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Original Article

A Web-based Survey on Psychotropics that Require Stable Supplies during Crises in the Japanese Mental Healthcare Setting

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Abstract

There have been a number of incidents in recent years that have raised concerns about the stability of medical supplies. In 2020, the Japanese Ministry of Health, Labour and Welfare designated 506 drugs as requiring stable supplies during crises, including 10 psychotropics. However, these psychotropics were not selected based on the views of all stakeholders in mental healthcare. In the present study, we conducted a web-based questionnaire survey of psychiatrists (n=1,210), pharmacists (n=217), and patients/their families (n=153) regarding psychotropics that require stable supplies during crises, followed by a consensus survey based on a modified Delphi panel at a symposium held at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology. The questionnaire survey revealed that more than 90% of psychiatrists and pharmacists and more than 80% of patients/their families accepted the selection of 10 psychotropics as medicines that require stable supplies during crises. In addition, a consensus survey selected four antipsychotics (risperidone, aripiprazole, olanzapine, and quetiapine), two antidepressants (mirtazapine and escitalopram), two mood stabilizers (sodium valproate and lithium carbonate), one anxiolytic (lorazepam), and one hypnotic (lemborexant) as psychotropics that require stable supplies during crises.

Keywords: psychotropics, stable supply, questionnaire survey, consensus survey

Introduction

Under Japan's universal health insurance system, high-quality medical care is provided that is globally

recognized. However, this healthcare system relies on the stable supply of pharmaceuticals. Yet, as highlighted by the occurrence of at least 112 cases of

pharmaceutical supply instability or shortages between April 2018 and January 2020, incidents casting doubt on the stability of pharmaceutical supply have frequently occurred in recent years. Against this backdrop, the concept of “drugs that require stable supply” was proposed at the “Meeting of Stakeholders on Measures for Ensuring the Stable Supply of Medical Drugs” established by the Ministry of Health, Labour and Welfare in March 2020.³⁾

Drugs that require stable supply are defined as “medicines proposed by the major academic societies under the umbrella of the Japanese Association of Medical Sciences as being indispensable for medical care, widely used, and requiring stable supply within their respective specialties. They are necessary for maintaining uninterrupted medical supply to protect the lives of the public and ensure national security, and require particular consideration for stable supply.” Currently, 506 pharmaceuticals are listed, including 10 psychotropics proposed by the Japanese Society of Psychiatry and Neurology (hereinafter referred to as “our society”).⁴⁾ However, our society's selection of these 10 psychotropic drugs was made based on an “expert consensus” among psychiatrists serving on the Pharmaceutical Affairs Committee and Board of Directors, partly due to time

constraints. Thus, it is difficult to consider that these 10 psychotropic drugs were determined after fully reflecting on the opinions of the entire psychiatric medical community.

Therefore, this time, we (the Pharmaceutical Affairs Committee of our society) conducted a web-based questionnaire survey targeting psychiatrists, pharmacists, and individuals with mental illness and their families. The purpose was to generate a consensus across the entire field of psychiatric care regarding psychotropics that require stable supply. The results were presented at the Committee Symposium during the 118th Annual Scientific Meeting of our society. This paper summarizes the findings.

I. Methods

This survey involved three types of web-based questionnaires targeting: 1) Psychiatrists, 2) Pharmacists, and 3) Patients and their families.

The psychiatrist questionnaire targeted psychiatrists who are members of our society. It included background factors such as (i) age, (ii) sex, (iii) years of psychiatric practice, (iv) primary workplace, (v) specialized disease groups (up to three), (vi) academic specialties (up to three), and, in addition to these background factors, (vii) their stance on selecting ten psychotropics

that require stable supply in psychiatry, assuming a crisis situation like a major natural disaster where many drugs become difficult to obtain, (viii) whether they would prioritize using these ten psychotropics in daily clinical practice if selected, (ix) whether they have encountered difficulties due to medication supply instability, (x) concerns arising during normal times if 10 psychotropics that require stable supply were selected, (xi) allocation by psychotropic drug category (antipsychotics, antidepressants, mood stabilizers, anxiolytics/hypnotics, other psychotropic drugs) when selecting 10 psychotropics that require stable supply in psychiatry, (xii) psychotropic drugs considered high priority for selection as psychotropics that require stable supply (antipsychotics, antidepressants, anxiolytics/hypnotics, and other psychotropic drugs: up to 5 types; mood stabilizers: up to 2 types).

The pharmacist survey targeted pharmacists who are members of the Japanese Society of Psychiatric Pharmacy and requested responses for (i), (ii), (vii), (viii), (ix), (x), (xi), and (xii). Among these, (viii) was rephrased to reflect the intent: “If 10 psychotropics that require stable supply were selected, would you prioritize these drugs in daily clinical practice?”

The questionnaire for individuals with mental illness and their families

targeted members of the Community Mental Health and Welfare Organization (COMHBO), the National Federation of Association of Families with Mental Illness in Japan (Minna Net), and the Japanese Alliance of Bipolar Disorder (Nautilus Association). It requested responses to (i), (ii), (vii), (viii), (ix), (xi), and (xii). It also included: (xiii) whether the respondent was a patient or family member; (xiv) whether they had experienced difficulty obtaining prescribed medication when needed; (xv) how much they would be troubled if 10 psychotropics that require stable supply were chosen and they could no longer take their previously prescribed medication in an emergency; (xvi) how concerned they would be if, after 10 psychotropics that require stable supply were chosen, they had to take a medication they previously discontinued due to side effects, (xvii) how concerned they would be if, after 10 psychotropics that require stable supply were selected, other medications might be discontinued or become unstable in supply. However, for (viii), the wording was rephrased to convey the intent: “If 10 types of psychotropics that require stable supply were selected, would you prefer your doctor to prioritize prescribing these drugs?” For (xi), respondents were asked to select the applicable option from: “Select roughly equal numbers of antipsychotics,

antidepressants, mood stabilizers, anxiolytics/hypnotics, and other psychotropic drugs,” “Select more drugs from a specific category,” or “Neither.” Furthermore, for those who selected “choose more of a specific category,” they were asked to select up to three categories they considered preferable.

