Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Shared care guidelines

Drug	FIRST GENERATION ANTIPSYCHOTIC LONG ACTING INJECTIONS (Depots) **Flupentixol decanoate, Haloperidol decanoate & Zuclopenthixol decanoate**
Specialty	ALL SPECIALTIES (excluding Children & Young People's Services)
Indication	SCHIZOPHRENIA and other psychoses
Overview	There are currently three first generation antipsychotic (FGA) long-acting injections (LAIs) recommended within the North of England Guidance. Flupentixol decanoate and zuclopenthixol decanoate are both recommended first line and haloperidol decanoate is recommended third line. FGA LAIs should be initiated by a specialist with expertise in psychotic disorders as part of a comprehensive treatment plan but prescribing, administration & monitoring responsibility can transfer to GPs under these shared care guidelines.
Specialist responsibilities	**Pre-treatment:** *(see each individual product SPC) for full details of contra-indications & cautions)* Assess suitability for treatment with a FGA LAI by reviewing the patient's medical history, completing a physical examination and completing the baseline monitoring as detailed in appendix 1. It should be noted that dose adjustment is required in patients 65 years or older. **Initial prescription - dosage and administration:** *(see BNF, SPC) and North of England Guidance for prescribing LAI for full details)* A small test dose should be administered to assess tolerance, then dose and dose interval should be adjusted according to the patient's symptoms and response to treatment. **Monitoring** The efficacy and tolerability of antipsychotic medication should be established by the specialist team by use of objective and validated measures, prior to transfer and at each review. Physical health monitoring should be completed by the specialist team for the first 12 months, then at each review (at least annually) • **Side effects** – use LUNSERS or GASS to assess tolerability at each review • **Physical Health monitoring** – for the first 12 months of treatment, then at each review (at least annually); see physical parameters in appendix 1 • **Clinical response** – use an appropriate measures, e.g. PANSS (positive and negative syndrome scale), CGI (clinical global impressions) and GAF (global assessment of functioning), to assess response prior to transfer and at each review. Where tolerability or clinical response is not demonstrated, the LAI should be stopped. On-going clinical need and patient preference for a LAI should be reviewed at least annually. **Transfer of prescribing / communication – see checklist** Prescribing, administration and monitoring responsibility may be transferred to the patient's GP after 3 months or once the treatment has been stabilised, whichever is the longer. The request must be made using the attached form with a covering clinic letter and a copy of this guideline (with contact details added) – the following details should be clearly communicated at transfer, and after each subsequent review: • **Diagnosis** • **Dose** of FGA LAI (must not exceed BNF max. – if HDAT then not suitable for transfer) • **Date** and **site** of last administration, and **date when next dose is due** • **Action** to be taken by GP if the patient does not attend for their scheduled dose • Completed and required **monitoring** • **Discontinued medication** for same diagnosis • **Date** of next specialist review The transfer request should be sent one month in advance of the patient needing their next dose. Acceptance should not be assumed until the GP responds positively using the attached form (scanned & e-mailed to the specialist team)

Specialist responsibilities (continued)

Discharge
Patients prescribed a FGA LAI should not be discharged from secondary mental health services. In exceptional circumstances an individual agreement for discharge may be considered for a patient who expressly indicates that they do not want to be seen by secondary mental health services. However, discharge should only be considered if FGA LAI treatment is stable, and the patient is adherent to treatment and compliant with monitoring requirements. Discharge arrangements should involve a proper discussion with the GP and the rationale for discharge must be clearly documented.

GP responsibilities

Transfer of prescribing / communication:
Notify specialist immediately (within 2 weeks) if transfer of prescribing and monitoring responsibility is accepted or not so that alternative arrangements can be put in place if necessary. Contact specialist if communication of prescribing, administration & monitoring requirements is not clear.

Maintenance (repeat) prescription:
Prescribe the FGA LAI in accordance with specialist advice received on transfer and following reviews. The maximum dose of each FGA LAI that the GP would be expected to prescribe is as follows:

Zuclopenthixol decanoate: 600 mg weekly

Flupentixol decanoate: 400 mg weekly

Haloperidol decanoate: 300 mg every 4 weeks

Any dose above these is classed as "high dose antipsychotic treatment" and is not suitable for shared care (RED classification)

Administration:
See SPC and appendix 1 for detailed information regarding sites of administration, volumes of administration and action to take in response to missed or delayed doses.

