SHARED CARE GUIDELINE – ATYPICAL ANTIPSYCHOTICS (Including RISPERIDONE LONG ACTING INJECTION - LAI)

<table>
<tr><td>Introduction</td><td colspan="2">Amisulpride, Aripiprazole, Olanzapine, Quetiapine and Risperidone (all oral) and Risperidone LAI are currently approved for use in Cumbria under shared care arrangements. “First generation” (typical) antipsychotics are also approved for use, including depot formulations, but not subject to shared care. Monitoring requirements in Appendix 1 apply to all antipsychotics regardless of “class” or prescribing status.</td></tr>
<tr><td></td><td>Contact Details:

Consultant: _____

Care Co-ordinator: _____

Location: _____

Contact number: _____

Date: _____</td><td>Patient Identifier:

RNN number: _____

NHS number: _____

Surname: _____

Forename/s: _____

Date of Birth: _____

CareFirst number: _____</td></tr>
<tr><td>Details of medication</td><td colspan="2">Antipsychotic prescribed _____see supporting letter for further details (e.g., switching from previous therapy)

If “off-label” use, state diagnosis_____

Date started (if during in-patient admission or commenced by secondary care):

_____/_____/_____</td></tr>
<tr><td>Introduction</td><td colspan="2">Indication: Antipsychotics are indicated for schizophrenia, bipolar disorder. Refer to SPCs for individual licensed indications.

Patients with severe mental illness taking antipsychotics are at risk of cardiometabolic syndrome. The objective of this shared care guideline is to ensure appropriate screening for these risks and provide guidance for active intervention. Physical health monitoring is recommended for all patients with severe mental illness on antipsychotics.

“Off-label” uses – antipsychotics may also be recommended by specialists for non-licensed uses, e.g., treatment of psychotic illness other than in bipolar and schizophrenia, e.g., augmentation of depression, learning disabilities. Many off-label (non-licensed) uses are common in psychiatry. Use of antipsychotics supported by a respected body of medical opinion for example Maudsley guidelines, NICE, are approved by Cumbria Partnership NHS Foundation Trust, where Royal College of Psychiatrists guidance on “off-label” prescribing is followed. Shared care may be requested for these patients.</td></tr>
<tr><td>Dose & Administration</td><td colspan="2">Refer to BNF.</td></tr>
<tr><td>Secondary Care Responsibilities</td><td colspan="2">1. Decision to start/change antipsychotic.

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

• metabolic (including weight gain and diabetes)</td></tr>
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- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QTc interval)
- hormonal (including increasing prolactin)
- other (including unpleasant subjective experiences)

3. Provide written and verbal information. Medication leaflets and metabolic syndrome leaflets available on Choice and Medication website:

   http://www.choiceandmedication.org/cumbria/

4. Check past medical history and drug history for cautions, contra-indications and potential drug interactions. Contact GP for summary if necessary, or access SCR/MIG if available.
5. Baseline tests, including ECG if needed (see Appendix 1). To be undertaken by and results checked by specialist in secondary care, copy results to GP if out-patient.
6. Repeat baseline monitoring when new antipsychotic prescribed (not applicable to dose or formulation changes, e.g., oral to injection).
7. Inform primary care of reason for off-label use (see details of medication section above).
8. If clinically necessary and immediate start required, prescribe up to first 3 months (using FP10s) for the following:
   - first episode patients
   - re-initiation if patient has stopped treatment
   - concomitant use in depression or other co-morbidities
9. Commence prescription at lower end of licensed range and slowly titrate upwards.
10. If switching antipsychotic from a previous treatment, provide clear description of the switching regime to be prescribed (timings and dosages). Use trust approved standard format letter.
11. Prescribe lowest cost alternative as first choice, e.g., immediate release formulation, if modified release is substantially greater cost.
12. Prescribe long-acting injection for minimum 3 months to enable stable dose to be achieved, prior to requesting GP to continue prescription.
13. Justify, record and communicate reasons for dosages outside the BNF/SPC range, including if combination antipsychotic dose is >100% BNF dose (record additional monitoring in secondary care for >100%BNF max).
14. Record and communicate rationale for continuing or changing medication and effects of these changes.
15. Record and communicate to GP risk/benefit decision if prescribing with other medications known to increase risk of QTc prolongation (e.g., concomitant citalopram, escitalopram or others affecting QTc interval) (example lists: http://www.ggcprescribing.org.uk/media/uploads/ps_extra/pse_21.pdf http://www.gpnotebook.co.uk/simplepage.cfm?ID=-315293656)
16. Counsel patient on action to minimise weight gain.
17. Follow-up monitoring as Appendix 1 up to and including 12 months check, to be arranged by care co-ordinator, checked by specialist.
18. Review regularly during initiation for response to new treatment, side-effects and to ensure completion of switching from previous therapy. All measurements/ results recorded in secondary care to be also copied to GP.
19. Inform primary care if adverse results for glucose, lipids. Consider if alternative antipsychotic would be appropriate.

