are generally needed.

- Antipsychotics require two weeks to reach their full effect, though significant improvement is seen quickly.

- Always warn patients and their family about the side effects, and reassure them that they can be counteracted.

- It is essential that psychologists provide reassurance and containment. If possible, include the family and at least two psychologists in the first few sessions.

- One of the psychologists should be present at the medical visits.
The (sometimes rapid) improvement in hallucinatory symptoms and then delusions makes it possible to establish – with the psychologist’s help – the factors at the root of the disorder (often trauma and/or loss).

c/ Wounded patients

Physical trauma is common in natural disasters and armed conflict. The wounded are an especially vulnerable population, because associated psychological trauma is common, but may manifest itself secondarily.

- Pain management is essential. Post-operative analgesics (often morphine-type) help reduce insomnia and prevent anxiety- and/or depression-related decompensation.
- The most fragile of these patients (in particular, those with irreversible physical damage, like amputees and burn victims) can benefit greatly from individual psychological support. Support groups for amputees, with the participation of physical therapists, are very beneficial.
- The pain management protocol for amputation includes carbamazepine (for men) and gabapentin (for women), combined with amitriptyline 25 mg tab: ½ to 1 tab daily; beneficial by virtue of both its efficacy against neurological pain (phantom limb pain, in particular) and its psychotropic qualities; can be increased to a maximum of 150 mg daily (see pain protocol in the clinical guidelines).
- Some wounded patients may suffer psychological problems in response to events, and have the same symptoms as the general population, but exacerbated by their immobility, pain, feeling of uselessness, irreversible physical damage, and a future obliterated by disability. For them, psychological support is essential.
- Immobility and the post-operative context (possibility of another surgery) are relative contraindications for fluoxetine and clomipramine, which are too stimulating and thus anxiogenic, and which have too long a half-life.
  - Use paroxetine 20 mg tab: one tab per day
  - If amitriptyline is already being given, choose instead to increase the dose up to 100/150 mg, with the consent of the post-op physicians.
IV. Appendices: drug fact sheets

Amitriptyline
Biperiden
Chlorpromazine tablet
Chlorpromazine injection
Clomipramine
Diazepam tablet
Diazepam tablet
Fluoxetine
Haloperidol tablet
Haloperidol injection
Paroxetine
Promethazine
Risperidone
AMITRIPTYLINE
(Elavil®, Laroxyl®, Triptizol®...)

Therapeutic action
- Sedating tricyclic antidepressant

Indications
- Depression in adults, especially when a sedative effect is required (anxiety, agitation, insomnia)
- Neuropathic pain in adults

Presentation
- 10 mg, 25 mg and 50 mg tablets

Dosage
- Depression
  - Initial dose of 75 mg/day in 2 to 3 divided doses, or once daily at night, gradually increased, if necessary, to a maximum dose of 150 mg/day
- Neuropathic pain
  - Initial dose of 25 mg/day at night for one week, followed by 50 mg/day at night for one week then 75 mg/day at night
  - Reduce the dose by one-half in elderly patients

Duration
- Depression: minimum 3 months. The treatment should be withdrawn gradually; if signs of relapse occur, increase the dose.
- Neuropathic pain: continue several months after pain relief is obtained, then attempt to stop treatment.

Contra-indications, adverse effects, precautions
- Do not administer if: recent myocardial infarction, arrhythmia, impaired liver function, acute mania. Do not administer to children.
- May cause:
  - Antimuscarinic effects: dry mouth, urinary retention, disturbance of accommodation, constipation, tachycardia
  - Orthostatic hypotension, arrhythmia, cutaneous reactions, endocrine disorders, weight gain, sweating
  - Frequent drowsiness, tremor, insomnia, transient mental confusion
  - Effects linked to depressive illness may exacerbate suicidal tendencies and psychotic symptoms
- Adverse effects occur particularly in the elderly and in the event of overdose.
- Do not combine with another antidepressant, especially an MAOI.
- Avoid combination with atropine, epinephrine (adrenaline), methyl dopa (increased hypotension).
- Use with caution when driving or operating machinery: risk of drowsiness.
- Do not drink alcohol during treatment.
- Administer with caution, under medical supervision, in epilepsy, cardiovascular disease, hepatic or renal failure, prostatic hyperplasia, thyroid disease.
- Closely monitor patients with suicidal tendencies, especially in the initial stage of treatment.
- Pregnancy: avoid, especially at the end of pregnancy (antimuscarinic effects in neonates)
- Breast-feeding: avoid

