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High Dose Antipsychotic Therapy

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High Dose Antipsychotic Therapy

Guideline Scope

This guideline should be followed whenever a patient is prescribed antipsychotic drugs in the high-dose range, regardless of his/her location or of the status of the prescriber. Non-medical prescribers should not under any circumstances initiate high dose antipsychotic prescribing, but may be involved in reducing the antipsychotic dose in line with an agreed clinical management plan.

The guideline identifies the primary responsibilities of professional groups whenever high dose antipsychotic prescribing occurs. It should be borne in mind that good communication between prescribers in primary and secondary care is paramount in preventing unintended high dose antipsychotic prescribing. Any new prescription for an antipsychotic or increased dose should be communicated to other prescribers who may also have a responsibility for the care of the patient.

Prescribing should be in line with any T2 or T3 where applicable where the patient is subject to a treatment order under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Introduction

The Consensus statement on the risks and benefits of high-dose antipsychotic medication (Royal College of Psychiatry
College Report CR190, Revised January 2023) defines high-dose antipsychotics use as:

- *A total daily dose of a single antipsychotic which exceeds the upper limit stated in the summary of product characteristics or BNF …*

[or]

- *A total daily dose of two or more antipsychotics which exceeds the summary of product characteristics or BNF maximum using the percentage method.*

Doses above the BNF maximum are more likely to occur with the co-prescription of depot/long acting formulation and oral medication or a combination of typical and atypical drugs. It should also be noted that the prescribing of ‘as required’ antipsychotics may contribute to high-dose antipsychotic use. Good communication and documentation of ‘as required’ medication use may prevent inadvertent high dose prescribing.

The British Association for Psychopharmacology has provided the following advice regarding high dose antipsychotic prescriptions (2019):

- High dose antipsychotic therapy should only be used in treatment resistant schizophrenia after the failure of several adequate sequential trials of antipsychotic monotherapy and other evidence based treatments including optimized treatment with clozapine have been exhausted.
- All high dose prescriptions should be reviewed regularly with an assessment of therapeutic response, target symptoms and adverse effects.
- Physical health monitoring should include physical exam, haematological investigations and an ECG.
- High dose antipsychotic therapy should be continued after 3 months only if there is a clear benefit.

All patients on high-dose antipsychotic therapy must be monitored. These guidelines attempt to clarify the identification of patients on high-dose antipsychotics, factors to be taken into account before such prescribing and the documentation required when antipsychotics are prescribed in high-dose.

High Dose Antipsychotic Therapy (HDAT) Principles

1. See appendix I, **Identification of Patients on High-Dose Antipsychotic Therapy.**

2. Consider alternative approaches including certain antipsychotics which are considered more effective, namely haloperidol, amisulpride, risperidone and olanzapine. Adjuvant and newer antipsychotics should also be considered.

3. A depot antipsychotic preparation should be considered if adherence to oral antipsychotic medication is a concern.

4. Clozapine should be considered in established treatment resistant schizophrenia following failed treatment from two adequate trials of antpsychotics, at least one of which was a second generation antipsychotic.

3. **The responsibility to exceed the licensed dose of a single antipsychotic or a combination of more than one lies with the patient's consultant psychiatrist.** The decision should be discussed with the multidisciplinary team, the patient and/or carer and valid **consent** obtained. For detained patients, ensure compliance with the Mental Health (Care and Treatment) (Scotland) Act 2003. The details of the decision-making process should be recorded in the patient's case notes including the clinical indication for use of HDAT. That the patient was informed of the HDAT, or the reason why they have not been informed, should be documented in the notes.

4. HDAT may be prescribed in an emergency for acute symptoms. This **must** be discussed with a Consultant Psychiatrist before it is prescribed. If this is not possible the reason should be documented and the prescription reviewed at
the next opportunity by the Consultant or deputy.

5 Only the Consultant or deputy should make the decision to use HDAT regularly. The decision should be documented in the patient's notes.