All surveys were conducted using Google Forms without collecting personally identifiable information such as names or membership numbers. Due to space constraints, this paper did not address items (viii), (ix), (x), (xiv), (xv), (xvi), and (xvii).

II. Results

1. Background factors

A total of 1,210 psychiatrists responded to the questionnaire survey. By sex, 914 were male, 279 were female, and 17 did not respond. Age distribution was as follows: 17 respondents aged 29 or younger; 155 aged 30-39; 322 aged 40-49; 362 aged 50-59; 262 aged 60-69; 87 aged 70-79; and 5 aged 80 or older. Years of psychiatric practice: up to 3 years: 44; up to 10 years: 126; up to 20 years: 306; up to 30 years: 357; 31 years or more: 377. Primary workplaces were: main university hospitals (n=168), general hospital psychiatric departments (university hospital branches, public general hospitals, private general hospitals) (n=145), psychiatric hospitals (n=448),

psychiatric clinics (n=368), and other (university faculty/research institutes outside medical schools, mental health and welfare centers, occupational physicians/private companies, group employment, welfare-related), and non-psychiatric work (non-psychiatric clinics/hospitals, unemployed) accounted for 15. The most common specialized disease group was mood disorders (ICD-10 F3) with 873 individuals, followed by schizophrenia spectrum disorders (F2; n=737), neurotic disorders (F4; n=550), organic mental disorders (F0; n=413), developmental disorders (F8; n=164), hyperkinetic disorders (F9; n=150), substance use disorders (F1; n=83), sleep disorders (G47; n=74), epilepsy (G40; n=50), mental retardation (F7; n=44), behavioral syndromes associated with physiological disturbances and physical factors (F5; n=35), and personality disorders (F6; n=22). The most common specialty was individual psychotherapy (n=372), followed by psychopharmacology (n=280), diagnostics (n=253), community psychiatry (n=252), geriatric psychiatry (n=221), liaison and consultation psychiatry (n=209), child and adolescent psychiatry (n=165), psychopathology (n=157), psychiatric emergency care (n=129), psychosocial treatment and rehabilitation (n=88), social psychiatry (n=84),

psychobiochemistry and molecular psychiatry (n=72), psychophysiology (n=70), forensic psychiatry (n=59), diagnostic imaging (n=57), neuropsychology (n=46), ECT (n=45), group psychotherapy (n=26), and psychological testing (n=16). Additionally, 63 respondents selected “others.”

A total of 217 pharmacists responded to the questionnaire survey. Sex breakdown: 129 male, 83 female, 5 no response. Age breakdown: 5 aged 29 or younger, 54 aged 30-39, 72 aged 40-49, 60 aged 50-59, 25 aged 60-69, and 1 aged 70-79.

The questionnaire survey for patients and their families received 153 responses. The breakdown was 107 individuals with the condition, 45 family members, and 1 other. Sex breakdown: 56 male, 95 female, 2 no response. Age distribution was as follows: 7 respondents aged 29 or younger, 19 aged 30-39, 41 aged 40-49, 52 aged 50-59, 25 aged 60-69, 1 aged 70-79, and 5 aged 80 or older. Additionally, 3 respondents did not state their age.

2. Appropriateness of selecting psychotropics that require stable supply

Considering that failure to select 10 psychotropics that require stable supply could lead to situations where none could be prescribed during emergencies, those who responded “agree” or

“somewhat agree” to selecting 10 psychotropics were: 1,103 out of 1,210 psychiatrists (91.2%), 197 out of 217 pharmacists (90.8%), and 127 out of 153 patients/family members (83.0%).

3. Category-specific breakdown when selecting 10 psychotropics that require stable supply

The mean \pm standard deviation (median) of the category-specific distribution when selecting 10 psychotropics that require stable supply as stability-ensuring medications was as follows for psychiatrists (1,047 valid respondents): antipsychotics, 2.7 ± 0.7 (3) types; antidepressants, 2.2 ± 0.5 (2) types; mood stabilizers, 1.8 ± 0.5 (2) types; anxiolytics/hypnotics, 1.9 ± 0.6 (2) types; and other psychotropic drugs, 1.4 ± 0.9 (1) types. Similarly, among pharmacists (193 valid respondents), drugs averaged as follows: antipsychotics, 2.8 ± 0.8 (3) types; antidepressants, 2.0 ± 0.6 (2) types; mood stabilizers, 1.8 ± 0.5 (2) types; anxiolytics/hypnotics, 2.0 ± 0.6 (2) types; and other psychotropic drugs, 1.5 ± 0.9 (2) types.

Among patients and family members, 68 out of 84 valid respondents (81.0%) answered: “I choose roughly the same number of antipsychotics, antidepressants, mood stabilizers, anxiolytics/hypnotics, and other psychotropic drugs.” Thirteen

respondents (15.5%) answered: “select a specific type of medication more frequently,” and 3 respondents (3.6%) answered “neither.” Furthermore, in response to the question: “If you were to select more of a specific category of drug, which category do you think would be best to select more of?,” the most frequently selected drugs were antipsychotics, chosen by 27 out of 73 valid respondents (37.0%) (Table 1).

4. Antipsychotics to be selected as psychotropics that require stable supply (Table 2)

Regarding antipsychotics that require stable supply, risperidone, olanzapine, and aripiprazole occupied the top three positions for psychiatrists, pharmacists, and patients and their families alike.