Remarks
- In the treatment of neuropathic pain, amitriptyline is often combined with carbamazepine except in pregnant women.
- Sedative action occurs following initial doses. Antidepressant and analgesic effects are delayed for 10 to 20 days. Wait for several weeks before assessment of efficacy. This must be explained to the patient to encourage compliance.
- Combination with an anxiolytic or a neuroleptic may be useful in anxious or agitated patients.

Storage

Prescription under medical supervision

15/FD/May 2010
BIPERIDEN
(Akineton, etc.)

Therapeutic action and Indications: Antiparkinsonian; used mainly for counteracting neuroleptic-induced Parkinsonism (central and peripheral anticholinergic).

Presentation: 2 or 4 mg tablets (extended release), oral.

Dosage: 4 to 8 mg per day.

Contraindications and precautions:
- Due to anticholinergic effects, contraindicated in patients with glaucoma, prostate problems and heart disease.
- Use extra caution in elderly patients
- May cause drowsiness
- May cause dry mouth and accommodation problems

Pregnancy: to be avoided
Breastfeeding: to be avoided
CHLORPROMAZINE
(Largactil®, Megaphen®, Thorazine®...)

Prescription under medical supervision

Therapeutic action
- Sedative neuroleptic

Indications
- Acute and chronic psychoses
- Agitation
- Anxiety, not controlled by other anxiolytics

Presentation
- 25 mg tablet
  Also comes in 50 and 100 mg tablets.

Dosage
Varies from one person to another; doses should be increased gradually.
- Child: 1 to 1.5 mg/kg/day in 2 to 3 divided doses
- Adult: 25 to 150 mg/day in 2 to 3 divided doses

<table>
<thead>
<tr>
<th>AGE</th>
<th>0 months</th>
<th>2 years</th>
<th>1 year</th>
<th>5 years</th>
<th>15 years</th>
<th>ADULT</th>
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</thead>
<tbody>
<tr>
<td>WEIGHT</td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td>1/2 tab x 3</td>
<td>1 to 2 tab x 3</td>
</tr>
</tbody>
</table>

- Do not exceed indicated doses.
- Reduce dose by one-third or one-half for elderly patients.

Duration: according to clinical response

Contra-indications, adverse effects, precautions
- Do not administer if: * delirium tremens,
  * Parkinson's disease,
  * renal or hepatic failure (risk of overdose).
- Stop treatment if patient becomes febrile: possible neuroleptic malignant syndrome.
- May cause extrapyramidal disorders, orthostatic hypotension and photosensitisation.
- If prolonged treatment, check blood counts regularly (risk of agranulocytosis).
- Risk of increased sedation when combined with alcohol and drugs acting on the central nervous system such as diazepam, phenobarbital and chlorpheniramine.
- Pregnancy: CONTRA-INDICATED; when used in the treatment of psychosis, stop treatment one week before the expected time of delivery if possible.
- Breast-feeding: avoid

Remarks
- *Storage: below 30°C -

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CHLORPROMAZINE
(Largactil®...)

Prescription under medical supervision

Therapeutic action
- Sedative and anti-emetic neuroleptic

Indications
- Acute psychosis, agitation, aggressiveness, severe anxiety not controlled by other anxiolytics
- Very severe vomiting, intractable hiccup

Presentation and route of administration
- 50 mg in 2 ml ampoule (25 mg/ml) for deep IM injection or infusion
  Also comes in 5 ml ampoule containing 25 mg (5 mg/ml).