6. **Action**
   - Indicate on the medicine chart that the patient is receiving high-dose antipsychotics by filling out "high dose monitoring applicable" section.
   - A High-Dose Antipsychotic Monitoring Sheet (Appendix III) **s**hould be completed for the patient and filed in notes under investigations.

(a) Consider **risk factors** such as:

- Cardiac history (particularly MI, arrhythmias, abnormal ECG)
- Hepatic / renal impairment
- Alcoholism / smoking
- Old age
- Obesity
-

(b) Consider **potential drug interactions** e.g.

- Drugs which are known to prolong QTc interval including anti-arrythmics
  For an up-to-date list of drugs known to prolong QTc interval, see online reference www.crediblemeds.org and follow link for QT drugs list, selecting option:
  'To view QT-prolonging drugs grouped by *risk* of Torsades, *possible risk* of Torsades and *conditional risk* of Torsades'

- Pharmacokinetic interactions i.e. drugs that increase antipsychotic plasma levels.(NB smoking can decrease plasma levels of antipsychotics, therefore, smoking cessation will increase plasma levels.)

- Diuretics which can cause electrolyte abnormalities e.g. hypokalaemia, hypocalcaemia, hypomagnesaemia.

(c) Obtain a pre-high-dose antipsychotic baseline ECG. If a prolonged QT interval is recorded (QTc > 440ms^{-1}), review treatment. Consider cardiology assessment. If it is decided to continue treatment,

record reasons for doing so in patient's case notes. All patients on HDAT should have regular ECGs (baseline, when steady-state serum levels have been reached after each dosage increment, and then every 6-12 months). Additional biochemical/ECG monitoring is advised if drugs that are known to cause electrolyte disturbances or QTc prolongation are subsequently co-prescribed.

(d) Serum urea and electrolytes and liver function should be checked before prescribing. Biochemical monitoring should be undertaken every 6 months and if drugs that are known to cause electrolyte disturbances of QTc prolongation are subsequently co-prescribed.

7. Where possible increase the dose slowly ideally over intervals of at least one week.

8. Review progress at least once every 3 months, reducing dose to within the licensed range if no significant progress is observed and consider alternative approaches, e.g. adjuvant therapy and newer or 2nd generation antipsychotics such as Clozapine. Continued use of high-dose therapy where there is no clinical response should be justified in the case notes. Consultants should consider seeking a second opinion from a colleague. The review should be documented in the patients' notes.

9. The Royal College of Psychiatrists Consensus Statement recommends monitoring of psychotic symptoms. Improvement in psychotic symptoms and side effects should be regularly assessed. Rating scales may be useful, for example CGI (Clinical Global Impression) & HoNoS (health of nation outcome scales) to assess progress and, GASS (Glasgow Antipsychotic Side effect scale) & LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) to assess side effects. These would be performed at weeks 0, 6 and 12, then at least annually.

HDAT Monitoring Responsibilities

Medical Staff Responsibilities

- Identify that a patient is on high-dose antipsychotics on the medicine chart and alert nursing team.
- On the High Dose Antipsychotic Monitoring Form (appendix III) complete the following:
  - Patient details
  - High dose details and %
  - Interacting medicines section
  - Risk factors
- Inform key worker and medical staff of high-dose status
- Arrange ECGs at recommended intervals
- Check FBC, U&Es andLFTs at recommended intervals and if change in hepatic function suspected
- Document reason for high-dose in clinical notes
- Inform patient and document consent in notes
- Ensure HDAT is authorised on Form T2 / T3, if applicable
- Ensure on patients' discharge that GP and other relevant community mental health personnel are informed of HDAT status and required checks
- Ensure that other medical prescribers (GPs and Psychiatrists) with a responsibility for the patient are informed of prescribing which generates HDAT
- Ensure a system by which the required tests and reviews will be conducted and is agreed with the relevant community mental health personnel & / or GP
- Ensure policy is followed for HDAT

Initiation of high-dose antipsychotic therapy is the responsibility of the consultant. Pharmacists will support monitoring by identifying patients on high dose therapy.