5. Antidepressants to be selected as psychotropics that require stable supply (Table 3)

Regarding psychotropics that necessitate stable supply, mirtazapine and duloxetine occupied the top two positions for both psychiatrists and pharmacists. Conversely, among patients and their families, neither mirtazapine nor duloxetine ranked in the top two; they placed fifth and third, respectively, while sertraline and paroxetine occupied the top two positions.

6. Mood stabilizers to be selected as psychotropics that require stable supply (Table 4)

Regarding mood stabilizers that require stable supply, sodium valproate and lithium carbonate ranked in the top two for psychiatrists, pharmacists, and patients and their families alike.

7. Anxiolytics and Hypnotics Recommended for Psychotropics That Require Stable Supply (Table 5)

Regarding anxiolytics and hypnotics recommended for psychotropics that require stable supply, both psychiatrists and pharmacists ranked lorazepam and lemborexant in the top two positions. In contrast, among patients and family members, lorazepam and lemborexant ranked only 5th and 8th, respectively. The top choice was etizolam, followed by flunitrazepam and brotizolam.

8. Other Psychotropic Drugs Recommended for Psychotropics That Require Stable Supply (Table 6)

Concerning other psychotropic drugs recommended for psychotropics that require stable supply, psychiatrists and pharmacists ranked biperiden and levetiracetam in the top two positions. In contrast, among patients and their families, these ranked only third and fourteenth, respectively, while atomoxetine and extended-release methylphenidate occupied the top two

positions.

III. Discussion

1. Circumstances Surrounding Psychotropics That Require Stable Supply

As mentioned at the beginning of this paper, recent years have seen frequent incidents raising doubts about the stability of pharmaceutical supply. For example, in March 2019, a manufacturing issue with injectable cefazolin, an antibiotic produced in China, led to a prolonged disruption in stable supply. Furthermore, in February 2020, the spread of the novel coronavirus disease (COVID-19) led to disruptions in the manufacturing and import/export of active pharmaceutical ingredients (APIs) dependent on overseas sources such as China and India. The background to these problems includes a tendency for the production of pharmaceutical raw materials and APIs to concentrate in a small number of pharmaceutical companies in specific countries due to profitability issues. Furthermore, as pharmaceutical manufacturing processes now span multiple countries, problems arising in any one country can have global repercussions. Consequently, it has been pointed out that measures leading to the secure and stable supply of pharmaceuticals are

necessary from the perspective of medical security.³⁾

The concept of “drugs that require stable supply” was proposed by the “Inter-agency Meeting on Measures for Ensuring the Stable Supply of Medical Drugs” to address such situations. Based on a list of 10 medicines selected from each subcommittee under the Japanese Association of Medical Sciences, a total of 506 medicines were proposed across all clinical fields: 216 oral medications, 244 injectable medications, and 46 topical medications.⁴⁾ Of these 506 medicines, 40 are psychotropic drugs (Table 7). Thirty of these 40 were proposed by societies other than ours, such as the Japan Epilepsy Society, the Japan Society of Neurology, the Japan Pediatric Society, and the Japan Society of Anesthesiologists,²⁾ while the remaining ten: risperidone, lithium carbonate, sodium valproate, aripiprazole, lorazepam, quetiapine, mirtazapine, zolpidem, escitalopram, and duloxetine, were proposed by our society. However, the process by which our society selected these 10 types, while constrained by time, was arguably open to criticism.

2. Consensus on psychotropics that require stable supply

In this questionnaire survey, over 90% of psychiatrists and pharmacists,

and over 80% of patients and their families, responded “agree” or “somewhat agree” to selecting these 10 psychotropic drugs as psychotropics that require stable supply. Therefore, selecting these 10 psychotropic drugs as psychotropics that require stable supply was considered to have gained the understanding of all stakeholders in psychiatric care.

Next, examining psychotropic drugs by category, psychiatrists selected an average (median) of 2.7 (3) types of antipsychotics, 2.2 (2) types of antidepressants, 1.8 (2) types of mood stabilizers, 1.9 (2) types of anxiolytics/hypnotics, and 1.4 (1) types of other psychotropic drugs. Pharmacists also selected 2.8 (3) types of antipsychotics, 2.0 (2) types of antidepressants, 1.8 (2) types of mood stabilizers, 2.0 (2) types of anxiolytics/hypnotics, and 1.5 (2) types of other psychotropic drugs. Thus, regarding the distribution of psychotropic drugs by category, a general consensus was reached between psychiatrists and pharmacists. It was considered appropriate to select 3 types of antipsychotics, 2 types of antidepressants, 2 types of mood stabilizers, 2 types of anxiolytics/hypnotics, and 1 type of other psychotropic drugs. Approximately 80% of patients and their families responded that

antipsychotics, antidepressants, mood stabilizers, anxiolytics/hypnotics, and other psychotropic drugs should be selected in roughly equal numbers. However, the largest proportion indicated that if selecting more drugs from a specific category, antipsychotics should be chosen. This was considered consistent with the consensus among psychiatrists and pharmacists.

Regarding specific items selected as psychotropics that require stable supply, differences in consensus formation were observed across categories. For antipsychotics, consensus was considered established among psychiatrists, pharmacists, and patients and their families for selecting three types: risperidone, olanzapine, and aripiprazole. For mood stabilizers, consensus was established for selecting two types: sodium valproate and lithium carbonate. Conversely, for antidepressants, anxiolytics/hypnotics, and other psychotropic drugs, while psychiatrists and pharmacists showed little difference in their selected items, patients and their families chose drugs significantly different from these. For example, regarding anxiolytics/hypnotics, while healthcare professionals prioritized lorazepam and lemborexant, patients and families prioritized etizolam, flunitrazepam, and brotizolam. Factors contributing to this divergence likely include the issue of