Dosage
Varies from one person to another:
- Child: 0.5 mg/kg/injection, do not exceed 75 mg/day
- Adult: 25 to 50 mg injection, do not exceed 150 mg/day

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>WEIGHT</td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
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<tr>
<td>25 mg/ml ampoule</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 to 2 ml</td>
</tr>
</tbody>
</table>

- Do not exceed indicated dose.

Duration
- According to indication and clinical response; several days of treatment are sometimes needed for severely agitated patients.

Contraindications, adverse effects, precautions
- Stop treatment if patient becomes febrile (possible neuroleptic malignant syndrome).
- May cause extrapyramidal disorder in case of prolonged treatment; hypotension orthostatic.
- Risk of increased sedation when combined with alcohol and drugs acting on the central nervous system such as diazepam, phenobarbital, chlorphenamine.
- Pregnancy: avoid prolonged use
- Breast-feeding: avoid

Remarks
- Storage: below 30°C —
CLOMIPRAMINE
(Anafranil®...)

Therapeutic action
- Tricyclic antidepressant

Indications
- Depression
- Severe post-traumatic stress disorder
- Panic disorder

Presentation
- 10 mg and 25 mg tablets and capsules
  Also comes in 50 mg and 75 mg tablets.

Dosage
- Adult: initially 25 mg once daily at bedtime, then increase the dose gradually up to 75 to 150 mg once daily
- Reduce doses in elderly patients and in patients with impaired renal or hepatic function: initially 10 mg/day, increased to 50 mg/day.

Duration
- 6 to 8 months minimum. The treatment should be withdrawn gradually; if signs of relapse occur, increase the dose.

Contra-indications, adverse effects, precautions
- Do not administer to patients with recent myocardial infarction, arrhythmia, severe hepatic impairment, urethro-prostatic disorders, glaucoma.
- May cause: drowsiness, dry mouth, constipation, tachycardia, orthostatic hypotension, blurred vision, urinary retention, weight gain, skin allergy, confusion in elderly patients, suicidal tendencies due to the suppression of psychomotor inhibition, exacerbation of anxiety or delusional symptoms.
- Administer with caution to patients with epilepsy, cardiovascular disease, renal or hepatic impairment.
- Do not combine with: sulpiride (Baranett®), MAO inhibitors; do not drink alcohol during treatment.
- Avoid combination with methylidopa (increased antihypotension), co-artemether.
- Monitor combination with: epinephrine and dopamine (risk of hypertensive crisis and arrhythmia), valproic acid and selective serotonin re-uptake inhibitors (increased plasma concentration of clomipramine), carbamazepine, phenytoin, and rifampicin (decreased plasma concentration of clomipramine), antihypertensives, atropine drugs.
- Closely monitor patients with suicidal tendencies, especially at the beginning of therapy.
- Advise patients that clomipramine may cause drowsiness and to be cautious when driving or operating machinery.
- Pregnancy: avoid. However, if treatment has been started before a pregnancy, do not stop treatment; reduce dosage at the end of pregnancy (risk of withdrawal syndrome in the newborn infant).
- Breast-feeding: avoid.

Remarks
- The use of clomipramine is not recommended in patients aged less than 15 years.
- It takes 10 to 20 days for the patient to feel the antidepressant effect. The therapeutic efficacy can only be assessed after 3 weeks of treatment. This must be explained to the patient to encourage compliance.
- Antidepressant or sedative treatment may be necessary during the first weeks of treatment in anxious or agitated patients.
- Storage: Store in a cool, dry place.
DIAZEPAM
(Valium®...)

Prescription under medical supervision

Therapeutic action
- Anxiolytic, sedative, anticonvulsant, muscle relaxant

Indications
- Agitation and anxiety
- Muscle spasms

Presentation
- 5 mg tablet
  Also comes in 2 mg and 10 mg tablets and 1% oral solution.

