# CLINICAL GUIDELINE:

| No: | Guidance for: Prescribing Guidance for the Treatment of Schizophrenia in Adults |
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| 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.

**Developed by**

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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 LUNSERS. 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, zuclopentixol 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** | | | | | | | | |
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| 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/HbA1c | | | | Blood Glucose/HbA1c | | 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) | |