“split votes” and problems related to the influence of actual prescribing practices in clinical settings. The “split vote” issue stems from the fact that while four types of selective serotonin reuptake inhibitors (SSRIs) and three types of serotonin-norepinephrine reuptake inhibitors (SNRIs) are currently available in Japan, noradrenergic and specific serotonergic antidepressants (NaSSAs) are limited to only mirtazapine. In surveys like this one, the voting behavior of “choosing either an SSRI (or an SNRI, or a NaSSA)” has a certain clinical validity and is a plausible scenario. However, vote splitting between SSRIs and SNRIs can cause the relative ranking of each drug to decline, potentially giving an advantage to mirtazapine, which avoids this “split vote” effect. The implication for prescribing practices in clinical settings is that the preference rankings among patients and their families may merely reflect the drugs the patients themselves are actually taking. In this questionnaire survey, while psychiatrists and pharmacists both highly rated lorazepam and lemborexant as the top anxiolytics/hypnotics to select for psychotropics that require stable supply, patients and their families rated etizolam, flunitrazepam, and brotizolam higher. However, according to Inada, K.'s prescription survey based

on 2012-2016 claim data,¹⁾ the most frequently prescribed sleep medications for new patients were zolpidem, brotizolam, etizolam, and flunitrazepam. Similarly, for other psychotropic drugs, healthcare professionals highly rated biperiden and levetiracetam, while patients and their families favored atomoxetine, methylphenidate extended-release, non-extended-release methylphenidate (14.3%: 4th), and guanfacine (11.9%: 5th). This may simply reflect the higher proportion of responses from individuals with attention deficit hyperactivity disorder (ADHD) and their families. Therefore, while the questionnaire survey itself was appropriately conducted, caution should be exercised in interpreting the results of a single vote as consensus.

An alternative approach could be to hold a panel discussion based on the voting results; however, this carries the risk of undue influence from specific individuals, such as those with authority or strong voices. Therefore, this study attempted to aggregate opinions using a method based on the Delphi technique, in addition to the initial questionnaire survey. The Delphi technique⁵⁾ is a method for aggregating opinions within a group by repeatedly conducting anonymous voting on a specific theme among a group of respondents and providing feedback on

the results. A key advantage of this method is that all voting is anonymous, eliminating the risk of excessive influence from specific individuals. The authors conducted three additional anonymous re-votes by symposium participants at the 118th Annual Meeting Symposium of this society, in addition to the initial anonymous questionnaire survey.

When considering the implementation of re-voting, various other issues requiring consideration were raised by the survey implementation team.

The first issue concerns the selection of sleep medications. Generally, when prescribing sleep medications, it is considered preferable to avoid benzodiazepine receptor agonists due to the risk of dependence. However, actual prescribing practices in clinical settings do not always follow this principle. Consequently, if a supply shortage of these medications occurs, it is anticipated that a large number of patients would suffer withdrawal symptoms. Considering this reality, there is room to argue that benzodiazepine receptor agonists, which can avoid withdrawal symptoms, should be prioritized over orexin receptor antagonists and melatonin receptor agonists as psychotropics that require stable supply.

The second issue concerns medications frequently used when oral administration is difficult, such as haloperidol IM/IV and clomipramine IV formulations in psychiatric emergencies and consultation-liaison psychiatry. It also includes diazepam IM/IV formulations, widely used in treating alcohol withdrawal syndrome and status epilepticus, and clozapine, used for treatment-resistant schizophrenia. While the patient population for these drugs is relatively small, they are considered markedly necessary for severely ill patients. The appropriateness of excluding these drugs solely because of their lower preference ranking is questionable.

The third issue is that the “other psychotropic drugs” category simply bundles together medications for different disease areas. Medications for dementia, attention deficit hyperactivity disorder (ADHD), alcohol dependence, anticonvulsants, and antiparkinsonian drugs were grouped under “Other Psychotropic Medications.” However, during the survey, participants first allocated a set number of votes per category for psychotropic drugs before voting on specific items within each category. This process may have led to different drug selections compared with a scenario without category grouping. Therefore, when conducting a re-vote, it was considered

preferable to confirm the preference ranking among all psychotropic drugs without predetermining the final category-specific allocation numbers.

3. Re-voting at the symposium

Considering the above issues, to build a more valid consensus on psychotropics that require stable supply, three re-votes were conducted by symposium participants during the symposium at the 118th Annual Meeting of our society. In the first re-vote, i.e., the second vote, the aggregated results of the questionnaire survey (hereinafter referred to as the first vote) were sequentially presented as symposium topics categorized by drug type. After each topic presentation, a re-vote was conducted for the corresponding category. However, for the second vote, the voting targets were limited to those judged to show high-level clinical necessity based on their high vote count in the first vote or their mechanism of action (ramelteon) or formulation (intravenous clomipramine, diazepam suppositories, and intramuscular biperiden). Participants were instructed to choose three antipsychotics, two antidepressants, two anxiolytics/hypnotics, and one other psychotropic drug. The results of the second vote were announced immediately, followed by the third vote in the same venue. The third vote

involved the same candidates as the second vote; participants selected three antipsychotics, two antidepressants, two mood stabilizers, two anxiolytics/hypnotics, and one other psychotropic drug. The results were similarly presented on the spot. The final fourth vote adopted a method where participants selected ten psychotropic drugs at once, without category-specific allocations. In the final fourth vote, 129 participants voted. For antipsychotics: risperidone, aripiprazole, olanzapine, and quetiapine; for antidepressants: mirtazapine and escitalopram; for mood stabilizers: sodium valproate and lithium carbonate; and for anxiolytics/hypnotics: lorazepam and lemborexant (Table 8). For the re-vote, voting eligibility was not specifically restricted. Due to practical constraints, information on background factors such as the voters' age, sex, or occupation could not be collected. However, it is considered that the majority of re-voters were members of our society. Therefore, the ten psychotropic drugs listed in Table 8 represent the consensus of the entire membership of our society regarding psychotropics that require stable supply, and it is considered that the opinions of stakeholders other than psychiatrists, including patients and their families, are also sufficiently reflected.