Dosage
- Child: 0.5 mg/kg/day in 3 divided doses
- Adults: 5 to 15 mg/day in 3 divided doses
- Do not exceed indicated doses.

<table>
<thead>
<tr>
<th>AGE</th>
<th>0 months</th>
<th>1 year</th>
<th>5 years</th>
<th>15 years</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kg</td>
<td>4</td>
<td>8</td>
<td>15</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

5 mg tablet

Duration: according to clinical response; the shortest duration possible.

Contraindications, adverse effects, precautions
- Do not administer to patients with severe respiratory insufficiency or severe hepatic impairment.
- Administer only in crisis and with caution to children.
- May cause:
  - feeling of incoordination, drowsiness (administer with caution when driving or operating machinery);
  - dependence and tolerance when used for more than 10-15 days. At the end of treatment, reduce doses gradually to avoid withdrawal syndrome or rebound effect.
  - in the event of overdose: ataxia, muscular weakness, hypotension, confusion, lethargy, respiratory depression, coma.
- Reduce the dose by one half in elderly patients and in patients with renal or hepatic impairment.
- Risk of increased sedation when combined with alcohol and drugs acting on the central nervous system: opioid analgesics, neuroleptics (chlorpromazine, haloperidol, etc.), antihistamines (chlorphenamine, promethazine), antidepressants (clomipramine, fluoxetine, etc.), phenobarbital, etc.
- Pregnancy: avoid
- Breastfeeding: avoid

Remarks
- Diazepam is subject to international controls; follow national regulations.
- Diazepam is not a treatment for depression, chronic anxiety, or post-traumatic stress syndrome.
- Storage below 30°C -
**DIAZEPAM**
(Valium®...)

*Prescription under medical supervision*

Use IV route only if technical equipment for ventilation is available at hand.

**Therapeutic action**
- Anxiolytic, sedative, anticonvulsant, muscle relaxant

**Indications**
- Seizures
- Tetanus
- Agitation associated with anxiety or confusion (delirium tremens), when oral administration is not possible

**Presentation and route of administration**
- 10 mg ampoules (5 mg/ml, 2 ml) for IM or very slow IV injection or infusion.
- Injectable solution may be used by oral and rectal route.
- For rectal or IV administration, dilute 2 ml (10 mg) of diazepam in 8 ml of 5% glucose or 0.9% sodium chloride.
- For rectal administration, use a syringe without a needle, or better, cut a nasogastric tube, CH3, to a length of 2-3 cm and attach it to the tip of the syringe.

**Dosage and duration**
- **Seizures**
  - Child: 0.5 mg/kg rectally or 0.3 mg/kg by slow IV injection, without exceeding 10 mg
  - Adult 10 mg rectally or by slow IV injection
  - If seizures do not stop within 5 minutes after the first dose, repeat once.
- **Tetanus**
  - The dosage range is variable, depending on severity. For information:
    - Child and adult: 0.1 to 0.3 mg/kg by slow IV injection, to be repeated every 1 to 4 hours, under close medical supervision.
- **Agitation, delirium tremens**
  - Adult: 5 to 10 mg by IM injection, to be repeated after one hour if necessary

**Contra-indications, adverse effects, precautions**
- Do not administer to patients with severe respiratory insufficiency or severe hepatic impairment.
- May cause:
  - Pain at the IV or IM injection site.
  - Hypotension, respiratory depression, particularly if administered IV, if injected too rapidly by IV route and if large doses are administered (tetanus).
  - In the event of overdose: hypotonia, lethargy, respiratory distress, coma.
- Reduce the dose by one half in elderly patients and patients with renal or hepatic impairment.
- Risk of increased sedation when combined with alcohol and drugs acting on the central nervous system: opioid analgesics, neuroleptics (chlorpromazine, haloperidol, etc.), antihistamines (chlorphenamine, promethazine), antidepressants (clomipramine, fluoxetine, etc.), phenobarbital, etc.
- Pregnancy: avoid if possible, except if vital
- Breast-feeding: avoid

**Remarks**
- Diazepam is subject to international controls: follow national regulations.
- Diluted solution is normally cloudy.
- Do not mix with other drugs in the same syringe or infusion.
- **Storage**: below 30°C – ☘
FLUOXETINE
(Fluctine®, Prozac®...)

