High Dose Antipsychotic Treatment (HDAT) Guideline

TARGET AUDIENCE	Nursing, medical and pharmacy staff working within Mental Health & Learning Disability services
PATIENT GROUP	All patients prescribed antipsychotics within high dose range

Clinical Guidelines Summary

This guidance has been developed to support the safe use of high dose antipsychotic treatment in both hospital and community settings across NHS Lanarkshire. High Dose Antipsychotic Treatment (HDAT) should be considered an exceptional clinical practice and will require additional monitoring to be undertaken. The decision to prescribe, continue to prescribe or recommend the use of high dose antipsychotics should be made by a senior psychiatrist and undertaken with consideration to the Royal College of Psychiatry Consensus Statement (Nov 2014)[1].

High dose Antipsychotic Treatment is defined as 'a total daily dose of a single antipsychotic which exceeds the upper limit stated in the SPC or BNF with respect to the age of the patient and the indication being treated, and a total daily dose of two or more antipsychotics which exceeds the SPC or BNF maximum using the percentage method.'[1]

When a decision has been made to prescribe HDAT, consent must be recorded in the patient's notes. A HDAT monitoring form must be used to record both baseline and ongoing monitoring. For Morse users, this form is completed electronically, paper versions are available for non-Morse users. Ongoing need for HDAT should be reviewed regularly and stepped down where appropriate. Any abnormal baseline or monitoring results must be escalated for review by the patient's team.

Contents

1. Introduction

This guidance has been developed to support the safe use of high dose antipsychotic treatment in both hospital and community settings across NHS Lanarkshire. High Dose Antipsychotic Treatment (HDAT) should be considered an exceptional clinical practice. The decision to prescribe, continue to prescribe or recommend the use of high dose antipsychotics should be made by a senior psychiatrist and undertaken with consideration to the Royal College of Psychiatry Consensus Statement (Nov 2014).[1]

2. High Dose Antipsychotic Treatment and the percentage method

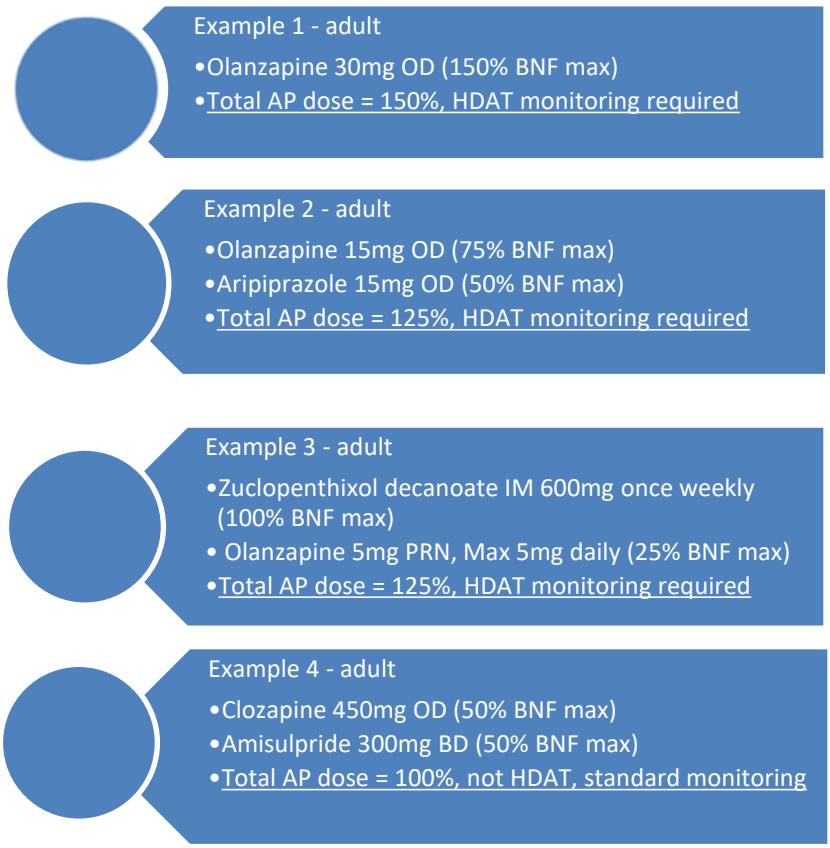
High Dose Antipsychotics can occur from two scenarios:

1. A single antipsychotic prescribed at a dose which exceeds the maximum daily dose stated in the SPC or BNF (with respect to the age of the patient and the indication being treated).
2. Two or more antipsychotics are prescribed at doses which, if converted to a percentage of the maximum daily dose stated in the SPC or BNF, the cumulative percentage is more than 100% (with respect to the age of the patient and the indication being treated). This is known as the percentage method.

