MANCHESTER CITY COUNCIL

Manchester Mental Health and Social Care Trust NHS

Shared Care Protocol for Atypical Antipsychotics

Version Number:	2
Name of originator/author:	Chief Pharmacist, 07813 783165 (with thanks to GMW)
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Scope:	Trustwide including GPs

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Document Control Sheet **Shared Care Protocol for Atypical Antipsychotics**	
Lead Executive Director	Medical Director
Author and Contact Number	Chief Pharmacist, 07813 783 165
Type of Document	Shared Care Protocol
Document Purpose	Ensure that the care of patients prescribed atypical antipsychotics is shared safely and effectively between primary and secondary care.

Scope of Document	Manchester Mental Health and Social Care Trust, and associated primary care practices.	Version Number	2
Consultation	Medicines Management Committee, GPs, CCGs,		
Approving Committee	Medicines Management Committee	**Approval Date**	May 2013
Ratification and Date	Clinical Governance Committee		*May 2013*
V1 Valid from Date	March 2011	*Current version is valid from approval date*	
Date of Last Review	May 2013	**Date of Next Review**	April 2016
Procedural Documents to be read in conjunction with this document:	Medicines Policy CPA Policy Admission, Transfer and Discharge Policy		
Training Requirements	None	**Financial Resource Impact**	Increase in prescribing in secondary care. Increase in baseline testing in secondary care.

Document Change History			
Changes to this document in different versions must be detailed below. Rationale for the change should also be given			
Version Number / Name of procedural document this supersedes	**Type of Change** i.e. Review / Legislation / Claim / Complaint	**Date**	**Details of Change**
2	Review	May 2013	Changes to monitoring requirements See Section 5 and Table 2
External references used in the creation of this document:			
BNF, SPC, NICE Guidelines			

Equality Impact Assessment					
Initial Assessment	**Yes/No**	**Comments**			
Does this document affect on group less or more favourably than another on the basis of:					
Race	No				
Ethnic Origins (including gypsies or travellers)	No				
Nationality	No				
Gender	No				
Culture	No				
Religion or Belief	No				
Sexual Orientation	No				
Age	No				
Disability - Learning disabilities, sensory impairment and mental health	No	Patient information leaflets available in 'Handy Guides and Fact Sheet', 'Basic Information Leaflets' and 'Quick Information Leaflets' from www.choiceandmedication.org.uk/mhsc/			
Is there evidence that some groups are affected differently?	No				
If you identify any potential discrimination, are there any valid exceptions, legal / justifiable? Choose an item.					
Is the impact of the document likely to be negative?	Yes	Impact for ongoing monitoring			
Can this impact be avoided?	No				
Have we considered alternatives to implementing the document without the impact?	Yes				
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If this initial screening assessment has led to identification of an adverse or negative impact a full Equality impact Assessment will need to be completed and approval of our Equality and Diversity Lead given.					
Date of Full EIA	Enter date or N/a	**Date of Approval**	Enter date or N/a	**E&D Lead**	
Fraud Proofing submitted	N/A	**Any issues ?**	Choose an item.		
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If not relevant to this procedural document give rationale:					

If you are unclear on any of the above requirements please email quality.admin@mhsc.nhs.uk

Shared Care Protocol for Atypical Antipsychotics

Contents

If you need to have this information translated into another language please contact the Mental Health Linkwork Scheme on 0161 276 5269 or e-mail linkworkers.mentalhealth@nhs.net.

If you require it in larger print, Braille, audio or other formats please contact the Communications Team on 0161 882 1093 or e-mail communications.admin@mhsc.nhs.uk

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Manchester Mental Health and Social Care Trust NHS

Shared Care Protocol for Atypical Antipsychotics

SHARED CARE PROTOCOL for ATYPICAL ANTIPSYCHOTICS	**Reference Number**
	Classification
SCOPE	**SHARED CARE PROTOCOL**
Trust wide and primary care practices	
Issue Date May 2013	
Author(s) Originator(s)	
Petra Brown	
To be read in conjunction with the following documents	BNF, SPC, NICE Guidelines, MMHSCT Medicines Policy
Authorised by **Date**	**Review Date**
Manchester Mental Health and Social Care Trust May 2013	April 2016
Authorised by	**Reviewed**
MMHSCT Medicines Management Group	May 2013

1. Introduction

This shared care protocol covers the prescribing of atypical antipsychotics for the treatment of licensed indications (please refer to Table 1 and the current BNF).

