Justice Health and
Forensic Mental Health Network

Justice Health NSW Guideline

Guidelines for Psychotropic Medications

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Guidelines for Psychotropic Medications

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Issue Date	2 April 2025
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Summary	This document sets out guidelines for the use of psychotropic medications within the adult custodial setting, adolescent setting and the Forensic and Long Bay Hospitals. This guideline provides direction to clinicians for the initiation and ongoing prescription of psychotropic medications, metabolic monitoring and additional monitoring to patients within Justice Health and Forensic Mental Health Network (Justice Health NSW) These guidelines must be read in conjunction with NSW Ministry of Health (MoH) and Justice Health NSW policies and guidelines.
Responsible Manager	Drugs and Therapeutics Committee (D&TC)
Applicable Sites	☐ Administration Centres ☐ Community Sites and programs ☒ Health Centres - Adult Correctional Centres or Police Cells ☒ Health Centres - Youth Justice Centres ☒ Long Bay Hospital ☒ Forensic Hospital ☒ Pharmacy Department
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Change summary	Reviewed by D&TC for currency. Updated: • Metabolic monitoring frequency for all patients to at least 6 months • Change ECG frequency to annually unless clinically indicated
Authorised by	Drugs and Therapeutics Committee (D&TC)

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Revision History

#	Issue Date	Guideline Name and Number	Change Summary
1	June 2018	Guidelines for Psychotropic Medications	Annual review by JH&FMHN D&TC, reviewed for currency • Hyperlinks for References updated • Update of sections *6. Metabolic Monitoring* and *7.Prescribing Antipsychotic Medications within the Adult Custodial and Forensic Mental Health Settings* to reflect current recommendations and standards Addition of 7.4 Psychostimulant Medications
2	May 2020	Guidelines for Psychotropic Medications	Reviewed to include feedback following the Network's Metabolic Monitoring Clinical Redesign Project: • Only patients who are prescribed antipsychotic medications require routine metabolic monitoring assessment • Routine metabolic monitoring assessment are to be completed every 3 months for inpatients and every 6 months/minimum once a year for ambulatory patients • Routine metabolic monitoring assessment includes the following components: o Height measurement o Weight measurement o Waist measure o Body Mass Index o Blood glucose level (random or fasting) o Pathology (as per the metabolic monitoring pathology order set) o ECG Reviewed to include procedures for prescribing from a release of information and for continuing prescriptions safely without a clinical review. Reviewed to outline the process for prescribing by Primary Care for level A patients. Reviewed additional drug monitoring for psychotropic medications to refer to medication Product Information, Therapeutic Guidelines and Australian Medicines Handbook for current monitoring recommendations. Reviewed to acknowledge the smoking and NRT ban in custody.
3	September 2022	6.051 - Guidelines for Psychotropic Medications	Review by the Network D&TC: • Hyperlinks for references updated • Update of medication chart terminology for transition to eMeds • Addition of quetiapine prescribing

			• Linking common adverse effects of antipsychotics and antidepressants to the Therapeutic Guidelines
4	December 2023	6.051 - Guidelines for Psychotropic Medications	As per December 2023 D&TC: Addition of lithium section for monitoring. Addition of information relating to patient refusal of psychotropic medications.
5	April 2025	6.051 - Guidelines for Psychotropic Medications	Reviewed by D&TC for currency. Updated: - Metabolic monitoring frequency for all patients to at least 6 months - Change ECG frequency to annually unless clinically indicated

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1 Preface

This document sets out guidelines for the use of psychotropic medications within the adult custodial setting, adolescent setting and the Forensic and Long Bay Hospitals. This guideline provides direction to clinicians for the initiation and ongoing prescription of psychotropic medications, metabolic monitoring and additional monitoring to patients within Justice Health and Forensic Mental Health Network (Justice Health NSW).

These guidelines must be read in conjunction with NSW Ministry of Health (MoH) and Justice Health NSW policies and guidelines, including but not limited to:

- MoH Policy Directive PD2022_032 Medication Handling
- MoH Policy Directive PD2022_056 Approval Process of Medicines for Use in NSW Public Hospitals
- MoH IB2012_024 Metabolic Monitoring, New Mental Health Clinical Documentation Module
- GL 2021_006 Physical Health Care for People Living with Mental Health Issues
- Policy 1.322 Recognition and Management of Patients who are Deteriorating Implementation Guide – Ministry of Health PD2020_018
- Procedure 6.139 Custodial Mental Health Patient Flow Procedure
- Custodial Mental Health Operations Manual
- Procedure 6.088 Seclusion and Restraint
- Procedure 6.153 Enforced Medication, Seclusion and Restraint – Mental Health Unit, Long Bay Hospital
- Justice Health NSW Medication Guidelines
- Justice Health NSW Prescribing Formulary
- Justice Health NSW Guidelines for the Management of Patients on Clozapine
- Justice Health NSW Physical Health Assessment and Care
- Pathology Results Management Procedure
- Business Rules Metabolic Monitoring Referrals and Appointment Management
- JHeHS Pathology Orders Business Process – Ambulatory Adult & Adolescent Health – Nurse Place Metabolic Monitoring & Clozapine Pathology Order

2 Objectives

The objectives of these guidelines are to provide:

- A framework for the prescribing of psychotropic medications, including a process for initiation and ongoing review of medications, for adults and adolescents
- Guidance on monitoring and managing adverse effects in patients prescribed psychotropic medications.

