

<b>Shared Care Guideline for</b> Typical antipsychotic depots		<b>Reference Number</b>
<b>Author(s)/Originator(s): (please state author name and department)</b>  Dr Seghal MMHSCT Medicines Management Committee		<b>To be read in conjunction with the following documents:</b> Current Summary of Product characteristics ( <a href="http://www.emc.org.uk">http://www.emc.org.uk</a> )  BNF
<b>Date approved by Drug and therapeutics committee: 10<sup>th</sup> September 2013</b>	<b>Review Date: 31<sup>st</sup> November 2016</b>	

<b>1. Licensed Indications</b>	Maintenance of schizophrenia and other psychoses.
<b>2. Therapeutic use &amp; background</b>	<p>Typical antipsychotic depot medication is part of a range of treatment and long-term care available for adults with schizophrenic illness &amp; other psychoses</p> <p>Depot injections are used for maintenance therapy, especially when compliance with oral treatment is unreliable. Evidence points that relapse rates in patients prescribed depots decrease in comparison to oral antipsychotics in the long term <b>(1)</b></p> <p>The management should be initiated by secondary mental health services. Advice should be available should the GP require this once the patient is stepped down to primary care. For some people this may mean continuing out-patient clinics or being under CPA follow up.</p> <p>Only patients initiated in secondary care and deemed to be on a stable maintenance dose of depot should be managed under this policy</p>
<b>3. Contraindications (please note this does not replace the SPC or BNF and should be read in conjunction with it).</b>	<p>Caution is advised in patients with hepatic impairment, renal impairment, cardiovascular disease, Parkinson's disease, epilepsy, prostatic hypertrophy or susceptibility to angle-closure glaucoma.</p> <p>When transferring from oral to depot therapy, dose by mouth should be reduced gradually.</p> <p>-Antipsychotics may be contraindicated in comatose states, CNS depression and phaeochromocytoma. Antipsychotic depot is not advised for use in</p>

	children																																
<b>4. Prescribing in pregnancy and lactation</b>	Pregnancy and breast-feeding: avoid. Discuss with consultant psychiatrist should this occur.																																
<b>5. Dosage regimen includes initiation though this would usually occur within secondary care.</b>	<b>Route of administration</b>	Deep intra-muscular injection																															
	<p><b>Preparations available</b>  Typical Antipsychotic depots include</p> <ul style="list-style-type: none"> <li>a) Haloperidol (as Decanoate)</li> <li>b) Flupentixol Decanoate</li> <li>c) Fluphenazine Decanoate</li> <li>d) Pipotiazine Palmitate</li> <li>e) Zuclopenthixol Decanoate</li> </ul> <p>Typical Depots are long acting. Any adverse effects that result from injections are likely to be long lived. <b>Therefore a small test dose is essential to avoid severe or prolonged adverse effects.</b></p> <p>Guide of doses &amp; frequencies of the depot is in the table below (<b>Additionally, refer to latest BNF and manufacturer's information</b>).</p> <table border="1"> <thead> <tr> <th>Drug</th> <th>Trade name</th> <th>Test dose (mg)</th> <th>Dose range (mg /week)</th> <th>Dosing interval (weeks)</th> </tr> </thead> <tbody> <tr> <td>Flupentixol</td> <td>Depixol</td> <td>20</td> <td>12.5-400</td> <td>2-4</td> </tr> <tr> <td>Fluphenazine</td> <td>Modecate</td> <td>12.5</td> <td>6.25-50</td> <td>2-5</td> </tr> <tr> <td>Haloperidol</td> <td>Haldol</td> <td>50</td> <td>12.5-75</td> <td>4</td> </tr> <tr> <td>Pipotiazine</td> <td>Piportil</td> <td>25</td> <td>12.5-50</td> <td>4</td> </tr> <tr> <td>Zuclopenthixol</td> <td>Clopixol</td> <td>100</td> <td>100-600</td> <td>2-4</td> </tr> </tbody> </table> <p>The test dose is used to gauge the acceptability to the service user of the injection being administered, and to observe for side effects.</p> <p>Begin with the lowest therapeutic dose</p> <p>Rarely, the (nut) oil vehicle used to suspend the drug can lead to systemic reactions (anaphylaxis). Before administration the patient must be assessed, and known allergies detailed.</p> <p>After the test dose an interval of 4 – 10 days is needed before starting titration to maintenance therapy.</p>				Drug	Trade name	Test dose (mg)	Dose range (mg /week)	Dosing interval (weeks)	Flupentixol	Depixol	20	12.5-400	2-4	Fluphenazine	Modecate	12.5	6.25-50	2-5	Haloperidol	Haldol	50	12.5-75	4	Pipotiazine	Piportil	25	12.5-50	4	Zuclopenthixol	Clopixol	100	100-600
Drug	Trade name	Test dose (mg)	Dose range (mg /week)	Dosing interval (weeks)																													
Flupentixol	Depixol	20	12.5-400	2-4																													
Fluphenazine	Modecate	12.5	6.25-50	2-5																													
Haloperidol	Haldol	50	12.5-75	4																													
Pipotiazine	Piportil	25	12.5-50	4																													
Zuclopenthixol	Clopixol	100	100-600	2-4																													