	20. Maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the condition has stabilised, whichever is longer. 21. Follow-up any significant changes including increased weight gain – refer to Appendix 2. 22. Inform primary care of changes in care co-ordinator. 23. Care co-ordinator to encourage/accompany to attendance at annual health check with GP if patient not attended when invited. 24. Stop the treatment if no longer considered appropriate, recording rationale. 25. On discharge from secondary services the discharge care plan to specify planned duration of medication and if and when a secondary care medication review should be requested by primary care. (Shared care no longer applies after discharge from secondary care services – monitoring of physical health and prescribing are at discretion of primary care). Consider if discharge appropriate if off-label use.
Primary Care Responsibilities	1. Provide the specialist with patient details of past medical history and latest medication list, if not available via SCR or MIG. 2. Inform specialist if there are any new contra-indications/cautions to the use of the medication. 3. Initiate or continue prescribing and titrate dose as recommended by specialist. 4. Prescribe adjustments of dose and cross-titrations as recommended by specialist. 5. Provide physical health interventions if screening in secondary care indicates (see Appendix 2 "Don't just screen - Intervene" tool). 6. Outcome and results from Annual check to be copied to care co-ordinator. 7. Inform care co-ordinator if patient does not attend annual check after 3 requests. 8. Inform care co-ordinator of any problems, for referral to specialist if appropriate. 9. If patient discharged from secondary care services, record primary care decision regarding prescribing and further physical health checks (shared care not applicable after discharge from secondary care).
Monitoring Requirements	SEE Appendix 1 SEE Appendix 2 Positive Cardiometabolic Health Resource – an intervention framework for patients with psychosis on antipsychotic medication – Lester UK adaptation – "Don't just screen-Intervene" tool.
Adverse Effects	Common side-effects: weight gain, dizziness, postural hypotension (especially during initiation), hyperglycaemia, diabetes, extra-pyramidal symptoms Refer to SPC www.medicines.org.uk and BNF for side-effects with specific drugs.
Common Drug Interactions	Refer to SPC www.medicines.org.uk and BNF.
Contraindications	Refer to SPC www.medicines.org.uk and BNF.

Further Information	Refs: BNF Positive Cardiometabolic Health resource – an intervention framework for patients with psychosis on antipsychotic medication – Lester UK adaptation: http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx NICE CG 178 February 2014 Psychosis and schizophrenia in adults: treatment and management
This guidance does not replace the SPC's, which should be read in conjunction with this document.	

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APPENDIX 1

Monitoring requirements for adult patients prescribed antipsychotics

		Responsibility			
		Secondary care			Primary care
Test/ Measurement	**Why is it important?**	**Baseline**	**3 months**	**12 months**	**Annually**
Weight, waist measurement, BMI (Plot on chart)	Antipsychotic drugs can cause weight gain and this can contribute to an increased risk of cardiovascular and metabolic problems.	✓	✓	✓	✓
		***Weight - weekly for first 6 weeks (on chart). Waist circumference annually**			
Nutritional status, diet, level of physical activity	Antipsychotic drugs can cause weight gain	✓		Clinical decision	Clinical decision
Blood Pressure (sitting/lying and standing) **Pulse**	Hypotension is a side effect of many antipsychotics and it is important to monitor this during periods of initiation and stabilisation. Longer term it is important to monitor and manage factors that influence a patients CV risk.	✓	✓	✓	✓
Blood Glucose, HbA1c (fasting sample if possible)	Antipsychotics can increase the risk of developing diabetes.	✓	✓	✓	✓
Lipids (Total cholesterol, HDL cholesterol, Total/ HDL-cholesterol ratio, Triglycerides – (fasting sample if possible)	Some antipsychotics can cause small adverse changes in lipid profiles. Triglyceride levels can rise during periods of weight gain.	✓	✓	✓	✓
Liver function (Bilirubin, Alk Phos, ALT, Albumin, Total protein, Gamma-GT)	Patients with hepatic impairment may have reduced capacity to metabolise drugs and dose reductions may be required. Drug induced liver damage can be due to direct dose related hepatotoxicity or hypersensitivity reactions. Risk factors for hepatotoxicity include – increased age, female gender, alcohol, prescribed enzyme inducing drugs, obesity.	✓		✓ *(not required for amisulpride or sulpiride)*	Clinical decision