3 Outcomes

These guidelines have been established to facilitate:

- Evidence based practice for psychotropic medication prescribing
- Monitoring of potential adverse effects resulting from psychotropic medication prescribing.

4 General Information

For the purpose of these guidelines, a ‘psychotropic medication’ is a medication that is used to treat the symptoms of mental illness and/or behavioural disorder. A list of psychotropic medications used within Justice Health NSW can be located in Appendix A – Psychotropic Medications used within Justice Health NSW. Psychotropic medications may influence thinking, mood and behaviours. The

class of psychotropic medications include antidepressants, mood stabilisers, antipsychotics, stimulants, anxiolytics, and hypnotics.

Available evidence suggests that mental illness is more prevalent within custodial and forensic mental health settings than in the general community, with high levels of psychosis, depression, anxiety, personality disorders, and substance abuse/dependence. Psychotropic medications have an important role in the management of patients in custody and secure forensic mental health facilities. Notwithstanding the benefits of psychotropic medications, adverse effects of psychotropic medications are common and potentially serious. There is the potential for the misuse of psychotropic medications for sedation for primary insomnia and there is also a need to monitor for any adverse effects of psychotropic medications.

All psychotropic medications currently used in clinical practice exhibit adverse effects that range from mild to life-threatening. These effects can be detected in a variety of ways, including patient self-report through to asymptomatic abnormalities detected by routine blood tests. Some of these changes are idiosyncratic and may not be clinically significant. Nevertheless, some adverse effects, such as agranulocytosis associated with medications like clozapine and carbamazepine, require regular and frequent monitoring of blood parameters. In general, where a medication has a high incidence of side effects or a rare but potentially fatal effect, more frequent monitoring is required.

Psychotic illnesses and their treatment are associated with an increased risk of metabolic syndrome. Antipsychotic medications are associated with a broad range of potentially serious adverse effects. Second-generation atypical antipsychotic agents may be more likely to produce metabolic adverse effects such as obesity and type II diabetes whereas older typical antipsychotics are more likely to be associated with extrapyramidal side effects.

The increased rate of diabetes is usually related to insulin resistance through weight gain, but other mechanisms may exist. The management of psychosis or severe behavioural disturbance takes priority over concerns about the potential metabolic sequelae of treatment, but the prevalence of the latter requires that all patients taking psychotropic agents be actively screened and treated.

People with psychotic illness are a high risk group for developing diabetes, with increased rates of medical co-morbidities. Preventative measures, combined with early detection and treatment of hyperglycaemia and other metabolic disorders, are critical. Patients treated with psychotropic medications require baseline and, thereafter, regular monitoring of parameters including weight, blood glucose, lipid levels, and blood pressure.

All health professionals involved in the care of patients with mental disorders can contribute to the identification of adverse effects including abnormal glucose metabolism. Improved diet, increased physical activity, and smoking cessation to lead to healthier outcomes.

5 Prescribing Psychotropic Medications within the Adult Custodial and Forensic Mental Health Settings

5.1 Prescribing from a Release of Information (New reception)

Each new reception into custody undergoes a screening assessment by a registered nurse. This includes a history of physical and mental health conditions, allergies, current medications and basic physical observations.

Release of information (ROI) requests are made for outside practitioners to confirm existing medical/ mental health conditions and obtain confirmation of prescribed medications. Medication needs to be reviewed and/or prescribed within 72 hours of the reception into custody.

Once an ROI is received, a medical practitioner is required to review the prescription and decide whether ongoing prescription is clinically indicated. Where practical this should occur within office hours.

In order to prescribe for the patient without a face to face clinical assessment, the following information should be supplied to the prescriber by the nurse (or be uploaded on JHeHS)

1. A copy of the current (less than 3 months) release of information containing the community prescription
2. The patient's medical record
3. Physical observations
4. Written confirmation from the reception nurse (or other clinician) that the patient has been compliant with the prescribed medication prior to arrest
5. A description of any side-effects described by the patient
6. Confirmation of allergies
7. Details of opioid agonist therapy
8. Pregnancy status

The prescriber reviews the above information including the medication dosages, medication combinations and potential for interactions and side-effects.

If the prescriber is content with all of the above, they may chart the medications without a face to face clinical review of the patient.

The prescriber will document the following in the medical record:

- clinical reasoning for the prescription
- order metabolic monitoring if required
- order other monitoring based on the need to monitor for side-effects of particular medications

The Requesting Nurse is responsible for updating the PAS waitlists (GP or psychiatry/nurse practitioner mental health (NPMH) clinic/ metabolic monitoring) as required.

If the prescriber has concerns about prescribing the medications without a face to face review, they should request that the nurse:

1. Arrange for the patient to be seen in a psychiatry/NPMH or GP clinic and advise the nurse of the priority rating for this review.
2. Prescribe a safe medication combination

The prescriber should document their concerns in JHeHS so that the reviewing prescriber is aware of the issues.

5.2 Quetiapine Prescribing

In 2020 quetiapine was listed as a prescribed restricted substance, more commonly referred to as Schedule 4 Appendix D (S4D) medicine. In response to this there was a review of the prescription of quetiapine for patients in custody in Justice Health NSW which resulted in changes to the prescription of this medication in Adult Custodial and Youth Justice Settings.