Monitoring – annually (additionally as clinically indicated) – see appendix 1 for detail

- Weight (+BMI and waist circumference where possible)
- Urea & electrolytes, including creatinine
- eGFR
- Lipid profile (total cholesterol, HDL-cholesterol, total/HDL-cholesterol ratio, triglycerides – fasting sample)
- Full blood count
- HbA1c
- Blood pressure (sitting/lying and standing) and pulse
- ECG – only if clinically indicated or patient is "high risk"

Any physical health monitoring by GP should be communicated to the specialist

Referral:
Refer back to the specialist should any of the following occur:

- Significant adverse reaction or intolerable side effects
- Lack of efficacy / patient's condition deteriorates
- Development of co-morbidities / necessity to prescribe interacting drugs
- Pregnancy
- Failure to attend for administration of dose within permitted timeframe

Adverse events

See SPC and *BNF* for full details of known adverse effects
Common side effects include agitation, constipation, dizziness, drowsiness, dry mouth, arrhythmias and erectile dysfunction. Please note that side effects may persist after stopping a LAI FGA until the drug has cleared from its depot site. Report any suspected adverse events to MHRA via the Yellow Card scheme

Specialist contact details
(to be added by specialist prescriber when transferring prescribing)

Name:
Base:
Telephone no:
E-mail address:

AMBER ▲	TRANSFERRING PRESCRIBING OF LONG ACTING / DEPOT INJECTIONS

GP details:

Patient details (name/address/DOB/NHS number):

Diagnosis: Specify clinical rationale if first line option or standard formulation not prescribed

Checklist for transfer:

- ☐ The patient has completed at least 3 months of treatment and is suitable for 28 day prescriptions
- ☐ The medication and patient's mental health are stable (i.e the patient has completed their response to medication and there are no recognised problems with compliance or significant acute risks of harm to self or to others).
- ☐ A minimum of one month's notice is being provided to the GP to ensure adequate time to add the prescription to the GP system
- ☐ The patient & medication meets all of the criteria defined within the shared care protocol
- ☐ A clear and a copy of the shared care protocol has been sent to the GP
- ☐ Arrangements have been made to continue prescribing until the GP agrees to shared care being established for this patient
- ☐ Arrangements have been made for the necessary secondary care responsibilities to be carried out (as defined in the protocol)
- ☐ There has been consideration of STOMP (if applicable)

Medication details: (generic & brand name, dose and dose interval):

Discontinued medication (list any medicines discontinued when this AMBER treatment initiated):

Last Administration (details of date and site of administration and date next dose due):

Monitoring results:

Secondary care review frequency:

Actions requested of GP: **Please continue to issue prescriptions and administer the FGA LAI detailed above until advised** The treatment has been explained to the patient and they understand they should contact you for future prescriptions. You will be informed of any changes to treatment, if you are not required to issue prescriptions or if treatment is to be discontinued. Please contact the prescriber on the number below if there is any change in the patient's condition, if the patient fails to regularly collect prescriptions, if non-compliance with treatment is suspected or you require advice.

Secondary care contacts:	**Contact details (address/telephone no):**
Care coordinator (name):	
Consultant (name):	
Prescriber (name):	
Signature & date:	

Acceptance of prescribing responsibility by GP:

Patient's name:	**NHS Number:**
Address:	
Medication:	
I confirm receipt of prescribing transfer information for the above patient and accept prescribing responsibility	
GP's name: *(Please print name in BLOCK CAPITALS*)	
Signature/ Practice Stamp:	
Date:	
Please scan & e-mail back to (e-mail address):	
or return as soon as possible to (postal address):	

Appendix 1 Monitoring requirements for antipsychotic long-acting injections

Test/ Measurement	Why is it important?	Baseline	3 months after initiation	Annually *
Weight (Waist circumference and BMI where possible)	Antipsychotic drugs can cause weight gain and this can contribute to an ↑ risk of cardiovascular and metabolic problems	√ Then weekly for the first 6 weeks	√	√
Urea and electrolytes, (including creatinine or estimated GFR)	Pateints with renal impairment may have reduced capacity to excrete drugs and dose reductions may be required. Hypolkaleamia is linked to QTc lengthening and other ECG abnormaliites	√		√
Lipids (Total cholesterol, HDL cholesterol, Total/ HDH-cholesterol ratio, Triglycerides - fasting sample)	Some antipsychotics can cause small adverse changes in lipid profiles. Triglyceride levels can rise during periods of weight gain – TGs should only be measured with a fasting sample	√	√	√
Full Blood Count (Hb, WBC, Platelets)	BNF advises caution when using antipsychotics in patients with blood dyscrasias Antipsychotics can cause blood dyscrasias including agranulocytosis and leucopenia	√		√
Blood Glucose: HbA_{1c}	Antipsychotics can increase the risk of developing diabetes.	√	√	√
Blood Pressure (sitting / lying and standing) and pulse	Hypotension is a side effect of many antipscyhotics and it is important to monitor this during peiods of initation and stabilisation. Longer term it is important to montior and manage factors that inluence a patients CV risk	√	Frequently during dose titration (determined by clinical situation) and also after 12 weeks	√
Prolactin	Antipsychotics can increase prolactin levels. This can inhibit sex hormones – oestrogen and testosterone and may ↑ risk of osteoporosis	√	Thereafter, only if clinically indicated (symptoms of hyperprolactinaemia)	

