Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

NHS
Doncaster
Clinical Commissioning Group

Guidance for the Management of Oral Antipsychotics

V1.0

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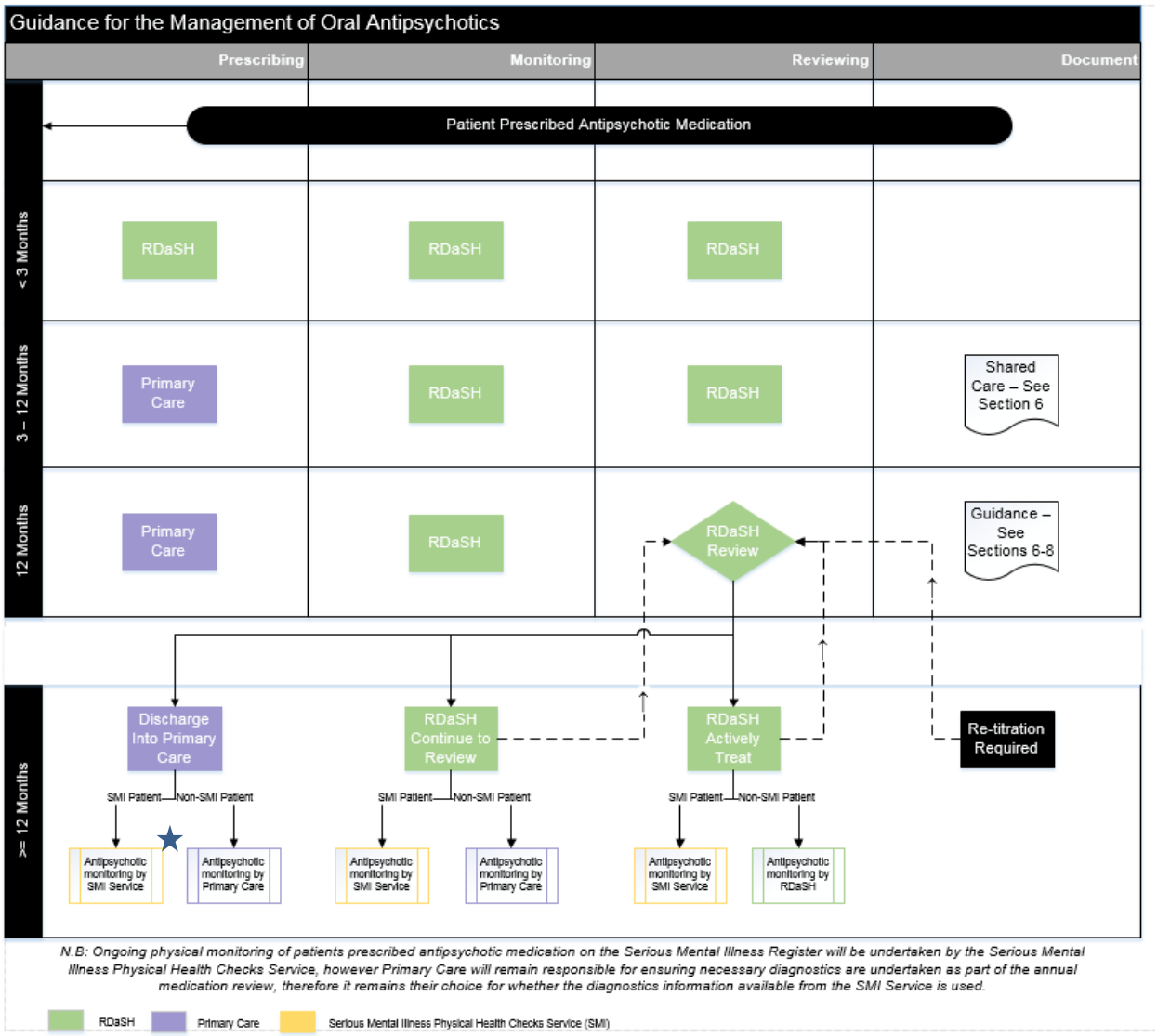
1. EXECUTIVE SUMMARY

This document sets out guidelines for the assessment and treatment of patients who are prescribed antipsychotics and delineated responsibilities when care for the patient is to be shared between Primary Care and Specialist Services.

It is acknowledged that the detail contained within this document may need to be supplemented by personal dialogue between clinicians.

This document is intended to be used when an antipsychotic has been prescribed for mental health uses, and treatment has been initiated by mental health services. If the antipsychotic is intended to be used for other purposes, this document is not appropriate.

The following diagram provides an overall outline for the management of oral antipsychotic medication.



★A small number of patients fall outside this guidance and should be considered on an individual basis. This guidance will be updated to include these patients in due course.

2. INTRODUCTION

This document is intended to provide clear guidance to General Practitioners (GPs) and hospital prescribers regarding the procedures to be adopted when clinical (and therefore prescribing and financial) responsibility for a patient's treatment is transferred from secondary to primary care.

