BNSSG Shared Care Guidance
Please complete all sections

Section 1: Heading

Drug	Typical Depot Antipsychotics
Amber *one month*	
Indication	The maintenance treatment of schizophrenia and paranoid psychoses. See SPC for individual depots as slight variations exist www.medicines.org.uk
Speciality / Department	Mental Health
Trust(s)	Avon and Wiltshire Mental Health Partnership NHS Trust
	NHS Bristol CCG
	NHS North Somerset CCG
	NHS South Gloucestershire

Section 2: Treatment Schedule

Usual dose and frequency of administration	Given by deep intramuscular injection. Dose as per SPC for individual drug. • Flupenthixol: 2-4weekly • Zuclopenthixol: 2-4weekly • Haloperidol: 4 weekly • Fluphenazine: 2-5 weekly
Route and formulation	Deep intramuscular oily injection. Please note that some of the preparations contain sesame oil – check allergy status.
Duration of treatment	Long term

Section 3: Monitoring

Baseline tests - where appropriate

By AWP Specialist Team

1. *ECG, BP and pulse
2. Creatinine phosphokinase (CPK) , fasting blood glucose, fasting lipid profile (HDL & triglycerides)
3. LFTs, U&Es, TSH, FBC, prolactin
4. Waist circumference, weight & BMI
5. VTE risk assessment including e.g. reduced mobility

*Cardiovascular screen: ECG – patients with schizophrenia are at a higher risk of heart disease and depot antipsychotics may cause QTc prolongation and induce arrhythmias.

Subsequent tests - where appropriate

When stable dose has been reached and after 3 months of starting or switching depot. Primary care to organise:

1. Fasting blood glucose, fasting lipid profile (HDL & triglycerides)
2. Prolactin – irrespective of symptoms
3. Waist circumference, weight (plotted on a chart) & BMI
4. Where possible, assess patient for VTE risk and consider preventative measures.

Routine at 12 months and annually after first year:

1. BP and pulse
2. Creatinine phosphokinase, fasting blood glucose, fasting lipid profile (HDL & triglycerides)
3. LFTs, U&Es, TSH, FBC, prolactin
4. Waist circumference, weight (plotted on chart) & BMI
5. *ECG if indicated
6. Where possible, assess patient for VTE risk and consider preventative measures.

*Cardiovascular screen: ECG – Schizophrenic patients are at a higher risk of heart disease and depot antipsychotics may cause QTc prolongation and induce arrhythmias.

Results and when to refer:

1. Raised prolactin (above threshold)

Symptoms in women include amenorrhoea, menstrual disorders, galactorrhoea and reduced libido and in men, reduced libido, impotence & gynaecomastia.
The longer the patient is exposed to hyperprolactinaemia, the greater the risk of reduced bone density and hypogonadism.

Action: Reduce dose or alternative oral antipsychotic may be necessary. Refer to specialist team for advice.

Treatment with calcium and vitamin D should be considered and started by the GP.

2. Significant weight gain -. 5% over baseline

Antipsychotics are associated with weight gain especially in the first 6 to 9 months of treatment (average 2 to 10lb or ~0.9 to 4.5kg).

Action: Encourage healthy balanced diet and regular exercise. Recommend annual follow-up by GP.

3. Abnormal ECG / Cardiac disorders: QTc prolongation and arrhythmias.

See below when to refer to cardiologist. Also seek advice from AWP Specialist.

GPs should also be aware of non-psychotropic drugs which are associated with QT prolongation. Some examples include: Erythromycin, clarithromycin, ampicillin, co-trimoxazole, some quinolones Quinidine, amiodarone, sotadol, Chloroquine, mefloquine, Quinine Methadone, tamoxifen, diphenhydramine

Section 4: Side Effects

Side effects	Pain may occur at injection site and occasionally erythema, swelling and nodules. Minor side effects include drowsiness, especially at the start of treatment, nasal stuffiness, dry mouth, insomnia, agitation, extrapyramidal symptoms (tremor,

