Primary Care Psychotropic good practice guidance

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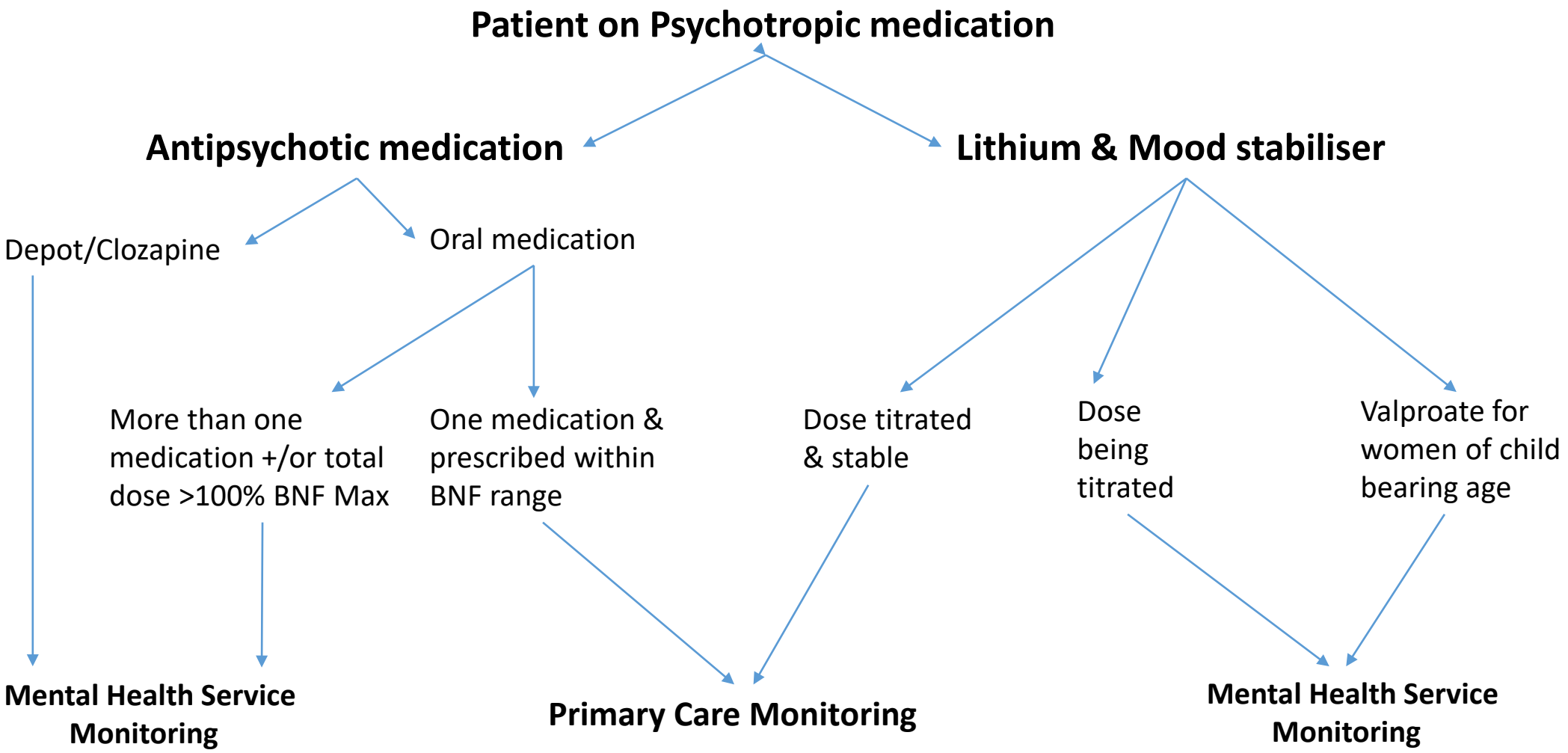
Principles for monitoring of patients prescribed psychotropic medication

1. Long-term condition management of patients with physical and mental health conditions remains part of general medical services
2. Many patients prescribed psychotropic medication have multi-morbidity and are attending primary care services for monitoring and management of a number of health conditions
3. The trusted longitudinal relationship between patients and the Practice multi-disciplinary team provides continuity of care and improved outcomes for patients
4. Monitoring in primary care should be considered as part of Community Treatment and Care services work to support chronic disease management

This guidance should be used to support prescribers in their management of patients