GPs, as independent contractors, have the right to decline to take clinical and prescribing responsibilities for a patient on their medical list who is being treated elsewhere. However the reason for this action must be documented. In the view of the Doncaster & Bassetlaw APC, it would be the exception for a GP to refuse to take clinical and prescribing responsibilities for an individual drug, where guidelines include adequate support, education, and information as approved by the Doncaster & Bassetlaw APC.

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

Traffic light system classification

Clinicians should refer to the Doncaster Traffic Light System on the CCG Medicines Management Website (http://medicinesmanagement.doncasterccg.nhs.uk/tls/) for the current classification of individual antipsychotics; however a summary is outlined below.

	Traffic light system classification			
Drug Class	**Green[G]**	**Amber-G[AG]** Patient on SMI register	**Amber[A]** Patient NOT on SMI register	**Red[R]**
Antipsychotics		Chlorpromazine Flupentixol Promazine Sulpiride Trifluoperazine Zuclopenthixol Benperidol Haloperidol Levomepromazine Prochlorperazine Pericyazine Pimozide		
Atypical Antipsychotics		Amisulpiride Aripiprazole Olanzapine Quetiapine Risperidone Paliperidone		Clozapine Lurasidone Cariprazine All non-oral antipsychotic formulations

Amber G (AG) – Antipsychotics used in the management of patients on the SMI register* will be initiated in secondary care:

- Prescribing will remain with secondary care until the dose is stable and seen to be effective (generally about 3 months) at which stage primary care will be asked to prescribe
- Relevant monitoring will remain with secondary care up to and including the first annual check, at which stage it will pass to primary care, for suitable patients and may be completed in the SMI service
- Secondary care will ensure an annual review for any patient continuing under their active care

Amber (A) – Antipsychotics used in the management of patients NOT on the SMI register* will be initiated in secondary care

- Prescribing will remain with secondary care until the dose is stable and seen to be effective (generally about 3 months) at which stage primary care will be asked to prescribe
- Relevant monitoring will remain with secondary care up to and including the first annual check, at which stage it will pass to primary care, for suitable patients but ongoing monitoring will need to be completed by GP practices
- Secondary care will ensure an annual review for any patient continuing under their active care

Red (R) – Prescribing initiated and retained by specialist – Prescribing monitoring performed in secondary care

*The SMI register should consist of all the people who have a recorded diagnosis of schizophrenia, bipolar affective disorder or other long term psychotic illness. In respect of coding for QoF SMI disease registers the following diagnostic read codes have been used to define this cohort:

- Schizophrenia Eu20
- Schizotypal personality Eu21
- Persistent delusional disorder Eu22
- Acute/transient psychotic disorders Eu23
- Induced delusional disorder Eu24
- Schizoaffective disorders Eu25
- Manic episodes Eu30
- Bipolar disorder Eu31
- Severe depression with psychosis Eu323
- Non-organic psychosis E1 (and all subsets)

3. DEFINITION

Antipsychotic drugs are also known as ‘neuroleptics’ and (misleadingly) as ‘major tranquillisers’. Antipsychotic drugs generally tranquilise without impairing consciousness and without causing paradoxical excitement but they should not be regarded merely as tranquilisers. For conditions such as schizophrenia the tranquilising effect is of secondary importance.

In the short term they are used to calm disturbed patients whatever the underlying psychopathology, which may be schizophrenia, brain damage, mania, toxic delirium, or agitated depression. Antipsychotic drugs are used to alleviate severe anxiety but this too should be a short-term measure.

Antipsychotic drugs are considered to act by interfering with dopaminergic transmission in the brain by blocking dopamine D_2 receptors, which may give rise to the extrapyramidal effects, and also to hyperprolactinaemia. Antipsychotic drugs may also affect cholinergic, alpha-adrenergic, histaminergic, and serotonergic receptors.

4. BACKGROUND INFORMATION

a. National Institute for Health and Care Excellence

Within both hospital and community settings, antipsychotic medicines remain the primary treatment for schizophrenia. There is well-established evidence for their efficacy in both the treatment of acute psychotic episodes and relapse prevention over time.

Antipsychotics are usually prescribed within the recommended Summary of Product Characteristics dosage range, and there is little evidence to support the use of higher dosage or combination with another antipsychotic if monotherapy proves to be ineffective. Antipsychotics are also used in combination with a range of other classes of drugs, such as anticonvulsants, mood stabilisers, anticholinergics, antidepressants and benzodiazepines.

In first-episode or early schizophrenia (including people with a recent onset of schizophrenia and people who have never been treated with antipsychotic medication), the evidence suggested there were no clinically significant differences in efficacy between the antipsychotic drugs.

b. Indications for use

This guidance includes, but is not restricted to the treatment of patients with antipsychotics and their corresponding licensed indications.