	rigidity, bradykinesia, akathisia, acute dystonia), hypersalivation and weight gain. Depot antipsychotics generally do not produce acute movement disorders at the time of administration; this may take hours to days. Neuroleptic Malignant Syndrome (extremely rare adverse effect of all antipsychotics). Venous thromboembolism, including cases of pulmonary embolism and cases of deep vein thrombosis have been reported with antipsychotic drugs – frequency unknown. *Refer to NICE CG92 and MHRA.* At present there are insufficient data available to determine any difference in risk between atypical and conventional antipsychotics, or between individual drugs. All possible risk factors for VTE should be identified before and during antipsychotic treatment and preventative measures taken. See individual SPC's for up to date information – www.medicines.org.uk
Management	1. Tardive dyskinesia – A wide variety of movements can occur such as: lip smacking or chewing, tongue protrusion (fly catching), choreiform hand movements, pelvic thrusting. Can lead to difficulty in speaking, eating or breathing. Can be worse under stress. Action: Reduce dose, discontinue and change to an alternative e.g. atypical antipsychotic, if appropriate. Seek advice from AWP specialist. 2. Pseudo-parkinisonism (tremor), dystonia – reduce dose; an anticholinergic may be prescribed e.g. procyclidine (NB: anticholinergic must be reviewed at least every 3 months (procyclidine can cause euphoria)). Switch to antipsychotic less likely to cause it. Seek advice from AWP specialist if needed. 3. Suspected Neuroleptic Malignant Syndrome (NMS) - Signs and symptoms include hyperthermia, fever, sweating, muscle rigidity, autonomic instability, altered consciousness, confusion, fluctuating blood pressure, tachycardia, raised CPK and altered LFTs. Action: Discontinue antipsychotic. Contact specialist immediately. Call for ambulance. Repeat CPK. 4. Somnolence / drowsiness Action: Advise patient not to drive or operate machinery. Consider specialist for advice. 5. Insomnia – refer to specialist if becomes an issue. 6. Constipation Action: Recommend a high fibre diet. Consider adding a bulk-forming and / or stimulant laxative. 7. Dry mouth Action: Suggest sugar-free gum, artificial saliva or occasional boiled sweets. 8. Hypotension / dizziness – advise patient to take time when getting up.

Referral back to specialist	Persistent side effects unresolved by reducing dose or which are intolerable to the service user or are of concern.

Section 5: Drug Interactions

Please list clinically significant drug interactions (eMC link please click here)

Significant Drug Interactions	Antipsychotics can: 1. Enhance response to alcohol, barbiturates and other CNS depressants. 2. Enhance anticholinergic effects when given with antichlolinergic drugs. 3. Increase risk of ventricular arrhythmias when co-administered with other drugs known to significantly increase the QT interval. Co-administration should be avoided. Relevant classes include: • Class Ia and III antiarrhythmics (e.g. quinidine • amiodarone, sotadol, dofetilide) • Some antipsychotics (e.g. thioridazine) • Some macrolides (e.g. erythromycin) • Some antihistamines • Some quinolone antibiotics (e.g. moxifloxacin) • Tricyclic antidepressants • Lithium • Cisapride • Drugs known to cause electrolyte disturbances such as thiazide diuretics (hypokalaemia) and drugs known to increase the plasma concentration of the antipsychotic should also be used with caution as they may increase the risk of QT prolongation and malignant arrhythmias. 4. Impair the anti-parkinsonian effect of L-dopa, effect of anti-convulsants, metabolism of tricyclic antidepressants and the control of diabetes. 5. Increase the effect of anticoagulants and antidepressants. Concomitant use of drugs such as metoclopramide, piperazine or antiparkinsonian drugs may increase the risk of extrapyramidal effects such as tardive dyskinesia
Reminder to ask patient about specific problems	Development of any side effects which may be attributable to the depot including pain or nodule formation at injection site.

Section 6: Contra-indications, Cautions and Special Recommendations

Please list

Hypersensitivity to the active substance or to any of the excipients. Circulatory collapse, depressed level of consciousness due to any cause (e.g. intoxication with alcohol, barbiturates or opiates) coma.

Section 7: Advice to the patient

Advice for prescribing clinician to inform patient

Report any adverse effects and inform prescriber if they wish to take any new medication – prescribed or bought.

Section 8: Responsibilities for Secondary Care

Core Responsibilities 1. Initiate treatment and prescribe the *first month* of treatment. 2. Undertake the clinical assessment and monitoring for the *first month* of treatment.

3. Communicate details of the above in 1 and 2 to GP within the *first month* of treatment. This information should be transferred in a timely manner.
4. Refer patients to GP and provide information of further action where appropriate e.g. blood test is due.
5. Provide advice to primary care when appropriate.
6. Review concurrent medications for potential interaction prior to initiation of typical depot antipsychotic.
7. Stop treatment where appropriate or provide advice on when to stop.
8. Report any adverse events to the MHRA.
9. Reminder to ask patients about particular problems - see section 5.