Therapeutic action
– Antidepressant (selective serotonin re-uptake inhibitor)

Indications
– Depression
– Severe post-traumatic stress disorder

Presentation
– 10 mg and 20 mg capsules or tablets
  Also comes in 20 mg/5 ml oral solution.

Dosage
– Adult: 20 mg once daily. For patients who have only a partial clinical response after 15 days,
  dosage may be increased to 40 mg/day (up to 60 mg/day if needed).
– Reduce doses in elderly patients and in patients with impaired hepatic function (administer
  on alternate days).

Duration
– 6 to 8 months minimum. The treatment should be withdrawn gradually; if signs of relapse
  occur, increase the dose.

Contra-indications, adverse effects, precautions
– Do not administer to patients aged less than 15 years; to patients with hypersensitivity to
  fluoxetine.
– May cause, especially at the beginning of therapy:
  • nervousness, insomnia, drowsiness, headache, suicidal tendencies due to the suppression
    of psychomotor inhibition, exacerbation of anxiety or delusional symptoms,
  • gastrointestinal disturbances, allergic reactions, hyperglycaemia (particularly in diabetic
    patients, closely monitor blood glucose), confusion due to hypernatraemia, haemorrhage.
– Do not combine with MAOIs; do not drink alcohol during treatment.
– Administer with caution to patients with epilepsy, glaucoma, cardiac disease, hepatic or
  renal impairment, thyroid dysfunction, coagulation disorders.
– Monitor combination with: oral anticoagulants (risk of haemorrhage), carbamazepine,
  phenytoin, tricyclic antidepressants and ergotamine (increased plasma concentration of
  these drugs), lithium, tramadol, pethidine.
– Closely monitor patients with suicidal tendencies, especially at the beginning of therapy.
– Advise patients that fluoxetine may cause drowsiness and to be cautious when driving or
  operating machinery.
– Pregnancy: avoid. However, if treatment has been started before a pregnancy, do not stop treatment
  reduce dosage at the end of pregnancy (risk of withdrawal syndrome in the newborn infant).
– Breast-feeding: avoid (safety is not established)

Remarks
– It takes 10 to 20 days for the patient to feel the antidepressant effect. The therapeutic
  efficacy can only be assessed after 3 weeks of treatment. This must be explained to the
  patient to encourage compliance.
– Anxiolytic or sedative treatment may be necessary during the first weeks of treatment in
  anxious or agitated patients.

Storage
HALOPERIDOL
(Haldol®, Serenace®...)

Prescription under medical supervision

Therapeutic action
- Neuroleptic

Indications
- Acute psychoses: severe states of agitation or aggressiveness, delirium, acute mania
- Chronic psychoses: schizophrenic delirium, hallucinations
- Anxiety not controlled by anxiolytics

Presentation
- 2 mg and 5 mg tablets
- Also comes in 1 mg and 20 mg tablets; 2 mg/ml and 20 mg/ml oral solution.

Dosage
- Psychoses
  - Child over 3 years: initial dose of 25 to 50 µg/kg/day in 2 to 3 divided doses
  - If necessary, increase cautiously up to a maximum of 150 µg/kg/day
  - Adult: 2 to 40 mg/day in 2 to 3 divided doses
  - If necessary, increase gradually up to 40 mg/day according to clinical response.
- Anxiety
  - Adult: 1 mg/day in 2 divided doses

Duration
- Psychoses: according to clinical response
- Anxiety: short-term treatment