Patients who enter custody and are prescribed 200mg or less of quetiapine, should have this reduced and then ceased. Patients prescribed more than 200mg quetiapine should be continued on that dosage with a waiting list appointment made to see a psychiatrist/NPMH to review this prescription in line with best practice guidelines. Following this review quetiapine will be either ceased or changed to an alternate psychotropic medication. Only in exceptional circumstances where there is evidence that alternate psychotropic medications have failed, quetiapine will be considered for continuation.

5.3 ROAMS prescribing in an emergency or out of hours

ROAMS practitioners may be contacted out of hours for medication orders for new receptions or for re-writes of medication orders that have expired. They need to ensure that:

1. The medication order is current
2. The patient confirms that they have been taking the medication daily prior to arrest
3. The patient is not experiencing side-effects
4. Basic observations (BP, pulse, temperature)
5. They have checked for any allergies
6. They have checked for any medical co-morbidities
7. They have checked whether the patient is on opioid agonist therapy
8. If the patient is in custody they have reviewed the latest prescriber entry
9. There is a waiting list made for a prescriber in the appropriate stream to review the patient

5.4 Re-prescribing long term medications without a face to face clinical review

It is best practice for patients on long term medications to be reviewed by a clinician or mental health nurse who can discuss with the prescriber at least every 6 months. Unfortunately, this is not always possible due to the high demand and low resources in custody.

A practitioner may re-prescribe a long term medication order without clinical review by following these guidelines:

1. The current medication order confirms that the patient has been compliant with their prescribed medications
2. The prescriber agrees that the medication order is clinically appropriate and safe
3. Review JHeHS and/or the medical file for results of investigations to monitor for side-effects such as metabolic syndrome/ ECG
4. Request that the patient has a booked psychiatry, GP or nurse practitioner waitlist entry for face to face review of the patient
5. Order metabolic and other monitoring as indicated

If the practitioner has clinical concerns about re-prescribing the medications then they may write a short-term medication order. The prescriber should document their clinical reasoning for the duration of the order in the medical record and intention for when the order expires. Prescribers should be mindful to minimise delays or interruptions to patients' regular medication. Short term orders should not be used to "prompt" clinical review, as prioritisation for assessment is based on patient's clinical acuity. The nurse requesting the medication review is responsible for booking any PAS appointments indicated.

5.4.1 Multidisciplinary Review of Patients by Primary Care Mental Health Consultation Liaison Nurses

The GP service is supported by Primary Care Mental Health Consultation Liaison Nurses who provide case coordination of appropriate patients with mental health disorders. The prescribing of psychotropic medication occurs remotely after a case review of each patient with prescribing medical officers in the Primary Care Clinical Director group or their delegates.

5.5 Initiation of a psychotropic for the first time in custody

5.5.1 Antipsychotic Medications

Antipsychotic medications are those medications generally used in the treatment of psychotic disorders such as schizophrenia, schizoaffective disorder, bipolar and other affective psychoses and delusional disorder. These medications are sometimes divided into 'first generation' and 'second generation' antipsychotics, based on their affinity for specific neuroreceptors and their side effect profile. First generation antipsychotics still commonly in use include:

- Chlorpromazine
- Droperidol[1]
- Flupentixol
- Haloperidol
- Periciazine
- Zuclopenthixol

Second generation antipsychotics are now more widely prescribed due to their lower propensity to cause extrapyramidal side effects and tardive dyskinesia. These include:

- Amisulpride
- Aripiprazole
- Asenapine
- Brexpiprazole
- Cariprazine[1]
- Clozapine
- Lurasidone
- Olanzapine
- Paliperidone
- Quetiapine
- Risperidone
- Ziprasidone

Each patient will require medical assessment and after a history, mental state examination, further information gathering, for example, corroborative history where available, a provisional diagnosis and clinical formulation should be documented in the health record.

If it is determined by a medical practitioner or MHNP that antipsychotic medication may be indicated, an assessment of the risk/benefit ratio should be considered. This will involve weighing up the potential benefits of medication against potential adverse effects. As part of this, it is important to consider the patient's physical co-morbidities or health-related risk factors, such as diabetes, obesity or cardiovascular disease. If clinically appropriate, discussion of the risk to benefit ratio should occur with the patient, with documentation that potential adverse effects have been explained. The pre-commencement work-up and ongoing administration of clozapine poses particular challenges and a high level of psychiatric and nursing oversight of any patient on this medication is mandatory. Refer to Justice Health NSW Guidelines for the Management of Patients on Clozapine.

Note: Intramuscular Clozapine is available for use only in the Forensic Hospital

[1] not in the Network Prescribing Formulary and requires Individual Patient Use approval.

5.5.2 Antidepressant medications

There are a number of classes of antidepressant medications available, including the 'older' classes, for example, tricyclic antidepressants (TCA) and monoamine oxidase inhibitors (MAOIs), as well as the 'newer' classes, most commonly 'selective serotonin reuptake inhibitors' or SSRIs; and 'serotonin noradrenaline reuptake inhibitors' or SNRIs. Caution should be exercised when prescribing an antidepressant with other medications that may raise serotonin levels due to the risk of 'serotonin syndrome'.
TCAs and MAOIs must be supervised in correctional centres due to the potential for hoarding and trading and the subsequent risk of overdose, where they may be fatal.

