



CLINICAL GUIDELINE:

No:	Guidance for: Prescribing Guidance for the Treatment of Schizophrenia in Adults
Agreed by:	The Pharmacological Therapies Committee. January 2016
	Trust Clinical Governance Committee. 2016

Aim of guideline

The National Institute for Health and Care Excellence (NICE) published a guideline on the Treatment of Schizophrenia in Adults in February 2014. This guideline gives further advice on considerations when prescribing antipsychotics in Schizophrenia, including initial choice, monitoring and follow-up, as well as the approach to treatment-resistant Schizophrenia.

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Who it applies to

This is prescribing guidance.

Process for review / feedback

Antipsychotic prescribing within the BSMHFT will be audited in a number of ways via the Pharmacological Therapies Committee for adherence to this guidance. This guidance will be updated annually in the light of any changes to any national or local prescribing practice.

The next review date will be January 2018

Prescribing Guidance for the Treatment of Schizophrenia in Adults

Primary care – make a referral to specialist mental health services

Newly diagnosed

Should be seen by appropriate service as soon as possible regardless of age
Make full assessment and diagnosis

Facilitate the choice of medication by service user/carer by providing suitable information eg from the 'choice and medication' website.

Treat with a single oral antipsychotic, chosen from the list of available antipsychotics, at normal licensed doses or within the BNF maximum limit. (Some exceptions may be necessary for under 18s. Consult individual product SPCs for further information)

There is no good evidence for a difference in efficacy or outcomes between first and second generation antipsychotics. Both groups can be considered first choices

Physical health and side effect monitoring must be carried out as per trust policy 'Physical Health Assessment and Management' See Appendix 1

Review regularly throughout initial stages of treatment.

On going

Monitor mental state objectively to assess response to treatment.

If non-responsive despite increasing dose to maximum dose and checking for side effects and adherence, then re-assess diagnosis and consider alternative medication

Check medication adherence, using plasma assays if necessary. If problematic consider support for adherence before considering depot or other long acting preparation

Ensure treatment is consistent with MHA consent to treatment paperwork

Assess the impact of side effects systematically. Side effect rating scales may be used eg GASS or LUNBERS. If problematic review medication with service user/carer and consider alternative medication using 'choice and medication' to guide choice of alternatives.

Where maximum BNF doses are exceeded, follow Trust guidance on high dose antipsychotics. Ensure MHA consent to treatment paperwork covers high dose antipsychotics.

Assess co-morbid substance misuse and if appropriate refer to substance misuse service. Follow dual diagnosis pathway

Help service user to create advance statement

Physical health and side effect monitoring must be carried out annually. as per trust policy 'Physical Health Assessment and Management' See Appendix 1

Once the patient is stable, there are no significant risks and prescribing is considered suitable for primary care then consider with the patient's GP the transfer of prescribing to primary care.

Treatment resistant

Offer **clozapine** if there is an inadequate response to the sequential use of two different antipsychotics, prescribed at adequate doses for a reasonable length of time, at least one of which is a non-clozapine second generation antipsychotic

Consider clozapine augmentation if a partial response has been seen and serum levels are within therapeutic range
Agents for which there is evidence include sulpiride, amisulpride, risperidone or lamotrigine. Choice should be discussed with the patient

If clozapine is not appropriate and high dose antipsychotics are considered, follow Trust High Dose Antipsychotics Treatment guidance. Ensure MHA consent to treatment paperwork covers high dose antipsychotics.

Follow GMC and RCPsych guidance on prescribing medicines 'off-label'

When service users mental state has responded to treatment and they are stable on the minimum effective dose consider return to primary care who will then take on responsibility for physical monitoring (see Appendix 1). The definition of stability is:

- No significant change in the prescription for a minimum of 1 month.
- No increases of doses of any treatment and no new treatment starts.
- No significant acute risks.
- Any compliance issues are manageable in primary care.
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Liaise with primary care with regard to any issues of risk Be prepared to retain prescribing if GP is uncomfortable or unwilling to take on complex prescribing. Send a copy of the Birmingham, Sandwell, Solihull and Environs Area Prescribing Committee ESCA on antipsychotic treatment.

High dose antipsychotic prescribing should normally be retained within specialist services until doses have reduced to within licensed range.

Violence and Aggression: For guidance on the treatment of violence and aggression with medication refer to the trust Rapid Tranquilisation Policy

List of Approved Medicines (Tier 1)

risperidone, olanzapine, quetiapine, amisulpride, aripiprazole, haloperidol, perphenazine, sulpiride, trifluoperazine, zuclopenthixol, flupentixol, clozapine, chlorpromazine, pericyazine, levomepromazine (for RT/PRN use only) .

flupentixol decanoate, fluphenazine decanoate, haloperidol decanoate, pipotiazine palmitate, zuclopenthixol decanoate

Medicines with additional requirements for prescribing (Tier 2) – require consultant documentation of reasons for prescribing, (including why “first tier” drugs are not appropriate and why clozapine is not an option if treatment-resistant) as well as the agreement of the long term prescriber. Complete restricted medicines form on RiO

Quetiapine XL (See PTC guidance), pimozide, penfluridol

Medicines for which prior approval is required (Tier 3) – follow guidance for each medicine

risperidone LAI, Olanzapine LAI, paliperidone LAI, aripiprazole LAI

References

1. NICE CG178 Psychosis and schizophrenia in adults: treatment and management February 2014.
2. Choice and medication – accessed via Trust intranet <http://www.choiceandmedication.org/bsmhft/>
3. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry, 12th Edition, Wiley Blackwell, London 2015
4. Bazire S. Psychotropic Drug Directory 2014 Lloyd-Reinhold Communications LLP London 2014
6. Royal Coll. of Psychiatrists. College Report CR142. January 2007. Use of licensed medicines for unlicensed applications in psychiatric practice.

Appendix 1 – Monitoring of Specific Drugs

Investigations, test results and treatment									
Monitoring stage	Baseline		During Initiation		At three months		At Annual Review		
Monitoring setting	Secondary care		Secondary care		GP/outpatients clinic		GP/outpatients clinic		
Who undertakes the monitoring	Undertaken by specialist initiating medication		Undertaken by specialist initiating medication		Undertaken by specialist initiating medication or by GP with prior agreement		Undertaken by GP unless prescribing is retained by the specialist		
Parameters	Weight		Weight		Weight		Weight		
	BMI		BMI		BMI		BMI		
	Pulse		Pulse		Pulse				
	Blood Pressure		Blood Pressure		Blood Pressure				
	Blood Glucose/Hb A1c				Blood Glucose/Hb A1c		Blood Glucose/HbA1c		
	U&Es						U&Es		
	Renal Function						Renal Function		
	Full Blood Count						Full Blood Count		
	Liver Function tests						Liver Function tests		
	Blood lipids					Blood lipids		Blood lipids	
	Prolactin							Prolactin (if indicated such as gynaecomastia, menstrual disturbance, galactorrhoea)	
	ECG (if indicated in the SPC)							ECG (if indicated in SPC)	