Nursing Staff Responsibilities – document initially, after dose changes and three monthly on the high dose monitoring chart

- TemperatureBlood pressure and pulse checks at recommended intervals
- Document "high dose" status in Nursing Notes / Care Record
- Check that monitoring form is being completed and forms uploaded to EMIS after each completion and bring to medical staff attention if monitoring not in place
- Ensure that high-dose status is discussed at MDT reviews

References

Barnes et al. Evidence based guidelines for the pharmacological treatment of schizophrenia: updated recommendations from the British Association of Psychopharmacology. British Association of Psychopharmacology. 2019

Huhn, M et al (2019). Comparative efficacy and tolerability of 32 oral antipsychotics for the acute treatment of adults with multi-episode schizophrenia: a systematic review and network meta-analysis. *Lancet.*, 394: 939-951.

Harrington *et al, (2002)* The results of a multi-centre audit of the prescribing of antipsychotic drugs for in-patients in the UK. *Psychiatric Bulletin,* **26**, 414-418.

Royal College of Psychiatry. Consensus statement on the risks and benefits of high-dose antipsychotic medication. *College Report*
CR190 2014 (Revised January 2023)

The Maudsley Prescribing Guidelines in Psychiatry, 14th Edition, 2021.

Appendix I: Identification of Patients on High Dose Antipsychotic Therapy

High dose antipsychotic prescribing may be achieved in TWO ways:

A. Single antipsychotic drug prescribed at a daily dose above the BNF upper recommended limit (High Dose single drug).

B. More than one antipsychotic prescribed concurrently (High Dose through the prescribing of multiple drugs). In defining what constitutes a high-dose of antipsychotics for patients receiving more than one antipsychotic at doses within the normal BNF ranges, use the percentage method for calculating high dose status. When expressed as a percentage of their respective recommended maximum dose and added together, a cumulative dose of greater than 100% is considered 'high dose'

Antipsychotic	**Maximum Licensed (Adult) Daily Doseie 100%** (mg/day)
Amisulpride oral	1200
Asenapine oral	10
Aripiprazole oral	30
Aripiprazole IM injection	30
Cariprazine oral	6
Chlorpromazine oral	1000
Clozapine oral	900
Flupentixol oral	18
Haloperidol oral	20
Haloperidol IM Injection	20
Lurasidone oral	148
Olanzapine Oral	20
Olanzapine IM injection	20
Paliperidone oral	12
Pericyazine oral	300
Perphenazine oral	24
Pimozide oral**	20
Prochlorperazine oral	100
Promazine oral	800
Quetiapine oral	800
Risperidone oral	16-
Sulpiride oral	2400
Trifluoperazine oral	50 (suggested by POMH_)
Zuclopenthixol Oral	150
Zuclopenthixol Acetate IM injection	150 (Elderly 100)
DEPOTS / LONG ACTING INJECTIONS	Maximum licensed dose (mg)
Aripiprazole **depot**	400mg/month
Flupentixol **depot**	400mg /week
Haloperidol **depot**	75mg /week
Olanzapine **depot**	300mg/fortnight
Paliperidone **depot**	150mg/month
Pipotiazine **depot**	50mg /week
Zuclopenthixol **depot**	600mg / week
Risperidone **Consta**	25mg/week (50mg/fortnight)

For example:
A patient on Clozapine 700mg and Amisulpride 400mg daily.
Sum of percentages: 78% + 33% = 111% (>100%, therefore High-dose)

Use of "Discretionary" (PRN or 'as required') antipsychotic medication should also be taken into account.
** Subject to annual ECG irrespective of dosage.
♦POMH: Prescribing Observatory for Mental Health, Royal College of Psychiatrists

Appendix II: Prescribing Guidance: The Use of More Than One Antipsychotic Drug at the Same Time

More than one antipsychotic drug should only be given concurrently as part of a considered treatment plan.