***(Titration involves adjusting dose and assessing response, to ensure the maintenance dose provides maximum therapeutic benefit with minimal side effects).***

All depots can be safely administered at their licensed dosing intervals. There is no evidence to suggest that shortening the dose interval improves efficacy. Moreover, injections are painful, so less frequent administration is desirable.

The 'observation', that some patients deteriorate in the days before the next depot is due, is probably incorrect or misleading. For some hours (or even days for some preparations) plasma levels of antipsychotics continue to fall albeit slowly, after the next injection. Thus patients are more at risk of deterioration immediately after a depot injection, and not before it.

In trials, relapse seems only to occur 3-6 months (or longer) after withdrawing depot therapy; which is roughly the time required to clear steady state drug levels from the body.

**Please prescribe:** dosing will vary considerably between individual patient and preparation. Please prescribe as per secondary care communication.

Is titration required	Yes ✓ by secondary care	No
-----------------------	-------------------------	----

**Adjunctive treatment regime**

Procyclidine or alternative anticholinergic medication may be prescribed if the person is suffering from extra pyramidal side effects.

**Conditions requiring dose reduction**

To be agreed as part of shared care with the consultant psychiatrist. Doses may be reduced if adverse effects occur, but should only be increased after careful assessment over at least one month – preferably longer

**Usual response time**

Attainment of peak plasma levels, therapeutic effect and steady state plasma level are all delayed with depot medication.

**Duration of treatment**

Treatment should be continued as per individual agreement.

**Treatment to be terminated by**

Either GP in conjunction with the specialist or via mental health services.

<p><b>6. Drug Interactions</b></p> <p><i>For a comprehensive list consult the BNF or Summary of Product Characteristics</i></p>	<p>The following drugs may be prescribed: see SPC for full list of interactions and side-effects</p>		
<p><b>7. Adverse drug reactions</b></p> <p><i>For a comprehensive list (including rare and very rare adverse effects), or if significance of possible adverse event uncertain, consult Summary of Product Characteristics or BNF</i></p>	<p><b>Specialist to detail below the action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs.</b></p>		
<p><b>Adverse event</b> System – symptom/sign</p>	<p><b>Action to be taken</b> <small>Include whether drug should be stopped prior to contacting secondary care specialist</small></p>	<p><b>By whom</b></p>	
<p>Extra Pyramidal Symptoms (EPS) such as parkinsonism, acute dystonic reaction, akathisia</p>	<p>If extra pyramidal side effects noted, anticholinergic drugs (e.g. Procyclidine, Orphenadrine) are generally used to reduce the unpleasant symptoms.</p>	<p>GP or specialist.</p>	
<p>tardive dyskinesia</p>	<p>If signs or symptoms of tardive dyskinesia appear, the medication should be reviewed by the psychiatrist to decide on best management i.e. reduction in the dose, or cessation of or alternative antipsychotic</p>	<p>specialist</p>	
<p>autonomic effects, such as blurring of vision, increased intra-ocular pressure, dry mouth and eyes, constipation and urinary retention</p>	<p>Treat symptomatically and consult psychiatrist if problematic</p>	<p>GP and / or specialist</p>	
<p>Seizures</p>	<p>the medication should be reviewed by the psychiatrist</p>	<p>Specialist</p>	
<p>increased prolactin levels</p>	<p>the medication should be reviewed by the psychiatrist</p>	<p>specialist</p>	
<p>sedation</p>	<p>Treat symptomatically and consult psychiatrist if problematic</p>	<p>GP</p>	

	Weight gain	Treat symptomatically and consult psychiatrist if problematic	GP		
	Pain and swelling at injection site	Alternate sites of injection. Review volume prescribed. Ensure correct injection technique. Ask for review of depot	GP / specialist if not resolving		
	<b>The patient should be advised to report any of the following signs or symptoms to their GP without delay:</b> all of the above				
	<b>Other important co morbidities:</b> See SPC and BNF for list of co-morbidities				
	Any adverse reaction to a black triangle drug or serious reaction to an established drug should be reported to the MHRA via the "Yellow Card" scheme.				
<b>8. Baseline investigations</b>	<b>List of investigations / monitoring :</b>  Weight / BMI / waist circumference Lipid profile Blood glucose BP / heart rate U and E. ECG if possible				
<b>9. Ongoing monitoring requirements to be undertaken by GP</b>	<b>Is monitoring required?</b>	<b>Yes: suggested monitoring and frequency. To agree on a case by case basis actions to be taken / by whom and any other monitoring required.</b>			
	<b>Monitoring</b>	<b>Frequency</b>	<b>Results</b>	<b>Action</b>	<b>By whom</b>
	Movement disorder	annual			
	Weight gain / BMI / waist circumference	<i>Annual</i>			
	Annual QoF monitoring	<i>annual</i>			
	Sexual side-effects ( e.g. impotence, further detail in BNF )	<i>annual</i>			

