Dorset Medicines Advisory Group

SHARED CARE GUIDELINES FOR PRESCRIBING ATYPICAL ANTIPSYCHOTICS IN ADULTS AND OLDER PERSONS IN SCHIZOPHRENIA AND RELATED PSYCHOSES

INTRODUCTION

Within the "traffic light" system Amisulpiride, Aripiprazole, Olanzapine, Quetiapine and Risperidone have been classified as amber for the treatment of schizophrenia and related psychoses.

NICE Guidance CG178: The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees.

The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements

GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in [Appendix A] and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes

AREAS OF RESPONSIBILITY FOR SHARED CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of atypical antipsychotics in schizophrenia and related psychoses can be shared between the specialist and general practitioner (GP). GPs are invited to participate. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable.

Sharing of care assumes communication between the specialist, GP and patient. The intention to share care is usually explained to the patient by the doctor initiating treatment. It is important that patients are consulted about treatment and are in agreement with it.

The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Specialist Responsibilities	
1	To provide specialist assessment and determine a management strategy and ensure a care plan has been arranged.
2	Where appropriate: • to initiate and stabilise treatment • obtain agreement from the patient's GP to continue prescribing once treatment has been stabilised; • monitor the patient and their therapy as clinically appropriate.
3	To ensure that baseline monitoring is carried out. Refer to 'quick reference monitoring guide' at the end of the document.
4	To ensure the choice of antipsychotic drug be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of the drugs and their side effects. The individual's advocate or carer should be consulted where appropriate. If there is more than one first-

	line option of atypical antipsychotic the drug with the lowest purchase cost should be considered.
5	To provide the GP with appropriate prescribing information within the care plan and any additional information requested in conjunction with the CMHT. A copy of the care plan should be sent to the GP.
6	To be available for advice if the patient's condition changes.
7	To ensure the patient has given informed consent to their treatment.
8	To provide the patient's therapy and prescriptions until their dose and mental state have been stabilised.
9	To obtain agreement from the patient's GP for the transfer of prescribing or management responsibility.
10	To notify the GP of any changes in prescribed therapy or clinical status and ensure that the patient has sufficient medication until the GP has received this notification.
11	To provide adequate advice in writing about the proposed duration and dose of any ongoing treatment in all cases where the patient is discharged from secondary care on maintenance treatment. Procedures should be in place for the rapid re-referral of the patient by the GP if required.
12	To provide advice and specific information about the drug treatment. Product Information Leaflets are available at the point of dispensing.
13	The identified care co-ordinator in the care plan will have the primary responsibility for discussing the care plan with the patient.

General Practitioner Responsibilities	
1	Initially, to refer the patient for specialist advice, (see notes above). Patients presenting with acute psychosis (in particular first onset cases) should be prioritised for urgent assessment and treatment in secondary care.
2	To review the patient in accordance with the patient's care plan.
3	To re-refer the patient or seek specialist advice from the Psychiatrist or CMHT in accordance with the patient's care plan or at such a time as is necessary.
4	To deal with general health issues of the patient and provide routine physical health checks – monitor increased risk of cardiovascular disease and promote healthy lifestyle. Be aware of neurological, metabolic and endocrine side effects including hyperlipidaemia, hyperglycaemia and weight gain.
5	To prescribe maintenance psychotropic and general therapy when this has been agreed with the CMHT.
6	Monitoring concordance with therapy in partnership with the CMHT. Particular care should be taken in establishing arrangements for obtaining repeat prescriptions.
7	To notify the specialist of any relevant changes in other medications or clinical status.

Patient's role (or that of carer)	
1	To take the medication regularly and enter a concordant relationship with those involved in the delivery of their care.
2	Report any adverse effects to their GP/specialist service nurse whilst taking the medication.
3	To ensure they have a clear understanding of their treatment.
4	Attend appropriate GP and other follow up appointments
5	Share any concerns in relation to treatment with their GP or Consultant.
6	Use written and other information on the medication.
7	Seek help urgently if suspect side effects, or otherwise unwell.

SUPPORTING INFORMATION

Dose and Administration

Refer to BNF regarding individual atypical agents and attached guidance on titration

Standards for the use of atypical antipsychotics in schizophrenia and related psychoses