Use within a hospital setting is less problematic due to the direct administration by nursing staff and higher levels of supervision. However, they remain 'second line' medications, with most patients being prescribed SSRIs or SNRIs as first line antidepressant treatment.

5.5.3 Benzodiazepines

Within the custodial settings, Drug and Alcohol medical practitioners generally prescribe benzodiazepines (mainly diazepam) for short periods of time, usually less than 7 to 10 days, for alcohol, opioid or benzodiazepine withdrawal and often symptomatic drug withdrawals such as cannabis. They are not recommended for the ongoing treatment of anxiety disorders, due to their risk of dependence, as well as potential for abuse, hoarding and trading within the correctional setting.
Within hospital settings, benzodiazepines are more frequently prescribed for the management of acute agitation. They are commonly administered by the oral route but can also be given via the intra-muscular route.

Clonazepam is a specific benzodiazepine which has a high potential for abuse within a correctional setting. A patient prescribed clonazepam in a correctional centre should be carefully reviewed with advice from a Drug and Alcohol specialist. Initiation should only occur if a neurologist recommends its use for the management of epilepsy or other neurological disorder and an IPU is approved by the Clinical Director (or delegate).

5.5.4 Psychostimulant Medications

There are a number of psychostimulant medications that are available for the treatment of Attention Deficit Hyperactive Disorder. Refer to the Justice Health NSW Guidelines for the Management of Psychostimulants.

5.5.5 Lithium

Lithium is an effective treatment for moderate to severe mania and in the maintenance treatment of bipolar disorder. It has a narrow therapeutic window and as such the prescription of lithium should proceed with caution, with clear discussions involving patients about the usual side-effects, monitoring and signs of toxicity.

Prior to treatment, EUC, TFTs are required. An ECG is indicated if the patient has a known underlying cardiac condition. A baseline measurement of weight is also desirable.

Lithium levels should be checked 5-7 days after a dose change until the desired level is reached. Once established on treatment plasma lithium levels should be checked 3-6 monthly with EUC and TFTs. Weight and BMI should also be monitored.

Although there are no specific guidelines regarding routine follow-up ECG's in patients on lithium, policy guidelines in relation to metabolic monitoring should be followed.

Lithium medication does not have to be supervised, the decision should occur on a patient-by-patient basis and in consultation with the individual. Factors to consider include, patients' history of adverse side-effects, patients' ability to reliably take the medication and patients' history of overdose/self-harm/suicide attempts.

Because lithium is predominantly removed from the body by the kidneys, factors that can impair this can suddenly result in levels becoming acutely toxic i.e. an acute episode of gastroenteritis with vomiting/diarrhoea resulting in dehydration, the use of anti-inflammatory medication (such as aspirin, ibuprofen, naproxen, etc), certain blood pressure medications (ACE inhibitors, angiotensin II receptor antagonists) and the use of diuretics.
Refer to Therapeutic Guidelines: Acute Lithium Poisoning and Chronic Lithium Accumulation.

As lithium can cause cardiac abnormalities to develop in a baby if given in the first 3 months of a pregnancy, caution should be used in prescribing it in women of childbearing years.

6 Psychotropic Prescribing for Young People in Custodial and Forensic Mental Health Settings

Young people in custody in NSW have multiple health and social needs as evidenced by the YPiCHS studies carried out collaboratively by Youth Justice New South Wales (YJNSW) and Justice Health NSW most recently in 2015.[2] Psychiatric diagnosis in this group is often evolving, given contributions of: environment and adverse experiences, drug and alcohol use, developmental level, trauma and other psychosocial factors.

Regarding the choice of agents and prescribing practice, a range of Practice Guidelines are available from a range of health organisations, including NSW Health, NICE, RANZCP, UK RCPsych, NIMH, Beyond Blue, American Academy of Child and Adolescent Psychiatry, that Adolescent Forensic Mental Health clinicians are recommended to consult. These guidelines are regularly updated and contain the latest information regarding efficacy, monitoring and risk/benefit analysis in regard to prescribing and treatment in Child and Adolescent Psychiatry. These guidelines should be utilised by all Justice Health NSW clinicians providing treatment to young people in the community or in custody and applied, with necessary adaptations in the youth detention settings.

When a decision is made that, for an individual, the potential benefits of psychotropic treatment outweigh any risks, there is an obligation on the prescriber and members of the Justice Health NSW treating team, to ensure adequate screening and monitoring for response and side effects, including metabolic monitoring. Issues that need to be considered before deciding on medication treatment include the well documented premature mortality in psychiatric patients, underestimation of antipsychotic-induced weight gain, metabolic syndrome prevalence in youth with first episode psychosis, cardiometabolic risk in children and adolescents and the available data on metabolic syndrome in children and adolescents in Australia and internationally. Additionally, staff should consult the HeAL statement (www.iphys.org.au) and the Adolescent Positive Cardiometabolic Health Resource.

The purpose of physical monitoring differs for different medications. Clinicians should ensure that they are aware of side-effect profiles of each medication they prescribe and are employing physical monitoring appropriately, including consideration that they are not exposing young people to unnecessary procedures.