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		Responsibility			
		Secondary care			Primary care
Full Blood Count (Hb, WBC, Platelets)	BNF – advises caution when using antipsychotics in patients with blood dyscrasias. Antipsychotics can cause blood dyscrasias including agranulocytosis and leucopenia. SPC Olanzapine recommends FBC if prescribed valproate concomitantly.	✓		✓	Clinical decision
Renal function	Routine monitoring	✓		✓	Clinical decision
ECG (QTc Interval)	Many antipsychotics are associated with ECG changes and some are linked to prolongation of the QTc interval. In the community, ECGs should be offered as below, at baseline (secondary care responsibility). Clinical decision to offer follow up and annual ECGs depending on clinical history, new medication etc. • Patients on antipsychotics requiring ECG monitoring (annual and at dose changes– all patients on haloperidol, pimozide, sertindole) • Physical examination identifies specific cardiovascular risk (e.g., diagnosis of hypertension) • If there is a personal history of cardiovascular disease (e.g., – known ischaemic / structural heart disease QTc prolongation). • If a patient is on other drugs known to cause ECG abnormalities (refer to BNF or table to estimate risk) • On high dose antipsychotic therapy (HDAT) – every 1-3 months in early stages of high-dose therapy • Any other clinically appropriate reason All inpatients should have an ECG on admission ECG QTc result: <440ms (men), <470ms (women): no action unless other abnormalities >440ms(men), >470ms (women), <500ms : consider reduction in dose or switch to drug of lower risk >500ms : stop suspected causative drug(s), switch to drug of lower risk http://www.rcpsych.ac.uk/PDF/10%20Natarajan%20and%20Mahalingappa%20IC2012.pdf (slide 50;and advice on ECGs in high dose –slide 47)				
Prolactin	Antipsychotics can increase prolactin levels. This can inhibit sex hormones – oestrogen and testosterone - and increase may risk of osteoporosis.	✓		✓	✓
Review of the side effects of drug treatment, response and adherence	Before treatment the side effects the patient is most willing to tolerate should be assessed. Link to patient information and comparison charts: http://www.cumbriapartnership.nhs.uk/your-medication.htm Record indications and expected benefits and risks of antipsychotic, and expected timescale for change in symptoms and appearance of side-effects. Record reasons for using dosages outside BNF /SPC range.	✓	✓	✓ (Secondary care responsibility at 6-12 month reviews)	✓ (Secondary care responsibility at 6-12 month reviews)

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		Responsibility			
		Secondary care			Primary care
	Record rationale for changing or stopping medication and effects of changes. On review the response to treatment, adherence and side effects experienced should be assessed including: • Extrapyramidal symptoms, akathisia, dystonia and tardive dyskinesia • Common side-effects e.g. – sedation • Impact on functioning • *Less common but serious adverse effects e.g. palpitations.* Trust recommended side-effect rating scale – Glasgow Antipsychotic Side-effect Scale – GASS				
References	1. Maudsley Prescribing Guidelines 2011, BNF 66 September 2013 2. SPC of individual medicines, available at www.medicines.org.uk 3. NICE CG178 – Psychosis and schizophrenia in adults: treatment and management. February 2014 4. Royal College of Psychiatrists Consensus Statement on high dose antipsychotic prescribing May 2006 5. Lester UK Adaptation Positive Cardiometabolic Health Resource – http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive Cardiometabolic Health chart- website.pdf 6. Choice and medication – Medicines information leaflets and comparison charts 7. http://www.cumbriapartnership.nhs.uk/your-medication.htm				

Appendix 2 –The Positive Cardiometabolic Health Resource (the Lester UK adaption) may be downloaded here