- Atypical antipsychotics for continuous or maintenance phase treatment should only be initiated by a Consultant Psychiatrist or appropriate specialist
- Patients must be given the opportunity to make an informed decision about choice of therapy whenever possible and this process should be recorded in the patient's notes. The use of advanced directives should be developed and documented.
- **Where more than one atypical is appropriate, the drug with the lowest purchase cost should be prescribed. If an alternative is prescribed the rationale should be documented and shared with the GP**.
- Atypical antipsychotics should be prescribed as sole antipsychotic except:
  - ✓ When switching from one drug to another, when there may be overlap
  - ✓ Acute exacerbation in a stable patient. Where patients are normally stable on a depot typical neuroleptic or a dose of an oral typical close to the threshold for producing severe side effects, an atypical may be temporarily added. However, this should be monitored regularly over the period of re-stabilisation which will not usually exceed 12 weeks. Where it is not possible to either withdraw the additional atypical or upwardly adjust the dose of typical, a switch to an atypical alone should be considered.
  - ✓ Intensive care situations where rapid sedation is desirable and local policies include them as a treatment option.
  - ✓ Patients who are non-responders to clozapine or for whom clozapine is not an option (e.g. as a result of haematological side effects).
- Patients managed on a combination of a typical and atypical antipsychotic must be under direct consultant supervision and the reason for such usage clearly documented in the patient's notes
- The lowest possible effective dose should be used, with patients being given a sufficient trial on low doses before further dose increases. Special caution should be taken in elderly patients. All increases in dosage should be fully documented in the patient's notes. BNF recommended doses should not normally be exceeded and, if they are, the reason **must** be documented in the patient's notes, and the guidance from the Royal College of Psychiatrists followed
- An adequate trial of the medication (optimum dose for a minimum of 6-8 weeks) must be given and any response must be regularly monitored and recorded in the patient's notes
- Patients unresponsive to adequate trials of two antipsychotics, one of which should be an atypical, should be considered for a trial of clozapine.
- Oral treatment should be monitored according to the guidelines for monitoring antipsychotics **(Appendix A)**
- Depot atypical therapy must only be used in conjunction with locally agreed guidelines and protocols

Use in Caution in the following patients

- Patients with Dementia
- Patients with prolonged QT interval on ECG, hypokalemia, low magnesium, metabolic disorders, concomitant use of drugs which prolong QT interval (NB: applies also to many typical antipsychotics and tricyclic antidepressants).
- In the elderly, where starting doses should be lower and dosage titration should be slower, with careful monitoring for side effects.
- Diabetes. Predisposition to diabetes.

The manufacturer's summary of product characteristics (SPC) and the most current edition of the British National Formulary should be consulted for full information on contra-indications, warnings, side-effects and drug interactions.

QUICK REFERENCE GUIDE

Baseline	Following initiation	From 12 months
Weight	Weekly for 6 weeks then at 12 weeks	Annually
Waist	-	Annually
BP and Pulse	at 12 weeks	Annually
ECG if symptomatic, family history or SPC recommends	If symptomatic	Annually if symptomatic
Lipids	At 12 weeks	Annually
Glucose – fasting and HbA_{1c}	At 12 weeks	Annually
Prolactin	-	Annually
Overall physical health	Regularly and systematically throughout treatment	

References

1. NICE Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia (TA 43) June 2002 superseded by NICE CG178 published Sep 2014
2. Atypical Antipsychotics and Stroke. CEM/CMO/2004/1 Circular. Committee of the Safety of Medicines. March 2004.
3. British National Formulary. September 2007.
4. Kent and Medway NHS Guidelines for the use of atypical antipsychotics in schizophrenia and related psychoses. January 2004.

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Appendix A: Detailed Guidance on Monitoring Patients on Atypical Antipsychotics

The key to safe prescribing of these drugs and maximisation for opportunities for health promotion and reduction of secondary morbidity with patients with a severe and enduring mental illness revolves around clinical rather than laboratory assessment of the patient. The use of broad side effect rating scales such as the LUNSERS is recommended. Further clinical or laboratory investigation can then be arranged as appropriate.

Apart from the LUNSERS, probably the most useful investigation is weight, especially given the complex relationship between weight and other physical problems, particularly glucose tolerance and blood pressure.

Patients with a severe and enduring mental illness often smoke, have poor nutritional habits and take little exercise. Routine assessment of drug side effects presents an opportunity for holistic approach to patient care and often has the benefit of improving patient/clinician relationship.

Drug / Area of concern			Clozapine (red drug - prescribed and monitored in secondary care)	Olanzapine	Risperidone	Aripiprazole	Amisulpride	Quetiapine
	Investigation							
Weight gain	**Weight**	**Level of concern**	**+++**	**+++**	**+**	**+**	**+**	**+**
		Baseline action	**weight waist**	**weight Waist**	**Weight Waist**	**Weight Waist**	**Weight Waist**	**weight Waist**
		Monitoring	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist - annually**	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist – annually**	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist – annually**	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist – annually**	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist – annually**	**Wt – wkly for 6wks, at 12wks, 1yr and annually Waist - annually**
		Intervention	**Advise/monitor appropriately if patients experience weight gain**	**Advise/monitor appropriately if patients experience weight gain**	**Advise/monitor appropriately if patients experience weight gain**	**Advise/monitor appropriately if patients experience weight gain**	**Advise/monitor appropriately if patients experience weight gain**	**Advise/monitor appropriately if patients experience weight gain**
Diabetes	**Blood glucose**	**Level of concern**	**+++**	**+++**	**+**	**+**	**+**	**+**
		Baseline action	**fasting blood glucose History HbA_{1c}**	**fasting blood glucose History HbA_{1c}**	**fasting blood glucose History HbA_{1c}**	**fasting blood glucose History HbA_{1c}**	**fasting blood glucose History HbA_{1c}**	**fasting blood glucose History HbA_{1c}**
		Monitoring	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**
		Intervention	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**
Hyperlipidaemia	**[Cholesterol, LDL, HDL, Triglycerides]**	**Level of concern**	**+++**	**+++?**	**+**	**+**	**+**	**+**
* PH IHD, FH IHD		**Baseline action**	**Full screen History ***	**Full screen History**	**Full screen History**	**Full screen History**	**Full screen History**	**Full screen History**