NB if the dose of any antipsychotic exceeds the maximum dose for that drug, it is an off-label use and local unlicensed use protocols should be followed in addition to HDAT guidance. See NHSL Medicines Approval Process

Appendix 1 provides a quick guide to BNF maximum licensed doses of antipsychotics.

Percentage method examples



3. General recommendations for prescribing or recommending HDAT

- The use of HDAT should be an exceptional clinical practice and generally only employed when an adequate trial of standard treatments, including clozapine have failed.
- Documentation of rationale, target symptoms, response and side effects should be standard practice so there is on-going consideration of risk-benefit ratio.
- Failure of previous therapy due to non-compliance should be ruled out.
- The decision to use HDAT should be made by a senior psychiatrist, involving the MDT, where possible with valid consent obtained and documented.
- Contraindications should be ruled out and other risks minimised where possible.
- For patients subject to statutory treatment plans, the use of HDAT must be reflected in their T2/T3 certificate.
- HDAT may sometimes be used in an emergency for acute symptoms. This can happen, particularly, with the use of as required antipsychotics. Prescribers should be aware when prescribing as required medications, of inadvertently causing the potential for HDAT. This should be discussed with a senior psychiatrist before this happens.
- A common sense approach should be taken with the elderly or frail individuals who may be more sensitive to the side effects of antipsychotics and require monitoring equivalent to that of HDAT at lower doses.
- The use of more than two antipsychotics should prompt an urgent review in treatment.

4. Consent and Legislation

The decision to prescribe High Dose Antipsychotics and the rationale behind this should be discussed and agreed with the patient and/or carer and documented in the clinical notes. Informed and valid consent should be obtained before prescribing antipsychotics in the high dose range. A 'Patient Consent to Unlicensed Medicine Use' form (previously known as Form C) may be considered to document patient consent.[2]

Discussion tools are available from the Choice and Medication website and may be useful in aiding discussions regarding high dose antipsychotic therapy. e.g. handy fact sheets on Unlicensed Use, QTc and HDAT. https://www.choiceandmedication.org/nhs24/ [3]

For patients receiving treatment under the Mental Health (Care & Treatment) (Scotland) Act 2003 or Adults with Incapacity (Scotland) Act 2000, ensure that the statutory treatment plan on a T2 or T3 certificate or section 47 references the use of HDAT.

If a patient refuses to consent to monitoring associated with HDAT, then this should be clearly documented within their clinical notes. Ongoing refusal to engage with monitoring must prompt review and consideration of cessation of HDAT.

5. Risks Associated with High Dose Antipsychotic Treatment

5.1 General increase of side effects

Many side effects of antipsychotics are dose dependent and so the likelihood of a patient experiencing side effects to medication increases with HDAT. Cumulative side effects associated with the use of more than one antipsychotic may be particularly troublesome, therefore a side-effect self-rating scale should be used at every HDAT review. Monitoring side

effects and addressing intolerances to medication can not only improve the patient's physical health but can also help facilitate adherence to the medication.

The preferred rating scale is the Glasgow Antipsychotic Side Effect Scale (GASS). A Clozapine specific version of GASS is also available (GASS-C). Easy read versions of these forms are available from the mental health pharmacy team.

5.2 Cognitive side effects of antipsychotics

Cognition should be regularly monitored for patients on HDAT. Cognitive function may be impaired with increasing dose and the cumulative effects of more than one antipsychotic. This may be particularly problematic where antimuscarinic side effects predominate, particularly where antimuscarinic drugs are used for extrapyramidal side effects.