2. Scope

Support for the use of these drugs comes from:-
NICE Guidance - www.nice.org.uk

- CG82: Schizophrenia March 2009
- CG38: Bipolar Disorder July 2006
- CG45: Antenatal and postnatal mental health Feb 2007

British Association for Psychopharmacology consensus guidelines – www.bap.org.uk

- Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association for Psychopharmacology (2010)
- Evidence-based guidelines for treating bipolar disorder (2009)

Guidance should be used in conjunction with the BNF and SPC.

3. Clinical Condition being treated

Clinical condition, licensed indications, formulations, dosage.

TABLE 1: SUMMARY OF LICENSED INDICATIONS, FORMULATIONS AND DOSAGE (from BNF March 2013)

ATYPICAL	INDICATION	DOSAGE RANGE (please consult BNF for further details about initial doses and dose titration)	FORMULATION
AMISULPRIDE **Generic available.** **2nd Line GMMMG formulary choice**	Schizophrenia	Predominately negative symptoms – 50 - 300mg daily. Acute psychotic episode 400mg – 800mg daily in 2 divided doses Max 1.2g daily.	Tablets Solution
ARIPIPRAZOLE **2nd Line GMMMG formulary choice**	Schizophrenia Treatment and recurrence prevention of mania	10mg – 30mg daily 15mg – 30mg daily	Tablets Oral Solution Orodispersible tabs
CLOZAPINE Red Drug. Prescribing should remain in secondary care	Treatment resistant schizophrenia Psychosis in Parkinson's disease	200 - 450mg daily. Max 900mg daily. Note titration requirements, and need for re-titration after more than 48 hours treatment break. 25 - 37.5mg at bedtime. Max 100mg daily.	Tablets Oral suspension
OLANZAPINE **Generic available** **1st line GMMMG formulary choice**	Schizophrenia, combination therapy for mania, preventing recurrence in bipolar disorder Mania (monotherapy)	10mg daily, adjusted to 5 - 20mg daily. Max 20mg daily. 15mg daily adjusted to 5-20mg daily. Max 20mg daily.	Orodispersible tablets Tablets Prolonged release injection
PALIPERIDONE GMMMG do not recommend the use of this drug	Schizophrenia Psychotic or manic symptoms of schizoaffective disorder	3 – 12mg daily	MR tabs Prolonged release injection
QUETIAPINE **Generic available** **1st line GMMMG formulary choice**	Schizophrenia Mania Depression in bipolar disorder Prevention of relapse in bipolar disorder	Varies according to indication and whether the normal or modified release tablets are prescribed – please consult the current BNF for dosing details.	Tablets XL tablets (modified release tablets for once daily dosing)

QUETIAPINE **(additional indication for XL preparation only). 2nd Line GMMMG formulary choice**	Adjunctive treatment of major depression	150mg - 300mg daily	
RISPERIDONE **Generic available** **1st line GMMMG formulary choice**	Acute and chronic psychoses Mania Short term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others. Short term treatment (up to 6 weeks) of persistent aggression in conduct disorder (under specialist supervision).	Varies according to indication – please consult the current BNF for dosing details.	Liquid Orodispersible tablets Tablets Long acting injection

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, but this will be only in exceptional circumstances.

Monitoring clinical outcomes and side effects will generally take place in secondary care specialist mental health services.

Physical health monitoring will generally take place in primary care. See section 5 – 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, in conjunction with current BNF advice.

5. Regimen Management

Consultant/Specialist Services Responsibility

a) Perform mental health assessment prior to starting atypical antipsychotics.

b) Perform baseline tests before starting.

These may include: -

1) Weight, height (BMI) or waist measurement, if possible prior to antipsychotic initiation.

2) Glucose (ideally fasting, but otherwise random)/HbA_{1c}, if possible prior to antipsychotic initiation.
3) Lipid screen (ideally fasting, but otherwise random), if possible prior to antipsychotic initiation.
4) BP, pulse
5) ECG if indicated i.e. if specified in SPC, if the patient has cardiovascular disease or a specific cardiovascular risk, or if the patient is on drugs that could also prolong QT interval such as tricyclic antidepressants, quinine.
6) FBCs, U&Es, LFTs
7) CPK, Bone Profile, Prolactin, TFTs. (The need for these may depend on the choice of antipsychotic).

'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.'

Good practice will usually indicate that patients receiving these types of medication within secondary care will be managed under the Care Programme Approach (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.