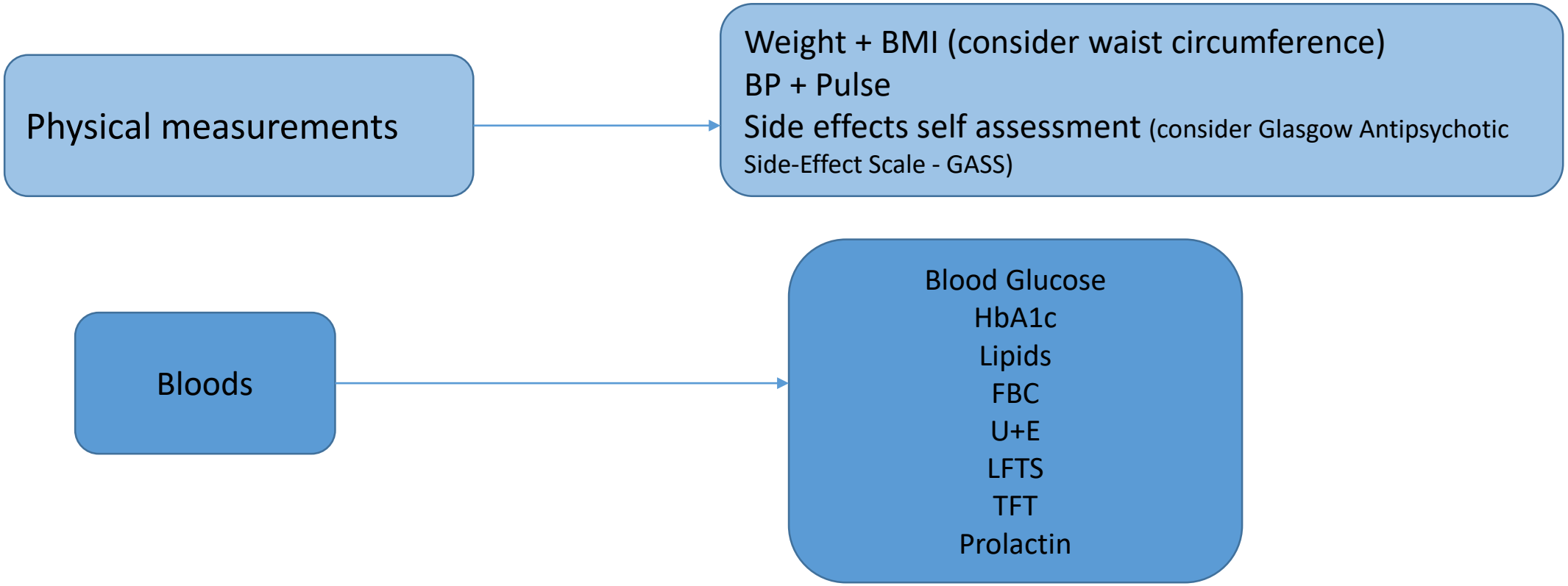
A recent BMJ article outlined guidance for monitoring drugs in people with bipolar disorder and supports the local discussion and agreement: www.bmj.com/content/380/bmj-2022-070678


Patient on Psychotropic medication
Antipsychotic medication
Lithium & Mood stabiliser
Depot/Clozapine
Oral medication
More than one medication +/or total dose >100% BNF Max
One medication & prescribed within BNF range
Dose titrated & stable
Dose being titrated
Valproate for women of child bearing age
Mental Health Service Monitoring
Primary Care Monitoring
Mental Health Service Monitoring

Principles for discharge of patient from Mental Health Services

1. Patient is stable from a mental health perspective
2. Medication doses are stable, i.e. not in the midst of a dose regimen change with requirements for additional monitoring or review
3. Patient should only be on one anti-psychotic medication, prescribed within the BNF range
4. Patients may remain with Mental Health Service for clinical review but ongoing drug monitoring transferred to Primary Care as the ongoing prescribers of the medication; this should be clearly stated in all correspondence
5. Appropriate drug dosages and ranges should be outlined in all correspondence
6. Advice should be outlined in relation to de-prescribing of medication
7. Advice should be outlined in relation to action of abnormal results

Primary Care Antipsychotic Annual Review



Antipsychotics should NOT be commenced by Primary Care

Should GPs choose to commence prescribing of antipsychotics, bloods should be carried out at baseline, after three months, annually and following any dose change. ECG should be carried out at baseline and following any dose change.

