



*National Institute for
Clinical Excellence*

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Schizophrenia

**Core interventions in the treatment and
management of schizophrenia in primary
and secondary care**

Clinical Guideline 1

December 2002

Developed by the National Collaborating Centre
for Mental Health

Clinical Guideline 1

Schizophrenia

Core interventions in the treatment and management of schizophrenia in primary and secondary care

Issue date: December 2002

To order copies

Copies of this guideline can be ordered from the NHS Response Line; telephone 0870 1555 455 and quote reference number N0176. A version written for people with schizophrenia, their advocates and carers, and the public, called *Treating and managing schizophrenia (core interventions)* is also available from the Response Line; quote reference number N0177 for an English only version and N0178 for an English and Welsh version.

This document has been circulated to the following:

- NHS Trust Chief Executives in England and Wales
- PCT Chief Executives
- Local Health Group General Managers
- Medical and Nursing Directors in England and Wales
- GPs in England and Wales
- Consultant Psychiatrists in England and Wales
- Consultant Psychologists in England and Wales
- Community Psychiatric Nurses (via *CPNA Journal*)
- Mental Health Nurse Consultants
- Chief Pharmacists, Heads of Drug Purchasing, Heads of Drug Information, Pharmaceutical Advisors, GP Prescribing Advisors and Purchase Advisors in England and Wales
- Strategic Health Authority Chief Executives in England and Wales
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- NHS Clinical Governance Support Team
- Chief Medical, Nursing Officers and Pharmaceutical Officers in England and Wales
- Medical Director & Head of NHS Quality – Welsh Assembly Government
- Representative bodies for health services, professional organisations and statutory bodies, Royal Colleges

This guidance is written in the following context:

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgment. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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This guideline addresses the major treatments and services for people with schizophrenia. Future updates may cover other treatments and services, and update the scientific evidence base developed here.

This guidance is evidence based. The grading scheme used for the recommendations (A, B, C, NICE 2002, good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline produced by the National Collaborating Centre for Mental Health (see Section 5). Reference to NICE 2002 indicates recommendations derived from the NICE technology appraisal of atypical antipsychotics (see Section 6).

1 Guidance

For the purposes of this guideline, the treatment and management of schizophrenia has been divided into three phases:

- initiation of treatment at the first episode
- acute phase
- promoting recovery.

The guideline makes good practice points and recommendations for psychological, pharmacological and service-level interventions in the three phases of care in both primary care and secondary mental health services. Drugs considered in this guideline are restricted to those licensed for use in the UK prior to May 2002, and the psychological treatments dealt with here are for use in addition to antipsychotic medication. For further information on the scope of the guidance, see Section 2.

The first section that follows contains the good practice points and recommendations that apply across all three phases of care.

1.1 Care across all phases

1.1.1 Optimism

The effects of schizophrenia on a person's life experience and opportunities are considerable; service users and carers need help and support to deal with their future and to cope with the changes the illness brings.

- 1.1.1.1 Health professionals should work in partnership with service users and carers, offering help, treatment and care in an atmosphere of hope and optimism.

GPP

1.1.2 Getting help early

For most people experiencing a schizophrenic breakdown, the level of distress, anxiety and subjective confusion, especially during first episodes, leads to difficulty in accessing services.

- 1.1.2.1 Service users and their relatives seeking help should be assessed and receive treatment at the earliest possible opportunity.

GPP

1.1.3 Assessment

The purpose of this guideline is to help improve the experience and outcomes of care for people with schizophrenia. These outcomes include the degree of symptomatic recovery, quality of life, degree of personal autonomy, ability and access to work, stability and quality of living accommodation, degree and quality of social integration, degree of financial independence and the experience and impact of side effects.

- 1.1.3.1 The assessment of needs for health and social care for people with schizophrenia should, therefore, be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues.

GPP

1.1.4 Working in partnership with service users and carers

- 1.1.4.1 Health professionals involved in the routine treatment and management of schizophrenia should take time to build a supportive and empathic relationship with service users and carers; this should be regarded as an essential element of the routine care offered.

GPP

The families of people with schizophrenia often play an essential part in the treatment and care of their relative, and with the right support and help, can positively contribute to promoting recovery. Parents of people with schizophrenia often feel to blame, either because they have 'passed on' the genes causing schizophrenia, or because they are 'bad parents'.

- 1.1.4.2 Clear and intelligible information should be made available to service users and their families about schizophrenia and its possible causes, and about the possible role families can have in promoting recovery and reducing relapse.

GPP

1.1.5 Consent

Whatever treatments are offered, it is essential to engage the service user in a collaborative, trusting and caring working relationship at the earliest opportunity. Professionals should take into full account the particular nature of schizophrenia: namely, that the illness may affect people's ability to make judgments, to recognise that they are ill, to comprehend clearly what professionals might say to them and to make informed decisions about their treatment and care.

1.1.5.1 Health professionals should make all efforts necessary to ensure that a service user can give meaningful and properly informed consent before treatment is initiated, giving adequate time for discussion and the provision of written information. **GPP**

1.1.6 Providing good information and mutual support

1.1.6.1 Health professionals should provide accessible information about schizophrenia and its treatment to service users and carers; this should be considered an essential part of the routine treatment and management of schizophrenia. **GPP**

1.1.6.2 In addition to the provision of good-quality information, families and carers should be offered the opportunity to participate in family or carer support programmes, where these exist. **GPP**

1.1.7 Language and culture

1.1.7.1 When talking to service users and carers, health professionals should avoid using clinical language or keep it to a minimum. Where clinical language is used, service users and carers should have access to written explanations. **GPP**

1.1.7.2 All services should provide written material in the language of the service user, and interpreters should be sought for people who have difficulty in speaking English. **GPP**

1.1.8 Advance directives

1.1.8.1 Although there are limitations with advance directives regarding the choice of treatment for individuals with schizophrenia, it is recommended that they are developed and documented in individuals' care programmes whenever possible. **NICE 2002**

1.1.8.2 When advance directives have been agreed, copies should be placed in primary-care and secondary-care case notes/care plans, and copies given to the service user and his or her care coordinator. If appropriate, and subject to agreement with the service user, a copy should be given to his or her carer. **GPP**

1.2 Initiation of treatment (first episode)

1.2.1 Early referral

It is most likely that the first point of contact for people who may be developing schizophrenia for the first time will be a primary care professional. Rapid identification, early referral and good liaison with secondary services are a priority.

- 1.2.1.1 In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist.

GPP

1.2.2 Early intervention services

- 1.2.2.1 Because many people with actual or possible schizophrenia have difficulty in getting help, treatment and care at an early stage, it is recommended that early intervention services are developed to provide the correct mix of specialist pharmacological, psychological, social, occupational and educational interventions at the earliest opportunity.
- 1.2.2.2 Where the needs of the service user and/or carer exceed the capacity of early intervention services, referral to crisis resolution and home treatment teams, acute day hospitals or inpatient services should be considered.

GPP

GPP

1.2.3 Early treatment

- 1.2.3.1 Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency.

GPP

1.2.4 Pharmacological intervention

- 1.2.4.1 It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia.

NICE
2002

- 1.2.4.2 Atypical antipsychotics at the lower end of the standard dose range are the preferred treatments for a person experiencing a first episode of schizophrenia.

C

1.2.5 Second opinion

After the first episode, many people are unsure about their diagnosis and may need help with this.

- 1.2.5.1 A decision by the service user, and carer where appropriate, to seek a second opinion on the diagnosis should be supported, particularly in view of the considerable personal and social consequences of being diagnosed with schizophrenia.

GPP

1.3 Treatment of the acute episode

1.3.1 Service-level interventions

The services most likely to help people who are acutely ill include crisis resolution and home treatment teams, early intervention teams, community mental health teams and acute day hospitals. If these services are unable to meet the needs of a service user, or if the Mental Health Act is used, inpatient treatment may prove necessary for a period of time. Whatever services are available, a broad range of social, group and physical activities are essential elements of the services provided.

- 1.3.1.1 Community mental health teams are an acceptable way of organising community care and may have the potential for effectively co-ordinating and integrating other community-based teams providing services for people with schizophrenia. However, there is insufficient evidence of their advantages to support a recommendation which precludes or inhibits the development of alternative service configurations.
- 1.3.1.2 Crisis resolution and home treatment teams should be used as a means to manage crises for service users, and as a means of delivering high-quality acute care. In this context, teams should pay particular attention to risk monitoring as a high-priority routine activity.
- 1.3.1.3 Crisis resolution and home treatment teams should be considered for people with schizophrenia who are in crisis to augment the services provided by early intervention services and assertive outreach teams.

C

B

C

- 1.3.1.4 Crisis resolution and home treatment teams should be considered for people with schizophrenia who may benefit from early discharge from hospital following a period of inpatient care. C
- 1.3.1.5 Acute day hospitals should be considered as a clinical and cost-effective option for the provision of acute care, both as an alternative to acute admission to inpatient care and to facilitate early discharge from inpatient care. A
- 1.3.1.6 Social, group and physical activities are an important aspect of comprehensive service provision for people with schizophrenia as the acute phase recedes, and afterwards. All care plans should record the arrangements for social, group and physical activities. GPP

1.3.2 Pharmacological interventions

During an acute episode, antipsychotic drugs are necessary. Wherever possible, service users should make an informed choice as to the antipsychotic they prefer. If a service user is unable to make his or her preference known, an atypical should be prescribed. It is best to use a single drug, using doses within the *British National Formulary (BNF)* dose range and not to use high or loading doses. Clinical response and side effects should be monitored routinely and regularly. If, with conventional antipsychotics, side effects are troublesome or symptom control is inadequate, an atypical should be offered. During an acute episode, some service users become behaviourally disturbed and may need rapid tranquillisation. The recommendations for this can be found in subsection 1.5.