- There is no evidence to support combinations of first and second generation antipsychotics having fewer neurological side effects than first generation medicines alone
- Polypharmacy regimes are more complex, potentially confusing and error prone.
- Polypharmacy with antipsychotics does not allow an accurate assessment of the effectiveness of each drug nor the effect of dose titration of any given drug accurately.
- There are few good RCTs of antipsychotic polypharmacy (there are some RCTs of clozapine augmentation). Although this does not mean that some combinations are not effective in some individuals, more robustly evidence-based approaches should be considered before resorting to non-evidence based and higher-risk treatments.
- "High dose" can inadvertently occur with combinations. PRN antipsychotics are particularly problematic in this respect.
- Subtle drug interactions can occur with combinations through P450 and other enzyme systems.

Before combination antipsychotics are used, check:

- The diagnosis is correct
- Plasma levels (if appropriate) are therapeutic and drug compliance assured.
- Treatment duration has been fully adequate.
- Delayed onset of action
- Adverse social and psychological factors are minimised.
- Alternative adjunctive drug therapies have been tried.
- An objective measure of effectiveness of drug therapy on symptomatology is used.

If a combination will result in exceeding 100% BNF maximum dose the High-dose antipsychotic policy should be adhered to.

Appropriate indications for use of combination therapy include:

√ Failure to respond to Clozapine
√ Failure to tolerate Clozapine
√ Where Clozapine had produced a partial response, as augmentation.
√ During the switch from one antipsychotic to another
√ As a temporary measure during an acute exacerbation of illness.

Inappropriate indications would include:

x Utilising drug for sedative rather than antipsychotic effect.
x Initiation before adequate length of trial of first drug (at least 6 weeks).
x As a substitute for planning, communicating and completing a change to alternative antipsychotic therapy.
x Where clinical improvement occurs before a switch is completed. An improvement seen during the switch *may* indicate a trial of the combination if appropriate.
x Where inadequate resources and/or modifiable environment factors are associated with higher medication dosages

If multiple antipsychotics are to be used:

- The patient should be informed and consent obtained and documented, using relevant legislation as needed (this is to cover t2/3).
- The rationale for use should be documented in the patients' clinical notes.
- The clinical indication for use should be documented in the patients' clinical notes.
- The use of multiple antipsychotic therapies should be reviewed regularly (at least every 3 months) with regard to the clinical indication and the result of this review documented.
- If no improvement is seen at review, discontinuation of multiple antipsychotic therapies should be considered and decision documented.
- More than two regular antipsychotics would indicate the need for further medication review with pharmacy support; a second medical opinion should be considered.

Appendix III: High Dose Antipsychotic Monitoring Form

This form must be completed for all high dose therapy patients – preferably prior to commencing treatment.

Name:	**DOB:**
CHI:	**Consultant:**

High dose therapy checklist - *please circle as appropriate.*

PMH – contraindications/Cautions				
History of cardiac disorders?	**Y**	**N**		
Hepatic impairment?	**Y**	**N**		
Renal impairment	**Y**	**N**		
Obesity	**Y**	**N**		
Heavy smoker	**Y**	**N**		
Heavy alcohol intake	**Y**	**N**		
Old age	**Y**	**N**		
Details:				

If there are any relative contraindications highlighted please state reasons why high dose therapy is to continue:

Rationale for High-Dose Antipsychotic Therapy

Failure to respond to Clozapine		During the switch of one antipsychotic to another	
Failure to tolerate Clozapine		As a temporary measure during an exacerbation of illness	
Partial response to Clozapine: as augmentation		Other:	