Contra-indications, adverse effects, precautions
- Do not administer to children under 3 years; to patients suffering from Parkinson's disease.
- In case of isolated hyperthermia (or associated with severe extrapyramidal disorders), stop treatment: possible neuroleptic malignant syndrome.
- May cause:
  - Sedation or drowsiness, orthostatic hypotension;
  - Extrapyramidal syndrome (requiring administration of anticholinergic antiparkinsonian drugs), early or tardive dyskinesia in case of prolonged treatment (may be exacerbated by antiparkinsonian drugs);
  - Galactorrhea, amenorrhea, impotence.
- Administer with caution in hepatic or renal failure, to elderly patients, persons who drive or operate machinery, epileptics.
- Do not combine with levodopa.
- Risk of increased sedation when combined with alcohol and depressants of the central nervous system (hypnotics, anxiolytics, morphine and derivatives, antihistamines, etc.).
- Avoid alcohol during treatment.
- Pregnancy: avoid
- Breast-feeding: avoid

Remarks
- Haloperidol may induce more extrapyramidal reactions than chlorpromazine, but less often provokes sedation and orthostatic hypotension.
- Storage: no special temperature requirements -

23/FD/May 2010
HALOPERIDOL
(Haldol®, Serenace®...)

Prescription under medical supervision

Therapeutic action
- Neuroleptic

Indications
- Acute psychoses: psychomotor agitation, acute mania, delirium tremens
- Severe vomiting induced by antimarialleptic drugs

Presentation and route of administration
- 5 mg in 1 ml ampoule (5 mg/ml) for IM injection or IV infusion

Dosage
- Adult: 2 to 10 mg/day by IM injection, repeated at intervals of 4 to 8 hours if necessary
- In patients receiving chemotherapy: 5 mg by IV infusion or 1 to 5 mg by IM injection, repeated after 12 hours if necessary

Duration: according to clinical response

Contra-indications, adverse effects, precautions
- Do not administer to children and to patients suffering from Parkinson’s disease.
- In case of hyperthermia following an injection, stop treatment: possible neuroleptic malignant syndrome.
- May cause extrapyramidal syndrome, dyskinesia, orthostatic hypotension.
- Do not combine with levodopa.
- Do not drink alcohol during treatment.
- Risk of increased sedation when combined with depressants of the central nervous system (morphine and derivatives, anxiolytics, antihistamines...).
- Pregnancy: avoid
- Breast-feeding: avoid

Remarks
- Haloperidol decanoate is a long-acting form acting as a pro-drug, releasing slowly haloperidol, used in the long-term treatment of psychotic disorders in patients stabilised on oral treatment (one IM injection every 3 to 4 weeks).
- Haloperidol may induce more extrapyramidal reactions than chlorpromazine, but less often provoke sedation and orthostatic hypotension.
- If administered by infusion, protect the bottle from light.
- Storage below 30°C —
Paroxetine
(Deroxat, etc.)

**Therapeutic action:** SSRI (selective serotonin reuptake inhibitor) antidepressant

**Indications:** Major depressive episode, post-traumatic stress disorder, panic disorder or generalized anxiety disorder. Standard treatment for anxiety disorders with depressive and/or post-traumatic symptoms, and for immobilized patients.

**Presentation:** 20 mg scored tablets

**Dosage:** One tablet per day. Improvement generally begins one week after starting treatment, but may not become evident until after the second week of treatment. If necessary, the dosage can be increased to 30 and then 40 mg.

**Duration:** Ideally, this medication should be taken for at least six months. It should be stopped very gradually, in half-tablet increments, and then every other day, in order to limit withdrawal symptoms, which are relatively common, especially if treatment is stopped abruptly. Monitor for signs of relapse, which indicate the need to prolong treatment.

**Contraindications, adverse effects, precautions:**

- Do not administer to patients with known hypersensitivity to SSRIs or to children under 18 years.
- Patients at risk of suicide should be monitored especially closely early in treatment.
- Do not combine with MAOI or tricyclic antidepressants; use caution in patients taking other medications (risk of serotonergic syndrome), especially anticoaguulants and nonsteroidal anti-inflammatory agents.
- Use caution in patients with epilepsy, glaucoma, diabetes, cardiovascular disease, and renal or hepatic insufficiency. Caution is advised when drinking alcohol and taking this medication.