Schizophrenia

Schizophrenia is one of the terms used to describe a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behaviour. Individuals who develop schizophrenia will each have their own unique combination of symptoms and experiences, the precise pattern of which will be influenced by their particular circumstances.

Bipolar Disorder

Please refer to Lithium Shared Care document and Anti-Epileptic medications in the management of Bipolar Amber-G guidance document if being used for this indication.

Bipolar Disorder, also known as manic-depressive illness, is a serious medical illness that causes shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe.

Bipolar disorder causes dramatic mood swings from overly "high" and/or irritable to sad and hopeless, and then back again, often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood. The periods of highs and lows are called episodes of mania and depression.

Dementia

Please refer to Dementia Shared Care documentation and BPSD (Behavioural and Psychological Symptoms in Dementia) if being used for this indication. All are available on http://medicinesmanagement.doncasterccg.nhs.uk/

Dementia is a decline in mental ability which affects memory, thinking, problem-solving, concentration and perception. Dementia is almost invariably a disease of ageing. About 1 in 20 people over the age of 65 are affected, and 1 in 5 people over the age of 80. Dementia in people under 65 is known as early onset or pre-senile dementia and is rare, affecting under 1 in 1000.

Dementia occurs as a result of the death of brain cells or damage in parts of the brain that deal with our thought processes. The most common form of dementia is Alzheimer's disease. We do not know what causes Alzheimer's disease but we do know that ageing seems to be a factor. The second most common type of dementia is vascular or multi-infarct dementia. This occurs as a result of lack of blood and oxygen to the brain in a series of tiny 'strokes'.

Augmentation of Antidepressant in Resistant Depression

Resistant or refractory depression is difficult to treat successfully and requires a flexible approach with responses to a particular treatment option not readily predicted by pharmacology or previous treatments. While quetiapine is the only antipsychotic licenced for this use, The Maudsley Prescribing Guidelines in Psychiatry list olanzapine, quetiapine, risperidone and aripiprazole as potential first choice additions in resistant depression.

Learning Disability Key Points

People with learning disabilities are more prone to common psychiatric illness's such as schizophrenia and bipolar illness. Other accepted indications for antipsychotics will be for challenging behaviours in those with developmental disorders in those with learning disability, where other non pharmacological interventions have failed to control the symptoms adequately.

For more specific guidance on challenging behaviour refer to the current Frith Guidelines, Maudsely and NICE guidelines and secondary care

In these instances the treatment will have been initiated and stabilised by secondary care, and before asking for shared care. A clear treatment plan including indication, advice on if dose adjustment is reasonable, when and how treatment will be reviewed by secondary care.

Valid consent can be an issue in LD where in people lacking the ability to consent, this treatment is given in best Interest of the patient under Section 5 of Mental Capacity Act, or this decision is taken by the LPA holder)

Specific considerations for LD

- People with LD are more susceptible to side effects, detection of which is harder than in the general population, typical antipsychotics may be better tolerated.
- Information should be in LD Easy Read Information forms
- Patients with LD are likely to be more sensitive to side effcts, so a slower titration and final dose may be required.
- They may require a longer period of treatment to assess proper response.
- Risk of interactions may be higher in people with LD on polypharmacy, especially those on Anti-epileptic medication.
- People with LD with comorbid conditions and/or polypharmacy may require more frequent monitoring.

Expected duration. If the treatment is long term then the physical health monitoring will be in line with the management of schizophrenia.

General reasons for contacting secondary care outside of routine review or patient specific guidance include:

- Lack of efficacy
- Intolerable side effects

- Significant interactions with newly prescribed medication
- New or changes to co-morbid illness which may impact on medication.

Emotionally Unstable Personality Disorder (Borderline Personality Disorder)

Borderline personality disorder (BPD) is common in psychiatric settings, with a reported prevalence of up to 20%. In BPD, individuals have an increased vulnerability to all mental illness; specifically co-morbid depression, anxiety spectrum disorders and bipolar illness which occurs more frequently than would be expected by chance association alone, and the lifetime risk of having at least one co-morbid mental disorder approaches 100%.

Although it is classified as a personality disorder, it is increasingly recognised to be, in part, an affective disorder and the stress/vulnerability model is particularly relevant to exacerbation of the disorder and presentation to health services. Several symptoms of BPD may intuitively be expected to respond to drug treatment (including affective instability, transient stress related psychotic symptoms, suicidal and self- harming behaviours and impulsivity). While no drug is specifically licensed for the treatment of BPD there is an increasing body of evidence for the use of second generation antipsychotics and mood stabilisers.

Three independent systematic reviews have been published. NICE guidance claims evidence is not sufficiently robust to support a recommendation of **routine** use of drug treatment for BPD or the individual symptoms/behaviours of the disorder, although they may be considered in the overall treatment of co-morbidities. The two further review's analysis concludes that the evidence was sufficiently robust to inform clinical practice.