<b>10. Pharmaceutical aspects</b>	No special considerations required.
<b>11. Secondary care contact information</b>	<p><b>If stopping medication or needing advice please contact:</b></p> <p><b>Dr</b> _____</p> <p><b>Contact number:</b> _____</p> <p><b>Hospital:</b> _____</p>
<b>12. Criteria for shared care</b>	<p>Prescribing responsibility will only be transferred when</p> <ul style="list-style-type: none"> <li>▪ Treatment is for a specified indication and duration.</li> <li>▪ Treatment has been initiated and established by the secondary care specialist.</li> <li>▪ The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements</li> </ul>

**13. Responsibilities of initiating specialist**

Consultant psychiatrist responsible for

Initiation & stabilization of dose regime  
Reviewing patient's mental state at regular intervals

Monitoring patient's initial reaction to and progress on the drug.

Reviewing depot dosage and suitability until stable

Providing GP with diagnosis, relevant clinical information and baseline results, treatment to date and treatment plan, duration of treatment before review.

Providing GP with full details of dose, preparation and dosing interval.

Providing support in terms of advice or training for administering depots if needed.

Providing GP with details of outpatient consultations, ideally within 14 days of seeing the patient *or* informing GP if the patient does not attend appointment

Providing GP with advice on when to stop this drug or when to ask advice

Providing patient with relevant drug information to enable Informed consent to therapy

Providing patient with relevant drug information to enable understanding of potential side effects and appropriate action

To respond to any urgent queries from GPs regarding service users on depots.

---

**14. Responsibilities of the GP / primary care**

To continue treatment as directed by the specialist

To monitor and prescribe in collaboration with the specialist according to this protocol

To ensure that the monitoring and dosage record is kept up to date

To discontinue medication if lack of efficacy, full relapse or side effects following discussion with specialist

Symptoms or results are appropriately actioned, recorded and communicated to secondary care when necessary.

To ensure the physical health is monitored and information shared with secondary care

CPN/practice nurse responsible for

- a) Administering depot
- b) Assessing side effects
- c) Informing GP of any difficulties such as non-adherence, side effects

---

**15. Responsibilities of the patient**

To take medication as directed by the prescriber, or to contact the GP if not taking medication

To attend hospital and GP clinic appointments

To report adverse effects to their Specialist or GP

<b>16. Additional Responsibilities</b>	<b>List any special considerations</b>	<b>Action required</b>	<b>By whom</b>	<b>Date</b>
<b>17. Supporting documentation</b>	The SCG must be accompanied by a patient information leaflet. <a href="http://www.emc.org.uk">www.emc.org.uk</a>			
<b>19. Shared care agreement form</b>	Attached below			

### Supporting References

(1) Schooler NR. Relapse and rehospitalisation: comparing oral & depot antipsychotics. J Clin Psychiatry 2003;64(Suppl 16): 14-17

# Shared Care Agreement Form

## Specialist request

### \*IMPORTANT: ACTION NEEDED

Dear Dr *[insert Doctors name here]*

Patient name: *[insert Patients name here]*

Date of birth: *[insert date of birth]*

Diagnosis: *[insert diagnosis here]*

This patient is suitable for treatment with *[insert drug name]* for the treatment of *[insert indication]*

This drug has been accepted for Shared Care according to the enclosed protocol (as agreed by Trust / LHB / AWMSG). I am therefore requesting your agreement to share the care of this patient.

Treatment was started on *[insert date started]* *[insert dose]*.

If you are in agreement, please undertake monitoring and treatment from *[insert date]*

NB: date must be at least 3 months from initiation of treatment.

Baseline tests: *[insert information]*

Next review with this department: *[insert date]*

You will be sent a written summary within 14 days. The medical staff of the department are available at all times to give you advice.

Please use the reply slip overleaf and return it as soon as possible.

Thank you.

Yours

*[insert Specialist name]*

# Shared Care Agreement Form

## GP Response

Dear Dr *[insert Doctors name]*

Patient *[insert Patients name]*

Identifier *[insert patient date of birth/address]*

I have received your request for shared care of this patient who has been advised to start *[insert text here]*

- A I am willing to undertake shared care for this patient as set out in the protocol
- B I wish to discuss this request with you
- C I am unable to undertake shared care of this patient.

GP signature

Date

GP address/practice stamp