

Prescribing Guidance

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Quick Reference Guide

This guidance covers the safe and appropriate use of high dose antipsychotic treatment. It is not a substitute for sound clinical decision making and should be viewed in line with other relevant national and BNF guidance.

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Related Guidance

Starting Medication

Trust Prescribing and Initiation of Medicines procedure.

Psychotropic Drug Monitoring

Trust guidance on psychotropic drug monitoring.

Links to Trust policies & guidance:

[Medicines Optimisation – Interactive Guide](#)

Title	Guidance on the use of High Dose Antipsychotic Treatment		
Approved by	Drug & Therapeutics Committee	Date of Approval	23 July 2026
Protocol Number	PHARM-0016-v10	Date of Review	01 August 2029

Key messages & definition

Key messages

- The use of high dose antipsychotics is “off-label” and should be exceptional clinical practice, only employed when an adequate trial of standard, evidence-based and licensed treatments, have failed or been otherwise excluded (including clozapine).
- Documentation of target symptoms, response and side-effects, ideally using validated rating scales (e.g. BPRS, LUNERS), should be standard practice so that there is sufficient information to enable ongoing consideration of the risk: benefit ratio for the individual patient.
- Rigorous physical health monitoring (including ECG) is essential.

Definition of HDAT

Single oral / IM antipsychotic

- The regular dose, expressed in mg per day, exceeds the 100% dose on the [POMH ready reckoner](#) (link for internal use only), or the maximum dose in the [oral](#) or [IM](#) table.

Single depot / LAI antipsychotic

The regular dose, either:

- Exceeds the “maximum single dose” stated in the Summary of Product Characteristics (SPC) or BNF, **or**
- Expressed in mg per week* equivalent, exceeds the 100% dose on the [POMH ready reckoner](#) or the maximum dose in the [depot / LAI](#) table.

Any combination of antipsychotics

(including cross-tapering & “as required” prescriptions)

- The dose of each antipsychotic, expressed as a percentage of the maximum dose on the [POMH ready reckoner](#) or [oral](#) / [IM](#) / [depot / LAI](#) tables**, added together exceeds 100%.

**for aripiprazole & paliperidone, see [table](#) for maximum dose of each formulation*

***tables must be used for patients aged 65 & over as the licensed maximum dose may be different to that for 18–64 year olds; a table of [advisory max. doses for patients aged 65 & over](#) is also included.*

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Maximum Licensed Oral doses

Oral Antipsychotic	Maximum Licensed Dose mg/day (i.e. 100%) for 18-64 year olds	Maximum Licensed Dose mg/day (i.e. 100%) for age 65 years & over
Amisulpride	1200	
Aripiprazole	30	
Cariprazine	6	
Chlorpromazine	1000	500
Clozapine	900	
Flupentixol	18	
Haloperidol	20	5
Lurasidone	148 (base)	
Olanzapine	20	
Paliperidone	12	
Quetiapine (mania & MR preparations)	800	
Quetiapine (schizophrenia/standard-release preparations)	750	
Risperidone	16	4 ^a
Sulpiride	2400	
Zuclopenthixol	150	

a. 2 mg/day for short term treatment (up to 6 weeks) of persistent aggression in moderate-severe Alzheimer's disease.

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Maximum Licensed IM doses

Antipsychotic IM Injections	Maximum Licensed Dose mg/day (i.e. 100%) for 18-64 year olds	Maximum Licensed Dose mg/day (i.e. 100%) for age 65 years & over
Aripiprazole	30	
Haloperidol	20 (TEWV max recommended dose: 15 mg/day)	5
Olanzapine	20	
Zuclopenthixol acetate (Acuphase®) ^b	75 mg per day 150 mg per 48 hours	50 mg per day 100 mg per 48 hours
	Maximum cumulative dose 400 mg per course. Maximum 4 injections per course.	

b. should be included in HDAT calculations to determine if additional monitoring is required for 7 days following administration.

