Greater Manchester West NHS
Mental Health NHS Foundation Trust

SHARED CARE PROTOCOL for ATYPICAL ANTIPSYCHOTICS	**Reference Number MMG, GMW, CLINICAL GUIDELINE – MMG5**	
SCOPE **Greater Manchester West Mental health NHS Foundation trust** **Bolton Primary Care Trust** **Salford Primary Care Trust** **Trafford Primary Care Trusts**	**Classification** **SHARED CARE PROTOCOL**	
Issue Date **SEPTEMBER 2010**	**Updated MMG,GMW,CLINICAL GUIDELINE 5**	
Author(s) Originator(s) **Joan Miller, MMG GMW Mental Health NHS Foundation Trust** **Peter Haddad, MMG, GMW** **Margaret Campbell, MMG, GMW** **Thanks to Dr Adrian Heald Consultant Endocrinologist,Tom Tasker GPwSI Mental Health NHS Salford**		
To be read in conjunction with the following documents	**BNF ,SPC,NICE Guidelines**	
Authorised by **MMG, GMW Mental Health NHS Foundation Trust**	**Date** **SEPT 2010**	**Review Date** **SEPT 2012**
Authorised by Greater Medicines Management Group	**Date** **MARCH 2011**	

1. Introduction

This shared care protocol covers when atypical antipsychotics are prescribed for the treatment of
(1) Schizophrenia
(2) Bipolar illness
(3) Schizoaffective illness
(4) Psychotic symptoms such as hallucinations, thought disorder, paranoia, delusions , conceptual disorganisation, grandiosity and psychomotor agitation who do not have a diagnosis of schizophrenia or bipolar illness.

(5)For unlicensed indications approved by NICE such as psychotic depression and in significant distressing anxiety in Bipolar disorder where psychological treatment has failed.

See table 1 for Summary of Formulations
See 'Prescribing tool 'on Trust INTRANET on medicines management page for side effects and current costs of antipsychotics. The most cost effective atypical antipsychotic should be prescribed taking into account the side effect profiles, concurrent treatment and co-morbidities. Check GMW prescribing algorithm for schizophrenia before prescribing antipsychotics .The reason for selecting the drug should be recorded in the clinical notes along with the treatment plan.

2. Scope

Support for the use of these drugs comes from:-
NICE Guidance www.nice.org.uk
NICE Guidance Schizophrenia March 2009
NICE Guidance Bipolar Disorder July 2006
NICE Guidance Antenatal and postnatal mental health Feb 2007(reissued April2007)
Olanzapine and Valproate Semisodium in the treatment of acute mania associated with Bipolar 1 disorder, September 2003.
Guidance should be used in conjunction with the BNF and SPC
A.H. Barnett et al. Minimising Metabolic and Cardiovascular Risk in Schizophrenia Diabetes ,Obesity and Dyslipidaemia
J.Psychopharmacology 2007 21: 357 -373

3. Clinical Condition being treated

Clinical condition, licensed indications, formulations, dosage.

TABLE 1 Summary of Licensed Indications, Formulations, Dosage-adult only. For elderly or Child see BNF or SPC.

ATYPICAL	INDICATION	DOSAGE RANGE	FORMULATION
AMISULPRIDE	SCHIZOPHRENIA	Predominately negative symptoms - 50-300mg daily. Acute psychotic episode 400mg –800mg daily in divided doses Max 1.2g daily	TABS SOLUTION
ARIPIPRAZOLE	SCHIZOPHRENIA MANIA in BIPOLAR 1 and prevention of new manic episodes in respondent patients	10mg – 15mg daily Max dose 30mg daily 15mg once daily for initial treatment or recurrence prevention Max 30mg once daily	TABS, Oral Solution, Orodispersible tabs. I/M (rapid control in schizophrenia)
CLOZAPINE USUALLY RED DRUG FOR INFO ONLY	TREATMENT RESISTANT SCHIZOPHRENIA PSYCHOSIS IN PARKINSONS DISEASE	200-450mg daily (max 900mg) 25-37.5mg bedtime max100mg	TABS

OLANZAPINE	SCHIZOPHRENIA, COMBINATION THERAPY FOR MANIA, PREVENTING RECURRENCE IN BIPOLAR DISORDER MANIA (MONOTHERAPY)	5-20mg (max 20mg) 15mg daily adjusted to 5-20mg daily	VELOTABS TABS
QUETIAPINE	SCHIZOPHRENIA MANIA Depressive Symptoms in Bipolar Disorder Preventing Relapse in Bipolar Disorder Add-on treatment of major depressive episodes in patients with Major Depressive Disorder (MDD) who have had sub-optimal response to antidepressant monotherapy .	300-450mg daily Tabs Max 750mg daily XL Max 800mg daily 400 – 800mg daily max 800mg/daily 200mg – 600mg 300-800mg daily 150mg-300mg daily (only XL licensed)	TABS usually twice daily TABS XL once daily
RISPERIDONE	Schizophrenia Manic episodes associated with Bipolar Disorder Short term treatment of persistent aggression in Alzheimer's dementia unresponsive to other approaches.	4-6mg doses above 10mg only if benefit outweighs risk (max 16mg daily) 0.25micrograms twice daily increased as per SPC Max 1mg twice daily	LIQUID QUICKLETS TABS

Mental Health Specialist Services will offer patients atypical antipsychotics usually after assessment. Where there is clear evidence of psychotic symptoms and an individual is refusing to attend secondary care services they may be initiated in primary care.

