

Guidance for recommended on going physical monitoring of psychotropic medication in primary care

SWLSTG doctors should communicate all baseline physical monitoring that was done as an inpatient prior to initiating psychotropic medicines

If a woman of child bearing age check if pregnant/breast feeding or planning a pregnancy.

Antipsychotics

Adults Annual: fasting glucose, lipid profile, FBC, LFTs, U&E, eGFR, weight, BMI, pulse, blood pressure, prolactin if indicated, TFTs (with quetiapine only). It is good practice for all patients on antipsychotics to be offered an annual ECG however for patients on high dose antipsychotic therapy (single or cumulative doses > 100% BNF maximum) or who have co-morbid cardiovascular disease should have 6 monthly ECG.

VTE risk assessment on initiation or if a change in risk factors for VTE.

Child and adolescents (children and adolescents under 18yrs)

6-monthly: BP, pulse, BMI & weight (ECG if there is a familial CVD history). Ask about side effects regularly. **Annual:** Fasting blood glucose, plasma lipids, full blood count & liver function tests.

ADHD Medicines (see ADHD shared care guideline)

Adults 3 months: Weight, Pulse and BP. ECG only if family history, PMH or physical examination indicates likelihood of cardiovascular disease.

Annual: Weight.

Child and adolescents 6 monthly: Blood pressure, pulse & height. Monitor weight every 3 months in children 10 years and under. Monitor weight at 3 and 6 months after starting treatment in children over 10 years and every 6 months thereafter.

LFTs / FBC should be measured if signs of liver impairment (seen with atomoxetine).

Lithium (see Lithium Shared Care guideline)

Levels 3 monthly: Take level 12 hours post dose & 1 week after initiation or dose change: Mania or BPAD: 0.5-1.0mmol/L. Upper levels (0.8-1.0mmol/L) for treatment resistance or mania. Unipolar depression augmentation 0.4-1.0mmol/L. **6 monthly:** TFTs, eGFR & calcium. **Annual:** TFT (6-monthly in rapid cycling), fasting glucose, lipid profile (over 40s), blood pressure, weight & BMI.

Child and adolescents additional monitoring of height and prolactin monthly for the first 6 months then 6 monthly.

Valproate

At 6 months: BMI, weight, FBC & LFT. **Annual:** FBC, LFTs, eGFR, TFT, fasting glucose, lipid profile (over 40s), blood pressure, weight & BMI. **Levels taken pre-dose:** Not recommended routinely. >92mg/L may give a better response in mania, no recommendation for BPAD prophylaxis. Normal levels 50-100mg/L. Take levels 5-7 days after a stable dose.

Child and adolescents additional monitoring of height and prolactin monthly for the first 6 months then 6 monthly.

Carbamazepine

At 6 months: LFTs, FBC, weight & BMI. **6 monthly:** U&E, eGFR & levels. **Annual:** TFT, fasting glucose, lipid profile (over 40s), blood pressure, weight, height, LFTs & FBC. **Levels:** Two after initiation & dose change. Then every 6 months. Recommended level 7-12mg/L.

Child and adolescents additional monitoring of height and prolactin monthly for the first 6 months then 6 monthly.

Lamotrigine

Annual: TFT, fasting glucose, lipid profile (over 40s), blood pressure, weight, & height.

Child and adolescents additional monitoring of height and prolactin monthly for the first 6 months then 6 monthly.

Antidepressants

Baseline ECG advisable for escitalopram, citalopram and tricyclic antidepressants (TCAs).

Annual ECG is recommended if risk factors for or existing cardiovascular disease are present.

Specific Monitoring

FBC if signs of agranulocytosis (Mirtazapine, TCAs)

Enhanced monitoring of INR for patients on anticoagulation (SSRIs, TCAs, mirtazapine)

BP monitoring (Mirtazapine, MAOIs, venlafaxine)

Agomelatine (non-formulary) - Liver Function Tests - Baseline then at 3, 6, 12 and 24 weeks and when clinically indicated: <https://www.medicines.org.uk/emc/product/6564/rmms>

This list is not exhaustive. Prescribers should refer to the summary of product characteristics (SPC) for product specific monitoring and interactions: <https://www.medicines.org.uk/emc/>

Patient information leaflets including information about common side effects (e.g. [weight gain with antipsychotics](#), drowsiness, metabolic syndrome) and what to do can be found on the Choice and Medication website: <https://www.choiceandmedication.org/swlstg-tr>

Physical health monitoring while on Antipsychotics – Who is responsible?

Patients newly initiated on an antipsychotic

NICE recommends that patients physical health monitoring is completed by secondary care for at least the first 12 months. After which time, if a patient is stable, physical monitoring should be transferred to primary care. If a patient's condition is stabilised or where it is in the patient's best interest the secondary care team may choose to request that physical monitoring is transferred to primary care with the agreement of the GP or under shared care before 12 months.

Patients under shared care

The GP is responsible for the physical health monitoring of patients under shared care, this includes those whose depot/long acting antipsychotic is administered in primary care. All monitoring should be fed back to secondary care who have a responsibility to ensure that monitoring has been completed in primary care. All secondary care clinicians should have access to all SWL acute Trust pathology systems to check blood test results.

Patients whose medicines are prescribed by secondary care

For those patients whose medicines are prescribed by SWLSTG e.g. depot/long acting antipsychotics and clozapine, the responsibility for ensuring the physical monitoring is complete lies with the Trust prescriber. Where/who carries out the physical monitoring may vary for these patients e.g. GP surgery, acute Trust, clozapine clinic. Physical monitoring in primary care should be encouraged where GPs are happy to do so. This facilitates timely physical health interventions e.g. the initiation of statins for high cholesterol. It is encouraged that monitoring for patients on clozapine should be completed by the clozapine clinic.

Support for GPs

Some patients may not engage well with the primary care team, making physical monitoring difficult. Secondary care teams should offer support to primary care when requested to facilitate this process e.g. a patient may not respond to requests from the GP surgery to come in for a physical health check but may engage if encouraged by a member of the Community Mental Health Team whom they know and trust.

Responsibility for:	Patient group			
	st 1 12 months after antipsychotic Initiated *All other psychotropics	Patients under shared care	Patients receiving medicines from SWLSTG	Patients on CPA
Carrying out physical monitoring	SWLSTG, however primary care may be requested to do the checks *SWLSTG until transfer of care	GP	SWLSTG, however primary care may be requested to do the checks	SWLSTG, however primary care may be requested to complete physical health checks which works within the CPA framework.
Ensuring physical monitoring occurs	SWLSTG	SWLSTG	SWLSTG	SWLSTG