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Maximum Licensed LAI / depot doses

Long-Acting Injection (LAI) / Depot Antipsychotics	Maximum Licensed Dose (i.e. 100%) for 18-64 year olds	Maximum Licensed Dose (i.e. 100%) for age 65 years & over
Aripiprazole – monthly	400 mg per month ^c	
Aripiprazole – 2-monthly	960 mg every 2 months	
Flupentixol decanoate (Depixol®)	400 mg per week / single dose ^d	
Haloperidol decanoate (Haldol®)	75 mg per week ^e	18.75mg per week
Olanzapine (Zypadhera®)	150 mg per week	
Paliperidone – monthly	150 mg per month ^c	
Paliperidone – 3-monthly (Trevicta®)	525 mg every 3 months	
Paliperidone – 6-monthly (Byannli®)	1000 mg every 6 months	
Risperidone – fortnightly (Risperdal Consta®)		
Risperidone - monthly (Okedi®)	25 mg per week	
Zuclopenthixol decanoate (Clopixol®)	600 mg per week / single dose ^d	

c. monthly dose interval should be used, not 28 days; a dose interval shorter than 28 days is considered HDAT & not suitable for shared care

d. any single dose exceeding the maximum single dose is considered HDAT (even if the maximum weekly dose equivalent is not exceeded e.g. zuclopenthixol decanoate 750 mg every 2 weeks) & not suitable for shared care

e. % of maximum must be calculated using absolute dose prescribed; if oral co-prescribed, DO NOT convert the depot dose to oral equivalence – follow the methodology for [“any combination of antipsychotics”](#)

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Advisory Maximum doses for age 65+

(May also be suitable for younger patients with significant health conditions or frailty that may impact drug metabolism & falls risk)

Antipsychotic	Oral (mg/day)	LAI
Amisulpride	Schizophrenia: 400 Late life psychosis: 200 (Caution > 100 or > 50 if dementia)	
Aripiprazole	Schizophrenia: 20 Agitation: 15 (combined oral/IM) ^f	400 mg / month
Cariprazine	Bipolar depression/adjunct MDD: 3 Schizophrenia/Mania or mixed bipolar: 6	
Clozapine ^g	New initiation: 100 Parkinson's Psychosis: 50	
Flupentixol	Lower starting dose	40 mg every 2 weeks
Lurasidone	111 (base)	
Olanzapine	Schizophrenia: 15 Agitation/psychosis in dementia: 10 ^f	Lower starting dose (not recommended >75 years)
Paliperidone	No adjustment needed if renal function ok	1M LAI: 100mg / month ^h 3M LAI: 350mg / 3 months 6M LAI: 700mg / 6 months
Quetiapine (IR & MR)	300	
Risperidone	See licensed dose table	25mg / 2 weeks
Sulpiride	No adjustment needed if renal function ok	
Zuclopenthixol	Lower starting dose	200mg / 2 weeks

f. same maximum for short-acting IM injection;

g. For existing clozapine patients on higher doses, see clozapine guidance for advice.

h. Consider using lower loading doses for older patients e.g. as for renal impairment: Day 1: 100mg; Day 8: 75mg.

Considerations before HDAT

Efficacy

- There is no firm evidence that high doses of antipsychotics are any more effective than standard doses, for any clinical indication.
- All currently available antipsychotics (with the possible exception of clozapine) exert their effect primarily through antagonism (or partial agonism) at post-synaptic dopamine receptors. There is increasing evidence that in some patients with schizophrenia, symptoms do not seem to be driven through dysfunction of dopamine pathways; so increasing dopamine blockade in such patients is futile.

Adverse effects

- The majority of side-effects associated with antipsychotics are dose-related, including extrapyramidal side effects (EPSE), sedation, postural hypotension, anticholinergic effects, QT prolongation and sudden cardiac death. Thus, high dose antipsychotic treatment would be expected to worsen the incidence and severity of adverse effects.

Before prescribing HDAT, ensure that:

- Sufficient time has been allowed for a response to standard dose treatment.
- At least two different antipsychotics have been tried sequentially.
- Clozapine has been considered / failed / not tolerated / refused or is contra-indicated.
- Compliance with treatment is not in doubt.
- Adjunctive medications (e.g. antidepressants, mood stabilisers) are not indicated.
- Psychological interventions have failed or are not appropriate.
- The patient's physical health status has been considered, and they are likely to tolerate HDAT; age and frailty should be taken into account when considering an appropriate maximum dose.

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Decision to prescribe HDAT

Decision making and consent

- The decision to start HDAT should be taken by a level ST4 doctor or above with membership of the Royal College of Psychiatrists (or equivalent professional body of home country) and should involve completion of an individual risk/benefit assessment. The decision to continue HDAT, following reviews, can additionally be made by a level 3 non-medical prescriber. The decision to increase HDAT must only be taken by the responsible consultant.
- The decision to start, continue or increase HDAT should involve consultation with the wider clinical team, the patient, any family if relevant or involved in patient consent, and with a patient advocate (if the patient wishes).
- Patient consent should be gained if they have capacity to provide this; if they do not have capacity, and HDAT is considered to be in their best interests, a second opinion should be sought.
- INPATIENTS: a decision by a doctor below ST4 or NMP to prescribe additional regular or “as required” antipsychotic treatment for a patient admitted out-of-hours, which results in HDAT, must be made following discussion with an ST4 doctor or above whenever possible; if this is not possible, the decision must be reviewed by an ST4 doctor or above (includes SAS doctors), or a level 3 NMP, by the end of the next working day.