Prescribing multiple psychotropic agents to adolescents requires careful consideration and documentation of the risk/benefit analysis, informed consent from young people and their carers, and discussion with the relevant Child and Adolescent Psychiatrist or Clinical Director Adolescent Forensic Mental Health (CDAMFH) when required. Consent is legally required from the legal caregiver if the young person is under 14. Where necessary a second opinion, or review by another Child and Adolescent Psychiatrist and/or a primary care physician should be organised through the CDAFMH.

In regards to monitoring, clinicians should refer to *Section 9 Routine Metabolic Monitoring* and the document Professional Practice Guideline 7: Guidance for psychotropic medication use in children and adolescents.

[2] Justice Health Forensic Mental Health Network and Juvenile Justice NSW. (2017) *2015 Young People in Custody Health Survey: Full Report*. Malabar, Australia.

Because many adolescents are medication naïve, compliant only in custody or have intermittently taken medication in the community, the opportunity for ensuring monitoring of therapeutic effects and side effects of medication whilst adolescents are in custody should be taken. Although some adolescents may have physical investigations before entering custody, accessing this information can be difficult and it is recommended that these guidelines are followed for every young person, unless there is documented evidence of adequate investigations elsewhere with results available.

Agents that are most prescribed in this age group and those available on the Justice Health NSW Prescribing Formulary are outlined in the adult section of this document. Clinicians are advised to seek additional information regarding recommended monitoring for other agents they prescribe and to be aware that additional precautions will be necessary where multiple psychotropic agents are prescribed, or where an individual has a recognised physical vulnerability. In this document physical monitoring refers to blood investigations, weight, height, BMI, waist circumference, blood pressure, pulse and ECG.

Regarding young people in custody, psychotropic medication should be initiated by a Consultant Psychiatrist or a supervised psychiatry registrar. If there is an urgent need to prescribe medication and this is initiated by an appropriately credentialed GP or CMO, discussion should take place at the earliest opportunity with the attending psychiatrist for the relevant Health Centre and referral made for follow-up.

Clinicians should ensure that when they prescribe medication for an adolescent, they document both treatment effects being pursued and likely side-effects. Monitoring for response should include targeted symptom review and objective measures of response where available. Likewise, the use of checklists for monitoring of side-effects can be helpful (e.g. Abnormal Involuntary Movement Scale).

Prescribing for young people in the custodial setting necessitates interdisciplinary collaboration regarding potential problems that may arise with any medication, and mental state and physical monitoring to occur between psychiatric reviews. A collaborative approach is required involving Justice Health NSW nursing staff, the Justice Health NSW custodial mental health team including psychiatrists, GPs, Youth Justice psychology, and Youth Justice Youth Workers. The use of the Health Problem Notification Form is encouraged to ensure that all staff managing the young person in custody are aware of any clinical concerns, including side-effects, and can report these to the clinic.

Consent should be sought from a young person and, if they are younger than age 14 years, from their parent/carer for both treatment and investigations. Where a young person is judged to have the capacity to consent to their own treatment (refer to the Justice Health NSW Policy 1.085 Consent to Medical Treatment – Patient Information), discussion should still take place with a parent/carer regarding the treatment (unless the young person refuses consent to speak to the caregiver). If a young person does not wish to involve their parent/carer in the treatment discussion, this must be documented and revisited regularly with the young person. In the case of a young person in the Care of the Minister, written consent from the Department of Communities and Justice (DCJ) case manager needs to be sought before commencing treatment. Both the consent and discussion with the young person regarding potential side effects should be documented in the health record for young people prescribed psychotropic medications. If young people refuse to participate in physical monitoring whilst receiving treatment, a risk-benefit analysis of continuing the treatment should be undertaken and a second opinion should be sought through the CDAFMH.

7 Medication Refusals

Where a patient who is prescribed a psychotropic medication, refuses their medication on two consecutive days (48 hours):

1. the refusal should be escalated to an on-site psychiatrist/nurse practitioner (where available) or to ROAMS psychiatrist for advice;
2. the patient should be waitlisted for review in line with the PAS Waitlist Priority Protocol;
3. the patient's HPNF should be reviewed and updated if clinically indicated; and
4. contact with ROAMS, waitlisting and HPNF review should be documented in JHeHS. If in Forensic Hospital, document in JHeHS and raise with the treating team for review and action.

8 Off-Label Medicine Use

8.2 Prescribing of off-label medicine

MoH Policy PD2022_056 Approval Process of Medicines for Use in NSW Public Hospitals defines 'off-label medicine use' as " the use of a medicine other than that specified in the Therapeutic Goods Administration (TGA)-approved product information including when the medicine is prescribed or administered for another indication, at a different dose, or via an alternate route of administration".

This definition excludes:

- an unlicensed medicine that is yet to be evaluated or approved in Australia by the TGA, and
- TGA registered medicines whose formulation is modified, for example, extemporaneous or compounded preparations, such as preparation of special creams or a liquid suspension by crushing tablets. This is considered unlicensed use.[3]

The Council of Australian Therapeutic Advisory Groups (CATAG) document *Rethinking medicines decision-making in Australian Hospitals - Guiding Principles for the quality use of off-label medicines* (2013) sets out seven overarching guiding principles for the quality use of off-label medicines:

1. Consider the off-label use of a medicine only when all other options, including the use of medicines approved by the TGA, are unavailable, exhausted, not tolerated or unsuitable.
2. Use high-quality evidence to determine appropriateness of off-label medicine use.
3. Involve the patient/carer in shared decision-making when recommending the use of an off-label medicine.
4. Consult the Drug and Therapeutics Committee when prescribing an off-label medicine, except when the use of a medicine off-label is considered routine.
5. Ensure appropriate information is available at all steps of the medicines management pathway.
6. Monitor outcomes, effectiveness and adverse events.
7. Consider liability and accountability when using medicines off-label.