- 1.3.2.1 The choice of antipsychotic drug should be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of the drugs and their side-effect profiles. The individual's advocate or carer should be consulted where appropriate. NICE 2002
- 1.3.2.2 Antipsychotic therapy should be initiated as part of a comprehensive package of care that addresses the individual's clinical, emotional and social needs. The clinician responsible for treatment and key worker should monitor both therapeutic progress and tolerability of the drug on an ongoing basis. Monitoring is particularly important when individuals have just changed from one antipsychotic to another. NICE 2002

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|---------|---|--------------|
| 1.3.2.3 | The dosage of conventional antipsychotic medication for an acute episode should be in the range of 300–1000 mg chlorpromazine equivalents per day for a minimum of 6 weeks. Reasons for dosage outside this range should be justified and documented. The minimum effective dose should be used. | C |
| 1.3.2.4 | In the treatment of the acute episode for people with schizophrenia, massive loading doses of antipsychotic medication, referred to as ‘rapid neuroleptization’, should not be used. | C |
| 1.3.2.5 | The oral atypical antipsychotic drugs (amisulpride, olanzapine, quetiapine, risperidone, zotepine) should be considered as treatment options for individuals currently receiving conventional antipsychotic drugs who, despite adequate symptom control, are experiencing unacceptable side effects, and for those in relapse who have previously experienced unsatisfactory management or unacceptable side effects with conventional antipsychotic drugs. The decision as to what are unacceptable side effects should be taken following discussion between the patient and the clinician responsible for treatment. | NICE 2002 |
| 1.3.2.6 | When full discussion between the clinician responsible for treatment and the individual concerned is not possible, in particular in the management of an acute schizophrenic episode, the oral atypical drugs should be considered as the treatment options of choice because of the lower potential risk of extrapyramidal symptoms (EPS). In these circumstances, the individual’s carer or advocate should be consulted where possible and appropriate. Although there are limitations with advance directives regarding the choice of treatment for individuals with schizophrenia, it is recommended that they are developed and documented in individuals’ care programmes whenever possible. | NICE 2002 |
| 1.3.2.7 | It is not recommended that, in routine clinical practice, individuals change to one of the oral atypical antipsychotic drugs if they are currently achieving good control of their condition without unacceptable side effects with conventional antipsychotic drugs. | NICE 2002 |
| 1.3.2.8 | Antipsychotic drugs, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover. | C |
| 1.3.2.9 | When prescribed chlorpromazine, individuals should be warned of a potential photosensitive skin response as this is an easily preventable side effect. | B |

1.3.2.10 Where a potential to cause weight gain or diabetes has been identified (and/or included in the Summary of Product Characteristics) for the atypical antipsychotic being prescribed, there should be routine monitoring in respect of these potential risks.

B

1.3.3 Early post-acute period

Towards the end of an acute episode of schizophrenia, service users should be offered help to better understand the period of illness, and given the opportunity to write their account in their notes. Carers may also need help in understanding the experience. Assessment for further help to minimise disability, reduce risk and improve quality of life should be routinely undertaken during recovery from the acute phase. In particular, psychological and family help, contingency planning and identifying local resources/services are important. Advice about drug treatments to maintain recovery is also important.

Service user focus

1.3.3.1 Consideration should be given, where practicable, to encouraging service users to write their account of their illness in their notes.

GPP

1.3.3.2 Psychoanalytic and psychodynamic principles may be considered to help health professionals to understand the experience of individual service users and their interpersonal relationships.

GPP

Assessment

The purpose of this guideline is to help improve the experience and outcomes of care for people with schizophrenia. These outcomes include the degree of symptomatic recovery, quality of life, degree of personal autonomy, ability and access to work, stability and quality of living accommodation, degree and quality of social integration, degree of financial independence and the experience and impact of side effects.

1.3.3.3 The assessment of needs for health and social care for people with schizophrenia should, therefore, be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues.

GPP

Psychological treatments

- 1.3.3.4 Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia. **A**
- 1.3.3.5 Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user. **A**
- 1.3.3.6 Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service user preferences should be taken into account, especially if other more efficacious psychological treatments are not locally available. **C**

Medication advice

- 1.3.3.7 Given the high risk of relapse following an acute episode, the continuation of antipsychotic drugs for up to 1 to 2 years after a relapse should be discussed with service users, and carers where appropriate. **GPP**
- 1.3.3.8 Withdrawal from antipsychotic medication should be undertaken gradually whilst regularly monitoring signs and symptoms for evidence of potential relapse. **GPP**
- 1.3.3.9 Following withdrawal from antipsychotic medication, monitoring for signs and symptoms of potential relapse should continue for at least 2 years after the last acute episode. **GPP**

1.4 Promoting recovery

There are a number of options for promoting and maintaining recovery. The general principles for all phases apply equally in this situation. Early intervention to provide early additional treatment and care should the need arise remains important.

1.4.1 Primary care

Primary care professionals have an important part to play in the physical and mental health care of people with schizophrenia. They are best placed to monitor the physical health of people with schizophrenia and should do so regularly. Case registers will be an important means of doing so. In addition, primary care workers should monitor the mental health and treatment of their service users, work closely with secondary services and refer before crises arise wherever possible.

1.4.1.1 The organisation and development of practice case registers for people with schizophrenia is recommended as an essential step in monitoring the physical and mental health of people with schizophrenia in primary care.

GPP

1.4.1.2 GPs and other primary health workers should regularly monitor the physical health of people with schizophrenia registered with their practice. The frequency of checks will be a clinical decision made jointly between the service user and clinician. The agreed frequency should be recorded in the patient's notes.

GPP

1.4.1.3 Physical health checks should pay particular attention to endocrine disorders, such as diabetes and hyperprolactinaemia, cardiovascular risk factors, such as blood pressure and lipids, side effects of medication, and lifestyle factors such as smoking. These must be recorded in the notes.

GPP

1.4.1.4 The decision to re-refer a service user from primary care to mental health services is a complex clinical judgment that should take account of the views of the service user and, where appropriate, carers. Issues of confidentiality should be respected when involving carers. Referral may be considered in a number of circumstances, but particular factors indicating referral include the following:

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- where treatment adherence is a problem, referral is usually indicated
- a poor response to treatment would make referral a higher priority
- if co-morbid substance misuse is suspected, referral is indicated
- if the level of risk to self or others is increased, referral to secondary services is indicated
- when a person with schizophrenia first joins a GP practice list, referral to secondary services for assessment and care programming is indicated, subject to the full agreement of the service user.

1.4.2 Secondary services

Secondary services should undertake regular and full assessment of the mental and physical health of their service users, addressing all the issues relevant to a person's quality of life and well-being. When a service user chooses not to receive physical care from his or her GP, this should be monitored by doctors in secondary care. Carers should be contacted routinely, subject to the agreement of the service user, and should be provided with a care plan.

The possible presence of co-morbid conditions, including substance and alcohol misuse or physical illness, or the existence of a forensic history, will necessitate the development of treatment and care plans outside the scope of this guideline. Nevertheless, full assessment of these issues should be included.

- 1.4.2.1 A full assessment of health and social care needs should be undertaken regularly, including assessment of accommodation and quality of life, the frequency of which should be based upon clinical need, and following discussion with the service user. The agreed frequency of assessment should be documented in the care plan.

GPP

The higher physical morbidity and mortality of service users with schizophrenia should be considered in all assessments. Whilst this would normally be expected to be the role of primary care services, secondary care services should nevertheless monitor these matters where they believe a service user may have little regular contact with primary care.

- 1.4.2.2 Primary and secondary care services, in conjunction with the service user, should jointly identify which service will take responsibility for assessing and monitoring the physical health care needs of service users. This should be documented in both primary and secondary care notes/care plans and clearly recorded by care co-ordinators for those on the enhanced care programme approach (CPA).

GPP

- 1.4.2.3 Moreover, all non-professional carers who provide regular care for a person on CPA should have an assessment of their caring, physical and mental health needs, at a frequency agreed in conjunction with the carer and recorded in their own (carer) care plan.

GPP

1.4.3 Service interventions

The range of services needed for people with schizophrenia are diverse and need to be tailored to individual circumstances and current local resources. However, some people with schizophrenia have high needs for care and tend to be lost from ordinary services. Assertive outreach teams (or assertive community treatment – ACT) are an effective way of helping to meet those needs and are better at staying in touch than ordinary services. Also, most people with schizophrenia will need rapid access to help in crises. Services need to plan how to best deliver help and treatment ensuring that teams are functionally integrated.

- 1.4.3.1 Assertive outreach teams should be provided for people with serious mental disorders including people with schizophrenia.

B

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| 1.4.3.2 | Assertive outreach teams should be provided for people with serious mental disorders, including for people with schizophrenia, who make high use of inpatient services and who have a history of poor engagement with services leading to frequent relapse and/or social breakdown (as manifest by homelessness or seriously inadequate accommodation). | B |
| 1.4.3.3 | Assertive outreach teams should be provided for people with schizophrenia who are homeless. | B |
| 1.4.3.4 | Where the needs of the service user and/or carer exceed the capacity of assertive outreach teams, referral to crisis resolution and home treatment teams, acute day hospitals or inpatient services should be considered. | GPP |
| 1.4.3.5 | Crisis resolution and home treatment teams should be considered for people with schizophrenia who are in crisis to augment the services provided by early intervention services and assertive outreach teams. | C |
| 1.4.3.6 | Integrating the care of people with schizophrenia who receive services from community mental health teams, assertive outreach teams, early intervention services and crisis resolution and home treatment teams should be carefully considered. The CPA should be the main mechanism by which the care of individuals across services is properly managed and integrated. | GPP |

1.4.4 Psychological interventions

Psychological treatments should be an indispensable part of the treatment options available for service users and their families in the effort to promote recovery. Those with the best evidence of effectiveness are cognitive behavioural therapy and family interventions. These should be used to prevent relapse, to reduce symptoms, increase insight and promote adherence to medication.

Relapse prevention and symptom reduction: cognitive behavioural therapy and family interventions

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|---------|---|---|
| 1.4.4.1 | Cognitive behavioural therapy should be available as a treatment option for people with schizophrenia. | A |
| 1.4.4.2 | In particular, cognitive behavioural therapy should be offered to people with schizophrenia who are experiencing persisting psychotic symptoms. | A |
| 1.4.4.3 | Cognitive behavioural therapy should be considered as a treatment option to assist in the development of insight. | B |

- | | | |
|----------|--|---|
| 1.4.4.4 | Cognitive behavioural therapy may be considered as a treatment option in the management of poor treatment adherence. | C |
| 1.4.4.5 | Longer treatments with cognitive behavioural therapy are significantly more effective than shorter ones, which may improve depressive symptoms but are unlikely to improve psychotic symptoms. An adequate course of cognitive behavioural therapy to generate improvements in psychotic symptoms in these circumstances should be of more than 6 months' duration and include more than ten planned sessions. | B |
| 1.4.4.6 | Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user. | A |
| 1.4.4.7 | In particular, family interventions should be offered to the families of people with schizophrenia who have recently relapsed or who are considered at risk of relapse. | A |
| 1.4.4.8 | Also in particular, family interventions should be offered to the families of people with schizophrenia who have persisting symptoms. | A |
| 1.4.4.9 | When providing family interventions, the length of the family intervention programme should normally be longer than 6 months' duration and include more than ten sessions of treatment. | B |
| 1.4.4.10 | When providing family interventions, the service user should normally be included in the sessions, as doing so significantly improves the outcome. Sometimes, however, this is not practicable. | B |
| 1.4.4.11 | When providing family interventions, service users and their carers may prefer single-family interventions rather than multi-family group interventions. | A |

1.4.5 Pharmacological interventions

Antipsychotic drugs are an indispensable treatment option for most people in the recovery phase of schizophrenia. The main aim here is to prevent relapse and help keep a person stable enough to live as normal a life as possible. Drugs are also necessary for psychological treatments to be effective.