Conclusion

This time, the Pharmaceutical Affairs Committee of the Japanese Society of Psychiatry and Neurology conducted a web-based questionnaire survey regarding psychotropics that require stable supply, targeting psychiatrists who are members of the Japanese Society of Psychiatry and Neurology, pharmacists who are members of the Japanese Society of Psychopharmacology, and patients and their families. However, this survey has several limitations.

The most significant problem is the inherent ambiguity of the concept of “psychotropics that require stable supply” itself. This concept emerged from discussions surrounding the stable supply of pharmaceuticals. However, the options should differ depending on whether the scenario envisaged involves problems occurring only in the manufacturing process of a very small number of drugs, problems in the distribution of drugs in some domestic regions due to a major disaster, or problems in the supply of drugs on a global scale due to events like war. Considering that the April 2020 inquiry from the Ministry of Health, Labour and Welfare itself contained ambiguities, this survey deliberately proceeded without clarifying the concept. However, it is desirable to conduct separate

surveys in the future that consider various scenarios where pharmaceutical supply becomes unstable.

The second issue is the small sample size for the survey targeting patients and their families, particularly regarding the preference ranking for psychotropic drugs, where data were obtained from only 42 to 75 individuals. However, given the inherent difficulty in securing a large number of participants willing to cooperate in the questionnaire survey, and judging that the drawbacks of excluding patients and their families from the opinion aggregation process would be greater, the small sample size was considered acceptable for this study.

Despite these limitations, conducting a web-based questionnaire survey and obtaining stakeholder opinions on psychotropics that require stable supply, which could significantly impact future pharmaceutical administration and psychiatric care, was considered highly meaningful and worthy of reporting. Furthermore, the approach of presenting the committee's deliberations at a symposium and advancing discussions through real-time interaction with attendees was innovative and may indicate a new direction for future academic symposiums.

Conflicts of interest relevant to this paper are disclosed below:

Ataru Inagaki: (Manuscript fees) IQVIA Services Japan K.K.; (Research funding/grants) Otsuka Pharmaceutical Co., Ltd., Shionogi & Co., Ltd., Dainippon Sumitomo Pharma Co., Ltd. (now Sumitomo Pharma Co., Ltd.), Takeda Pharmaceutical Company Limited, Meiji Seika Pharma Co., Ltd., and Janssen Pharmaceutical K.K.; Inagaki participates in a research project operated with funds provided by these six companies; he did not personally receive any research funding.

Ken Inada: (Lecture fees) Eisai Co., Ltd., (Research funding/grants, etc.) Sumitomo Pharma Co., Ltd.

Takashi Tsuboi: (Speaker fees) Sumitomo Pharma Co., Ltd., Viatrix Pharmaceuticals Japan Inc., Takeda Pharmaceutical Company Limited.

Kazuo Mishima: (Speaker fees) Eisai Co., Ltd., MSD K.K., Nobelpharma Co., Ltd., (Research funding/grants, etc.) Taisho Pharmaceutical Co., Ltd., [Scholarship (incentive) donations, etc.] Eisai Co., Ltd., [Other (Pharmaceutical/Medical Device Company Advisory Boards, etc.)] Nobelpharma Co., Ltd., Mochida Pharmaceutical Co., Ltd., Sony Group Corporation.

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Pharmaceutical Co., Ltd., Sumitomo Pharma Co., Ltd., Pfizer Japan Inc., Meiji Seika Pharma Co., Ltd., [Other (advisory roles for pharmaceutical/medical device companies, etc.)] Shionogi & Co., Ltd., Otsuka Pharmaceutical Co., Ltd., Takeda Pharmaceutical Company Limited, Lundbeck Japan K.K., Sumitomo Pharma Co., Ltd.

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References

1) Inada, K., Enomoto, M., Yamato, K., et al.: Prescribing pattern of hypnotic medications in patients initiating treatment at Japanese hospitals: a nationwide, retrospective, longitudinal,

observational study using a claims database. *Drugs Real World Outcomes*, 8 (3); 277-288, 2021

2) 厚生労働省: 各学会から提出された「汎用され安定確保に特に配慮が必要な医薬品」一覧. 2020
(<https://www.mhlw.go.jp/content/10807000/000654245.pdf>) (参照 2022-09-11)
(in Japanese)

3) 厚生労働省: 医療用医薬品の安定確保策に関する関係者会議取りまとめ. 2020
(<https://www.mhlw.go.jp/content/10807000/000758432.pdf>) (参照 2022-09-11)
(in Japanese)

4) 厚生労働省: 安定確保医薬品及びカテゴリ設定(令和3年6月1日修正版). 2021
(<https://www.mhlw.go.jp/content/10807000/000785498.pdf>) (参照 2022-09-11)
(in Japanese)

5) Minds 診療ガイドライン作成マニュアル編集委員会編: Minds 診療ガイドライン作成マニュアル 2020 ver. 3.0. 日本医療機能評価機構 EBM 医療情報部 2021
(https://minds.jcqh.or.jp/docs/various/manual_2020/ver3_0/pdf/all_manual_2020ver3_0.pdf) (参照 2023-06-11) (in Japanese)

表1 「どれか特定の薬を多めに選ぶ場合、どの種類の薬を多めに選ぶと良いと思いますか？ 1～3番目に多く選んだ方が良いと思う薬を以下から選んでください。(当事者・家族向け設問)」

	抗精神病薬	抗うつ薬	気分安定薬・ 抗けいれん薬	抗不安薬・ 睡眠薬	その他	わからない/ 選べない
1 番目 (n=73)	27	3	20	12	0	11
2 番目 (n=72)	11	8	16	24	1	12
3 番目 (n=73)	9	20	14	9	6	15

Table 1: “If you were to choose more of a specific type of medication, which type do you think should be chosen more? Please select the medications you think should be chosen most frequently (1st to 3rd most frequently) from the following.” (Question for patients and their families)