5.3 QT interval prolongation

Antipsychotics can prolong the QTc interval. Prolonged QTc interval is considered a risk factor for arrhythmias, including Torsades de Pointes (TdP). Evidence suggests the risk of arrhythmia is exponentially related to extent of prolongation beyond normal limits. Although this evidence is limited, there is strong evidence that a QTc of greater than 500msec is a major risk for arrhythmia.

QTc prolongation with antipsychotics is a dose-dependent risk, therefore monitoring of QTc and for risks associated with prolongation are more important with HDAT. Monitoring should be particularly vigilant for people with ongoing conditions associated with increased risk of QTc prolongation and other arrhythmias, in the presence of other risk factors and at any time when risks are increased.

5.4 Risk factors for QTc prolongation with antipsychotics

Risk factor	Rationale for potential risk of QT prolongation
Cardiac history	▪ particularly myocardial infarction, arrhythmias, bradycardia, abnormal ECG, long QT syndrome, heart failure, previous episodes of TdP. ▪ consider family history
Electrolyte abnormalities	▪ predisposes to QTc prolongation particularly hypokalaemia, hypocalcaemia & hypomagnesaemia ➢ K < 3.5mmol/l ➢ Mg < 0.7mmol/l ➢ Adjusted Ca < 2.1mmol/l ▪ consider co-administration of drugs which have the potential to cause abnormalities e.g. if diuretics started ▪ consider electrolyte disturbance during periods of diarrhoea/vomiting ▪ correct for low potassium, magnesium and calcium prior to, and throughout treatment
Renal impairment	▪ potentially decreases clearance of renally excreted antipsychotics ▪ may increase risk of electrolyte disturbance
Hepatic impairment	▪ potential impact on hepatic metabolism and clearance of antipsychotics ▪ QT prolongation is increased in alcoholic liver disease
Alcoholism	▪ increased risk of hepatic impairment
Smoking	▪ increased risk of ischaemic heart disease ▪ impact on hepatic metabolism of some antipsychotics
Substance misuse	▪ due to risk of QT prolongation with certain substances
Increasing age	▪ elderly more susceptible to QT changes
Extremes of weight	▪ impact of obesity on CV risk and hepatic function ▪ very low BMI increases risk of electrolyte abnormalities and dehydration
Female gender	▪ women have longer QT intervals
Extreme physical exertion	▪ e.g. individuals subject to restraint
Interacting drugs	▪ co–administration of other drugs which prolong QTc. ▪ See CredibleMeds website for medicines that prolong QTc interval. ▪ N.B. some antipsychotics (e.g. haloperidol) are contra-indicated with other drugs causing QTc prolongation ▪ any drug which may increase plasma levels of an antipsychotic e.g. co-administration of drugs which inhibit metabolising enzyme. ▪ also consider patients who are slow metabolisers (if known). ▪ medicines known to cause electrolyte disturbance (as above)

Adapted from GG&C High Dose Antipsychotic Monitoring Policy with permission[4]

5.5 Management of QTc prolongation

Management of QTc prolongation in HDAT[5,6]			
QTc Interval*	**Males**	**Females**	**Recommendations**
Normal	<440ms	<470ms	No action unless abnormal T-wave morphology
Borderline prolonged	>440ms but <500ms	>470ms but <500ms	Consider reducing the dose and/or switching to a lower risk antipsychotic. Repeat ECG and consider cardiology advice/review.
Prolonged	>500ms	>500ms	Seek immediate cardiology advice. Stop causative drug(s) and switch to an alternative with a lower effect on QTc. Repeat ECG
Abnormal T-waves, if present consider reducing the dose or switching to a lower risk antipsychotic. Consider seeking cardiology advice.			
A change in baseline QTc of >20ms should raise concern and should be assessed in conjunction with the overall QTc interval.			
The QT interval varies with heart rate. A number of formulas are used to correct the QT interval for heart rate. Once corrected it is expressed as the QTc interval, which is reported on the ECG printout. The QTc is commonly normalised to a heart rate of 60bpm and may be inaccurate in patients with faster or slower heart rates.			

6. Monitoring High Dose Antipsychotic Treatment

Additional monitoring is required when patients are prescribed HDAT. On initiation a plan should be agreed for ongoing monitoring including frequency of monitoring, roles and responsibilities of the MDT and review dates. See appendix 2 for the HDAT monitoring form.