Specialist Services will provide advice on choice of drug, initiation, titration and monitoring when necessary. Monitoring clinical outcomes and side effects will generally take place in secondary care specialist mental health services.
Physical healthcare monitoring will generally take place in primary care. See section – Regimen Management ,Table 2 and Appendices for local arrangements.

4. Product information and treatment regimen to be used

For information on licenses,doses and formulations see table 1.

For information on side effect profiles , advice and cost see information on GMW Trust INTRANET Medicines Management page.
Where there is a choice of atypical antipsychotic the most cost effective medication should be prescribed,see GMW algorithm for schizophrenia. The reason for selecting the drug should be recorded in the clinical notes along with the treatment plan.

5. Regimen Management

Consultant/Specialist Services Responsibility

a) Perform mental health assessment prior to starting Atypical Antipsychotics.
b) Recommend or perform baseline tests before starting.
These may include: -
1) weight, height (BMI) waist measurement
2) Fasting glucose or random if not possible.
3) Fasting lipid screen or random if not possible
4) BP, pulse
5) ECG if indicated ie. patient on drugs that could prolong QT interval such as tricyclic antidepressants, quinine or patient has cardiac disease.
6) FBC, U&E,LFT,CK,Bone Profile,Prolactin,TFT

If primary care doctors are being asked to undertake the baseline investigations then this will need to be confirmed with the individual G.P. in advance.

'These guidelines are based upon evidence regarding the best practice for prescribing antipsychotic medication. However, in clinical practice, especially when patients are acutely unwell, it may be difficult to adhere to the recommendations at that time. Clinicians therefore need to carefully weigh the risks and benefits of expedient decisions, record the reasons for their actions and remedial plans.'

7) Good practice will usually indicate that patients receiving these types of medication within secondary care will be managed under CPA, especially if this is a new or emerging illness. CPA requires that all aspects of care, physical as well as psychological, should be planned (often with other agencies), documented and communicated. Secondary Care prescribers therefore will need to be familiar with CPA policy guidance. A copy of the CPA should be sent to the GP including the medication treatment plan.

TABLE2 Recommendations for initial evaluation and ongoing monitoring in patients on antipsychotics

	Initial visit[#]	4 weeks *	8 weeks *	12 weeks	6 months	12 months	Annually thereafter
Personal/family history of diabetes	X					X	X
BMI = Weight/[†]Height^2	X	X	X	X	X	X	X
Waist circumference (cm)	X	X	X	X	X	X	X
Blood pressure	X	X	X	X	X	X	X
Fasting blood glucose[‡] (repeat if abnormal)	X	X	X	X	X	X	X
Fasting lipid profile in patients >40yrs or FH of hyperlipidaemia	X				X	X	X
Prolactin	X					X	X
Renal, LFTs, Bone	X				X	X	X
Creatine kinase	X				X	X	X

* Measurement at these timepoints is desirable but not always practical

[#] Some assessments may not be possible at initial evaluation. Clinical judgement should be used to establish which evaluations can be carried out at a later date

† Measurement of height only required at initial visit

‡ Random blood glucose levels are acceptable in patients for whom fasting blood tests are impractical

Adapted from Barnett et al, Br J Psychopharmacology May 2007

GP Responsibilities See Appendix 2 for Local Agreement with PCT

6. For Cautions ,Contraindications and full list of side effects see BNF/SPC . For comparison of side effects see Table3

TABLE 3 Comparison of commonly reported side effects

ATYPICAL	EPS Liability	Effect on Prolactin*	Effect on Weight	Sedation	Potential for postural hypotension	Miscellaneous (for full side effect profile see BNF/SPC)
AMISULPRIDE	+	++	+	--------	----------	Occasionally Bradycardia
ARIPIPRAZOLE	--------- (but mild akathisia in 1st 2 weeks)	----------	+	--------	----------	
CLOZAPINE	---------	----------	+++	+++	+	Impaired glucose tolerance Diabetes Mellitus Hypertriglyceridaema Constipation, Tachycardia. Can rarely cause myocarditis and cardiomyopathy. FBC monitoring mandatory.
OLANZAPINE	+ at higher doses	+	+++	++	----------	Impaired glucose tolerance Diabetes Mellitus Rarely Tachycardia Hypertriglyceridaemia
QUETIAPINE	----------	----------	+	+	+	Hypertriglyceridaemia higher Cholesterol reduced Thyroid Hormone concentrate
RISPERIDONE	+	++	+	+?	+	Tachycardia

------- Absent
\+ Low
++ Moderate
+++ High

*Prolactin levels can be increased and cause: - gynaecomastia, galactorrhea, sexual dysfunction, amenorrhoea and oligoamenorrhea

Sustained increased Prolactin may lead to hypogonadism, which may cause decreased bone density. Patients with schizophrenia have a rate of Type 2 Diabetes that is 2 to 4 times that in the general population. Poor diet, lack of exercise and medication may be part of or add to this risk.