Antipsychotic advice

Side effect monitoring: discussion of side effects

Consider asking patient to complete the Glasgow Antipsychotic Side-effect Scale (GASS)

www.somersetccg.nhs.uk/wp-content/uploads/2021/09/GASS-Scale.pdf

Score of; 0-21 absent/ mild side effects
22-42 moderate side effects
43-63 severe side effects

ECGs: Should be carried out when medication is commenced or dosages changed but otherwise no requirement for an annual ECG

Action on abnormal blood results:

1. **Antipsychotic started by specialist AND patient open to Mental Health**
- Discuss abnormal result with current MH practitioner

2. Antipsychotic started by specialist, no longer open to Mental Health

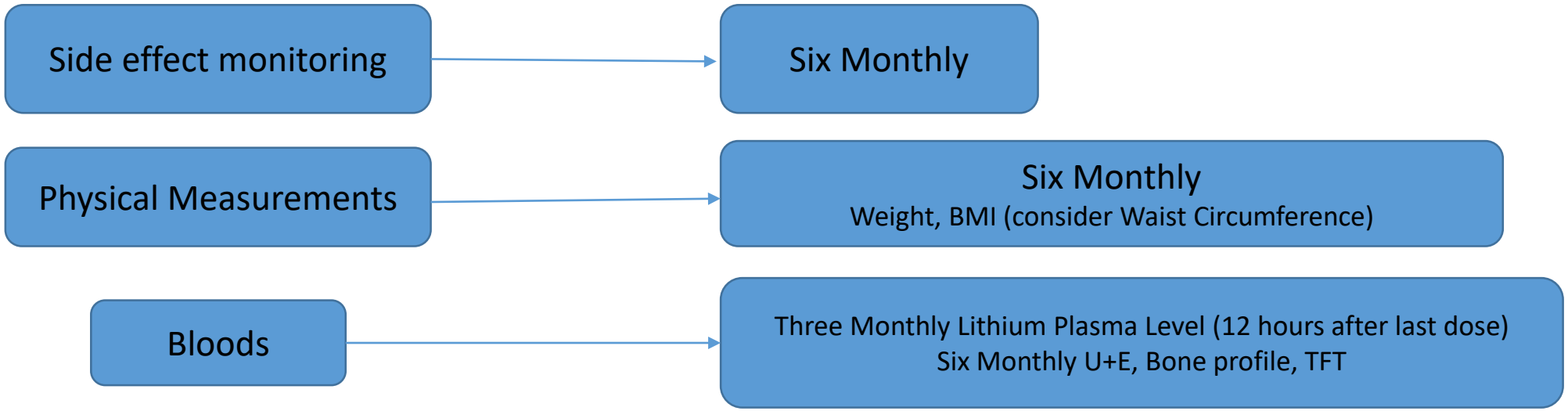
- Check discharge advice
- If unclear, contact Mental Health service for advice

3. Antipsychotic started in Primary Care on the advice of a specialist (should not be initiated by Primary Care)

- Consider metabolic syndrome:
  Is medication necessary? Consider reducing and/ or stopping. If required seek advice regarding potential alternative medication
- Provide relevant lifestyle advice and/or intervention for abnormal result e.g. smoking cessation/ statin/ diet advice
- Prolonged QTc - is QT prolonging medication(s) necessary?
    - Consider co-prescribed medicines – interactions etc.
    - Consider antipsychotic dose reduction or stopping.
    - Consider alternative with less effect on QTc other than antipsychotic medication
    - Seek Mental Health advice if appropriate

If a patient being monitored by Mental Health is found to have a new physical health diagnosis e.g. Diabetes, this result should be communicated to Primary Care who will have responsibility for chronic disease management

Primary Care Lithium Monitoring



Lithium should **NOT** be commenced by Primary Care and monitoring will only be taken over by Primary Care when the dose has been titrated and stabilised

ECG should be considered if on medications that prolong QTc interval
Contraception should be discussed with women of childbearing potential

Lithium monitoring for stable patients has historically been the responsibility of Primary Care prescribers and following QOF moved to be included as part of General medical services and global sum payments

Lithium Advice

Guidance for 18-65yr old adults only
Older adults can be toxic at levels <1.0 and should be discussed with OPMH team
There should be a clearly documented individualised target range for Lithium level on discharge

1. Patient presents with symptoms of toxicity: withhold Lithium, check U+E + eGFR + Lithium and refer for urgent medical treatment
Seek advice from Mental Health services before restarting Lithium