Antipsychotics / Antidepressants / Mood stabilizers and anticonvulsants / Anxiolytics and hypnotics / Other / Don't know/ Can't choose
1st choice (n=73) 27 / 3 / 20 / 12 / 0 / 11
2nd choice (n=72) 11 / 8 / 16 / 24 / 1 / 12
3rd choice (n=73) 9 / 20 / 14 / 9 / 6 / 15

表2 抗精神病薬の選好順位（第10位まで）

選好順位*	精神科医 (n=1,210)	薬剤師 (n=217)	当事者・家族 (n=74)
1. リスペリドン	1,024 (84.6%)	189 (87.1%) ①	40 (54.1%) ②
2. オランザピン	759 (62.7%)	149 (68.7%) ③	31 (41.9%) ③
3. アリピプラゾール	758 (62.6%)	155 (71.4%) ②	42 (56.8%) ①
4. クエチアピン	616 (50.9%)	123 (56.7%) ④	30 (40.5%) ④
5. ハロペリドール筋注静注製剤	350 (28.9%)	39 (18.0%) ⑦	4 (5.4%) ⑩
6. ハロペリドール	206 (17.0%)	55 (25.3%) ⑥	12 (16.2%) ⑥
7. レボメプロマジン	194 (16.0%)	32 (14.7%) ⑧	6 (8.1%) ⑪
8. クロザピン	193 (16.0%)	64 (29.5%) ⑤	10 (13.5%) ⑦
9. クロルプロマジン	152 (12.6%)	11 (5.1%) ⑰	5 (6.8%) ⑬
10. スルピリド	127 (10.5%)	9 (4.1%) ⑱	9 (12.2%) ⑧

* 便宜上、精神科医における選好順位を示した。

丸囲みの数字は薬剤師、当事者・家族における選好順位を示した。

薬品名に剤形に関する断りのないものはすべて経口薬である。

Table 2: Antipsychotic preference rankings (Top 10)

Preference ranking* / Psychiatrists (n=1,210) / Pharmacists (n=217) / Patients and their families (n=74)

1. Risperidone	1,024 (84.6%) / 189 (87.1%)① / 40 (54.1%)②
2. Olanzapine	759 (62.7%) / 149 (68.7%)③ / 31 (41.9%)③
3. Aripiprazole	758 (62.6%) / 155 (71.4%)② / 42 (56.8%)①
4. Quetiapine	616 (50.9%) / 123 (56.7%)④ / 30 (40.5%)④
5. Haloperidol IM/IV Injection	350 (28.9%) / 39 (18.0%)⑦ / 4 (5.4%)⑩
6. Haloperidol	206 (17.0%) / 55 (25.3%)⑥ / 12 (16.2%)⑥
7. Levomepromazine	194 (16.0%) / 32 (14.7%)⑧ / 6 (8.1%)⑪
8. Clozapine	193 (16.0%) / 64 (29.5%)⑤ / 10 (13.5%)⑦
9. Chlorpromazine	152 (12.6%) / 11 (5.1%)⑰ / 5 (6.8%)⑬
10. Sulpiride	127 (10.5%) / 9 (4.1%)⑱ / 9 (12.2%)⑧

*For convenience, the preference ranking among psychiatrists is shown. The numbers in circles indicate the preference ranking among pharmacists and patients and their families. All drugs without a specified dosage form are oral medications.

表3 抗うつ薬の選好順位（第10位まで）

選好順位*	精神科医 (n=1,210)	薬剤師 (n=217)	当事者・家族 (n=53)
1. ミルタザピン	847 (70.0%)	178 (82.0%) ①	10 (18.9%) ⑤
2. デュロキセチン	663 (54.8%)	146 (67.3%) ②	16 (30.2%) ③
3. エスシタロプラム	623 (51.5%)	144 (66.4%) ③	11 (20.8%) ④
4. セルトラリン	559 (46.2%)	96 (44.2%) ⑤	21 (39.6%) ①
5. パロキセチン	343 (28.4%)	63 (29.0%) ⑥	17 (32.1%) ②
6. トラゾドン	323 (26.7%)	97 (44.7%) ④	3 (5.7%) ⑭
7. ベンラファキシン	258 (21.3%)	29 (13.4%) ⑧	10 (18.9%) ⑤
8. フルボキサミン	170 (14.1%)	39 (18.0%) ⑦	9 (17.0%) ⑧
9. ボルチオキセチン	163 (13.5%)	29 (13.4%) ⑧	1 (1.9%) ⑰
10. クロミプラミン	154 (12.7%)	17 (7.8%) ⑫	9 (17.0%) ⑧

* 便宜上、精神科医における選好順位を示した。

丸囲みの数字は薬剤師、当事者・家族における選好順位を示した。

薬品名に剤形に関する断りのないものはすべて経口薬である。

Table 3: Antidepressant preference rankings (Top 10)

Preference ranking* / Psychiatrists (n=1,210) / Pharmacists (n=217) / Patients and their families (n=53)

1. Mirtazapine	847 (70.0%) / 178 (82.0%)① / 10 (18.9%)⑤
2. Duloxetine	663 (54.8%) / 146 (67.3%)② / 16 (30.2%)③
3. Escitalopram	623 (51.5%) / 144 (66.4%)③ / 11 (20.8%)④
4. Sertraline	559 (46.2%) / 96 (44.2%)⑤ / 21 (39.6%)①
5. Paroxetine	343 (28.4%) / 63 (29.0%)⑥ / 17 (32.1%)②
6. Trazodone	323 (26.7%) / 97 (44.7%)④ / 3 (5.7%)⑭
7. Venlafaxine	258 (21.3%) / 29 (13.4%)⑧ / 10 (18.9%)⑤
8. Fluvoxamine	170 (14.1%) / 39 (18.0%)⑦ / 9 (17.0%)⑧
9. Vortioxetine	163 (13.5%) / 29 (13.4%)⑧ / 1 (1.9%)⑰
10. Clomipramine	154 (12.7%) / 17 (7.8%)⑫ / 9 (17.0%)⑧

*For convenience, preference rankings among psychiatrists are shown. Numbers in circles indicate preference rankings among pharmacists and patients and their families. All drugs without dosage form specifications are oral medications.