The service user and clinician should jointly decide the choice of drug, but service user preferences are central. Oral and depot preparations can be used. Follow *BNF* guidance on dosing and test dosing. If conventional antipsychotics have been used and are not effective or are causing unacceptable side effects, change to an atypical. If an atypical is causing diabetes or excessive weight gain, this must be monitored or consider changing to a different atypical or a conventional antipsychotic. Always monitor and record clinical response, side effects and service user satisfaction. If a person is satisfied with the drug he or she is taking, make no changes. Do consider the use of psychological interventions if a person has persisting symptoms or frequent relapses.

If a service user has had two antipsychotics (including one atypical) each for 6–8 weeks without significant improvement, check out possible causes for a lack of response and consider clozapine. In some circumstances it may be supportable to add a second antipsychotic drug to clozapine if there has been a suboptimal response at standard doses. Do not use more than one antipsychotic drug in other situations, except when changing from one drug to another. Other adjunctive treatments are outside the scope of this guideline.

Relapse prevention: oral antipsychotics

1.4.5.1 The choice of antipsychotic drug should be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of the drugs and their side-effect profiles. The individual's advocate or carer should be consulted where appropriate.

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1.4.5.2 The oral atypical antipsychotic drugs (amisulpride, olanzapine, quetiapine, risperidone and zotepine) should be considered as treatment options for individuals currently receiving typical antipsychotic drugs who, despite adequate symptom control, are experiencing unacceptable side effects, and for those in relapse who have previously experienced unsatisfactory management or unacceptable side effects with typical antipsychotic drugs. The decision as to what are unacceptable side effects should be taken following discussion between the patient and the clinician responsible for treatment.

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2002

1.4.5.3 It is not recommended that, in routine clinical practice, individuals change to one of the oral atypical antipsychotic drugs if they are currently achieving good control of their condition without unacceptable side effects with typical antipsychotic drugs.

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|---------|---|--------------|
| 1.4.5.4 | Antipsychotic therapy should be initiated as part of a comprehensive package of care that addresses the individual's clinical, emotional and social needs. The clinician responsible for treatment and key worker should monitor both therapeutic progress and tolerability of the drug on an ongoing basis. Monitoring is particularly important when individuals have just changed from one antipsychotic to another. | NICE 2002 |
| 1.4.5.5 | Targeted, intermittent dosage maintenance strategies should not be used routinely in lieu of continuous dosage regimens because of the increased risk of symptom worsening or relapse. However, these strategies may be considered for service users who refuse maintenance or for whom some other contraindication to maintenance therapy exists, such as side-effect sensitivity. | C |
| 1.4.5.6 | Antipsychotic drugs, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover. | C |

Relapse prevention: depot antipsychotics

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| 1.4.5.7 | A risk assessment should be performed by the clinician responsible for treatment and the multidisciplinary team regarding concordance with medication, and depot preparations should be prescribed when appropriate. | NICE 2002 |
| 1.4.5.8 | Depot preparations should be a treatment option where a service user expresses a preference for such treatment because of its convenience, or as part of a treatment plan in which the avoidance of covert non-adherence with antipsychotic drugs is a clinical priority. | B |
| 1.4.5.9 | For optimum effectiveness in preventing relapse, depot preparations should be prescribed within the standard recommended dosage and interval range. | A |
| 1.4.5.10 | Following full discussion between the responsible clinician and the service user, the decision to initiate depot antipsychotic injections should take into account the preferences and attitudes of the service user towards the mode of administration and organisational procedures (for example, home visits and location of clinics) related to the delivery of regular intramuscular injections. | GPP |
| 1.4.5.11 | Test doses should normally be used as set out in the <i>BNF</i> and full licensed prescribing information on depot antipsychotics is available from the Summary of Product Characteristics, which can be found in the electronic medicines compendium (www.emc.vhn.net). | GPP |

1.4.5.12 As with oral antipsychotics, people receiving depots should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen.

GPP

Treatment-resistant schizophrenia

1.4.5.13 The first step in the clinical management of treatment-resistant schizophrenia (TRS) is to establish that antipsychotic drugs have been adequately tried in terms of dosage, duration and adherence. Other causes of non-response should be considered in the clinical assessment, such as co-morbid substance misuse, poor treatment adherence, the concurrent use of other prescribed medicines and physical illness.

GPP

1.4.5.14 If the symptoms of schizophrenia are unresponsive to conventional antipsychotics, the prescribing clinician and service user may wish to consider an atypical antipsychotic in advance of a diagnosis of treatment-resistant schizophrenia and a trial of clozapine. In such cases, olanzapine or risperidone may be worth considering. Service users should be informed that while these drugs may possibly be beneficial, the evidence for improvement in this situation is more limited than for clozapine.

C

1.4.5.15 In individuals with evidence of TRS, clozapine should be introduced at the earliest opportunity. TRS is suggested by a lack of satisfactory clinical improvement despite the sequential use of the recommended doses for 6 to 8 weeks of at least two antipsychotics, at least one of which should be an atypical.

NICE
2002

Combining antipsychotics

1.4.5.16 Antipsychotic drugs, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover.

C

1.4.5.17 However, the addition of a second antipsychotic to clozapine may be considered for people with TRS for whom clozapine alone has proved insufficiently effective.

C

1.4.6 Employment

The overall aim of mental health services is to help service users get back to living an ordinary life as far as possible. Assessment should be comprehensive and this includes assessing a person's work potential. Mental health and social care services also need to help support the development of employment opportunities for people with schizophrenia.

- 1.4.6.1 People with schizophrenia experience considerable difficulty in obtaining employment and many remain unemployed for long periods of time. The assessment of people with schizophrenia should include assessment of their occupational status and potential. This should be recorded in their notes/care plans. **GPP**
- 1.4.6.2 Supported employment programmes should be provided for those people with schizophrenia who wish to return to work or gain employment. However, it should not be the only work-related activity offered when individuals are unable to work or are unsuccessful in their attempts to find employment. **C**
- 1.4.6.3 Mental health services, in partnership with social care providers and other local stakeholders, should enable people to use local employment opportunities, including a range of employment schemes to suit the different needs and level of skill, for people with severe mental health problems, including people with schizophrenia. **GPP**

1.5 Rapid tranquillisation

During an acute illness, some service users can become behaviourally disturbed and may need help to calm down; for the majority of service users, though, rapid tranquillisation is not necessary and should not be resorted to routinely. It is important to ensure that the environment is properly adapted for the needs of the acutely ill and that communication between staff and service users is clear and therapeutic in order to minimise frustration and misunderstandings. Staff on psychiatric inpatient units should be trained in how to assess and manage potential and actual violence using de-escalation techniques, restraint, seclusion and rapid tranquillisation. Staff should also be trained to undertake cardiopulmonary resuscitation.

If drugs are needed to calm an individual, an oral preparation should be offered first. If intramuscular injection proves necessary, lorazepam, haloperidol or olanzapine are the preferred drugs. If two drugs are needed, consider lorazepam and haloperidol. If haloperidol is used, anticholinergics should be administered. Vital signs and side effects should be regularly monitored and full physical and mental health assessment undertaken at the earliest opportunity. Rapid tranquillisation may be traumatic – patients will need debriefing with full explanation, discussion and support.

- 1.5.1.1 Health professionals should identify and take steps to minimise the environmental and social factors that might increase the likelihood of violence and aggression during an episode, particularly during periods of hospitalisation. **C**

Factors to be routinely identified, monitored and corrected include: overcrowding; lack of privacy; lack of activities; long waiting times to see staff; poor communication between patients and staff; and weak clinical leadership.

1.5.2 Aims of rapid tranquillisation

The aim of drug treatment in such circumstances is to calm the person, and reduce the risk of violence and harm, rather than treat the underlying psychiatric condition. An optimal response would be a reduction in agitation or aggression without sedation, allowing the service user to participate in further assessment and treatment. Ideally, the drug should have a rapid onset of action and a low level of side effects.

- 1.5.2.1 Staff who use rapid tranquillisation should be trained in the assessment and management of service users specifically in this context: this should include assessing and managing the risks of drugs (benzodiazepines and antipsychotics), using and maintaining the techniques and equipment needed for cardiopulmonary resuscitation, prescribing within therapeutic limits and using flumazenil (benzodiazepine antagonist).

1.5.3 Training for behavioural control/rapid tranquillisation

- 1.5.3.1 Staff need to be trained to anticipate possible violence and to de-escalate the situation at the earliest opportunity, and physical means of restraint or seclusion should be resorted to 'only after the failure of attempts to promote full participation in self-care'.
- 1.5.3.2 Training in the use and the dangers of rapid tranquillisation is as essential as training in de-escalation and restraint. Health professionals should be as familiar with the properties of benzodiazepines as they are with those of antipsychotics.
- 1.5.3.3 Specifically, health professionals should:
- be able to assess the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possibly be physically ill
 - understand the cardio-respiratory effects of the acute administration of these drugs and the need to titrate dosage to effect
 - recognise the importance of nursing, in the recovery position, people who have received these drugs and also of monitoring pulse, blood pressure and respiration

- be familiar with, and trained in, the use of resuscitation equipment; this is essential as an anaesthetist or experienced 'crash team' may not be available
- undertake annual retraining in resuscitation techniques
- understand the importance of maintaining an unobstructed airway.