Test/ Measurement	Why is it important?	Baseline	Annually
ECG (QTc Interval)	Many antipsychotics are associated with ECG changes and some are linked to prolongation of the QT interval. All new inpatients should have an ECG on admission. For long stay patients and those in the community. When clinically indicated ECGs should be performed at baseline and annually. Factors that may determine if ECG monitoring is clinically indicated include: • If there is a personal history of cardiovascular disease (e.g. - known ischaemic / structural heart disease QT prolongation), • If physical examination identifies cardiovascular risk factors • If patients on antipsychotics that require ECG monitoring e.g. - haloperidol or pimozide (check summary of product characteristics for more information) • If a patient is on high dose antipsychotic therapy (HDAT) • If patient is on other drugs known to cause ECG abnormalities (e.g. Tricyclic antidepressants, erythromycin, anti-arrhythmics – see BNF for further information) • If the patient has Factors which may predispose to arrhythmias including: o Electrolyte abnormalities – hypokalaemia, hypocalcaemia, hypomagnesaemia o Systemic disease – liver disease, renal disease, hypothyroidism		
Pregnancy test		If there is any uncertainty about the possibility of pregnancy, a urine pregnancy test should be carried out	
Smoking status	Linked to CV risk	√	√
Drug screening		If indicated by history or clinical picture	
Review of the side effects of drug treatment, efficacy and adherence	Before treatment the side effects the patient is least willing to tolerate should be assessed. On review the treatment efficacy patient adherence and side effects experienced should be assessed. Including : • Extrapyramidal symptoms, akathisia, dystonia and tardive dyskinesia • Common side effects e.g. – sedation • Less common but serious adverse effects e.g. palpitations. An appropriate rating scale may be useful (e.g. GASS)	√	√

***** For annual reviews by TEWV team - it is recommended that, prior to the review, the GP completes required blood tests such that results are available to the TEWV team at the review. TEWV team to complete non-invasive monitoring, e.g. weight, at review.

Appendix 1 – Administration Information

Sites of injection and tolerances for administration due date

Every effort must be made to administer depot injections on the prescribed due date. If administration is not possible on the expected date due to circumstances outside of the control of the healthcare professional, then the tolerances listed below can be utilised to maintain therapeutic plasma levels. If administration within these tolerances is not possible, seek advice of the specialist team.

Drug	Administration site	Tolerances (based on usual dose interval)		
		Weekly	Two weekly	Four weekly
Flupentixol Decanoate (Depixol®)	Gluteal / lateral thigh	+/- 2 days	-2 / +7 days	
Haloperidol Decanoate (Haldol®)	Gluteal		-2 / +6 days	-2 / +14 days
Zuclopentixol Decanoate (Clopixol®)	Gluteal / lateral thigh		-2 / +7 days	

Maximum Administration volume

Flupentixol Decanoate

Depixol®
Depixol Injection 20 mg/ml is not intended for use in patients requiring doses of greater than 60 mg (3 ml) of flupentixol. Injection volumes of 2 – 3 ml should be distributed between two injection sites.

More concentrated solutions of flupentixol decanoate (Depixol Conc Injection or Depixol Low Volume Injection) should be used if doses greater than 3 ml (60 mg) are required.

The injection volumes selected for Depixol Conc. Injection or Depixol Low Volume Injection should not exceed 2 ml.

Psytixol®
The appropriate presentation of Psytixol should be selected to achieve an injection volume which does not exceed 2 ml. Volumes greater than 2 ml should be distributed between two injection sites.

Haloperidol Decanoate – Haldol Decanoate®

Administration of volumes greater than 3 ml is uncomfortable for the patient, such large volumes are not recommended.

Zuclopenthixol Decanoate – Clopixol®

Injection volumes of greater than 2 ml should be distributed between two injection sites.