For areas which use Morse an electronic version of this form is available and should be used. For non-Morse users a paper copy should be completed and retained in the patients notes. A copy of this should be transferred when the patient moves between inpatient and outpatient settings.

6.1 Parameters and Frequency of monitoring

HDAT Monitoring parameter	Monitoring Frequency	Additional situations to undertake HDAT monitoring
• Clinical progress and the reason for continuation of HDAT documented • Ensure consent/ T2/T3 still valid • Changes to risk factors • ECG for QTc and T-wave abnormality* • LFTs and U&Es including Mg and Ca • NEWS observations, including temperature & blood pressure • Side effects using GASS or an alternative e.g. Easy-Read GASS or alternative health recordings • Consider monitoring weight, lipids, blood glucose and/or HbA1c, especially where drugs used carry increased risk of metabolic disturbance.	Baseline - before increasing into high dose range At 1 month At 3 months Every 3 months (3-6 monthly if stable and agreed with MDT)	○ After dose increases ○ After adding interaction medicine ○ When there are any concerns, acute illness etc.

***The Royal College of Psychiatrists recommends that ECGs should be performed every few days following initiation of HDAT or dose escalation until steady state is reached.[1]**

7. Review of High Dose Antipsychotic Medication

The key recommendation of the Royal College of Psychiatrists Consensus Statement is that any prescription of high-dose antipsychotic treatment should be seen as an explicit, time-limited individual trial with a distinct treatment target. Doses should be increased slowly and not more than once weekly for oral antipsychotics (long-acting antipsychotic injections should have longer intervals between dose increases). There should be a clear plan for regular clinical review including monitoring. The high-dose regimen should only be continued if the trial shows evidence of benefit that is not outweighed by tolerability or safety problems. For this reason, the aim of treatment and the outcome should be clearly documented in the patient's notes. **It is recommended that if there is no improvement after 3 months doses should be reduced to standard doses.**

8. Acute/ emergency use of HDAT

HDAT may sometimes be used in an emergency for acute symptoms. This can happen, particularly, with the use of as required antipsychotics. Prescribers should be aware when prescribing as required medications, of inadvertently causing the potential for HDAT. The decision to increase antipsychotic treatment that will result in breaching the HDAT threshold should be discussed with a senior psychiatrist in advance.

Baseline parameters should be obtained if this is possible. If this is not possible because of the patient's acute symptoms, this should be clearly documented in the patient's notes. For patient's subject to statutory treatment plans, the use of HDAT must be reflected in their

T2/T3/T4 certificate. Treatment should be reviewed very regularly and monitoring parameters, particularly ECG, obtained at the earliest opportunity.

The monitoring form has provision to note the short term use of HDAT in an acute emergency situation. This section can also be used if cross titrating puts a patient into the HDAT range on a short term, temporary basis. Baseline parameters should be carried out prior to switching to assess risk factors with ECGs, blood pressure and temperature monitored during the switch.

9. Communication between care settings

It is essential that information on HDAT is clearly communicated when patients move between care settings, e.g. from secondary to primary care or between inpatient settings. Monitoring documentation should be retained in the patients notes and a copy transferred to the new team along with dates for future monitoring, review and rationale for treatment. Where electronic monitoring forms are available these should be used in preference to paper copies.

Primary care should be notified of the patient's high dose status and the implications this has, highlighting the increased risk of side effects including QTc prolongation, which should be considered when prescribing other medications. Prescribing Support suggest that primary care highlight HDAT use in the patient's e-notes on their prescribing system, e.g. adding a 'Patient Warning' on Vision, which appears when accessing patient's electronic file.[7] The letter in Appendix 3 can be used to inform the primary care team of the high dose status, providing additional information around HDAT.

10. Roles and Responsibilities

Overall responsibility for treatment with HDAT lies with the Consultant/Specialist Psychiatrist.

A clear plan should be documented within the patients' notes by the senior psychiatrist with MDT support to outline the plan for initiation, ongoing monitoring and review of patients receiving HDAT.
The responsibility for ongoing monitoring of HDAT sits with mental health services. Responsibilities may vary depending on the location of the patient and the multidisciplinary team members involved in their care.