表 4 気分安定薬の選好順位

選好順位*	精神科医 (n=1,210)	薬剤師 (n=217)	当事者・家族 (n=65)
1. バルプロ酸ナトリウム	1,017 (84.0%)	201 (92.6%) ①	28 (43.1%) ②
2. 炭酸リチウム	1,015 (83.9%)	185 (85.3%) ②	52 (80.0%) ①
3. ラモトリギン	164 (13.6%)	28 (12.9%) ③	26 (40.0%) ③
4. カルバマゼピン	122 (10.1%)	12 (5.5%) ④	9 (13.8%) ④

* 便宜上, 精神科医における選好順位を示した。
丸囲みの数字は薬剤師, 当事者・家族における選好順位を示した。
薬品名に剤形に関する断りのないものはすべて経口薬である。

Table 4: Preference rankings for mood stabilizers

Preference ranking* / Psychiatrists (n=1,210) / Pharmacists (n=217) / Patients and their families (n=65)

1. Sodium Valproate	1,017 (84.0%) / 201 (92.6%)① / 28 (43.1%)②
2. Lithium Carbonate	1,015 (83.9%) / 185 (85.3%)② / 52 (80.0%)①
3. Lamotrigine	164 (13.6%) / 28 (12.9%)③ / 26 (40.0%)③
4. Carbamazepine	122 (10.1%) / 12 (5.5%)④ / 9 (13.8%)④

*For convenience, preference rankings among psychiatrists are shown. Circled numbers indicate preference rankings among pharmacists and patients/family members. All drugs without dosage form specifications are oral medications.

表 5 抗不安薬・睡眠薬の選好順位 (第 10 位まで)

選好順位*	精神科医 (n=1,210)	薬剤師 (n=217)	当事者・家族 (n=75)
1. ロラゼパム	533 (44.0%)	115 (53.0%) ②	16 (21.3%) ⑤
2. レンボレキサント	502 (41.5%)	134 (61.8%) ①	11 (14.7%) ⑧
3. ジアゼパム	378 (31.2%)	87 (40.1%) ④	10 (13.3%) ⑩
4. ジアゼパム筋注静注製剤	346 (28.6%)	45 (20.7%) ⑧	3 (4.0%) ⑰
5. エスゾピクロン	344 (28.4%)	101 (46.5%) ③	13 (17.3%) ⑦
6. ゾルピデム	310 (25.6%)	64 (29.5%) ⑤	19 (25.3%) ④
7. アルプラゾラム	309 (25.5%)	45 (20.7%) ⑧	10 (13.3%) ⑩
8. フルニトラゼパム	290 (24.0%)	54 (24.9%) ⑥	21 (28.0%) ②
9. プロチゾラム	269 (22.2%)	49 (22.6%) ⑦	21 (28.0%) ②
10. エチゾラム	238 (19.7%)	38 (17.5%) ⑫	29 (38.7%) ①

* 便宜上, 精神科医における選好順位を示した。
丸囲みの数字は薬剤師, 当事者・家族における選好順位を示した。
薬品名に剤形に関する断りのないものはすべて経口薬である。

Table 5: Preference rankings for anxiolytics and hypnotics (Top 10)

Preference ranking* / Psychiatrists (n=1,210) / Pharmacists (n=217) / Patients and their families (n=75)

1. Lorazepam	533 (44.0%) / 115 (53.0%)② / 16 (21.3%)⑤
2. Lemborexant	502 (41.5%) / 134 (61.8%)① / 11 (14.7%)⑧
3. Diazepam	378 (31.2%) / 87 (40.1%)④ / 10 (13.3%)⑩
4. Diazepam IM/IV preparations	346 (28.6%) / 45 (20.7%)⑧ / 3 (4.0%)⑰
5. Eszopiclone	344 (28.4%) / 101 (46.5%)③ / 13 (17.3%)⑦
6. Zolpidem	310 (25.6%) / 64 (29.5%)⑤ / 19 (25.3%)④
7. Alprazolam	309 (25.5%) / 45 (20.7%)⑧ / 10 (13.3%)⑩
8. Flunitrazepam	290 (24.0%) / 54 (24.9%)⑥ / 21 (28.0%)②
9. Brotizolam	269 (22.2%) / 49 (22.6%)⑦ / 21 (28.0%)②
10. Etizolam	238 (19.7%) / 38 (17.5%)⑫ / 29 (38.7%)①

*For convenience, preference rankings among psychiatrists are shown. Numbers in circles indicate preference rankings among pharmacists and patients and their families. All drugs without dosage form specifications are oral medications.