1.5.4 Principles of rapid tranquillisation

- 1.5.4.1 The psychiatrist and the multidisciplinary team should, at the earliest opportunity, undertake a full assessment, including consideration of the medical and psychiatric differential diagnoses. **C**
- 1.5.4.2 Drugs for rapid tranquillisation, particularly in the context of restraint, should be used with caution because of the following risks:
- loss of consciousness instead of sedation
 - over-sedation with loss of alertness
 - possible damage to the therapeutic partnership between service user and clinician
 - specific issues in relation to diagnosis.
- 1.5.4.3 Resuscitation equipment and drugs, including flumazenil, must be available and easily accessible where rapid tranquillisation is used. **C**
- 1.5.4.4 Because of the serious risk to life, service users who are heavily sedated or using illicit drugs or alcohol should not be secluded. **C**
- 1.5.4.5 If a service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously. **C**
- 1.5.4.6 Violent behaviour can be managed without the prescription of unusually high doses or 'drug cocktails'. The minimum effective dose should be used. The *BNF* recommendations for the maximum doses (*BNF* – section 4.2) should be adhered to unless exceptional circumstances arise. **C**
- 1.5.4.7 With growing awareness that involuntary procedures produce traumatic reactions in service users, following the use of rapid tranquillisation, service users should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation. This should be documented in their notes. **GPP**

- 1.5.4.8 Service users should also be given the opportunity to write their account of their experience of rapid tranquillisation in the notes.

GPP

1.5.5 Route of drug administration

- 1.5.5.1 Oral medication should be offered before parenteral medication.
- 1.5.5.2 If parenteral treatment proves necessary, the intramuscular route is preferred over the intravenous one from a safety point of view. Intravenous administration should only be used in exceptional circumstances.
- 1.5.5.3 Vital signs must be monitored after parenteral treatment is administered. Blood pressure, pulse, temperature and respiratory rate should be recorded at regular intervals, agreed by the multidisciplinary team, until the service user becomes active again. If the service user appears to be or is asleep, more intensive monitoring is required.

C

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1.5.6 Pharmacological agents used in rapid tranquillisation

- 1.5.6.1 The intramuscular (IM) preparations recommended for use in rapid tranquillisation are lorazepam, haloperidol and olanzapine. Wherever possible, a single agent is preferred to a combination.
- 1.5.6.2 When rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam should be considered.
- 1.5.6.3 IM diazepam is not recommended for the pharmacological control of behavioural disturbances in people with schizophrenia.
- 1.5.6.4 IM chlorpromazine is not recommended for the pharmacological control of behavioural disturbances in people with schizophrenia.
- 1.5.6.5 When using IM haloperidol (or any other IM conventional antipsychotic) as a means of behavioural control, an anticholinergic agent should be given to reduce the risk of dystonia and other extrapyramidal side effects.

C

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C

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/pdf/schizophreniascope.pdf

2.1 This guideline is relevant to adults (> 18 years) with a diagnosis of schizophrenia with the onset before 60 years of age, and for all healthcare professionals involved in the help, treatment and care of people with schizophrenia and their carers. These include:

- adults with a diagnosis of schizophrenia and their families/carers
- professional groups who share in the treatment and care for people with a diagnosis of schizophrenia, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, occupational therapists, pharmacists and GPs
- professionals in other health and non-health sectors who may have direct contact with or be involved in the provision of health and other public services for those diagnosed with schizophrenia. These may include A&E staff, paramedical staff, prison doctors, the police and persons who work in the criminal justice and education sectors
- those with responsibility for planning services for people with a diagnosis of schizophrenia, and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

2.2 The guidance does not specifically address the treatment and management of people with:

- very-early onset (childhood-onset) schizophrenia
- very-late onset (age of onset at 60 years of age or greater) schizophrenia
- schizophrenia with co-existing learning difficulties
- schizophrenia with co-existing substance misuse
- schizophrenia with co-existing significant physical or sensory difficulties
- schizophrenia who are homeless.

2.3 Although this guideline briefly addresses the issue of diagnosis, it has not made evidence-based recommendations nor has it referred to evidence regarding diagnosis, primary prevention or assessment.

3 Implementation in the NHS

3.1 In general

- 3.1.1 The implementation of this guideline will build on the National Service Frameworks for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales. The Priorities and Planning Framework for the NHS in England 2003–2006 sets key targets for improvements in mental health services including compliance with relevant NICE technology appraisals and clinical guidelines. Separate mental health strategies in Wales, for adults and for children and adolescents, were published in September 2001.
- 3.1.2 Local health communities should review their existing service provision for people with schizophrenia against this guideline as they begin the development of their Local Delivery Plans. The review should consider the resources required to implement fully the recommendations set out in Section 1 of this guideline, the people and processes involved, and the timeline over which full implementation is envisaged. Clearly, it is in the interests of service users and carers that the implementation timeline, as determined by each local health community, is as rapid as possible. NHS organisations should consider the value of advising service users and carers of their response to this guidance. In addition, NHS organisations should review the skills of existing staff and teams, identify gaps and put in place training arrangements that will ensure that staff are adequately equipped to implement the recommendations in this guideline.
- 3.1.3 Relevant local clinical guidelines and protocols should be reviewed in the light of this guidance and revised accordingly.

3.2 Audit

- 3.2.1 To enable clinicians to audit their own compliance with this guideline it is recommended that, if not already in place, management plans are recorded for each patient. This information should be incorporated into local clinical audit data recording systems and consideration given (if not already in place) to the establishment of appropriate categories in electronic record systems.

- 3.2.2 Prospective clinical audit programmes should record the proportion of patients whose treatment and care adheres to the guideline. Such programmes are likely to be more effective in improving patient care when they form part of the organisation's clinical governance arrangements and when they are linked to specific postgraduate activities.
- 3.2.3 Suggested audit criteria are listed in Appendix E. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

- 4.1 The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. The Guideline Development Group's full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Mental Health (see Section 5).
 - 4.1.1 Direct comparisons between atypical antipsychotics are needed to establish their respective risk/benefit profiles. Trials should pay particular attention to the long-term benefits and risks of the drugs, including diabetes, weight gain and quality of life.
 - 4.1.2 Adequately powered randomised controlled trials reporting all relevant clinical outcomes, including quality of life, are needed to further evaluate the use of cognitive behavioural therapy in people at first episode of schizophrenia and people at risk of relapse.
 - 4.1.3 Research studies are needed to establish the relative effectiveness of specialist teams (for example, crisis resolution and home treatment, and early intervention) as compared with community mental health teams, augmented or enhanced to deliver these functions.
 - 4.1.4 There is a need for more research on the development and evaluation of effective interventions for managing physical health of people with schizophrenia in general practice.

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline, *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*, will be published by the National Collaborating Centre for Mental Health; it will be available from its website, the NICE website (www.nice.org.uk) and the website of the National Electronic Library for Health (www.nelh.nhs.uk).

The members of the Guideline Development Group are listed in Appendix B. Information about the Institute's Guidelines Advisory Committee is given in Appendix C.

The booklet *The Guideline Development Process – Information for the Public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0038).

6 Related NICE guidance

National Institute for Clinical Excellence (2002) Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia. *NICE Technology Appraisal Guidance* No. 43. London: National Institute for Clinical Excellence. Available from www.nice.org.uk/cat.asp?c=32878

The appraisal guidance has been incorporated into this guideline.

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that is adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C based on the level of associated evidence or noted as a good practice point (see Box 2) – this grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996). 'NICE 2002' indicates that the recommendation is from the NICE technology appraisal of atypical antipsychotic drugs (see Section 6).

Box 1 Hierarchy of evidence

| Level | Type of evidence |
|-------|--|
| Ia | Evidence obtained from a single large randomised trial or a meta-analysis of at least three randomised controlled trials |
| Ib | Evidence obtained from a small randomised controlled trial or a meta-analysis of less than three randomised controlled trials |
| IIa | Evidence obtained from at least one well-designed controlled study without randomisation |
| IIb | Evidence obtained from at least one other well-designed quasi-experimental study |
| III | Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies |
| IV | Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities |

Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5: 8.

Box 2 Grading of recommendations

| Grade | Source |
|----------------------------------|--|
| A | At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels Ia and Ib) without extrapolation |
| B | Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels IIa, IIb, III), or with extrapolation from level I evidence |
| C | Expert committee reports or opinions and/or clinical experiences of respected authorities. This grading indicates that directly applicable clinical studies of good quality are absent (evidence level IV), or with extrapolation from higher levels of evidence |
| NICE 2002 | Recommendation drawn from the NICE technology appraisal of the use of the newer (atypical) antipsychotic drugs for schizophrenia |
| Good practice point (GPP) | Recommended good practice based on the clinical experience of the GDG |

Based on a scheme from: NHS Executive. *Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS*. London: 1996

Appendix B: The Guideline Development Group

Dr Tim Kendall

Co-Director, National Collaborating Centre for Mental Health;
Deputy Director, Royal College of Psychiatrists Research Unit; and
Consultant Psychiatrist and Medical Director, Community Health
Sheffield NHS Trust
Chair, Guideline Development Group

Mr Stephen Pilling

Co-Director, National Collaborating Centre for Mental Health;
Director, Centre for Outcomes Research and Effectiveness; and
Consultant Clinical Psychologist, Camden and Islington Mental Health
and Social Care Trust
Facilitator, Guideline Development Group

Professor Tom Barnes

Professor of Psychiatry, Imperial College Faculty of Medicine, London
Lead, Topic Group on Pharmacology

Professor Philippa Garety

Professor of Clinical Psychology, Guy's King's and St Thomas' School
of Medicine and the Institute of Psychiatry, King's College London
and the South London and Maudsley NHS Trust
Lead, Topic Group on Psychological Interventions

Professor Max Marshall

Professor of Psychiatry, University of Manchester
Lead, Topic Group on Service-level Interventions

Ms Emma Harding

Service User, and
Senior Project Worker, User Employment Programme,
SW London St George's Mental Health NHS Trust

Mr Graham Estop

Mental Health Charities in NICE

Mr Bill Hare

Rethink Severe Mental Illness

Mr Peter Pratt

Chief Pharmacist, Doncaster & South Humber NHS Trust and
Community Health Sheffield NHS Trust

Dr Paul Rowlands

Consultant Psychiatrist, Derbyshire Mental Health Services NHS Trust

Professor Irwin Nazareth

Professor of Primary Care and Population Studies,
Royal Free and University College London Medical School

Ms Liz Newstead

Lecturer/Clinical Nurse Specialist, Dorset Healthcare NHS Trust/
Bournemouth University

Ms Christine Sealey (Observer)

Guidelines Commissioning Manager, NICE

NCCMH Staff

Dr Catherine Pettinari: Senior Project Manager

Dr Craig Whittington: Senior Systematic Reviewer

Dr Judit Simon: Health Economist

Ms Rachel Burbeck: Systematic Reviewer

Mr Daniel Michelson: Research Assistant

Mr Lawrence Howells: Research Assistant

Ms Ellen Boddington: Research Assistant

Ms Celia Morgan: Research Assistant

Appendix C: The Guidelines Advisory Committee

The Guidelines Advisory Committee is an independent Committee established by NICE to validate the clinical guidelines developed by the National Collaborating Centres. The multidisciplinary Committee includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. A full list of members of the Guidelines Advisory Committee can be found on the NICE website.