		Monitoring	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**	**At 12weeks, 1 year then annually or if suggestive symptoms**
		Intervention	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**	**If outside N range**
Cardiac Effects	**BP, Pulse and ECG**	**Level of concern**	**+++**	**+**	**+**	**+**	**+**	**+**
*FHx premature death, congenital long QT, PHx cardiac problems, SPC recommendation		**Baseline action**	**History * Pulse Blood pressure**	**History * Pulse Blood pressure**	**History * Pulse Blood pressure**	**History * Pulse Blood pressure**	**History * Pulse Blood pressure**	**History * Pulse Blood pressure**
*chest pain, syncope, palpitations, fatigue dyspnoea, PUO, tachypnoea, oedema		**Monitoring**	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***	**Pulse and Blood pressure – 12wks then 1yr then annually ECG If suggestive symptoms ***
		Intervention	**Urgent assessment for myocarditis**	**Appropriate to findings**	**Appropriate to findings**	**Appropriate to findings**	**Appropriate to findings**	**Appropriate to findings**
Hyperprolactinaemia	**[Prolactin]**	**Level of concern**	**+**	**+**	**++/+++**	**+?**	**++**	**+**
		Baseline action	**History level**	**History level**	**History level**	**History level**	**History level**	**History level**
*Menstrual/libido changes, galactorrhoea, gynaecomastia		**Monitoring**	**If suggestive symptoms***	**If suggestive symptoms**	**If suggestive symptoms**	**If suggestive symptoms**	**If suggestive symptoms**	**If suggestive symptoms**
		Intervention	**? dose reduction/ drug swap**	**? dose reduction/ drug swap**	**? dose reduction/ drug swap**	**? dose reduction/ drug swap**	**? dose reduction/ drug swap**	**? dose reduction/ drug swap**
Bone marrow suppression	**FBC**	**Level of concern**	**+++**	**+**	**+**	**+**	**+**	**+**
*H/O anaemia, SOB, palpitations, CCF, tachycardia		**Baseline action**	**As per SMPC**	**History***	**History***	**History***	**History***	**History***
*change in exercise tolerance, sore throat, PUO, stomatitis, lymphadenopathy		**Monitoring**	**As per SMPC**	**Annual History***	**Annual History***	**Annual History***	**Annual History***	**Annual History***
		Intervention	**As per SMPC**	**FBC; stop if neutrophils <1..5**	**FBC; stop if neutrophils <1..5**	**FBC; stop if neutrophils <1..5**	**FBC; stop if neutrophils <1..5**	**FBC; stop if neutrophils <1..5**
Seizures	**EEG**	**Level of concern**	**+++**	**+**	**+**	**+**	**+**	**+**
*PH FH seizures		**Baseline action**	**History***	**History***	**History***	**History***	**History***	**History***
*seizures		**Monitoring**	**History***	**History***	**History***	**History***	**History***	**History***

myoclonus								
		Intervention	**EEG +/- valproate +/- referral**	**EEG**	**EEG**	**EEG**	**EEG**	**EEG**
Motor side effects	**Examination**	**Level of concern**	**+**	**+**	**++**	**+?**	**++**	**+**
* rigidity, tremor, akathisia, dyskinesia		**Baseline action**	**AIMS/ examination***	**AIMS/ examination**	**AIMS/ examination**	**AIMS/ examination**	**AIMS/ examination**	**AIMS/ examination**
* rigidity, tremor, akathisia, dyskinesia		**Monitoring**	**At dose change; patient complaint or clinician observation*; annually**	**At dose change; patient complaint or clinician observation; annually**	**At dose change; patient complaint or clinician observation; annually**	**At dose change; patient complaint or clinician observation; annually**	**At dose change; patient complaint or clinician observation; annually**	**At dose change; patient complaint or clinician observation; annually**
		Intervention	Dose change, drug swap or other appropriate	Dose change, drug swap or other appropriate	Dose change, drug swap or other appropriate	Dose change, drug swap or other appropriate	Dose change, drug swap or other appropriate	**Dose change, drug swap or other appropriate**