In relation to the prescribing of psychotropic medications in Justice Health NSW, TGA approved medicines that are listed in the Justice Health NSW Prescribing Formulary remain the first line options for treatment whenever available, suitable, or tolerated. If considering the off-label use of a psychotropic medication, prescribers must take into account the seven guiding principles set out above. If there is no high quality evidence supporting use of a particular medicine, and it is not suitable for 'exceptional' or 'research' indications, use of the medicine is not recommended.

MoH Policy PD2022_056 set outs three categories for off-label medicine use, those being:

- Routine use
- Exceptional use
- Conditional use.

The CATAG document set outs an additional category of 'research or investigation use', which is not covered in this document. Figure 1 in the CATAG document outlines the framework for assessing appropriateness, approval processes, consent and monitoring of off-label and unlicensed medicines. Consult the original document for full details.

The prescription of a psychotropic medicine in the routine-use category as defined in MoH Policy PD2022_056 and the CATAG document does not require an Individual Patient Use (IPU) approval.

The prescription of a psychotropic medicine in the exceptional-use category requires an IPU approval and approval from the Justice Health NSW Drugs and Therapeutics Committee (DTC). The responsibility for prescribing an off-label medicine rests with the prescriber and documented in JHeHS.

The off-label use of a medicine in the routine-use category should follow usual processes for patient consent to therapy with provision of information and discussion. This should occur as part of routine clinical care and does not require additional measures.

Any adverse drug reactions or interactions involving medicines used off-label should be reported on-line to the TGA through the Australian Adverse Drug Reaction Reporting System or via www.tga.gov.au by following the link to 'Report a problem.' The use of off-label medicines is monitored by the Justice Health NSW Pharmacy and reported routinely to the Justice Health NSW Drugs and Therapeutics Committee.

8.3 Role of Nurse Practitioner Mental Health in Off-Label Prescribing

A Nurse Practitioner Mental Health may not routinely prescribe off-label medications. Notwithstanding, there may be instances where off label use of medications is considered to be clinically appropriate. The Nurse Practitioner may renew the prescription of an off-label medication in the routine-use category previously prescribed by a consultant psychiatrist. The Nurse Practitioner may initiate the prescription of an off-label regime only following consultation with the Clinical Director or delegate.

When renewing medication previously prescribed by a consultant psychiatrist, the Nurse Practitioner must:

- Only renew the off-label prescription after completing a clinical assessment and if it is determined that the medication regime is safe and clinically appropriate
- Confirm their intention to order any dose that could be regarded as being unusually high by adding a comment to the medication order in JHeHS eMeds confirming the intention of the order
- Document the clinical assessment and reasons for continuation in the patient's clinical record
- Provide ongoing review and care of the patient as clinically appropriate
- Arrange for the patient to be clinically reviewed by a medical practitioner as clinically indicated.

When it is considered that off-label prescription of medication is indicated after a comprehensive clinical assessment, the Nurse Practitioner must:

- Consult with the Clinical Director or delegate regarding the patient's presentation and possible treatment options
- Document the clinical assessment, the consultation with the Clinical Director or delegate and reasons for use in the patient's clinical record
- Confirm their intention to order any dose that could be regarded as being unusually high by adding a comment to the medication order in JHeHS eMeds confirming the intention of the order
- Provide ongoing review and care of the patient as clinically appropriate
- Arrange for the patient to be clinically reviewed by a medical practitioner as clinically indicated.

All instances of off label prescribing by a Nurse Practitioner must be reported monthly to the Custodial Mental Health Clinical Governance Committee.

8.4 Physical health monitoring in adults

Many psychotropic medications are known to increase the risk of QT prolongation, potentially leading to cardiac arrhythmias. Concomitant prescribing of two drugs that prolong QT interval, for example, methadone with a QT prolonging psychotropic medication, further increases the risk. The balance of benefit verses harm should always be considered. Patients with prolonged QT should have electrolyte or metabolic disturbances excluded and, if on methadone, be discussed with a Drug and Alcohol Specialist. In many patients dose adjustments result in shortening the interval, however persistent prolongation may require cardiology review. The risk of severe cardiac arrhythmias increases substantially if the QT:HR is plotted above the line on the QT Interval Nomogram'. Refer to Drug-induced QT-Prolongation and Torsades.

Monitoring of physical health should include a physical examination when clinically indicated.

Further investigations should be guided by history and physical examination, and none should be considered to be mandatory and few 'routine'.

Forensic Hospital staff should refer to procedure Physical Health Assessment and Care.