10.1 Consultant Psychiatrist and Specialist Psychiatrist responsibilities

- High dose antipsychotic initiation and decision to continue HDAT is the responsibility of the consultant psychiatrist
- Discuss with multidisciplinary team and/or obtain informal second opinion prior to prescribing high dose antipsychotic therapy
- Document rationale for high dose antipsychotic therapy within patient's clinical notes
- Discuss rationale with patient and/or carer and document consent

- For patients subject to compulsory treatment - ensure statutory treatment plan on a T2/3 certificate or section 47 includes the use of doses in excess of BNF guidelines and reference the recommended monitoring within this policy prior to prescribing HDAT
- Develop and agree an HDAT monitoring plan (dependent on risk factors, drug interactions and antipsychotic(s) prescribed)
- Ensure a system by which the required monitoring is completed and any abnormal results are acted upon where appropriate
- Ensure at transition of care that other nursing/medical colleagues with a responsibility for prescribing and/or monitoring are informed of the patient's high dose antipsychotic therapy
- Correspond with primary care around HDAT prescribing. A Primary Care Information Letter template is available. See Appendix 3.

10.2 Nursing staff responsibilities (inpatient and community)

- Ensure that high dose antipsychotic therapy is discussed at review
- Ensure high dose antipsychotic monitoring is highlighted within nursing care plan
- Carry out physical health monitoring/ standard observations and enter on HDAT monitoring form (alongside NEWS for inpatients).
- Assess for medication side effects using Antipsychotic Side Effect Rating Scales e.g. GASS[8], GASS-C[9]
- Liaise with psychiatrist if there are any concerns regarding ongoing monitoring, patients physical condition or mental health. Refusal of monitoring should also be highlighted to the Psychiatrist.

10.3 Nurse team leader/ Senior charge nurse responsibilities

- Ensure that ward/ CMHT has a current register of all patients treated with high dose antipsychotic therapy
- Ensure that regular review and monitoring is undertaken for all patients on high dose antipsychotic register

10.4 Clinical pharmacist responsibilities (for inpatient wards with MH pharmacy cover)

- Discuss treatment options/ alternatives with medical staff
- Highlight risk factors including potential interacting medicines
- Highlight high dose antipsychotic therapy on HEPMA care plan
- Initiate high dose antipsychotic monitoring form at multidisciplinary review
- Support patient education

10.5 Inpatient prescriber responsibilities

- Alter the dose of antipsychotic(s) in line with a treatment plan agreed by the multidisciplinary team
- Be aware that the use of PRN antipsychotics may tip the patient into the high dose antipsychotic treatment range. Base line monitoring should be done if this is a possibility, however treatment should not be prescribed without discussing with a psychiatrist
- Ensure prescribing related to HDAT is included in the T2/T3 treatment plan or section 47 where appropriate

10.6 Primary care responsibilities

- Be aware of the patient's high dose antipsychotic status when notified by the psychiatrist and the implications of this on patient's physical health
- Consider the risks of initiating or stopping interacting medicines in patients who have a HDAT status
- Carry out additional monitoring if this is deemed necessary when starting or stopping interacting medications
- Ensure any antipsychotics prescribed are included in the repeat prescription list to trigger drug interactions on the prescribing system (Vision, EMIS)
- Record HDAT use on prescribing system to highlight to prescribers in primary care that patient is on HDAT, such as adding a pop-up 'Patient Warning' which appears when accessing patient's electronic file[7]
- Liaise with psychiatrist or mental health team around the use of HDAT when necessary

Appendices

Appendix 1 - Maximum doses of antipsychotics in adults

(refer to SPC or BNF for maximum doses of antipsychotics in other age groups e.g. older adults)