However, the two year review published in 2011 by NICE reported that "new evidence on pharmacological therapies for patients with borderline personality disorder show some drugs as being clinically effective". This is supported by a Cochrane review and "several ongoing trials focusing on upon efficacy and safety of olanzapine and quetiapine, and the use of lamotrigine in patients with affective instability".

Although this evidence is not considered robust enough to amend the guidelines of 2009, some stakeholders feel this is a viable adjunct to care.

Any proposal for transferring care with respect to the use of antipsychotics for the treatment of BPD will be part of a personal communication between consultant and GP prior to submission of the relevant proforma.

c. Side Effects

People's sensitivity and response to drugs varies enormously. One person may be able to tolerate standard doses with no significant side effects, while someone else may find the same dose has intolerable results.

Examples of side effects which may occur as a result of taking antipsychotics:

- **Neuromuscular effects** – e.g. parkinsonism, loss of movement (akinesia), restlessness (akathisia) and muscle spasms/dystonia
- **Sexual side effects** – e.g. breast development in men, drop in sexual desire, impotence, erection and ejaculation problems, loss of periods
- **Antimuscarinic or anticholinergic effects** – e.g. drowsiness, dry mouth, blurred vision, dizziness, constipation, feeling nauseous
- **Disturbances in heart rhythm**
- **Sedation**

- **Eye problems** – e.g. blurred vision, difficulty reading, degeneration of retina, glaucoma
- **Metabolic syndrome** – e.g. diabetes, weight gain and obesity, high BP, high cholesterol
- **Agranulocytosis**
- **Other physical effects** – e.g. Liver disorders, skin problems, unsettled body temperature
- **Emotional effects** – e.g. Excitement, agitation, aggression, depression, disturbed sleep

d. Side Effect Control

Adherence with antipsychotic medication is perhaps the main determinant of relapse in schizophrenia. The tolerability or experience of side effects of a particular antipsychotic medication has been regarded as both one of the key factors predicting continued adherence and crucially the experience of adverse antipsychotic side effects is commonly stated by patients as an important reason for non-adherence. This highlights the importance of an open and systematic discussion regarding medication-related side effects, as an acknowledgement of the risks as well as benefits of a particular treatment help to establish a collaborative approach between clinicians and service users and contribute to a therapeutic rapport. Antipsychotic side-effect rating scales have been used over the years to help identify and quantify the various side effects that can occur on these medications.

The Glasgow Antipsychotic Side Effect Scale (GASS) was developed in 2008 following a literature review, discussion with members of Glasgow mental health teams and feedback from service users. The scale is designed to allow a timely, sensitive and reliable method of gathering information on the number and severity of side effects an individual suffers from. The Scale and information for practitioners on how to use is included as Appendix 1.

5. TREATMENT

a. Non-Drug Treatment

NICE Clinical Guideline 178 for Psychosis and Schizophrenia February 2014 includes information on psychological therapies and psychosocial intervention evidence reviews on the following suggested non-drug treatments:

- Cognitive–behavioural therapy
- Cognitive remediation
- Counselling and supportive psychotherapy
- Family intervention
- Psychodynamic and psychoanalytic therapies
- Psychoeducation
- Social skills training

b. Drug Treatment

For contraindications or further information please see

- the current BNF (https://www.medicinescomplete.com/mc/bnf/current/) or
- summary of product characteristics for the individual drug (http://www.medicines.org.uk/)

6. ANTIPSYCHOTIC MONITORING

The table below identifies the responsibility for the physical health monitoring associated with the ongoing prescribing of Antipsychotics:

Timeframe	Patient Group	Responsibility for Monitoring
0 – 12 Months	All patients	RDaSH – Communicate results to Primary Care via clinical letter
12 Month + or patients discharged from Secondary Care	Patients on SMI register	Primary care via SMI service – results made available in GP record N.B: Ongoing physical monitoring of patients prescribed antipsychotic medication on the Serious Mental Illness Register (SMI) will be undertaken by the SMI Physical Health Checks Service, however Primary Care will remain responsible for ensuring necessary diagnostics (as detailed in Appendix 2) are undertaken as part of the annual medication review, therefore it remains their choice for whether the diagnostics information available from the SMI Service is used. The Serious Mental Illness Service Pathway is provided at Appendix 3.
	Patients not on SMI	Primary Care in line with Appendix 1 & 2 of this Guide.

7. WHERE A PATIENT'S CARE IS SHARED

There will be a period of time between the GP assuming the responsibility for prescribing and the point where a patient is discharged, when a patient's care is shared between primary and secondary care. At this point aspects of care will be transferred from secondary care to primary care.

This section describes the responsibilities of primary and secondary care at each stage of the journey and sets out the communication expected between providers at the point of transfer.