9 Routine Metabolic Monitoring

This section applies to routine metabolic monitoring for both adult and adolescent patients within Justice Health NSW. Justice Health NSW has determined that patients prescribed **antipsychotic medications require routine metabolic monitoring**. The requirements for routine metabolic monitoring are described in this section of the guideline. All additional monitoring is not part of routine metabolic monitoring and is to be ordered by a Medical Officer or Nurse Practitioner if clinically indicated.

Routine metabolic monitoring allows medical officers and nurse practitioners the opportunity to consider de-prescribing or switching the psychotropic medication or referring the patient for specialist consultation depending on the results of the monitoring. The goal is to stabilise mental health problems and assertively manage any consequences of treatment.

9.2 Monitoring patients at risk of metabolic syndrome

Metabolic syndrome is a cluster of cardiovascular risk factors that include insulin resistance, hypertension, central obesity, and dyslipidaemia. The purpose of monitoring is to prevent and identify health issues and to ensure patients are referred to appropriate services for further investigation and management. Medical officers are responsible to handover to nursing unit managers or nurses in charge when a patient has been prescribed a medication that requires metabolic monitoring and documents the requirement in the patient's progress notes. This will ensure patients who are identified for metabolic monitoring are waitlisted for appointments.

Table 1: Criteria for Clinical Diagnosis of Metabolic Syndrome

A person is diagnosed as having metabolic syndrome when they have any three or more of:

<table>
<tr><th>Measure</th><th>Categorical Cut Points</th></tr>
<tr><td>Elevated waist circumference</td><td>Population specific

<table><tr><th>Population</th><th>Men</th><th>Women</th></tr><tr><td>European/North American</td><td>≥102 cm</td><td>≥88 cm</td></tr><tr><td>Asian</td><td>≥90 cm</td><td>≥80 cm</td></tr><tr><td>Central and South American</td><td>≥90 cm</td><td>≥80 cm</td></tr><tr><td>Middle Eastern/Mediterranean</td><td>≥94 cm</td><td>≥80 cm</td></tr><tr><td>Sub-Saharan African</td><td>≥94 cm</td><td>≥80 cm</td></tr></table></td></tr>
<tr><td>Elevated triglyceride levels
(or drug treatment for elevated triglycerides)</td><td>≥1.7 mmol/L</td></tr>
<tr><td>Reduced HDL-C
(or drug treatment for reduced HDL-C)</td><td><1.0 mmol/L in men, <1.3 mmol/L in women</td></tr>
<tr><td>Elevated blood pressure
(or drug treatment for hypertension)</td><td>≥130 systolic or ≥85 diastolic</td></tr>
<tr><td>Elevated fasting glucose
(or drug treatment for elevated glucose)</td><td>>5.5 mmol/L
(can also use HbA1c > 5.6%)</td></tr>
</table>

9.3 Metabolic Monitoring Waitlist/Appointment

As per Justice Health NSW Business Rules Metabolic Monitoring Referrals and Appointment Management, patients identified as requiring metabolic monitoring must be added to the appropriate waiting list. In adult and adolescent ambulatory settings patients are to be placed on the primary care nurse waitlist or the primary care metabolic monitoring waitlist.

In the following assertive care areas, patients are to be placed on the Mental Health Nurse Outpatients waitlist;

- Silverwater Women's Mental Health Screening Unit (SWCC MHSU)
- Silverwater Women's Step down Unit (SWCC SDU)
- Metropolitan Remand and Reception Centre Mental Health Screening Unit (MRRC MHSU)
- Metropolitan Remand and Reception Centre Hamden Unit (MRRC Hamden)

A list name option must be used to identify the following;

- MM Initial (For all initial Metabolic Monitoring consultations)
- MM Follow up (For all follow up Metabolic Monitoring consultations)

Patients within the Long Bay Hospital and Forensic Hospital are to follow local procedures for scheduling patients for metabolic monitoring assessments.

9.4 Metabolic Monitoring PAS Alert

Patients requiring metabolic monitoring require a PAS alert to be created, the alert to be applied is Psychotropic Medications – Metabolic Monitoring.

9.5 Routine Metabolic Monitoring Assessment

Patients requiring metabolic monitoring within Justice Health NSW are to have routine metabolic monitoring assessment at least every 6 months or more often if clinically indicated. Routine metabolic monitoring assessments in the outreach settings are conducted by primary care nurses and in the assertive care areas by mental health staff.

Routine metabolic monitoring assessment includes the following components:

- Height measurement
- Weight measurement
- Waist measure
- Body Mass Index
- HbA1c
- Pathology (as per the metabolic monitoring pathology order set)

ECGs can be done annually unless clinically indicated.

Registered Nurses and Enrolled Nurses can order pathology, refer to Pathology Ordering Guide and Pathology Management. The pathology order set includes the following tests.

Table 2: Metabolic Monitoring Pathology Order Set

	Test	Description
Metabolic Monitoring	HDL	High Density lipoprotein
	LDL	Low Density lipoprotein
	TG	Triglycerides
	Tot Chol	Total Cholesterol
	HbA1c	Glycated haemoglobin test – average blood sugar level
	LFT	Liver Function Test

9.6 Results of Routine Metabolic Monitoring Assessment

Results of metabolic monitoring are to be documented in the metabolic monitoring e-form in JHeHs in preparation for when the patient's medications are reviewed. Blood pressure, pulse and blood glucose level (BGL) are also to be documented on the Standard Adult General Observation Chart (SAGO). ECG's are to be uploaded into JHeHS for sign off and pathology results are located in the pathology section in JHeHS for sign off.