Antipsychotic	Maximum licensed adult dose (mg/day) 100% BNF maximum
Amisulpride	1200
Asenapine	20
Aripiprazole oral/IM	30
Cariprazine	6
Chlorpromazine oral	1000
Chlorpromazine hydrochloride IM	200
Clozapine	900
Flupentixol	18
Haloperidol Oral / IM*	20
Lurasidone	148
Olanzapine Oral/IM	20
Paliperidone	12
Pericyazine	300
Pimozide**	20
Prochlorperazine	100
Promazine	800
Quetiapine	750 (Mania 800 or where MR prep is used)
Risperidone	16
Sulpiride	2400
Trifluoperazine	50 (suggested by POMH***)
Zuclopenthixol Oral	150
Zuclopenthixol Acetate IM	150 (Elderly 100)
DEPOTS / LONG ACTING INJECTIONS (LAI)	
Depot/Long acting injections (LAI)	Maximum licensed adult dose (mg/time interval) 100% BNF maximum
Aripiprazole monthly LAI (Abilify Maintena®)	400 / four weekly
Aripiprazole 2-monthly LAI (Abilify Maintena®)	960/ eight weekly
Flupentixol decanoate	400 /week
Haloperidol decanoate	75 /week
Olanzapine pamoate	300 / fortnight
Paliperidone LAI (Xeplion®)	150/month
Paliperidone 3-monthly LAI (Trevicta®)	525/3 months
Paliperidone 6-montly LAI (Byannli®)	1000/ 6 months
Risperidone LAI (Consta®)	50/fortnight
Zuclopenthixol decanoate	600 / week

*The maximum cumulative daily dose of IM/oral haloperidol is 20mg but in practice this would only exceed 15mg daily in exceptional circumstances.

**Pimozide is subject to regular ECG irrespective of dose

***Prescribing Observatory for Mental Health. POMH. Ready reckoner version 11, 2024

Appendix 2 – HDAT Review and Monitoring Form

At each HDAT review update Side A and complete review and monitoring parameters on side B

Patient name CHI (or affix patient label)	Consultant Psychiatrist	Is this a continuation from a previous HDAT Monitoring & Review form? Yes ☐ No☐ If yes, when was HDAT first initiated?	Relevant allergies or ADRs
	Name of person giving consent or T2/T3	Is HDAT for the acute short term use of as required medication or temporary to allow cross –titration? Yes☐ No ☐ T4 if appropriate ☐	

Risk Factors (see section 6.3.1)	Details
Cardiac History ☐ Abnormal electrolytes* ☐ Hepatic Impairment ☐ Renal Impairment ☐ Alcohol ☐ Smoking ☐ Illicit drugs ☐ Obese ☐ Learning Disability ☐ Elderly ☐ *correct low potassium and magnesium	

Details of acute as required antipsychotics or cross titration of antipsychotics which have the potential to cause temporary HDAT. Baseline parameters should be carried out before HDAT use (document reasons if this is not possible and do as soon as it is possible) Blood pressure, temperature, ECGs and GASS during temporary period of HDAT	Potential % cumulative maximum

Date Started	Antipsychotic	Daily Dose	% Maximum Dose	Cumulative % maximum of current antipsychotics	Date stopped	Interacting Medicines	Start Date or note if 'Pre HDAT'	Date stopped

Ensure this tool is double sided printed so monitoring record is on the reverse of this page

Patient name	CHI	Consultant psychiatrist

High Dose Antipsychotic Treatment Review and Monitoring Record

Details of abnormal results should be documented in patient notes along with a management plan

• Baseline (before increasing to HDAT) • At one month • At 3 months • 3 monthly (3-6 monthly if stable) • After dose increase • After change in interacting medicine MORE FREQUENTLY WHERE THERE ARE CONCERNS		**Rational** for initiation/ continuing justified & documented	**Consent/ T2/T3** still valid?	**Change to risk factors** Including dose change or new interacting medicine *(document details on page 1)*	**ECG**		**LFTs & U&Es, Mg, Ca**				Temp (^{0}C)	Pulse and Blood Pressure	Date GASS completed	Date next review due
					Date ECG card given	Enter QTc Interval normal Male <440ms Female <470ms	Date bloods Taken	Review by Psychiatrist						
								U&E	Mg Ca	LFTs				
Current Cumulative % maximum	Date, tick and/or enter details where indicated													
%	Signature													
Concerns / Abnormal results/ Follow up														
Current Cumulative % maximum	Date, tick and/or enter details where indicated													
%	Signature													
Concerns / Abnormal results/ Follow up														
Current Cumulative % maximum	Date, tick and/or enter details where indicated													
%	Signature													
Concerns / Abnormal results/ Follow up														
Current Cumulative % maximum	Date, tick and/or enter details where indicated													
%	Signature													
Concerns / Abnormal results/ Follow up														

Appendix 3 – Primary Care Information Letter

Dear

Regarding your patient CHI

I recommend that the following antipsychotic treatment be prescribed for this patient.