表6 その他の向精神薬の選好順位（第10位まで）

選好順位*	精神科医 (n=1,210)	薬剤師 (n=217)	当事者・家族 (n=42)
1. ピペリデン	522 (43.1%)	103 (47.5%) ②	10 (23.8%) ③
2. レベチラセタム	481 (39.8%)	112 (51.6%) ①	2 (4.8%) ⑭
3. アトモキセチン	367 (30.3%)	70 (32.3%) ③	13 (31.0%) ①
4. メチルフェニデート徐放剤	310 (25.6%)	47 (21.7%) ⑥	12 (28.6%) ②
5. ドネペジル	299 (24.7%)	55 (25.3%) ④	4 (9.5%) ⑦
6. メマンチン	252 (20.8%)	43 (19.8%) ⑧	2 (4.8%) ⑭
7. ジアゼパム坐剤	177 (14.6%)	52 (24.0%) ⑤	5 (11.9%) ⑤
8. グアンファシン	170 (14.0%)	27 (12.4%) ⑨	5 (11.9%) ⑤
9. ピペリデン筋注製剤	153 (12.6%)	9 (4.1%) ⑫	1 (2.4%) ⑰
10. フェニトイン静注製剤	119 (9.8%)	15 (6.9%) ⑮	1 (2.4%) ⑰

* 便宜上、精神科医における選好順位を示した。

丸囲みの数字は薬剤師、当事者・家族における選好順位を示した。

薬品名に剤形に関する断りのないものはすべて経口薬である。

Table 6: Preference rankings for other psychotropic drugs (Top 10)

Preference Ranking* / Psychiatrists (n=1,210) / Pharmacists (n=217) / Patients and their families (n=42)

1. Biperiden	522 (43.1%) / 103 (47.5%)② / 10 (23.8%)③
2. Levetiracetam	481 (39.8%) / 112 (51.6%)① / 2 (4.8%)⑭
3. Atomoxetine	367 (30.3%) / 70 (32.3%)③ / 13 (31.0%)①
4. Methylphenidate extended-release	310 (25.6%) / 47 (21.7%)⑥ / 12 (28.6%)②
5. Donepezil	299 (24.7%) / 55 (25.3%)④ / 4 (9.5%)⑦
6. Memantine	252 (20.8%) / 43 (19.8%)⑧ / 2 (4.8%)⑭
7. Diazepam suppositories	177 (14.6%) / 52 (24.0%)⑤ / 5 (11.9%)⑤
8. Guanfacine	170 (14.0%) / 27 (12.4%)⑨ / 5 (11.9%)⑤
9. Biperiden intramuscular injection	153 (12.6%) / 9 (4.1%) / 1 (2.4%)⑰
10. Phenytoin intravenous preparation	119 (9.8%) / 15 (6.9%)⑮ / 1 (2.4%)⑰

*For convenience, preference rankings among psychiatrists are shown. Numbers in circles indicate preference rankings among pharmacists and patients and their families. All drug names without dosage form specifications refer to oral medications.

**表7 医療用医薬品の安定確保策に関する関係者会議より
安定確保医薬品として提案されている向精神薬リ
スト (2022年3月25日現在)**

- カテゴリー A (最も優先して取組を行う安定確保医薬品)
 - ・ミダゾラム
- カテゴリー B (優先して取組を行う安定確保医薬品)
 - ・ジアゼパム坐剤, 抱水クロラール坐剤
- カテゴリー C (安定確保医薬品)
 - ・ゾルピデム, ニトラゼパム, フェノバルビタール, ロラゼパム, アセチルフェネトライド, エトスクシミド, エトトイン, ガバペンチン, カルバマゼピン, クロナゼパム, クロバザム, スチリペントール, スルチアム, ゾニサミド, トピラマート, トリメタジオン, バルプロ酸ナトリウム, ピガパトリン, フェニトイン, プリミドン, ペランパネル, ラコサミド, ラモトリギン, ルフィナミド, レベチラセタム, カベルゴリン, レポドパ, アリピプラゾール, エスシタロプラム, グアンファシン, クエチアピン, デュロキセチン, ミルタザピン, メチルフェニデート徐放剤, リスペリドン, 炭酸リチウム, ラメルテオン

* 下線を付した 10 種類は日本精神神経学会の提案による。

Table 7: List of psychotropics that require stable supply proposed by the stakeholder meeting on measures for stable supply of prescription drugs (as of March 25, 2022)

Category A (Psychotropics that Require Stable Supply with Highest Priority)

- Midazolam

Category B (Psychotropics that Require Stable Supply with Priority)

- Diazepam suppositories, chloral hydrate suppositories

Category C (Psychotropics that require stable supply)

- Zolpidem, Nitrazepam, Phenobarbital, Lorazepam, Acetylphenothiazide, Ethosuximide, Ethotoin, Gabapentin, Carbamazepine, Clonazepam, Clobazam, Stilipentol, Sulthiam, Zonisamide, Topiramate, Trimethadione, Sodium valproate, Vigabatrin, Phenytoin, Primidone, Perampanel, Lacosamide, Lamotrigine, Rufinamide, Levetiracetam, Cabergoline, Levodopa, Aripiprazole, Escitalopram, Guanfacine, Quetiapine, Duloxetine, Mirtazapine, Methylphenidate extended-release, Risperidone, Lithium Carbonate, Ramelteon

*The 10 types underlined are based on the proposal by the Japanese Society of Psychiatry and Neurology.

**表 8 第 4 回投票結果：向精神薬の選好
順位（第 10 位まで：n=129）**

1. リスペリドン	110 (85.3%)
2. パルプロ酸ナトリウム	107 (82.9%)
3. 炭酸リチウム	95 (73.6%)
4. アリピプラゾール	87 (67.4%)
5. ロラゼパム	77 (59.7%)
6. ミルタザピン	76 (58.9%)
7. レンボレキサント	69 (53.5%)
8. オランザピン	64 (49.6%)
9. エスシタロプラム	61 (47.3%)
10. クエチアピン	59 (45.7%)

表中の向精神薬はすべて経口薬である。

Table 8: Fourth voting results: Preference rankings for psychotropic drugs (Top 10: n=129)

1. Risperidone	110 (85.3%)
2. Sodium valproate	107 (82.9%)
3. Lithium carbonate	95 (73.6%)
4. Aripiprazole	87 (67.4%)
5. Lorazepam	77 (59.7%)
6. Mirtazapine	76 (58.9%)
7. Lemborexant	69 (53.5%)
8. Olanzapine	64 (49.6%)
9. Escitalopram	61 (47.3%)
10. Quetiapine	59 (45.7%)

All psychotropic drugs listed in the table are oral medications.