Documentation

- The decision to prescribe HDAT and the associated patient capacity and/or consent should be documented in the electronic patient record, including the assessment of risks and benefits, the aims of treatment and plans for assessment of response and review of outcomes.

Information to support shared decision making

- Choice & Medication offer patient information on HDAT to support shared decision making with patients and carers

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Baseline checks & monitoring

1. Exclude contra-indications

- ✓ Perform ECG* - to establish a baseline, and exclude cardiac contraindications, including long QT syndrome
- ✓ Check LFTs* – to exclude hepatic impairment

2. Consider other risk factors

- Personal or family history of cardiac disease (MI, arrhythmia)
- Renal impairment
- Alcoholism / smoking
- Old age / frailty (lower maximum doses & slower titration recommended)
- Obesity
- The effects of gender and ethnicity on pharmacokinetics of antipsychotic medicines.
- Interaction with **any** concomitant medication including illicit substances, e.g. potential to cause QT-prolongation, electrolyte disturbance or CYP-enzyme inhibition)

3. Perform other baseline checks*

- U&Es (and physical assessment of hydration status)
- Pulse, supine and standing blood pressure
- Temperature
- Prolactin levels
- HbA1c
- Lipid profile
- Weight / BMI / waist circumference
- Cognitive function (especially in older people)

** Some patients may require PRN antipsychotics or rapid tranquilisation on in-patient admission which results in HDAT; if the patient is too unwell or refuses ECG/bloods/physical examination before such treatment is needed the decision to proceed with treatment should be recorded in the electronic patient record.*

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Initiation, review & monitoring

1. Start HDAT monitoring record & add alert

- Start a “High Dose Antipsychotic Treatment Initiation & Monitoring” record using the [paper chart](#) or via the e-form in the electronic patient record (EPR).
- Paper copies should be placed in the patient EPMA folder (in-patients) or in the patient’s physical notes (community).
- Add a “HDAT” alert to the EPR.

2. Prescribing & ongoing review

- Where possible increase the dose of antipsychotic slowly, ideally over intervals of at least one week. Allow adequate time for response after each dose increment before a further increase is made.
- Review progress against treatment targets **at least once every 3 months** (more frequently in early treatment), using an appropriate rating scale to assess symptoms (e.g. BPRS) & side-effects (e.g. LUNSERS, AIMS).
- Gradually reduce the dose of antipsychotic to within the licensed range if no significant response/benefit is observed, remove HDAT alert once reduction complete.
- Continued use of HDAT where there is no clinical response should be justified in the EPR & consultants should consider seeking a second opinion from a colleague. The review should be documented in the EPR.

3. Monitoring (record on HDAT paper chart / EPR)

- **Hydration** – be mindful of signs of dehydration (e.g. thirst/dry mouth, lethargy, low volume/concentrated urine) on a continuous basis.
- **ECG** – repeat once steady-state reached after the dose increase, then routinely every 6 months. Repeat at times of acute illness, when interacting drugs are introduced or if patient experiences symptoms that could be due to arrhythmias, e.g. syncope or fits. If an ECG is not performed the reason should be documented in EPR.
- **LFTs, U&Es, temperature, pulse/BP** – every 3 months
- **Weight / BMI / waist circumference** – every 3 months
- **Prolactin, HbA1c, lipid profile** - every 12 months

Avoid initiating other medication which increase risks associated with HDAT, i.e. diuretics, anti-arrhythmics, anti-hypertensives, tricyclic antidepressants & drugs which might prolong QT interval, or increase serum antipsychotic levels. If unavoidable, seek advice from Pharmacy before prescribing.