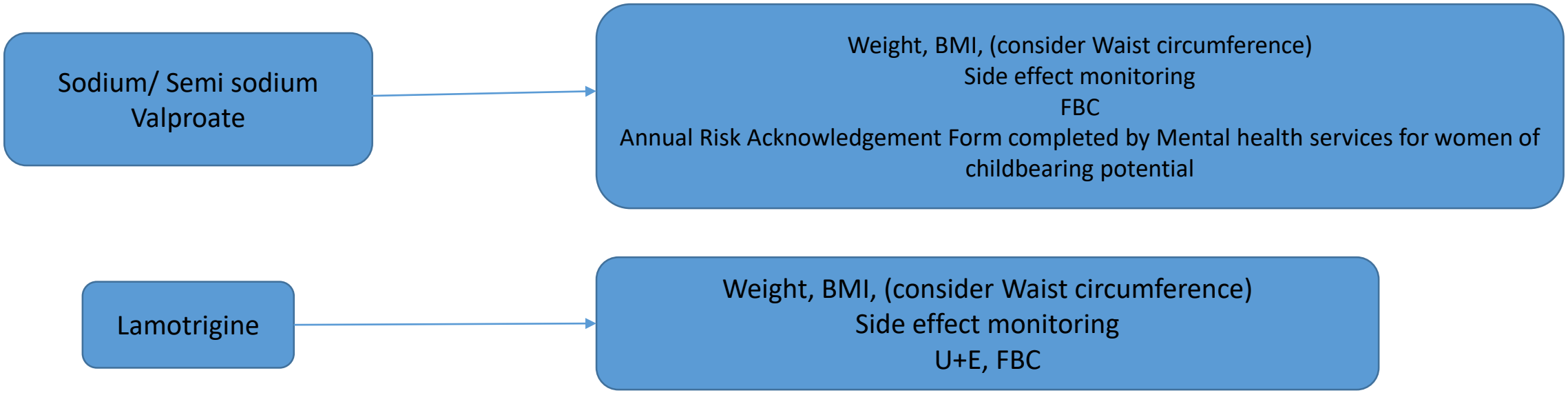
2. Level 1.0-1.2, no symptoms of toxicity: reduce Lithium by 200mg and check trough level after 5 days.
Inform Mental Health services of new dose if open to them

3. Level >1.2 without symptoms of toxicity: withhold Lithium, recheck trough level + U+E + eGFR
If level >1.2 withhold Lithium and recheck level in 2-3 days
Seek advice from Mental Health services before restarting Lithium

Lithium toxicity symptoms:
Consider if signs suggestive of dehydration, any change in mental or physical state e.g. confusion, falls or increased tremor
Symptoms: coarse tremor, muscle twitches, gastric upset, diarrhoea, muscle weakness, unsteady gait/ falls, slurred speech, blurred vision, drowsiness, confusion
Consider potential causes of toxicity, especially drug interactions e.g. ibuprofen

Caution: eGFR may over estimate renal function e.g. frail & older adults. Creatinine Clearance calculation may be more appropriate

Primary Care Mood Stabilisers Annual Review



Generally these medications should **NOT** be commenced by Primary Care

Some patients may be on these medications for other conditions- it is important to ensure the **correct** specialist review is sought

Pathway for advice from secondary care MH services

Patients open to MH services

- Contact MH team currently providing input through SCI-gateway referral for advice option
- Expected timeframe for response for routine contact would be 1-2 weeks
- Urgent advice from service can be accessed via telephone by contacting duty person at treating team

Patients not open to MH services

- Contact appropriate local CMHT through SCI-gateway referral for advice option
- Expected timeframe for response for routine contact would be 1-2 weeks
- Urgent advice from service can be accessed via telephone by contacting duty person at appropriate local CMHT (adult or OPMH)

Secondary care responsibilities

- **Monitoring**
  - Continued monitoring for all patients on Clozapine, depot antipsychotics, high dose antipsychotic regimes and combinations of antipsychotics
  - Communication of outcome of monitoring to primary care including prompt communication of any abnormal results
  - Responsibility for monitoring of all women of child bearing age who are prescribed valproate
  - Monitoring during initiation and dose titration of Lithium

Principles for de-prescribing of psychotropic medication in Primary Care

1. Patient is stable from a mental health perspective
2. Patient is NOT open to mental health services
3. Ensure rationale and potential for harm are explored with patient (and carer); antipsychotic prescribing is often continued chronically despite a lack of documented ongoing implications for many patients. It is important to reassess the continued need for treatment
4. Goal of de-prescribing is to reduce medication burden and harm whilst maintaining or improving quality of life
5. Antipsychotics can be safely reduced and de-prescribed using tapering strategies. A safe approach would be a 25-50% reduction every four weeks with reviews.
6. Referral of all stable patients to mental health services for de-prescribing is inappropriate. Referral is appropriate if there is a change in the patient's mental state or issues with medication
7. Advice can be sought from Mental Health colleagues in relation to de-prescribing
8. Canadian guidance in de-prescribing is helpful: Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia | The College of Family Physicians of Canada (cfp.ca)