9.6.1 Normal Results

If results are normal, including ECG's where the machine has identified normal results; the results can be documented and filed for review by the medical officer at the patients' next medication review or prescription rewrite.

9.6.2 Abnormal General Observations

If the patients' blood pressure, pulse and blood sugar level is in the yellow or red zones at the time taken escalate as per the SAGO charts yellow and red zones response pathway. Refer to Procedure 6.138 and Ministry of Health PD2020_018 Recognition and Management of Patients who are Deteriorating.

9.6.3 Abnormal ECG Results

If the ECG is borderline or abnormal according to the ECG machine, (prolonged QTc will be detected as abnormal) and the patient is asymptomatic of acute chest pain and symptoms, the nurse is to escalate to the prescriber. If the prescriber is unavailable, the nurse is to escalate to ROAMs for a plan of care.

If the ECG is borderline or abnormal, and the patient is symptomatic of acute chest pain and symptoms, the patient is to be transferred to hospital via ambulance.

9.6.4 Abnormal Pathology Results

Abnormal pathology results will be referred for action in accordance with the Pathology Results Management Procedure.

Table 3: Metabolic Monitoring Parameters

Waist Circumference	
Central obesity – waist circumference	Male (European) ≥ 94 cm, Male (South Asian, Japanese, South and Central American) > 90 cm Female ≥ 80 cm
BMI (= weight in kg/height in m^2)	
< 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
> 30.0	Obese
Blood pressure	**Target (mmHg)**
systolic	< 140
diastolic	< 90
Lipids	**Target (mmol/L)**
Total Cholesterol (TC)	< 5.5
Triglycerides	< 1.7
High-density lipoprotein (HDL)	> 1.03 (men) > 1.29 (women)
Low-density lipoprotein (LDL)	< 4.0 : < 2.0 if CHD
Blood glucose (mmol/L)	**Target**
Fasting Blood Glucose	< 5.6 Normal -7.0 Abnormal, action required > 7.0 At risk, treatment required
Random Blood Glucose 5.6 – 7.0	< 7.0 Normal 7.0-11.0 Abnormal, action required ≥ 11.1 At risk, treatment required

HbA1c	4%-5.6% Normal 5.7%-6.4% Abnormal, action required ≥ 6.5% At risk, treatment required

If a patient requires more frequent monitoring than routine monitoring, this is considered additional monitoring and must be ordered by a Medical Officer or Nurse Practitioner as per section 10 of this guideline.

10 Additional psychotropic medication information and monitoring

All psychotropic medications may have additional recommended monitoring requirements; refer to the medications' Product Information, Therapeutic Guidelines and the Australian Medicines Handbook for further details.

11 Ongoing monitoring of compliance with the guidelines

A metabolic monitoring audit has been developed to assist staff in identifying patients who require metabolic monitoring. This audit measures Justice Health NSW compliance in regards to alerts and waitlists and is to be completed every three months in all applicable sites.

The pharmacy department is responsible for all other monitoring of this guideline.

12 Emergency Sedation

Refer to Procedure 6.157 Acute Sedation – Mental Health Unit, Long Bay Hospital, Procedure 6.088 Seclusion and Restraint and Procedure 6.088 Seclusion and Restraint

Appendices

Appendix A - List of Psychotropic Medications used within Justice Health NSW
Appendix B - Therapeutic Interventions for Metabolic Abnormalities in Adolescent Patients
Appendix C - Therapeutic Guidelines Common Adverse Effects of Antipsychotics and Antidepressants

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Appendix A – Psychotropic Medications used within Justice Health NSW

Antipsychotic	Mood Stabilisers	Tricyclic Antidepressants	Serotonin Reuptake Inhibitors	Monoamine Oxidase Inhibitors	Other Antidepressants	Drugs for Attention Deficit Hyperactivity Disorder
Amisulpride	Carbamazepine	Amitriptyline	Citalopram	Moclobemide	Desvenlafaxine	Atomoxetine
Aripiprazole	Lithium Carbonate	Clomipramine	Escitalopram	Phenelzine	Duloxetine	Guanfacine
Brexpiprazole	Sodium Valproate	Dosulepin	Fluoxetine	Tranylcypromine	Mianserin	Dexamfetamine
Chlorpromazine		Doxepin	Fluvoxamine		Mirtazapine	Lisdexamfetamine
Clozapine		Imipramine	Paroxetine		Venlafaxine	Methylphenidate
Flupenthixol		Nortriptyline	Sertraline			
Haloperidol						
Lurasidone						
Olanzapine						
Paliperidone						
Periciazine						
Quetiapine						
Risperidone						
Ziprasidone						
Zuclopenthixol						

Appendix B - Therapeutic Interventions for Metabolic Abnormalities

Adults: Adult Positive Cardiometabolic Health Resource
Adolescents: Adolescent Positive Cardiometabolic Health Resource

Appendix C - Therapeutic Guidelines Common Adverse Effects of Antipsychotics and Antidepressants

A list of common adverse effects of antipsychotics and antidepressants are available in the Therapeutic Guidelines:

- Approximate relative frequency of common adverse effects of antipsychotics
- Approximate relative frequency of common antidepressant adverse effects