Consent obtained for high dose therapy

Patient Consent ☐ Section 47 ☐ T2 ☐ T3 ☐

Record of clinical monitoring (tick box when occurs) on 3 month basis and then annually. If results are abnormal, record in nursing/medical notes & inform the patients consultant. It is not anticipated that every patient will have CGI, HoNoS, GASS & LUNSERS performed but formal assessment of progress & side-effects is good practice,

HDAT monitoring	**Pre-HDAT**	**On going**	**On going**	**On going**	**On going**	**On going**	**On going**	**On going**	**On going**
Date									
Patient consented or declined monitoring									
Drug(s) and doses									
% BNF max									

Possible drug interactions									
ECG (tick if ok)									
U&Es (tick if ok)									
LFTs (tick if ok)									
FBC (tick if ok)									
BP (mmHg)									
Pulse									
Temp (°C)									
CGI									
HoNos									
GASS									
LUNSERs									

Appendix IV: Antipsychotic Dosage Chart

ANTIPSYCHOTIC DOSAGE READY RECKONER - VERSION 8

February 2019 - *Always check you are using the latest version*

POMH-UK PRESCRIBING OBSERVATORY FOR MENTAL HEALTH-UK

Depot/long-acting injection and IM antipsychotics

Depot: dose calculated as mg/week

IM/Inhaled: dose in mg/day

Percentage of BNF maximum adult dosage

		5	10	15	20	25	30	33	40	45	50%	55	60	67	70	75	80	85	90	95	100%
Flupentixol	Depot	20	40	60		100					200					300					400
Haloperidol	Depot							25			37.5			50							75
Zuclopenthixol	Depot			100				200			300			400			500				600
Aripiprazole	Long-acting										50										100
Olanzapine	Long-acting										75										150
Paliperidone *	Long-acting													25							37.5
Paliperidone Trevicta**	Long-acting																				43.75
Risperidone	Long-acting										12.5					18.75					25
Aripiprazole	IM							10			15			20							30
Chlorpromazine	IM			25		50					100					150					200
Haloperidol	IM					5					10					15					20
Levomepromazine	IM			25		50					100					150					200
Olanzapine	IM					5					10					15					20
Zuclopenthixol acetate* **	IM													50							75
Loxapine	Inhaled										9.1										18.2

* Maintenance dose licensed to be given monthly. ** Formulation licensed to be given every 3 months. ***A maximum of 150 mg in any 48-hour period and a maximum cumulative dose of 400 mg in any two week period.

To calculate a total daily prescribed antipsychotic dose as a percentage of the BNF maximum: determine the percentage of BNF maximum dosage for each antipsychotic that is prescribed, and then sum the percentages. For example, for a person prescribed clozapine 400mg a day and oral haloperidol 5mg PRN up to 3 times a day, the respective percentages would be 44% and 75%, giving a total antipsychotic prescribed dosage of 119% of the BNF maximum.

Contact pomh-uk@rcpsych.ac.uk to order copies of this Ready Reckoner www.rcpsych.ac.uk/pomh

ANTIPSYCHOTIC DOSAGE READY RECKONER - VERSION 8

February 2019 - *Always check you are using the latest version*

POMH-UK PRESCRIBING OBSERVATORY FOR MENTAL HEALTH-UK

Oral antipsychotics

Dose in mg/day

Percentage of BNF maximum adult daily dosage

		5	10	15	20	25	30	33	40	45	50%	55	60	67	70	75	80	85	90	95	100%
Amisulpride	Oral							400			600			800			1000				1200
Aripiprazole	Oral							10			15			20							30
Asenapine	Oral					5					10					15					20
Benperidol	Oral							0.5			0.75			1							1.5
Cariprazine	Oral					1.5					3					4.5					6
Chlorpromazine	Oral		100	150			300				500		600			750					1000
Clozapine	Oral			150				300	400		450			600							900
Flupentixol	Oral			3				6			9			12				15			18
Haloperidol	Oral		2			5					10		12			15					20
Levomepromazine	Oral		100			250					500					750					1000
Lurasidone	Oral					37					74					111					148
Olanzapine	Oral					5		7.5			10					15					20
Paliperidone	Oral					3					6					9					12
Pericyazine	Oral					75		100			150			200							300
Pimozide	Oral		2		4		6		8		10		12								20
Promazine	Oral			150				300			400					600					800
Quetiapine*	Oral		75	100	150				300		375		450				600				750
Risperidone	Oral		2			4		6			8					12					16
Sulpiride	Oral			400				800			1200			1600			2000				2400
Trifluoperazine**	Oral		5		10		15		20		25		30		35		40		45		50
Zuclopenthixol	Oral		20		30			50						100							150