Responsibility for the follow-up and management of test results lies with the clinician who orders the test result or on whose behalf those tests are done.

a. Aspects of care for which Secondary Care Team is responsible

- Diagnosis and assessment

- Check that proposed therapy is not contra-indicated because of concurrent therapy for other conditions the patient may be suffering from e.g. check drug-contraindications and drug-interactions. Contact specialist team if possible interactions found.
- Initiation and stabilisation of drug therapy, usually but not exceptionally, a period of 3 months.
- Patient/ family education
- Provide patient with appropriate information regarding treatment. https://www.choiceandmedication.org/rdash/ A positive decision to continue treatment should be communicated to the GP in writing, providing relevant details.
- Ensure patient is fully informed of, and engaged with the treatment plan.
- If the patient lacks mental capacity in this area then ensure that information is shared, if this is deemed to be in the best interests of the patient (Mental Capacity Act 2005)
- Ensure that Trust policy regarding informed consent is followed
- Provide a comprehensive treatment package in addition to medications including appropriate information/monitoring sheet(s)
- Ensure that shared care arrangements are in place before transfer of treatment (for non-SMI patients)
    - That the patient/carer is clear what is being monitored and by whom
    - That the patient knows what significant adverse effects/events to report urgently and to whom they should report (specialist)
    - Following review the GP should be written to if there is any medication or clinical changes, any concerns regarding the mental health or clinical status or to raise awareness of any clinical abnormalities.
    - If the patient is stable, and no changes are made during the review then the minimum frequency for a letter to be sent to the GP is once in a 12 month period.
- Extra monitoring needed for dose changes will be organised by specialist team and conveyed to patient.
- Engagement and agreement with the GP regarding the management of tests and results, when clarification is required.
- Monitor side effects of medication.
- Monitor patient's response to treatment
- Provision of an accessible advisory service to the GP in regard to individual patient clinical queries raised by the GP:
    - For the Adult Mental Health service the preferred method of communication for **routine** (Monday to Friday) queries is by telephone to the principal managing team.
    - A record of the advice provided in a telephone discussion can be provided to the GP, should they wish to receive a copy. This will be done by sending a copy of the medical notes made by the RDASH FT Clinician.

      A further option for routine (Monday to Friday) queries is via the following nhs.net email account:
      rdash.psychiatristadvice@nhs.net
      Receipt of emails are acknowledged within 48hours, prioritised and forwarded to the relevant team.
- Report adverse events to the MHRA

b. Aspects of care for which Primary Care Team is responsible

- Ensure that prescribing and monitoring arrangements are in place to support the transfer of treatment.
- When the patient's treatment is stable and the specialist wishes to transfer the treatment to primary care, **respond to the request for transfer of treatment and monitoring as soon as practicable (for Amber arrangement only i.e. non-SMI patient)**
- Check that proposed therapy is not contra-indicated because of concurrent therapy for other conditions the patient may be suffering from e.g. check drug-contraindications and drug-interactions. Contact specialist team if possible interactions found.
- Monitor treatment as stated in this guidance liaising with specialist service if further clarification is required
- Amend prescription as per requests from secondary care for dose changes in patients on established treatment (dose changes would typically occur within the first 12 months of antipsychotic intiiation)
- Be aware of which changes in parameters should trigger urgent referral back to the specialist
- Seek specialist advice promptly if signs/symptoms of changes occur
    a. Report adverse events to the MHRA if the drug has a black triangle status or is unlicensed, all events should be reported even if causal relationship is not known or if the adverse event is already known about
- Report adverse events to the consultant
    a. Stop treatment on advice of specialist, or immediately if intolerable side effects occur provided that it is safer to do so than to continue this therapy

C. Patient (or Carer's) Responsibilities

- Discuss potential benefits and side effects of treatment with the specialist and to raise any outstanding queries
- Check that where possible the specialists have provided a patient-held record or information sheet for monitoring and/or to alert other clinical staff to the treatment they are receiving
- Share any concerns they have in relation to treatment with the medicine
- Report any adverse effects to their specialist or GP whilst taking the medicine
- Report to the specialist if they do not have a clear understanding of their treatment
- Participate in the monitoring of therapy and the assessment of outcomes, to assist health professionals to provide safe, appropriate treatment

Communication

For prescribing of antipsychotics for patients on the SMI register: The specialist will write to the GP upon stabilisation of the patient's antipsychotic, for the GP to take over the prescribing of the antipsychotic and the monitoring arrangement of the antipsychotic as per SMI service specification.

For prescribing of antipsychotics for patients NOT on the SMI register: The specialist will request in writing the GP to accept prescribing and/or monitoring responsibility in line with Section 1 of this guidance.

For both the cohorts above, the said communication from the specialist to the GP should include as a minimum:

- Diagnostic assessment and full details of the prescribing regime
- Copy of the crisis and contingency plan
- Results from the most recent Physical Health Screening, including most recent GASS
- link to this guidance.