For each guideline, a number of Committee members oversee the development of the guideline and take responsibility for monitoring its quality. The Committee members who took on this role for this guideline were:

Professor Mike Drummond

Director
Centre for Health Economics
University of York

Professor Martin Eccles (Chairman of the Committee)

Professor of Clinical Effectiveness
Centre for Health Services Research
University of Newcastle upon Tyne

Dr Bernard Higgins

Consultant Chest Physician
Newcastle upon Tyne

Dr Marcia Kelson

Director
Patient Involvement Unit for NICE
College of Health
London

Mrs Judy Mead

Head of Clinical Effectiveness
Chartered Society of Physiotherapy

Appendix D: *Treating and managing schizophrenia (core interventions)*

Understanding NICE guidance – information for people with schizophrenia, their advocates and carers, and the public

The information in this appendix has been designed to support the production of your own information leaflets. You can download it from our website at www.nice.org.uk where it is available in English and Welsh. If you would like printed copies of the leaflets please ring the NHS Response Line on 0870 1555 455 and quote reference number N0177 for an English only version and N0178 for an English and Welsh version.

About this information

This information describes the guidance that the National Institute for Clinical Excellence (called NICE for short) has issued to the NHS on schizophrenia. It is based on *Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care*, which is a clinical guideline produced by NICE for health professionals working in the NHS in England and Wales. Although the information in this booklet has been written mainly for people with schizophrenia, it may also be useful for family members, those who care for people with schizophrenia, advocates (people who can liaise with the professionals on your behalf, especially if you are very ill) for people with schizophrenia, and anyone with an interest in schizophrenia or in healthcare in general.

This booklet briefly describes schizophrenia, how it starts and what life changes it may bring about. It also will tell you about the stages of the illness, and what treatment and care you should get when a person first becomes ill, when he or she has further breakdowns and what help a person should get to help him or her recover. It will tell you about the main treatments that should be available, including the teams and services who can help, the medicines that work best, and the psychological and family help. There is also a glossary explaining some of the technical words used.

Clinical guidelines

Clinical guidelines are about improving the care and treatment provided in the health service. The schizophrenia guideline produced by NICE has been prepared by health professionals, a group of people who represent those who use the health service (known as 'service users') and scientists with knowledge of schizophrenia.

The group has looked at the evidence available on the best way of treating or managing schizophrenia and made recommendations based on this evidence.

There is more about NICE and the way that the NICE guidelines are developed on the NICE website (www.nice.org.uk). You can download the booklet *The guideline development process – information for the public and the NHS* from the website, or you can order a copy by phoning 0870 1555 455 and quoting reference number N0038.

What the recommendations cover

NICE clinical guidelines can look at different areas of diagnosis, treatment, care, self-help or a combination of these. The areas that a guideline covers depend on the illness or disorder. The recommendations in *Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care* cover psychological treatments, treatment with medicines, and how best to organise mental health services in order to help people with schizophrenia. The guideline concentrates on services for adults of working age with schizophrenia. It doesn't look at schizophrenia in childhood or schizophrenia that starts in later life (starting over 60 years of age). And it doesn't look at the special problems of people with schizophrenia who also have learning difficulties, or hearing or sight problems, or at the additional problems of people with schizophrenia who also have problems with alcohol or drug misuse, or who are homeless (although we say something about this, we don't look at their specific problems in a detailed way). The guideline will only tell you a little about diagnosis and assessment methods. These areas may be covered by future guidelines.

This guideline will help you understand what kind of treatment (medicines and psychological therapy) and services are of most help to people with schizophrenia, and whether treatment is given as an outpatient, by a community mental health team, as an inpatient or in any other mental health service. It will also tell you about what your GP can do to help. A glossary describing some of the unfamiliar words and phrases used is included at the end.

The information that follows tells you about the NICE guideline on schizophrenia. It doesn't try to explain schizophrenia or describe the treatments in detail. If you want to find out more about schizophrenia, NHS Direct may be a good starting point. You can call NHS Direct on 0845 46 47 or view the NHS Direct website at www.nhsdirect.nhs.uk.

How guidelines are used in the NHS

In general, health professionals working in the NHS are expected to follow NICE's clinical guidelines. But there will be times when the treatments recommended will not be suitable for some people because of their specific medical condition, their general health, a person's wishes or a combination of these. If you think that the treatment or care you (or someone you care for) receive does not match the treatment or care described in the pages that follow, you should discuss your concerns with your psychiatrist, GP, advocate or other members of the mental health team.

If you want to read the other versions of this guideline

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care, a guide for professionals, and the full guideline (which contains all the details of the guideline recommendations and how they were developed) are both available on the NICE website (www.nice.org.uk).

About schizophrenia

Schizophrenia is a serious illness that affects about 1 in every 100 people at some time in their life. When people are ill with schizophrenia they usually hear voices (hallucinations) and develop strange ideas and beliefs that others don't agree with (delusions), although exactly what types of symptoms a person has is very individual. The first illness most commonly starts when a person is between 20 and 30 years old, although it may begin in the teenage years. Although schizophrenia is a serious illness there are many ways to help and a number of people get better, sometimes for good.

After the first breakdown, around one person in five is never ill again. But seven out of ten people have at least two breakdowns (known as 'acute episodes'), with the second usually happening within 5–7 years of the first. Although typically there's a pattern of repeated acute episodes, schizophrenia varies considerably between people. For example, some people may have only one relatively brief episode, while others experience symptoms for an extended period of time. Some people recover completely between episodes of illness, while others continue with some symptoms even when they're not acutely ill. For a small number of people, the illness develops into a chronic (long-lasting) disorder in which a person is never free of symptoms despite treatment. However, with treatment, the majority of people tend to improve or recover.

Development of the first illness

When the symptoms of schizophrenia first begin to develop, many people lose interest in ordinary things and relationships. They may appear odd and different to others. The symptoms may also come and go in the early stages of the illness – often they're noticed by a person's family or friends before the person becomes aware of them. When this happens, people with schizophrenia often feel that their world has changed and may say this is because of reasons that might seem far-fetched or odd to others, or reasons that might not appear to connect to the problem. Usually relatives and friends also notice that the person has changed 'in themselves'. Quite commonly, the illness will affect the person's ability to work, go to school or college or relate to friends and family. Without treatment, most people become much more obviously ill, and this is what's known as an acute episode.

When people have a 'breakdown' (the acute episode of schizophrenia)

When people become unwell, they may hear voices, have strange thoughts and ideas, and feel and behave differently. The symptoms can be very distressing for the person affected, their family and friends. At times, people who are ill may become very withdrawn and have trouble talking to other people, and even neglect themselves. The illness can also make people do or say things that they would not normally do, including unexpected outbursts of anger or upset. It can be difficult to understand them and their experiences.

Helping recovery

When people have been unwell, it's very important to make sure they can continue to get help and treatment to aid recovery and lower the chances of them becoming ill again. Treatment is sometimes necessary for quite a long time after they have recovered. They may also need help building up their lives again, and are likely to need support to do this. Exactly what and how much treatment and support a person needs will vary from person to person, and for the same person from time to time. This will need to be discussed at length by the person with schizophrenia and the healthcare professionals who have helped them. With the right help, treatment and support, people with schizophrenia can live normal lives. About a quarter of people will recover altogether, even after a number of years of illness.

Guideline recommendations

The following advice is written for people with schizophrenia, and their carers, and will tell you what help, treatment and care you can expect. At this point in time, not all the treatments outlined below are available in all parts of the country. This guideline will help services and health professionals to provide better treatment and care.

The first section outlines some issues that are important throughout all stages of the illness.

Care you can expect in all stages

The relationship with professionals

Whatever the stage of illness, it is very important that the professionals who work with you develop a supportive and caring relationship with you. They should be engaging and kind, and work in a constructive partnership with you and, preferably, with your family and/or carers. The effects of schizophrenia on a person's life experience and opportunities are considerable. Service users and carers need help and support in dealing with their future, and to be able to cope with the changes the illness brings. Professionals should work with you in a partnership and in an atmosphere of hope and optimism.

Getting help early

When you need help, especially if things are going wrong, you can expect help at an early stage. When most people have a breakdown, the level of upset, anxiety and confusion, especially when they first become unwell, can lead to problems in getting proper help. Sometimes people feel suspicious of friends, relatives and professionals, and their distressed state can alarm others who may respond in a less than helpful way. Many people who are experiencing a breakdown do not agree with others around them about the events or experiences they are having, nor with the explanations other people give. This means that people at the start of their illness can be misunderstood and they may be vulnerable as a result. Because of this, service users and their relatives seeking help should get the right help, treatment and care as soon as possible.

Full assessment

The first help you receive should be a full assessment. This is to make sure that the treatment and care you are offered are tailored to your particular needs and situation. At the assessment, you should be asked about your symptoms, how happy you are with your life, what your accommodation is like, your social life and how much or little

money you have. The staff doing the assessment will also need to ask you about your physical health, your work and your skills. If there are any issues you think are important for you, including things like your culture and religion, tell the staff who should give you the chance to discuss them.

Information about treatments and consent

When you are offered treatments, you should be given as much information as you want about the illness and its treatments *before* the treatment is started, and treatment should be started only after you have given your consent. The exception is if you have been 'sectioned' under the Mental Health Act – this is when you have been detained for assessment and/or treatment against your wishes, for example, because you are too unwell to make decisions. If you have been 'sectioned', you can expect as much care and help as anyone else, and that time will be taken to explain what is happening. The medical language used by doctors and nurses is sometimes very technical and can be confusing and so won't be used unless it is necessary. You will be given written material to explain things you don't understand. If you have trouble speaking and/or understanding English, an interpreter should be provided and information given to you in a language you can understand. Also remember that there are some very supportive voluntary organisations that may be able to help you and your carers at different times, sometimes with information, sometimes with family and carer support programmes.