Other specific to drug

1. Assess patient, establish diagnosis and develop care plan. Ensure care plan contains current contact details for care co-ordinator/ key worker and specialist. Forward a copy of care plan to the GP
2. Undertake physical health screen and assessment when patient is admitted to mental health services.
3. The choice and formulation of antipsychotic should be a joint decision between the patient and their clinician taking into consideration the risks and benefits of the treatment including the relative potential of individual antipsychotics to cause side effects such as extrapyramidal side effects and metabolic adverse effects such as weight gain.
4. Provide patient with information on the antipsychotic prescribed including a patient information leaflet (PIL). Information on mental health conditions, treatments and medication can be found at http://www.choiceandmedication.org/awp/
5. Ensure patient is fully informed about their treatment including its effect on any life choices such as pregnancy where depots are not recommended. Depot antipsychotics should only be given to pregnant women when, in the judgement of the attending physician, the potential benefits outweigh the possible risk.
6. Ensure that arrangements of appropriate blood tests have been made. Blood tests may be taken at the GP Surgery providing this has been communicated to the GP and the GP is in agreement. Secondary Care is responsible for the interpretation and monitoring of these blood test results for the first 3 months of treatment.
7. Review results of any baseline tests and relay any abnormal findings to the GP with appropriate advice.
8. Discuss the proposal of shared care agreement (SCA) with the patient. If possible obtain consent (verbal is fine) and document in notes. If patient declines SCA, then document this too.
9. Monitor treatment via service users Community Psychiatric Nurse (CPN) – maintain communication with patient's CPN to assess response to treatment.
10. Ask the GP whether he / she is willing to participate in shared care, once patient has been stabilised on treatment. This must be done using the shared care agreement signature sheet for the typical depot.
11. Ensure the key worker has drawn up a Care Programme involving the GP, and detailing who will be responsible for administering the injections and where, and sent a copy to the GP.
12. Ensure that the GP has a copy of the shared care agreement and a signed copy of the shared care agreement signature form.
13. Communicate promptly with the GP when treatment is changed.
14. Inform GP of concurrent therapy (as this may interact with other medication patient gets from GP).
15. Advise the GP on when and how to adjust the dose or stop treatment (assuming no relapse in patients condition) according to clinical parameters, and consult with the specialist.
16. Review patient / provide advice as requested via the GP or Primary Care Liaison Service as necessary.
17. Review the patient and treatment at least once a year until the patient is discharged from the mental health service, where this is possible.
18. Ensure that clear backup arrangements exist for GPs to obtain advice and support.
19. Any verbal communication between primary and secondary care should be confirmed in writing.
20. Establishing contact with patients who have disengaged with primary care, either through a patient's care co-ordinator, Community Mental Health Team (CMHT) or Assertive engagement.

Section 9: Responsibilities for Primary Care

Core responsibilities

1. Responsible for taking over prescribing after the first month

2. Responsible for the clinical assessment and monitoring after the first month
3. Review of any new concurrent medications for potential interactions.
4. Reporting adverse events to the MHRA.
5. Refer for advice to specialist where appropriate.
6. Reminder to ask patients about particular problems see section 5.

Other specific to drug

1. Reply to the request for shared care within 3 weeks of receipt of request using the shared care agreement signature sheet.
2. If the GP decides not to prescribe the typical depot it should still be added to the patient's repeat list as a 'non issued item' for information and safety purposes and 'Hospital prescribing only'. Do not prescribe on the dose line. This should also be done during the stabilisation period before the GP takes over the prescribing.
3. Ensure that the practice nurses who are administering the typical depot have a sufficient knowledge base of the depot and appropriate training of how to administer and what adverse effects to monitor for.
4. Adjust the dose / stop drug as advised by the specialist.
5. Inform specialist team of any change / addition in the patient's medication that may interact with the medication the patient receives from secondary care.
6. Liaise with the practice nurse administering the IM antipsychotic regarding follow-up of patient in the event of no attendance.
7. To request specialist review or seek specialist advice when necessary.
8. Once the patient has been discharged from specialist Mental Health Services, advice may be sought from the Primary Care Liaison Service on any aspect of the patient's mental health that is concern to the GP.
9. Monitor patient's overall health and compliance.
10. If a practice fails to make contact with a patient, having made reasonable attempts, after they miss one or more depot injections, they should be referred back to secondary care. Refer back to the specialist if the patient disengages with primary care.

Section 10: Contact Details

Name	Organisation	Telephone Number	Email address
Dr Specialist Consultant	AWP Mental Health NHS Trust		
Care co-Ordinator	AWP Mental Health NHS Trust		
Formulary Pharmacist	AWP Mental Health NHS Trust		
Primary Care Liaison Service: Bristol Intensive and Primary Care Liaison – interim to Speedwell then to Callington Road	AWP Mental Health NHS Trust	Phone: 0117 919 5670 Fax: 0117 919 5625	
Primary Care Liaison Service: North Somerset Intensive and Primary Care Liaison – Long Fox Unit	AWP Mental Health NHS Trust	Phone: 01934 836406 Fax: 01934 836405	

Primary Care Liaison Service: South Gloucestershire Intensive and Primary Care Liaison – Bybrook Lodge Blackberry hill hospital	AWP Mental Health NHS Trust	Phone: 0117 378 7960 Fax: 0117 378 7941	

Section 11: Document Details

Date prepared	09.05.16
Prepared by	**Ellen Yankah, Pharmacist, AWP Mental Health Trust**
Date approved by JFG	2 years or sooner if guidance changes
Date of review	Click here to enter details
Document Identification: Version	**Typical depot SCA BNSSG**

Section 12: Collaboration

This Shared Care Agreement has been developed by the Formulary Pharmacist with feedback from members of the AWP Medicines Management Group – includes consultants, senior nursing staff, pharmacists, clinical risk manager, Head of Medicines Management and occasionally representative from finance.

Section 13: References

1. Bethan Shepherd, Formulary Pharmacist AWP, Shared Care Agreement for Risperidone and Paliperidone, Long Action Injection July 2012.
2. Taylor D et al Maudsley Prescribing guidelines 12th edition.