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Roles & responsibilities: Consultant*

- Exclude potential reasons for sub-optimal response to standard antipsychotic treatment.
- Exclude all other evidence-based strategies; initiate HDAT, as a time-limited trial, only after these strategies have failed or have been considered inappropriate.
- Involve the multi-disciplinary team, the patient and/or their family and/or their advocate in decisions about using HDAT and provide [appropriate written information](#)
- Obtain patient consent if they have capacity to provide this; if they do not have capacity, and HDAT is considered to be in their best interests, a second opinion should be sought.
- Consider the possible [contraindications to and risks of HDAT](#) for the patient concerned.
- Document target symptoms, response and monitoring of side-effects, ideally using validated rating scales (e.g. BPRS, LUNBERS), to ensure that there is sufficient information to enable ongoing consideration of the risk: benefit ratio for the patient.
- Place an alert on the electronic patient record if HDAT is initiated / remove alert if HDAT discontinued
- Assess the response to and the need to continue HDAT **every 3 months** (can be extended to **6 months** in patients who have been on HDAT for longer than 12 months and are clinically stable)
- Re-assess and record patient capacity and consent to HDAT at each review
- **In-patients:** Review HDAT initiated by doctors below ST4 grade / NMPs at out-of-hours admission on the next working day. HDAT should be reviewed at least weekly during an in-patient admission.

**Can be delegated to resident doctor or L3 NMP but consultant retains responsibility.*

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Roles & responsibilities: Prescriber

- Document reason for HDAT in the electronic patient record (EPR). Include details of the target symptoms, the risks and benefits of the strategy, the aims and when the outcome will be assessed.
- Complete a “HDAT Initiation & Monitoring Record” chart on paper or EPR e-form when treatment initiated.
- Amend / update T2/T3/CTO forms to cover above BNF maximum doses for the prescribed antipsychotic drugs / formulations.
- Inform nursing staff and members of the clinical team of HDAT status; ensure HDAT alert added to EPR / removed if HDAT discontinued.
- Review and respond to any risk factors or abnormalities identified through monitoring; to any changes to patient’s physical health including increasing age and to any changes to **all** concomitant medication (for patients on long-term HDAT treatment).
- Check and review “as required” (PRN) antipsychotic medication regularly, including any for rapid tranquilisation (in-patients), with a view to reducing dose or stopping where possible.
- If HDAT has been initiated during an inpatient admission and the plan is to continue once discharged, ensure that GP and relevant community mental health teams are informed of HDAT status, all baseline/on treatment monitoring that has been completed and that [appropriate arrangements](#) for ongoing prescribing are made on discharge.
- Ensure a system by which the required ongoing monitoring and reviews will be conducted by agreement with the community mental health team and / or GP. This should include actions to take if a patient does not attend for HDAT monitoring.
- **In-patients:** Level 3 non-medical prescribers (NMPs) may initiate HDAT in line with the Trust NMP Policy and only following communication with a consultant (an ST4 doctor or above if out of hours) which must be recorded in the EPR and reviewed by a consultant (or ST4 and above doctor) on the next working day. HDAT should be reviewed at least weekly during an in-patient admission.

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Roles & responsibilities: Pharmacy

Pharmacists and Pharmacy Technicians:

- Identify patients on regular high dose antipsychotics or the **potential** for high dose treatment via administration of an “as required” prescription in addition to their regular doses.
- Ensure a “HDAT Initiation & Monitoring Record” or e-form has been started, and is available in an appropriate place for reference and updating by all members of the team involved in prescribing or monitoring
- **Inpatients only:** Indicate on EPMA that a high dose monitoring record is in use, and the format e.g. paper or e-form (and remove if HDAT discontinued). Check that a review of HDAT has been completed each week during admission.
- Ensure a HDAT alert has been added to the electronic patient record (and is removed if HDAT is discontinued)
- Ensure T2/T3/S62/CTO forms have been updated to cover >BNF maximum doses.
- Advise on the % BNF maximum doses being prescribed (N.B. maximum dose may be different in elderly patients).
- Advise on any interacting medicines (prescribed, OTC and illicit substances) and mitigation of risk
- Prompt medical staff if monitoring or review has not been completed.
- Ensure nursing staff are aware of all patients receiving HDAT.
- Ensure [appropriate arrangements](#) for ongoing supply of medication are made.

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Roles & responsibilities: Nursing Staff

- Complete or arrange monitoring checks as prompted by the monitoring record chart or e-form / prescriber / pharmacist / accredited pharmacy technician.
- Check that the monitoring record chart is being completed (paper chart or e-form); bring to prescribers' attention if checks haven't been done.

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Transfer of Prescribing

HDAT is off-label and considered not suitable for transfer to GPs:

- This includes:
 - HDAT resulting from a combination of antipsychotics even if the dose of the individual drugs is within their respective BNF maximum dose.
 - antipsychotics being used to augment clozapine therapy, where the combined dose is HDAT, even though the GP would only be required to prescribe the augmenting antipsychotic (in these cases the augmenting drug should be prescribed on the clozapine prescription).
 - [Depot / LAI's](#) where the prescribed doses or administration frequencies are off-label.
- GPs should be kept informed of details of antipsychotics prescribed by the Trust for their own clinical records.
- There may be individual cases when the GP is willing to accept responsibility to prescribe HDAT to facilitate patient care; in such cases, responsibilities should be agreed between the TEWV team and GP on an individual case basis.