Choosing treatments and advance directives

There are a number of different treatments for people with schizophrenia – many do the same things but have different side effects. It is important that the treatment you are offered suits you and doesn't give you unpleasant side effects. Once you have been ill, your doctors and other healthcare workers should try to help you write down which treatments you most like or dislike so that if you become ill again, professionals will know your preferences. These written preferences are kept in your GP's notes and in your psychiatric notes, and are called advance directives. When you make an advance directive, you should have a copy and, if you would like, your team can give a copy to your relative, advocate or carer.

The first illness (leading up to the first breakdown)

Most people go to see their GP when they are first ill, either because their family want them to or because they are feeling that things aren't right. If your GP thinks that you are having a breakdown, you can expect to be referred to a psychiatrist quickly. Alternatively, your GP may ask a special team of doctors, nurses and therapists called an 'early intervention service' to see you.

If your GP thinks that you are very ill or there are problems with getting help very quickly, he or she may offer you some medicine to help calm you. The type of medicine you should be offered is called an antipsychotic. In your first breakdown you should be offered one of the newest types of these medicines, which are called 'atypical' antipsychotics (their individual names are amisulpride, olanzapine, quetiapine, risperidone and zotepine); these tend to have different side effects from the older 'conventional' antipsychotics. Doctors usually prescribe low doses during a first illness, as you may be quite sensitive to them when you first take them. It might be that you always stay on low doses of medication but it could be that later in the illness you need higher doses. In any case, you should be told about the effects and side effects of these medicines and given written information about them. In other ways, your treatment during the first breakdown will be similar to that for the second or subsequent illnesses (see 'If you have a breakdown', below). After you have recovered from your first breakdown and the mental health team has discussed the diagnosis with you, and your carer if you wish, you may want to have a second opinion (when you are seen by another consultant psychiatrist). You should have help in getting to talk to another psychiatrist about the diagnosis. You may want to ask the psychiatrists looking after you to make the referral, or perhaps your GP.

If you have a breakdown (an acute episode of schizophrenia)

The teams who provide treatment

After your GP has seen you, you may be visited at home by a psychiatric nurse, a psychiatrist or other mental health worker, or you may be invited to come to a clinic. At this stage, your GP or other health professional may tell you that you are ill and will need further help and treatment. The teams who might see you include community mental health teams, early intervention teams, crisis resolution and home treatment teams or an acute day hospital. If you have been ill before, you may already be getting help from an assertive outreach team, who will also try to help you during a crisis. It is very important that you meet with them quickly as this may help more in the long run. When you meet the mental health team they will undertake a detailed assessment of your health, life situation and need for help. The different teams available to help people with schizophrenia are described in the glossary.

Where you'll be treated

If all goes well, you may be treated at home. If a crisis resolution and home treatment team treats you at home, they will be careful to check regularly on you to make sure that you are safely treated at home (this is called a 'risk assessment'). If the team that is treating

you at home can't provide all the treatment and care you need, you may be asked to come to an acute day hospital where you will receive treatment and help during the day and go home at night. Alternatively, if you are very ill, or you have been 'sectioned' under the Mental Health Act, you may be asked to come to an inpatient unit – a hospital that you stay at during the day and night. If you are in an inpatient hospital, you should be offered a transfer to an acute day hospital or to treatment at home as soon as the hospital team treating you think you are well enough. This should keep the time you are in hospital to a minimum.

Wherever you receive treatment, part of your treatment programme should, if you want it to, include social, group and physical activities; this is especially the case as you begin to recover. The activities will be recorded in your care plans (the treatment and health record your team keeps about you). You may want to see these.

Medicines during a breakdown

After your team have discussed all the treatment options with you, and your advocate or carer if you so wish, and have discussed the effects and side effects of treatments, you will be offered antipsychotic medicines, either 'conventional' or 'atypical' (only atypicals if this is your first breakdown). Different antipsychotics have different side effects. You'll be given enough information about the different medicines for you to be able to make an informed choice as to which one you would most prefer. Whichever medicine you choose, you should only take one antipsychotic medicine at a time, unless for a short while when changing from one to another (you may then take two while one is being reduced and the other is being started).

All medicines can have side effects, but if the medicine suits you, you may not experience any. If you do get side effects, they tend to be worse on higher doses, and using a lower dose may take them away. If the side effects don't go away it is usually best to try a different medicine. You should not be offered very high doses of these medicines. Usually your doctor will start you on a low dose and gradually increase the dose to a standard dose. If you are taking a conventional antipsychotic (such as haloperidol, chlorpromazine or trifluoperazine) that either gives troubling side effects or simply doesn't work very well, your doctors will suggest stopping the medicine and should offer you an atypical antipsychotic.

If you are unable to make a choice because you are very ill, the doctors should offer you an atypical antipsychotic because they tend to have different, and sometimes fewer, side effects. Whether you can choose or not, the team caring for you should regularly keep a check on side effects, and may use a questionnaire to help them do this. It usually takes about 3 to 6 weeks for antipsychotics (conventional or atypical) to work properly, although you may feel better sooner

than this. The team looking after you will keep an eye on whether the treatments are working or not. If the medicine you are given doesn't work by 6 to 8 weeks, you should then be offered a different antipsychotic medicine. If the medicine does work, your doctors will suggest that you take it for about 1 to 2 years after getting better so that you don't get ill again. If you are stable on an antipsychotic, with few or no side effects, it is best to stay on that medicine and not to change to another one.

Treatment for people whose behaviour is very disturbed

If you are ill enough to be admitted to hospital as an inpatient, especially if you have been admitted against your will under the Mental Health Act ('sectioned'), you may settle very quickly and feel better. However, sometimes the illness can make some people more likely to become very angry or upset, causing them to become threatening or even to hit others.

Preventing harm to you and others

The staff on the ward should make an effort to keep things as calm and as safe as possible around you. They will also try to talk to you and take time to explain all about what is happening on the ward and about your treatments. They will make every effort to clear up misunderstandings and to treat you respectfully and with dignity and kindness. If you do become very angry in these circumstances, the staff have been trained to help you calm down by talking and listening to you. If you lash out at anyone, they will stop you. Staff are also trained in physical methods of restraining someone who is very ill and threatening. If things get very 'out of hand', they may put you in a room away from others to prevent you hurting anyone or yourself. This is called seclusion.

Medicines to help calm you down

Before seclusion is used, you'll be offered some additional medication. If extra medicines are needed, your doctors should offer you a medicine that you can take by mouth (an 'oral preparation'). This may be a sedative called lorazepam, or an antipsychotic, either olanzapine or haloperidol. They will not use high doses, just enough to calm you without 'knocking you out'. If you refuse to take the extra medicines by mouth, the staff may give you these medicines by injection into your thigh or buttocks ('intramuscular injection'). They may force you to have this if your illness has made you feel violent and act in a violent way.

Injections that might be used

If intramuscular injection proves necessary, lorazepam, haloperidol or olanzapine are the preferred medicines. If haloperidol is used, the doctors should give you a second medicine to stop you going stiff or having a bad reaction to the haloperidol. These second medicines are called anticholinergic medicines (such as procyclidine or benztropine). Sometimes the doctors may feel that two 'calming drugs' are needed, in which case they will give you lorazepam and haloperidol together. Again, if haloperidol is used, they will also give you an anticholinergic medicine. In very rare circumstances, when the doctors need to calm you very quickly, they may wish to give you these medicines into a blood vessel, usually in your arm ('intravenous injection').

Making sure you are OK

If you are given urgent sedation (sometimes called rapid tranquillisation), the staff should regularly check your pulse and other signs that you are OK, such as blood pressure. You should also be regularly checked for side effects. As soon as possible, staff will ask to examine you, both physically and mentally. This is important so that the staff can be sure that they are giving the right medicine for your illness, and to be sure that you are not ill in some other way.

Helping you afterwards

Rapid tranquillisation can be very upsetting. The staff know this. As soon as possible after you have calmed down, the staff should spend time talking to you about what has happened and give you an explanation about why you have been urgently sedated. You can expect staff to be very caring and supportive at this time, so as to help you stay calm and understand what is going on. They will make detailed notes about what has happened, which you may wish to read. You may also want to write your own account in your notes. The staff should help you do this when you are calm enough to do so.

As you get better (towards the end of an acute episode)

As you begin to get better from your breakdown, your team will begin to plan what help you will need to help you recover.

Understanding your breakdown

Towards the end of an acute episode of schizophrenia, you should be offered help to understand the period of illness and given the chance to write your account in your notes, just as the doctors and nurses have done. You may well disagree with the staff working with you – they should discuss your disagreement and fully explain their position. Carers may also need help to understand the breakdown and your experience. Staff should be able to help your carers do so.

Assessing your needs for more help

After you have made a recovery, you will be assessed for what further help you might need, for example with difficult thoughts that trouble you, voices or other symptoms, which may not have completely gone away, or with help to reduce the chance that you might get ill again. You may be offered psychological help fairly quickly, or perhaps a member of your team will spend a fair bit of time talking over what has happened and help you understand things better.

The staff should also talk to you about what help you might need to get back to work or to go into education. They should also help you plan how to get back on your feet socially, and to sort out any physical health problems you have.

Planning treatments for the future

The treatments you receive after your breakdown can make further breakdowns less likely. Although you will probably need to take your antipsychotic medication for 1 or 2 years after your last breakdown, you can also be helped even more by psychological treatments: the best ones to help you are family work (sometimes called 'family interventions') and cognitive behavioural therapy (or CBT for short). These psychological treatments can help you recover better and make it less likely that you will have another breakdown.

You should also be given help to plan for any crises, both in terms of how to get help quickly, and to plan your treatments should you become ill again (making advance directives). Your doctors will also discuss medication with you. Generally, it's better to keep taking antipsychotics for 1 or 2 years after your last breakdown. When you decide to stop taking medication it's best to do this slowly and for one of the mental health team to see you to check if you start feeling worse. They will see you for about 2 years after your last breakdown.

Helping you recover

Services that can help

In the long term, there are a number of issues that a person with schizophrenia has to deal with over and above the problems other people have to deal with.

Once you have developed schizophrenia:

- there is a strong chance you'll have further breakdowns
- you may develop some long-lasting symptoms that can bother you
- your physical health may suffer over the years

- you may find it hard getting employment
- your carers may need help and support to help you better.