7. Special Considerations

Not Applicable.

8. <u>Back-up care available to GP from Hospital, including emergency contact procedures and help line numbers.</u>

Salford CMHT	Cromwell House	Tel	0161 787 6000
	Ramsgate House		0161 708 9512
	Prescott House		0161 702 9368

GMW Switchboard for Out of Hours	0161 773 9121
Trafford CMHT	0161 912 3891
Trafford South	0161 929 5159
Bolton CMHT North	01204463250
Bolton CMHT South	01204337550

9. <u>Statement of Agreement between GP and Consultant</u>.

This form is a request by the Consultant to share the suggested care pathway of your patient. If you are unable to agree to the sharing of care and initiating the suggested medication, please make this known to the Consultant within 14 days, ideally stating nature of your concern.

10. <u>Written information provided to patient</u>

Leaflet provided by specialist services if available, otherwise package inserts.

APPENDIX 1

Greater Manchester West NHS
Mental Health NHS Foundation Trust

REFFERAL FORM FROM CONSULTANT PSYCHIATRIST TO GP
SHARED CARE PROTOCOL for ATYPICAL ANTIPSYCHOTICS

From: (Name of Consultant Psychiatrist)	**To:** (Name of GP)
Name of GP practice:	

Name of Patient:		**Date of Birth:**				
NHS Number:		**Diagnosis:**				
Medication prescribed by Consultant Psychiatrist:						
Baseline Tests performed:	BMI	**Yes**		**No**		
	Waist Circumference	**Yes**		**No**		
	BP	**Yes**		**No**		
	Fasting (or random if not possible) Glucose	**Yes**		**No**		
	Fasting (or random if not possible) Lipids	**Yes**		**No**		
*** Recommended by NICE Guidance for Bipolar**	*FBC	**Yes**		**No**		
	*TFT	**Yes**		**No**		
	*LFT	**Yes**		**No**		
	*U&Es (eGFR)	**Yes**		**No**		
	*Physical health and further investigation if indicated e.g. ECG.	**Yes**		**No**		
	Details:					
If baseline tests are not completed please state why:						
Any abnormal results will be communicated to the GP.						

Name of Care Co-ordinator / CPN	
Telephone Number	

For the Consultant Psychiatrist

I would be grateful if we could adopt the shared care protocol for the above patient prescribed an atypical antipsychotic I accept my responsibilities as outlined in the enclosed SCP			
Signed Consultant Psychiatrist/Senior Clinician		**Date:**	

For the GP

I confirm I have received the SCP for Atypical antipsychotics YES/NO			
I agree to share the care of the above patient prescribed_____.			
I accept my responsibilities as outlined in the enclosed guideline. YES/NO			
Signed GP		**Date:**	

Greater Manchester West NHS
Mental Health NHS Foundation Trust

Salford PCT

GP Responsibility

a. To provide regular prescriptions for atypical antipsychotics as per guidance from specialist services/secondary care, except Clozapine
b. To be aware of the increased risk of diabetes, cardiovascular disease and hyperlipidaemia, in patients who have schizophrenia and/or are receiving regular atypical antipsychotics.
c. Provide health checks according to the following protocol whenever an atypical antipsychotic has been initiated or switched .
    i. Baseline observations i.e. before initiation to be performed by Specialist Mental Health Services **(unless in exceptional circumstances and if discussed and confirmed with GP)**
    ii. 3 month check to include:
        1. BP
        2. BMI ,waist measurement
        3. Fasting blood glucose (random blood glucose acceptable where fasting not possible)
    iii. 6 month check to include:
        1. BP
        2. BMI ,waist measurement
        3. Fasting Lipid profile
        4. Fasting Blood Sugar (random blood glucose acceptable where fasting not possible)
d. To inform specialist services of any physical health problems at the earliest opportunity.
e. If patient suffers any adverse reaction, the GP should liaise with secondary care/specialist services.
f. Perform full blood count if unexplained infection or fever. These drugs rarely cause neutropenia
g. To be aware of Neuroleptic Malignant Syndrome.

Symptoms include: -

Labile blood pressure	extrapyramidal side effects
High temperature	autonomic dysfunction
Rigidity	confusion

This is a rare side effect but the patient needs to be referred to A. & E. immediately for supportive therapy.

h. Annual Physical healthcheck as per QOF or local PCT protocol