The patient will be asked to make arrangements with their GP for continued supply.

8. DISCHARGE INTO PRIMARY CARE

The following section outlines the processes to be adopted when discharging patients who are prescribed antipsychotic medication to primary care services.

a. Procedure

i. Decision to Discharge

The decision to discharge a patient to primary care services must be agreed by the multi-disciplinary team; as a minimum this will include the Care Coordinator/Lead Professional, Prescriber, Consultant Psychiatrist/Nurse Consultant, and Team Manager.

ii. Criteria for Discharge

All patients considered for discharge must meet the following criteria:

- Has capacity and is consenting to treatment
- Not experienced a relapse of a psychotic nature during the last 12 months
- Stable on current medication
- Prescribing is within BNF limits
- Is appropriate for a 12 month review cycle. (May have been subject to a 6 month review cycle for cluster purpose only)

iii. Contacting Primary Care Pre-Discharge

RDASH employees are to contact Primary Care directly to discuss the patient discharge.

Contacting Primary Care will be the responsibility of the most appropriate clinician; to be determined by their knowledge of the patient. This will include:

- Consultant Psychiatrist
- Junior Doctor
- Nurse Prescriber

Primary Care will be invited to contribute to discharge planning. Discharge planning may take a number of different formats, including but not limited to, meetings, telephone calls, Skype and written correspondence.

iv. Physical Health and Antipsychotic Monitoring

Prior to discharge, patients must receive appropriate health screening in line with the RDaSH ‘At a Glance: Monitoring of Antipsychotics’ (Appendix 2). Monitoring must have been completed within the 3 months prior to discharge.

v. Discharge Paperwork

The following information as a minimum will be provided to Primary Care on discharge:

- Discharge Summary
- Crisis and Contingency Plan (EPR Care Plan)
- Physical Health Screening Tool results including GASS
- Antipsychotic Monitoring Guidance (Appendix 2)

b. Primary Care Management

i. Reviews

Primary Care should use the Antipsychotic Monitoring Guidance (Appendix 2) to inform their reviews.

ii. Advice

When a patient presents to Primary Care for advice regarding prescribing or with deteriorating mental health, Primary Care should follow the guidance detailed in the SMI service specification (Appendix 3).

iii. Additional Support Requirements

Where Primary Care requires additional support/advice, the following processes should be followed:

Timeframe	Primary Care Action	Secondary Care Action
Up to 6 months' post discharge	Contact the team previously responsible for the patient (contact details available in Crisis and Contingency Plan).	Direct call to appropriate clinician or via the duty system make reasonable attempts to contact the GP the same working day.
After 6 months' or out of hours (after 5pm)	Contact the Doncaster SPA. Email rdash.psychiatristadvice@nhs.net	Direct accordingly.

iv. Re-referral to RDaSH Secondary Mental Health Services

When a GP consultation indicates that the patient requires additional support from Secondary Mental Health Services the referral should articulate the rational and impression of risk to enable an appropriate response.

Reasons are likely to include however are not limited to:

- Patient mental health deteriorates to the point where a review/change of medication is required

- Risk (directly linked to the patients Mental Health) has escalated requiring intervention from Secondary Mental Health Services

Timeframe/Presentation	Primary Care Action	Secondary Care Action
Crisis	Contact the Doncaster SPA.	Direct accordingly.
Up to 6 months' post discharge	For prescribing advice, the Band 7 Nurse Prescriber within the SMI Physical Health Checks Service should be contacted. For re-referral, contact the Doncaster SPA.	
After 6 months' or out of hours (after 5pm)		

v. Out of Area Patients*

Patients registering with a Doncaster GP who are already prescribed antipsychotic medication by another GP should continue to have medication prescribed in this way; however where a GP has concerns regarding prescribing it is reasonable that they approach RDaSH for advice.

This request should be made to the Access and Liaison Team via the Doncaster SPA or email to rdash.psychiatristadvice@nhs.net

In particular complex cases it may be appropriate that the GP refer to RDaSH via the Doncaster SPA to undertake a review of the patient's medication.

The outcome of the review will determine who accepts on-going responsibility for the patient.

- If none to minor changes are made to the patient's medication (and the patients mental health is stable) then prescribing will remain with the GP.
- If a change of medication or significant dose changes are made then the patient will remain with RDaSH for the purpose of titration, stabilisation and monitoring.

Arrangements for discharge to the GP will only be made when clinically appropriate, and in line with the guidance detailed in this protocol.

*A small number of patients fall outside this guidance and should be considered on an individual basis. This guidance will be updated to include these patients in due course.