The services and mental health teams that can help you include your GP and the primary care team, community mental health teams, assertive outreach teams, crisis resolution and home treatment teams and early intervention teams. Staying in touch with services is very important so that you can get the treatments that will help. Through these teams, you can get services and treatments that have been proven to be effective. It is also important for the teams to keep an eye on your physical and mental health, and to provide ongoing help and support, including during a crisis. The aim of treatment in the long term is to promote your recovery by:

- reducing the chance of you having a breakdown (this is called 'relapse prevention')
- reducing your symptoms and helping you cope with them better ('symptom reduction')
- improving your physical health
- helping you find work or other activities
- supporting your family/carers and helping them to help you.

Your physical health

Many people with schizophrenia are at risk of developing significant physical health problems (for example, heart disease from smoking, or increased weight and diabetes from some medicines), so it is very important that your physical health is checked regularly. These physical health checks should pay particular attention to things such as weight gain, blood pressure and heart problems, blood sugar and the side effects of your medicines. As well as closely monitoring these types of physical signs, good advice on reduction of smoking, taking appropriate physical exercise and having a healthy diet are important aspects of physical health care in schizophrenia.

How your GP can help (primary care)

Your GP (rather than your psychiatrist) will usually look after your physical health. He or she should talk to you about your physical health, and the risks of illness. The GP should make an agreement with you to do physical health assessments at regular intervals agreed jointly between you and him/her. This might be as often as once a year if your GP thinks you are at risk of becoming physically ill. Whatever you decide, how often you have physical health checks should be written into your GP's notes and your psychiatrist will be told. To help your GP keep an eye on your physical and mental health, he or she should put your name on a register (this is just for the GP to keep a record of how and when he or she should be helping you).

Your GP or practice nurse should also help to look after your mental health. The GP may prescribe your medicines and ask about your mental health and progress. However, there may be times when your GP will want you to go back to your psychiatrist for assessment if you aren't already seeing him or her. The main reasons for your GP to refer you to the mental health team are if:

- you are not taking your medicine properly
- the treatment isn't working very well
- you are developing a problem with alcohol or drugs (some people with schizophrenia take drugs or drink too much because they feel anxious or depressed, but the drink and drugs usually make things worse)
- the GP thinks that you are becoming a danger to yourself or others (and this includes neglecting yourself)
- you have just changed GPs (tell your new GP that you have had a breakdown and he or she will offer to organise a referral for assessment).

If your GP refers you, you can expect to see the mental health team quickly.

How your mental health team can help (secondary care)

Assessing your needs and organising your care

If you are seen by a mental health team (most people with schizophrenia are), your care will be co-ordinated through the Care Programme Approach (CPA). This means you will have a named 'care co-ordinator' who will make sure that you and your carers and all the services and people involved in your care know what they should be doing. Your care co-ordinator and mental health team will make sure they know about your needs, and plan your treatment in detail with you. They should develop a care plan based upon an assessment of all your social, work, accommodation, financial, medical, psychological and cultural needs. If you don't see your GP or don't wish to, your psychiatrists could also do regular physical checks with you – they'll let your GP know that they are doing so. Your care co-ordinator and mental health team should decide with you how often these full assessments need to be done and write this in your notes. If you are on 'enhanced CPA' (usually because you need a lot of help) you may have full assessments every year.

Your carers/family can play an important part in helping your recovery. They also need help, especially in times of crisis. If you agree, the team who help you should contact your carers and provide information, support and develop a carer care plan to record the help they need.

The teams that will help, now and in the future

At the moment, most help will come from your community mental health team (CMHT for short). This will continue to be the case in Wales. However, in England other teams are being developed to give you extra help should you need it. For example, if you have had several breakdowns, have been on the wards a lot, have poor housing or are homeless, you should have most of your care provided by an assertive outreach team. If you have only recently had your first breakdown, your care should be provided through an early intervention team (who specialise in working with people during and for 3 years after their first breakdown). If the team caring for you are unable to meet all your needs during a crisis, they may ask a crisis resolution and home treatment team (CRHTT for short) to help provide support. If the CRHTT also can't give you enough support, they may refer you to an acute day hospital. After a crisis, you will usually go back to your original team.

Psychological treatments to help recovery

CBT and family work, when given with antipsychotic medication, can help reduce the number of breakdowns you have, more than just medicines alone. They probably won't stop breakdowns altogether, but they can help them happen less often. At the moment they are not widely available, but this will change over the next few years.

Cognitive behavioural therapy (CBT)

Cognitive behavioural therapy can help reduce the chance of another breakdown. It is also particularly useful if you have symptoms that won't go away and are troubling to you. CBT is also helpful if you are having trouble accepting that you have schizophrenia (sometimes called 'lack of insight'), and it may help if you tend not to take your medicine properly (sometimes called 'poor compliance'). If you have CBT, it is better to have longer treatments than shorter ones. For it to make a difference, you should have CBT treatment for more than 6 months, meeting for more than ten treatment sessions. If you are offered shorter treatments, the CBT may help you feel a bit less depressed, but it is unlikely to help you with other symptoms.

Family work

Because schizophrenia affects both the individual and his or her family or partners, working with the family or partner can be very helpful to everyone. If you live with or are in close contact with your family (including carers and partners), family work can also reduce the chance of you having further breakdowns. Family work is especially helpful for people who have had a breakdown in the last 3 months or are at risk of breaking down (say, because things have

gone particularly badly, or the person has had a lot of breakdowns over recent years). It is also helpful for people who have symptoms, such as voices or strange thoughts, that remain after a breakdown is over. Again, longer treatments are better than shorter ones. Family work should last for more than 6 months and include more than ten sessions of treatment. Family work also works better if you go for treatment with your family. Sometimes, though, it's better for your family to receive help separately. You'll need to discuss this with the team who are treating you. Family work can be given to single families on their own or to a group of families. You and your family may prefer to have family treatment on your own.

Although counselling doesn't stop breakdowns or change symptoms, you may want to spend some time talking to a mental health specialist and your preference for this should be respected by your mental health team, especially if CBT and family therapy are not easily available. Over time, CBT and family therapy will be much more widely accessible.

Medicines to help recovery

Antipsychotic medicines by mouth

Oral antipsychotic medicines (those taken by mouth) help to stop you breaking down and help you to have a more stable life. Also, if you want psychological help, you will need antipsychotic medicines at the same time. Remember, the decision about which medicine to take is best made by you and your doctors together.

If you are happy with the antipsychotic you are already taking and you are not experiencing troublesome side effects, then carry on with the medicine you are taking. If you are having a conventional antipsychotic and this has not suited you, you should be offered an atypical antipsychotic. If you are having an atypical that makes you put on weight, gives you diabetes, or causes sexual problems or excessive tiredness, you may be offered a different antipsychotic. Your doctors should keep a close eye on the side effects, as they are common and sometimes unpleasant. The lowest dose that keeps you stable is best.

Depot antipsychotics

If you find it hard to remember to take your medicines, or you stop taking them and break down more often, you may be offered regular injections of a long-acting antipsychotic. There are a number of different types that can be used. These are called 'depot antipsychotics' and are given every 2 to 4 weeks, depending on which type you take. The doctors and nurses helping you should talk to you about how and where (for example, in clinics or at home)

depot injections can be given and ask you about your preferences. If you do decide to try a depot antipsychotic the doctors will give you a test dose first to check that it suits you. Once you are taking a depot you should have your treatment reviewed regularly.

When the usual medicines do not work ('treatment-resistant schizophrenia')

If you have tried two different antipsychotics, including an atypical one, each for at least 6 to 8 weeks and are still getting ill, it's likely that your illness is resistant to the usual treatments. Your doctors will make sure that you are taking your medicines properly and re-assess you and your situation to check there aren't other reasons for you not getting better, such as drinking too much alcohol or taking illicit drugs, which can stop the medicines working properly. They may suggest having (further) psychological treatment. You may be offered another atypical (olanzapine or risperidone) if you haven't tried them already. If these don't work, you should then be offered a medicine called clozapine. This is a special type of atypical antipsychotic, which can only be given when a person's illness doesn't respond to the usual treatments. You will have to have some blood tests before and while you are taking this medicine. Your doctors will discuss this with you and give you written information about clozapine.

Sometimes clozapine may not get you properly better even after several months at proper doses. Your doctors may then suggest that you take another antipsychotic as well as the clozapine. This is the only situation when two antipsychotics should be prescribed together over a long period of time. If this doesn't work very well you shouldn't carry on taking two antipsychotics. Your doctors may suggest adding other medicines instead (these are called 'adjuncts' and are not covered here). They will need to discuss this with you at length before giving you other medicines.

Helping you get work

The overall aim of mental health treatment is to help people to get back to living an ordinary life as far as possible. This includes getting work of some kind. Unfortunately, people with schizophrenia find it very hard to get jobs, at least partly because of the stigma associated with schizophrenia. Your assessments by the mental health team should include a detailed assessment of your work history, skills and work potential, as well as what you really want to do. If 'supported employment schemes' are available, they should be offered to you if you want this. There are other types of work schemes that may also be locally available. If you want to try to get a job through these schemes, your mental health team will help you join one. Your local mental health and social care providers should also be helping develop local employment opportunities for people with schizophrenia.

Further information

You have the right to be fully informed and to share in decision-making about your healthcare. If you need further information about any aspects of your schizophrenia or treatment, please ask your specialist, GP or a relevant member of your health team. You can discuss this guideline with them if you wish, especially if you aren't sure about anything in this booklet they will be able to explain things to you.

For further information about the National Institute for Clinical Excellence (NICE), the Clinical Guidelines Programme or other versions of this guideline (including the sources of evidence used to inform the recommendations for treatment and care), you can visit the NICE website at www.nice.org.uk.

NICE has also issued guidance on the use of atypical antipsychotic medicines for the treatment of schizophrenia. This can be found on the NICE website at www.nice.org.uk/cat.asp?c=32878, and paper copies can be ordered from the NHS Response Line (phone 0870 1555 455). Quote the reference number N0106 for the health professionals' version and N0108 if you want the version for service users.

Glossary

Advance directives: written instructions agreed between a service user and health professional before treatment begins, in which the service user specifies his or her preferred treatments and identifies the treatments he or she does not wish to receive. They guide health professionals in the event that the service user becomes unable to make decisions for him or herself. Advance directives allow people, for instance, to set out treatment that they would not want to receive (for example, electroconvulsive therapy, or a medicine they know gives them bad side effects), or treatment preferences (for example, the service user may wish to be given lorazepam rather than haloperidol in the event of needing rapid tranquillisation). Doctors sometimes will not follow advance directives for medical reasons. If they don't, they will write this in a person's notes, explaining why they couldn't follow the directive.