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Definitions

Combination

A combination of two or more treatments, each of which represents an antipsychotic alone, i.e. it adds an extra effect without altering the action of the first drug.

Off-label

Prescribing a Licensed medication for a condition outside of their license.

Unlicensed

Prescribing a medicine that does not have a UK marketing license.

ECG Electrocardiogram

EPR Electronic Patient Record

HbA1c Glycosylated Haemoglobin

HDAT High Dose Antipsychotic Therapy

LAI Long-Acting Injection

LFTs Liver Function Tests

NMP Non-medical prescriber

U&Es Urea & electrolytes

References

NICE/Pharm Press (2026). British National Formulary ([BNF](#)). Accessed online 5/3/26

RCPsych. (2014, updated 2023). [CR190](#): The risks and benefits of high dose antipsychotic medication. Accessed online 5/3/26.

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Standards for audit (1)

Parameter	Audit standard	Gold standard
When starting HDAT: - The reason for HDAT should be documented in the care record - Patient consent should be documented (if they have capacity) or a T3 completed. - A medication alert should be added to the care record - A “HDAT initiation and monitoring record”, or equivalent record, should be commenced	<i>Patients who commenced HDAT within the last 6 months:</i> All parameters complete	<i>Patients who commenced HDAT within the last 6 months:</i> All parameters complete
Before starting HDAT patients should have a baseline physical assessment including: - ECG - Liver function tests - U&Es - Pulse, supine & standing BP - Temperature. - Prolactin levels - HbA1c - Lipid profile - Weight / BMI / waist circumference - Cognitive function - Assessment of hydration status	<i>Patients who commenced HDAT within the last 6 months:</i> All parameters assessed	<i>Patients who commenced HDAT within the last 6 months:</i> All parameters assessed

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Standards for audit (2)

Parameter	Audit standard	Gold standard
All patients on HDAT should have repeat assessment of the following every 3 months: • Liver function tests • U&Es • Temperature • Pulse, supine & standing BP • Weight / BMI / waist circumference	<i>Patients who commenced HDAT 3-6 months ago:</i> All parameters assessed at least once since baseline <i>Patients who commenced HDAT >6 months ago:</i> All parameters assessed at least twice in the last 13 months (pro-rata)	<i>Patients who commenced HDAT 3-6 months ago:</i> All parameters assessed at least once since baseline <i>Patients who commenced HDAT >6 months ago:</i> All parameters assessed 3 or more times in the last 13 months (pro-rata)
All patients on HDAT should have a repeat ECG at least every 6 months.	<i>Patients who commenced HDAT >6 months ago:</i> ECG done at least once within the last 13 months (pro-rata)	<i>Patients who commenced HDAT >6 months ago:</i> ECG done twice in the last 13 months (pro-rata)

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Standards for audit (3)

Parameter	Audit standard	Gold standard
All patients on HDAT should have repeat assessment of the following every 12 months: • Prolactin levels • HbA1c • Lipid profile	<i>Patients who commenced HDAT >6 months ago:</i> All parameters assessed within the last 13 months	<i>Patients who commenced HDAT >6 months ago:</i> All parameters assessed within the last 13 months
Progress should be reviewed at least every 3 months using an appropriate rating scale to assess symptoms (e.g. BPRS) and side-effects (e.g. LUNSERS, AIMS).	<i>Patients who commenced HDAT >6 months ago:</i> Assessed at least twice in the last 13 months (pro rata)	<i>Patients who commenced HDAT >6 months ago:</i> Assessed 3 or more times in the last 13 months (pro rata)
Formal medication review to assess response and need to continue HDAT should be completed: • Every 3 months for patients who have been on HDAT for less than a year. • Every 6 months for patients who have been on HDAT for more than a year.	<i>Patients who commenced HDAT >6 months ago:</i> Review done within the last 4 months (9 months if HDAT >1 year)	<i>Patients who commenced HDAT >6 months ago:</i> Review done within the last 3 months (6 months if HDAT >1 year)

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Document Changes

Ver.	Date of change	Details of change
10	23 July 2026	• New format and full refresh • Maximum dose information split by formulation • Advisory maximum doses for over-65s added • Roles and responsibilities clarified • Additional information added regarding decision making and review • Standards for audit added

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