* 750mg/day max for schizophrenia, 800mg/day max for mania or if XL preparation used. % given for schizophrenia.
** No max dose stated in BNF or SPC. 50mg used by convention.

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Appendix V: Audit Tool : Audit Criteria

Data collection	
Number of regular antipsychotics prescribed	Regular antipsychotics, dose per day (with BNF % maximum)
Number of as required antipsychotics prescribed	As required antipsychotics, maximum potential dose per day (with BNF % maximum)
Total BNF % maximum (regular + as required)	

	Criteria	Standard	Exception
1	All patients prescribed HDAT are identified as such on medicine chart	100%	None
2	Each patient identified as receiving HDAT has a high dose form with baseline information completed	100%	None
3	There is evidence from the HDAT form that monitoring is being completed and is up to date.	100%	None

2nd tier audit criteria

	Criteria	Standard	Exception
1	Case notes contain ECGs as per HDAT monitoring from past 12 months	100%	Reason(s) for not performing ECG is documented in notes
2	Case notes contain blood results as per HDAT monitoring from past 12 months.	100%	Reason(s) for not obtaining bloods is documented in notes
3	Evidence of observations (pulse, temp, bp) as per HDAT monitoring form over past 12 months	100%	Reason(s) for not performing observations is documented in notes
4	Evidence of rationale for HDAT within notes (if initiation was within 2 years)	100%	None
5	Evidence of patient consent (including discussion) in informal patients (if initiation was within 2 years) or compliance with MHA legislation (T2/T3)	100%	None
6	If medication is prescribed that is known to prolong the QTc interval, this is referred to on the HDAT form	100%	No medication known to prolong QTc interval is prescribed
7	Number of doses of as required medication • in last 2 weeks, in last 4 weeks, in last 8 weeks		

3rd tier – information gathering

Gender of patient	Consultant
Age of patient	Grade of prescriber of HDAT
Primary Diagnosis	Current length of admission
Ward type	Duration of HDAT prescription
Location	Additional risk factors Cardiac disease, hepatic impairment, renal impairment, old age, obesity, diuretics, antihypertensives

High Dose Antipsychotic Therapy (HDAT) Audit Tool

Date of collection…….Data collector ID……

Patient identifier/ CHI number……

This high dose antipsychotic therapy (HDAT) audit tool has been designed to monitor adherence to the current HDAT policy, but also to assess the incidence of HDAT prescribing within a designated clinical area. It is therefore advised that initial audit criteria should be collected for all patients prescribed antipsychotic therapy and then data collection continued for all those designated as 'high-dose.' Thus, providing data on both incidence of HDAT prescribing and adherence to current policy.

The audit tool has been subdivided into 3 sections:
initial (1st tier) audit criteria set for the most basic and easiest to collect HDAT audit
2nd tier audit criteria set for a more comprehensive HDAT audit and
3rd tier criteria set which is an information gathering exercise around HDAT prescribing

Initial (1st tier) audit criteria

Number of regular antipsychotics prescribed:
1 Δ 2 Δ 3 Δ >3 Δ

Number of as required antipsychotics prescribed:
1 Δ 2 Δ 3 Δ >3 Δ

Regular antipsychotic(s), dose per day and % BNF maximum:

Medicine	Daily dose	% BNF maximum	Total % BNF maximum (regular) (α)

As required antipsychotic(s), maximum potential dose per day and % BNF maximum:

Medicine	Maximum daily dose	% BNF maximum	Total % BNF maximum (as required) (β)

Total % BNF maximum = regular % (α) + as required % (β)

= ……...