9. REFERENCES

- NICE Clinical Guideline 178: Psychosis and schizophrenia in adults: treatment and management Full Guideline February 2014
- A new self-rating scale for detecting atypical or second-generation antipsychotic side effects **-** L. Waddell and M. Taylor *J Psychopharmacol* 2008; 22; 238 DOI: 10.1177/0269881107087976
- Making sense of antipsychotics booklet: MIND (http://www.mind.org.uk)

- Scottish Medicines Consortium no 549/09 Quetiapine (Seroquel) for major depressive episodes associated with bipolar disorder
- http://www.nimh.nih.gov
- http://www.mentalhealth.org.uk

10. SHARED CARE GUIDANCE DEVELOPMENT

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APPENDIX 1

Glasgow Antipsychotic Side-effect Scale (GASS)

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication. Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Also tick the end or last box if you found that the side effect was distressing for you.

Over the past week:	*Never*	*Once*	*A few times*	*Every day*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					
9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **Men only:** I have had problems getting an erection					

Tick yes or no** for the **last three months	*No*	*Yes*	*Tick this box if distressing*
21. **Women only**: I have noticed a change in my periods			
22. **Men and women**: I have been gaining weight			

Staff Information (for interpreting GASS questionnaire)

1. Allow the patient to fill in the questionnaire themselves. All questions relate to the previous week.

2. Scoring for questions 1-20

Patient answer	Points
Never	0
Once	1
A few times	2
Every day	3

Scoring for questions 21-22

Patient answer	Points
No	0
Yes	3

Total for all questions =

3. For male and female patients a score of:

   0-21 absent/mild side effects

   22-42 moderate side effects

   43-63 severe side effects

4. Side effects covered include:

Question	Parameter
1-2	sedation and CNS side effects
3-4	cardiovascular side effects
5-10	extra pyramidal side effects
11-13	anticholinergic side effects
14	gastro-intestinal side effects
15	genitourinary side effects
16	screening question for diabetes mellitus
17-21	prolactinaemic side effects
22	weight gain

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

APPENDIX 2

AT A GLANCE

V3.0 D3

MONITORING OF ANTIPSYCHOTICS

GENERAL INFORMATION

1. Diagnosis discussed with patient and appropriate information sheet given as necessary.
2. The choice of antipsychotic considered appropriate for the patient, has been discussed with the patient and / or advocate. This includes advanced plans / directives if available and likely side effects of the specific drugs (see formulary).
3. Written information (http://www.choiceandmedication.org/rdash/) regarding specific antipsychotic given to patient or carer
4. Baseline physical health checks are carried out, recorded and discussed with the patient / carer to specifically include taking cardiac, smoking and alcohol histories
5. Review date to assess efficacy and tolerability made in the diary, and patients treatment plan
6. This guidance is based on results being within normal limits. Tests may need to be repeated more often due to individual clinical indicators.
7. Additional detail is available in the trust formulary and individual drug SPCs
8. Monitoring [not necessarily prescribing]. 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.

CLOZAPINE: Clozapine monitoring schedule covered separately	**MONITORING SCHEDULE**				
	For BASE LINE	At ONE month	At THREE month	At SIX month	At 12 months then annually[1]
Blood pressure[2]	✓		✓		✓
Pulse	✓		✓		✓
Height & Weight[2,3]	✓	✓	✓	✓	✓
Waist circumference[2,3]	✓	✓	✓	✓	✓
Blood Glucose/HbA1c[2,4]	✓	✓	✓		✓
Lipids (preferably fasting)	✓		✓		✓
Renal function (U&E, eGFR)	✓				✓
Full blood count (FBC)	✓				✓
Liver function test (LFT)	✓				✓
TFT (Quetiapine only)	✓				✓
Prolactin[5]	✓			✓	✓
Creatine phosphokinase (CPK)[6]	✓				
Electrocardiogram (ECG)	✓				✓
Side-effects (GASS or like)[2]	✓				✓
Adherence to medication[2]					✓
Overall physical health[2]	✓				✓
Smoking status	✓				✓
Alcohol/ Drug status	✓				✓
Movement disorders[2,7]	✓				✓
Physical Activity[7]	✓				✓
Nutritional status[7]	✓				✓

LEGEND

✓ NICE guidance

✓ + Maudsley guidance

ECG –

Inpatients:
- At baseline for ALL patients on admission
- prior to discharge if there has been a change in treatment.
- when reaching target dose