TABLE 2: RECOMMENDATIONS FOR INITIAL EVALUATION AND ONGOING MONITORING IN PATIENTS ON ANTIPSYCHOTICS

	Initial visit*	4 weeks*	8 weeks*	12 weeks	6 months	9 months	12 months	6 monthly thereafter	Annually thereafter
U&Es, including eGFR	X						X		X
FBCs (different requirements for Clozapine)	X						X		X
Blood lipids (ideally fasting)	X			X	X	X	X		X
BMI = Weight/†Height	X	X	X	X	X	X	X		X
Waist circumference (cm)	X	X	X	X	X	X	X		X
Fasting blood glucose‡ (repeat if abnormal)	X	X			X		X	X	
ECG (also after a dose increase)	X						X		X
Blood Pressure	X	X	X	X	X		X		X
Prolactin	X				X		X		X
LFTs	X						X		X
Creatine Phosphokinase (CPK)	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 Maudsley guidelines (11th Edition).

c) To initiate medication.

d) To ask GP to take over prescribing of atypical antipsychotic, once patient is stabilised.

e) To monitor for side effects e.g. over sedation, sexual dysfunction, and movement disorders, although these should be less likely with atypical antipsychotics

f) To monitor the physical health of the patient as per NICE Schizophrenia Guidance, until care is transferred to primary care, and this has been agreed with primary care.

g) To inform GP of patient's response to medication and general progress.

h) To inform GP of any change in medication or if medication is to be stopped.

i) To inform GP if Clozapine is being prescribed using the clozapine GP information at the point given within the pathway

j) To send a copy of the shared care guideline when a request to transfer prescribing to primary care is made.

k) The recording of the above will be on AMIGOS

GP Responsibility

See Appendix 2 for local agreement with City wide commissioning on behalf of Central, North and South CCGs.

6. Summary of cautions, contra indications, side effects

For cautions and contraindications and a full list of side effects see BNF/SPC. For comparison of side effects, see Table 3.

TABLE 3: COMPARISON OF COMMONLY REPORTED SIDE EFFECTS (Adapted from Maudsley guidelines, 11th Ed)

ATYPICAL	EPS	Raised Prolactin*	Weight gain	Sedation	Hypotension	Antimuscarinic symptoms	Miscellaneous (for full side effect profile see BNF/SPC)
AMISULPRIDE	+	+++	+	--------	----------	--------	Occasionally Bradycardia
ARIPIPRAZOLE	+ (?)	---------	+ (?)	--------	---------	--------	
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
PALIPERIDONE	+	+++	++	+	++	+	
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 an increased risk of Type 2 Diabetes compared to 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. Statement of Agreement between GP and Consultant.

This guideline 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 by writing or phone, ideally stating the nature of your concern.

9. Written information provided to patient

Leaflets provided by specialist services if available, otherwise package inserts. Patient information leaflets available from www.choiceandmedication.org.uk/mhsc. This should be recorded on AMIGOS.

REFERRAL 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:**	

APPENDIX 2

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. To inform specialist services of any physical health problems at the earliest opportunity.

d. If patient suffers any adverse reaction, the GP should liaise with secondary care/specialist services.

e. Perform full blood count if unexplained infection or fever. These drugs rarely cause neutropenia.

f. 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.

g. Annual Physical healthcheck as per QOF or local protocol.

Appendix 3

Back-up care available to GP from Hospital, including emergency contact procedures and help line numbers.

Single Point of Access (S.P.A)	0161 276 6155
CMHT (Central - Chorlton & Whalley Range)	0161 277 1240
CMHT (Central – East)	0161 276 6577
CMHT (Central - West)	0161 445 0232
CMHT (Central - Central)	0161 901 2579
CMHT (South – South Mersey)	0161 277 1200
CMHT (South – North Mersey)	0161 448 8779
CMHT (North – West)	0161 277 1170
CMHT (North – East)	0161 219 2168
Later Life team (Central – East)	0161 248 2970
Later Life team (Central – West)	0161 248 2970
Later Life team (South - Stables)	0161 283 5822
Later Life team (South – Hall Lane)	0161 945 6287
Later Life team (North - East)	0161 882 2024
Later Life team (North - West)	0161 882 2108
Crisis Team (North)	0161 720 2045
Crisis Team (Central)	0161 276 5368
Crisis Team (South)	0161 277 1223
Assertive Outreach (Central and South)	0845 0068999
Assertive Outreach (North)	0161 205 5995