For all patients identified as high dose (>100% BNF maximum), continue with standards A1- A3 , B1-7 and information gathering

Standard A1:
All patients prescribed HDAT are identified with a HDAT sticker.

Yes Δ No Δ

Standard A2:
Each patient identified as receiving HDAT has a high dose form with baseline information completed.

Yes Δ No Δ

Standard A3:
There is evidence from the HDAT form that monitoring is being completed and is up to date.

Yes Δ No Δ

2nd tier audit criteria

Standard B1:

Case notes contain ECGs and evidence of any appropriate action as per HDAT monitoring form over past 12 months.

Yes Δ No Δ

Standard B2:
Case notes contain blood results and evidence of any appropriate action as per HDAT monitoring form over past 12 months.

Yes Δ No Δ

Standard B3:
There is evidence of observations (pulse, temp, bp) as per HDAT monitoring form over past 12 months.

Yes Δ No Δ

Standard B4:
There is evidence of rationale for HDAT within case notes (if initiation was within past 2 years)

Yes Δ No Δ

Standard B5:
There is evidence of patient consent (including discussion with patient) in informal patients (if initiation was within past 2 years) or compliance with MHA legislation (i.e. HDAT is mentioned on T2 or T3 form)

Informal Δ T2 Δ T3Δ Yes Δ No Δ

Standard B6:
If medication is prescribed that is known to prolong the QTc interval, this is referred to on the HDAT monitoring form.

Yes Δ No Δ N/A Δ

Standard B7:
The number of doses of as required antipsychotics given in last **2 weeks**

0 Δ 1 Δ 2 Δ 3 Δ 4 Δ 5 Δ 6Δ 7 Δ 8 Δ 9 Δ 10 Δ

Specify for > 10……..

The number of doses of as required antipsychotics given in last **4 weeks**

0 Δ 1 Δ 2 Δ 3 Δ 4 Δ 5 Δ 6Δ 7 Δ 8 Δ 9 Δ 10 Δ

Specify for > 10……..

The number of doses of as required antipsychotics given in last **8 weeks**

0 Δ 1 Δ 2 Δ 3 Δ 4 Δ 5 Δ 6Δ 7 Δ 8 Δ 9 Δ 10 Δ

Specify for > 10……..

3rd tier criteria – information gathering

Gender of patient:
M Δ F Δ

Age of patient:
<20 Δ 21-30 Δ 31-40 Δ 41-50 Δ 51-60 Δ 61-70 Δ >70 Δ

Primary Diagnosis:
Treatment resistant schizophrenia Δ Bipolar disorder Δ

Other ……..

Ward type:
Acute adult Δ IPCU Δ Continuing care Δ Rehab Δ

Forensic Δ Elderly Δ Adolescent Δ Other……..

Location:
……

Consultant:
……

Grade of prescriber of HDAT:
Consultant Δ ST4-6 Δ Staff Grade Δ ST1-3 Δ FY2Δ Other……

Current length of admission:
<2 weeks Δ 2-4 weeks Δ 1-3 months Δ 3-6 months Δ

6-12 months Δ >12 monthsΔ (specify for >12 months……..)

Duration of HDAT prescription:
<2 weeks Δ 2-4 weeks Δ 1-3 months Δ 3-6 months Δ

6-12 months Δ >12 monthsΔ (specify for >12 months……..)

Additional risk factors:

	Yes	No
Cardiac disease	Δ	Δ
Hepatic impairment	Δ	Δ
Renal impairment	Δ	Δ
Old age	Δ	Δ
Obesity	Δ	Δ
Diuretics	Δ	Δ
Antihypertensives	Δ	Δ

Other risk factors
……..