**Pregnancy:** to be avoided, but do not interrupt ongoing treatment; to be used if psychiatric presentation is severe.

**Breastfeeding:** no strict contraindication

**Comments:**

No symptomatic improvement is seen until after one week of treatment, so the patient should be warned. Early in treatment there can be unpleasant, transient side effects such as drowsiness, dizziness, headaches, vision problems, increased sweating, and sexual dysfunction. The patient should also know that stopping the treatment abruptly commonly causes withdrawal symptoms (dizziness, sensory disturbances, and sleep disorders).

Paroxetine is not on MSF’s essential drugs list (will be included in 2011), or that of the WHO.

**Storage:** below 30°C.
PROMETHAZINE
(Phenergan®…)

Prescription under medical supervision

Therapeutic action
- Sedating antihistaminic, anti-emetic

Indications
- Allergic reactions (contact dermatitis, seasonal allergy; allergy to drugs, insect bites, food, etc.)
- Nausea and vomiting

Presentation
- 25 mg tablet
  Also comes in 10 mg tablets and 1 mg/ml syrup.

Dosage
- Allergic reactions
  Child from 2 to 5 years: 5 to 15 mg once daily or in 2 divided doses
  Child from 5 to 10 years: 10 to 25 mg once daily or in 2 divided doses
  Child over 10 years and adult: 25 to 50 mg once daily or in 2 divided doses

- Nausea and vomiting
  Child from 2 to 10 years: 10 to 25 mg to be repeated every 6 hours if necessary
  Child over 10 years and adult: 25 mg to be repeated every 6 hours if necessary

Duration
- According to clinical response, single dose or for a few days if necessary

Contra-indications, adverse effects, precautions
- Do not administer to patients with uroth-prostatic disorders, glaucoma.
- Do not exceed indicated doses.
- Do not drink alcohol during treatment.
- Avoid in children under 2 years (safety is not established).
- May cause: drowsiness (administer preferably once daily at night), dryness of the mouth, constipation, urinary retention, blurred vision.
- Risk of increased sedation when combined with alcohol and drugs acting on the central nervous system: opioid analgesics, neuroleptics (chlorpromazine, haloperidol, etc.), other antihistamines (chlorphenamine), antidepressants (clomipramine, fluoxetine, etc.), phenobarbital, etc.
- Pregnancy: avoid at the end of pregnancy; no prolonged treatment.
- Breast-feeding: not recommended (drowsiness and risk of apnoea in the newborn infant)

Remarks
- Storage below 30°C – ³
RISPERIDONE
(Risperdal, etc.)

**Therapeutic action:** Antipsychotic; has fewer side effects than the standard neuroleptics.

**Indications:**
- acute psychoses: delusional states, agitation, or mania
- chronic psychoses: schizophrenia, late-onset schizophrenia, etc.
- at low doses, for anxiety in cases of failure with standard treatments

**Presentation:** 1 mg tablets (MSF list), 2 to 4 mg orally

**Dosage:**
- gradual adaptation over a three-day period; 1 mg twice a day, increasing to 4 mg on average (maximum 8 mg) for severe acute or chronic psychotic disorders.

**Duration:**
- according to the condition and clinical progress; three months for acute episodes, at least one year for chronic psychoses, less than one month for severe anxiety disorders.

**Contraindications, side effects, precautions:**

Use with caution in elderly patients, and those with kidney failure (reduce the dosage) or heart disease.

Unpleasant side effects: weight gain, hypotension, occasionally agitation and insomnia early in treatment

Extrapyramidal side effects, less common than with standard neuroleptics, can occur and should be counteracted. Beware of the rare, but possible, neuroleptic malignant syndrome; treatment should be stopped if unexplained fever occurs.

Combining this medication with alcohol or any other CNS depressant is not advised.

**Pregnancy:** no contraindication; to be used, if necessary, to preserve the mother’s mental balance.

**Breastfeeding:** to be avoided.