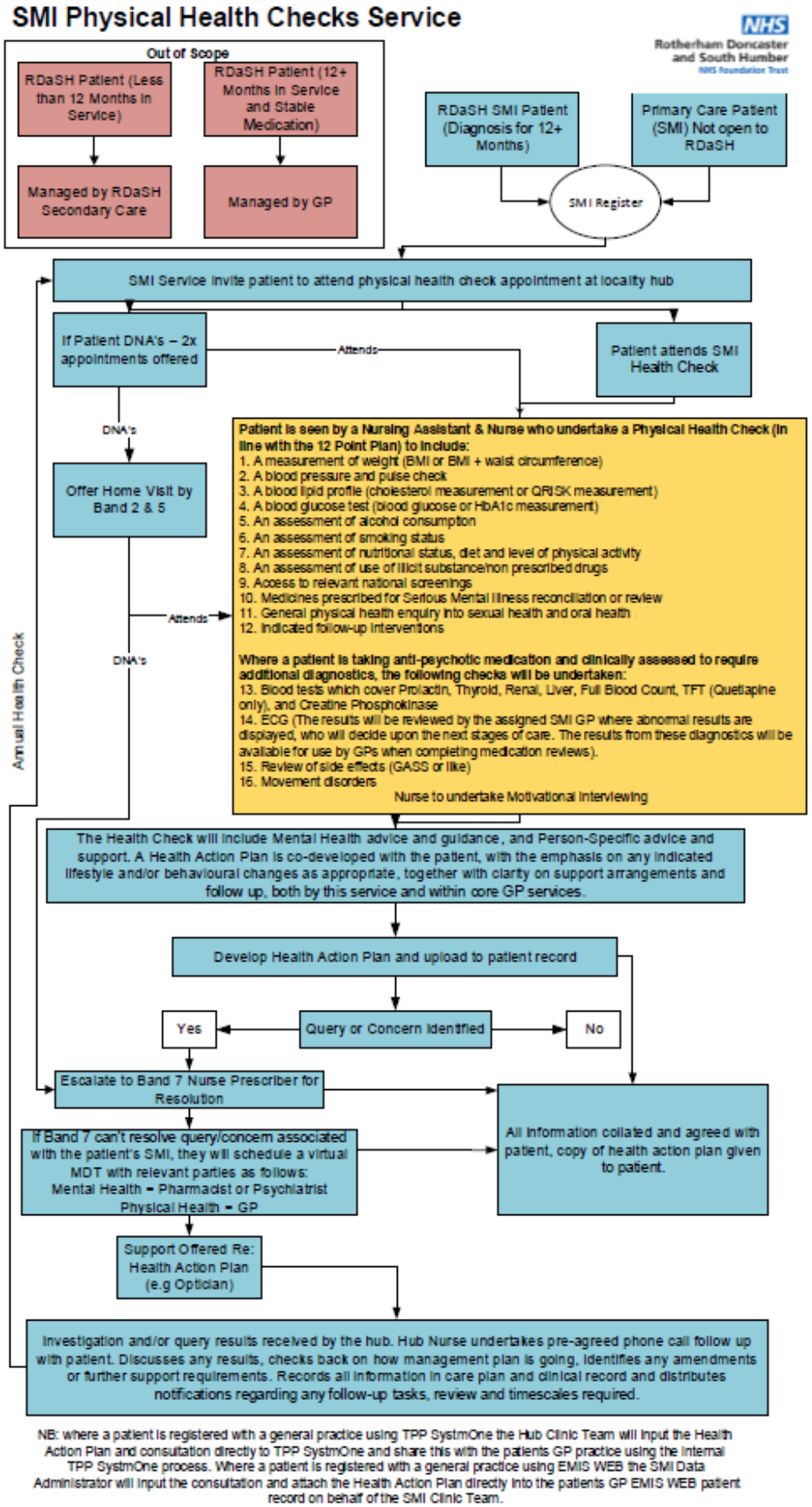
Community Patients:
- patients with a personal history of CVD
- where there is an identified cardiac risk factors
- where specified in the drug's SPC.

1. 'At 12 months then annually' column identifies the monitoring required in primary care as part of shared care or post discharge
2. Monitor and record regularly and systematically throughout treatment, ESPECIALLY THROUGH TITRATION or DRUG CHANGE.
3. Weight should be measured weekly for the first SIX weeks. All weight and waist circumference to be plotted on a chart
4. Blood Glucose – measured as FASTING blood sugar and HbA1c
   particularly important to monitor for olanzapine and clozapine
5. Prolactin – to be repeated at any time if patient is symptomatic
6. CPK – done at baseline and repeated in neuroleptic malignant syndrome (NMS) suspected
7. Movement disorders to be assessed at baseline, levels of physical activity and nutritional status to be used as reference points for further opportunistic assessments (annually as a minimum)

Agreed at RDaSH MMC: [Aug-2019] Review Date: + 2 years

Based on: NICE CG178 Psychosis & Schizophrenia in Adults and Maudsley Prescribing Guidelines in Psychiatry 13th Ed

APPENDIX 3



NB: where a patient is registered with a general practice using TPP SystmOne the Hub Clinic Team will input the Health Action Plan and consultation directly to TPP SystmOne and share this with the patients GP practice using the internal TPP SystmOne process. Where a patient is registered with a general practice using EMIS WEB the SMI Data Administrator will input the consultation and attach the Health Action Plan directly into the patients GP EMIS WEB patient record on behalf of the SMI Clinic Team.