Name of antipsychotic	Daily dose	% of maximum dose	Cumulative % max

The above dose(s) fall into the High Dose Antipsychotic Treatment (HDAT) range either because the maximum licence dose has been exceeded or cumulative % of the maximum licence dose of 2 or more antipsychotics is greater than 100%. Please refer to the NHSL High Dose Antipsychotic Treatment Guidance (HDAT), on the NHSL Clinical Guidelines website, for more information.

I have obtained consent from the patient or his/her legal representative and the patient is being monitored according to the NHSL HDAT guidance. A copy of the consent form is attached.

HDAT increases the risks of side effects including QTc prolongation. Consideration has been given to the current medicines that I am aware the patient is taking. Please be aware that additional changes to the patient's general medicines may have an impact on the risks associated with HDAT. Consideration should be given to U&E and/or ECG monitoring soon after initiating an interacting medicine to minimise risk to patient's physical health. Please liaise with the mental health team to communicate the results of any additional monitoring.

Prescribing Support suggest that Primary Care record HDAT use in the patient's e-notes on their prescribing system, e.g. adding a 'Patient Warning' on vision, to highlight the patient's HDAT status. *

Additional information if relevant

Thank you
Yours faithfully

Name of consultant or specialist psychiatrist

Signature of consultant or specialist psychiatrist

Date

*https://help.cegedim-healthcare.co.uk/DLM830/Consultation_Manager/Content/ConMgr/Quick_Reference_Topics/Adding_a_Patient_Warning.htm?Highlight=warning

References/Evidence

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2. Patient Consent to Unlicensed Medicine Use. https://rightdecisions.scot.nhs.uk/media/11ohbdnn/appendix-6-patient-consent-to-unlicensed-medicine-use.pdf
3. NHS 24 Choice and Medication. https://www.choiceandmedication.org/nhs24/
4. NHS Greater Glasgow and Clyde High Dose Antipsychotic Monitoring Policy. https://rightdecisions.scot.nhs.uk/m/1605/mhs-34-high-dose-antipsychotic-monitoring-policy.pdf
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8. Glasgow Antipsychotic Side-effect Scale (GASS), Right Decisions, NHS Lanarkshire Guidelines, Mental Health. glasgow-antipsychotic-side-effect-scale-gass.pdf
9. Glasgow Antipsychotic Side-effect Scale for Clozapine (GASS-C), Right Decisions, NHS Lanarkshire Guidelines, Mental Health. glasgow-antipsychotic-side-effect-scale-for-clozapine-gass-c.pdf

1. Governance information for Guidance document

Lead Author(s):	Caroline McLean
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CONSULTATION AND DISTRIBUTION RECORD	
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Consultation Process / Stakeholders:	• Psychiatry • MHLD Nursing • Mental health Pharmacy • LMC • Primary Care Support Pharmacy
Distribution	• Dissemination to all MH&LD, OAP & CAMHS Medical & Nursing & Pharmacy Staff, Wards and Community teams • MH&LD D&T Newsletter Prescribing Notes

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
Sept 21	L Dewar	Overall review (SLWG) with main points as follows; - • Reconfiguration and condensation of version 1 • Additional sections on Acute settings and Consent and legislation • HDAT Monitoring Form reconfigured and more detail added • Specialised responsibilities for community and inpatient setting merged but unchanged General practice responsibilities unchanged	2
Sept 24	C McLean	Change of format in line new CG template. Changes to content, main points as follow; • Removal of Tools 2,3,4,5. Key points from tools added to main text. • Responsibilities section altered to increase clarity. No change to responsibilities. • Good Practise Flow Chart for Monitoring Antipsychotics removed. • Page 5 version 2 stated prescribing for children should be considered HDAT. On discussion with CAMHS psychiatry this is not the case in practice, additional monitoring is carried but not using HDAT paperwork. • Page 7 – New table added, Management of QTc prolongation. • New – Appendix 1, Table of Maximum doses of antipsychotics.	3