Antipsychotic medication: there are two main types of antipsychotic medication, commonly referred to as conventional and atypical antipsychotics. Conventional antipsychotics have been around for many years while the atypical ones have only become available more recently. Conventional antipsychotics cause more extrapyramidal side effects (see below) than atypical antipsychotics, whereas, on average, atypicals may cause more weight gain than conventionals. Atypical antipsychotics include amisulpride, clozapine, olanzapine, quetiapine, risperidone, sertindole (in special circumstances) and zotepine.

Clozapine is only used for the treatment of treatment-resistant schizophrenia (see below). Conventional antipsychotics include chlorpromazine, haloperidol, trifluoperazine, flupenthixol and others. Your doctor or pharmacist will be able to tell you whether a medicine is a conventional or an atypical antipsychotic.

Assertive outreach team (also known as assertive community treatment): this service delivers intensive, and often comprehensive, treatment and care in community settings for people with serious mental health problems, especially people needing a lot of help.

Cognitive behavioural therapy: a psychological treatment that helps people to establish links between their thoughts, feelings or actions and their current or past symptoms and to re-evaluate their perceptions, beliefs or reasoning about the target symptoms. It's useful for reducing symptoms, reducing breakdowns and helping to understand the illness and may help people take their medicines regularly.

Community mental health team: the standard community-based team that offers assessment, treatment, and care to adults with mental health problems in the community.

Crisis resolution and home treatment teams: services that provide intensive home-based, crisis-orientated treatment of an acute episode by staff who deal with such situations during and beyond office hours. Teams can help manage acute episodes in the community rather than in inpatient care.

Depot antipsychotic: a special preparation of an antipsychotic in an oily solution, which is injected into the muscle. Following injection, the medicine is slowly released. This results in the medicine staying in the blood over fairly long periods, so that injections can be given every few weeks.

Early intervention teams/services: services that provide early identification and initial treatment, during the first 3 years of illness, to people aged between 14 and 35 years who have the first symptoms of schizophrenia.

Extrapyramidal side effects: problems with movement, such as parkinsonism (stiffness, shaking and slowness), akathisia (marked restlessness), and dystonia (altered muscle tension), which are common side effects of antipsychotics (especially conventional antipsychotics).

Family work (or family interventions): family sessions providing support and treatment that are based on psychological principles. Family work can improve symptoms and reduce the chance of breaking down. It's especially helpful for people who have recently had a breakdown, are at risk of having a breakdown, or have symptoms remaining after being ill.

Rapid tranquillisation: the use of medicine to quickly control extreme agitation, aggression and potentially violent behaviour that put the individual or those around them at risk of physical harm. The aim is to sedate the person to minimise the risk without the person losing consciousness.

'Sectioning': when a doctor believes that a person is so ill that he or she is unable to make a decision about treatment, or if a person who is ill refuses to receive treatment, the doctor can 'section' him or her under the Mental Health Act. If this happens, you will receive your care in an inpatient unit. This allows the doctors and nurses to assess and sometimes to treat you against your will. They can only treat your mental illness without your agreement; they can't make you have treatments for anything else (such as operations).

Service user: in this booklet, a person with schizophrenia who is receiving care from the NHS.

Standard doses: the recommended dose range listed in the British National Formulary (or BNF), a reference book for doctors.

Supported employment: an approach to helping service users find and stay in work, without going through lots of training first.

Tardive dyskinesia: abnormal movements of the lips, jaw, tongue and facial muscles, and sometimes the arms, legs and body, that the person can't help making. This can be a long-term side effect of antipsychotics, which can be irreversible.

Treatment-resistant schizophrenia (TRS): schizophrenia that doesn't appear to improve despite the person having tried a number of different antipsychotic medicines.

Appendix E: Technical detail on the criteria for audit of the treatment and management of schizophrenia in primary and secondary care (core interventions)

Objectives for an audit

One or more audits can be carried out in different care settings to ensure that:

- individuals with schizophrenia are involved in decisions about their care
- treatment options are appropriately offered for individuals with schizophrenia.

Individuals to be included in an audit

A single audit could include all individuals with schizophrenia. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people newly diagnosed with schizophrenia
- people previously diagnosed with schizophrenia
- people with treatment-resistant schizophrenia/persisting symptoms.

The audits described can be carried out on a suitable sample of individuals and can be carried out jointly by mental health and primary care teams.

Measures that could be used as a basis for an audit

Please see tables overleaf.

| Criterion | Standard | Exception | Definition of terms |
|---|--|--|--|
| <p>1 Family interventions</p> <p>Family interventions are offered to any family who lives with or is in close contact with a family member with schizophrenia, and especially where any of the following circumstances apply. The individual:</p> <ul style="list-style-type: none"> • has experienced a recent relapse • is considered at risk of relapse • has persisting symptoms. <p>The course of family intervention should be for longer than 6 months with more than 10 planned sessions.</p> | <p>Family interventions to be offered to 100% of families of individuals with schizophrenia who have experienced a recent relapse, are considered to be 'at risk' of relapsing, or who have persisting symptoms, and are living with or in close contact with their family.</p> <p>All individuals who receive family interventions should be offered more than 10 sessions, the course of treatment lasting for more than 6 months.</p> | <p>The individual with schizophrenia who is not able to participate in an informed discussion with the clinician responsible for treatment at the time and an advocate or carer is not available.</p> <p>The individual with schizophrenia who refuses to allow discussion of family interventions with his or her family.</p> <p>The family who refuses to participate in family interventions.</p> | <p>The notes should indicate that the clinician responsible for treatment has discussed the process and benefits of family interventions with the individual's and, subject to the individual's agreement, with his or her family, or that the individual was not capable of making a choice at the time. The notes should refer to the involvement of the individual's advocate or carer, where applicable.</p> <p>The term 'at risk' refers to following an acute episode, or if a person has had 2 or more episodes in the last year.</p> <p>The term 'persisting symptoms' refers to positive or negative symptoms, which persist, with limited or no response to anti-psychotic medication.</p> |

| Criterion | Standard | Exception | Definition of terms |
|--|---|---|--|
| <p>2 Cognitive behavioural therapy (CBT)</p> <p>CBT is offered to any individual with schizophrenia, and especially to the individual who is experiencing persistent psychotic symptoms.</p> <p>The course of CBT offered should normally be of more than 6 months' duration and include more than 10 planned sessions.</p> | <p>100% of individuals with schizophrenia who are experiencing persisting psychotic symptoms should be offered CBT.</p> <p>All individuals who receive CBT should be offered treatment lasting for over 6 months and including more than 10 planned sessions.</p> | <p>The individual with schizophrenia who is not able to participate in an informed discussion with the clinician responsible for treatment at the time and an advocate or carer is not available.</p> | <p>The notes should indicate that the clinician responsible for treatment has discussed the process and benefits of CBT, or that the individual was not capable of making a choice at the time.</p> <p>The term 'persisting symptoms' refers to positive or negative symptoms, which persist, with limited or no response to antipsychotic medication.</p> |

| Criterion | Standard | Exception | Definition of terms |
|--|--|---|---|
| <p>3 Assertive outreach teams (AOT)/assertive community treatment (ACT)</p> <p>AOT/ACT services are provided for the individual with schizophrenia where any of the following circumstances apply:</p> <ul style="list-style-type: none"> • risk of repeated relapse • high use of inpatient services • poor history of engagement with services • homelessness. | <p>100% of individuals with schizophrenia who are at risk of repeated relapse, have made high use of inpatient services, or have a poor history of engagement with services, or are homeless are offered treatment via an AOT/ACT.</p> | <p>The individual with schizophrenia has been accepted for treatment with an AOT but the individual refuses all attempts to engage with the team.</p> | <p>The notes should indicate that the clinician responsible for treatment has discussed the process and benefits of AOT, or that the individual was not capable of making a choice at the time. The notes should refer to the involvement of the individual's advocate or carer, where applicable.</p> <p>Service users should report that this choice was offered.</p> <p>The term 'risk of repeated relapse' refers to following an acute episode or if a person has relapsed 2 or more times in the last year.</p> <p>The term 'high use' refers to the top 100 people in terms of frequency of inpatient admission and/or length of stay.</p> <p>'Homeless' refers to no fixed abode, not in owner- or renter-occupied accommodation.</p> |

| Criterion | Standard | Exception | Definition of terms |
|---|--|--|--|
| <p>4 Parenteral medication</p> <p>A patient who has received parenteral medication during rapid tranquillisation has baseline recordings, repeated at regular intervals, for blood pressure, pulse, temperature, and respiratory rate.</p> | <p>100% of patients receiving parenteral medication during rapid tranquillisation have baseline and follow-up recordings of blood pressure, pulse, temperature and respiratory rate.</p> | <p>Where to carry out such procedures would cause further agitation and increase the possible risk to either the individual with schizophrenia or to others.</p> | <p>The notes contain a record of the individual's blood pressure, pulse, temperature and respiratory rate, monitored at the specified time intervals, which depends upon a full clinical assessment, which is recorded in the notes. Where baseline observations are not carried out, the reasons for this are recorded in the clinical notes.</p> |
| <p>5 Rapid tranquillisation</p> <p>Patients who are subject to rapid tranquillisation are debriefed and offered the opportunity to write their account in the notes.</p> | <p>100% of patients who are subject to rapid tranquillisation have recorded in their notes that they have been debriefed with record of patient's entry in the notes.</p> | <p>Those patients who refuse to be debriefed and/or to write in their own notes. This must be recorded in the notes.</p> | <p>-</p> |

| Criterion | Standard | Exception | Definition of terms |
|--|--|---|---|
| <p>6 Polypharmacy</p> <p>Individuals receive only one antipsychotic at a time.</p> | <p>100% of individuals with schizophrenia.</p> | <p>Individuals with schizophrenia who are receiving clozapine but who have not responded sufficiently; and individuals who are changing from one antipsychotic to another.</p> | <p>The audit should include a discussion of the treatment choice with the individual with schizophrenia, relevant outcomes including the incidence of side effects, and the reasons for prescribing antipsychotics, the reasons for prescribing additional antipsychotics, dose/dose range and total dose equivalents, and the prescribing of other drugs in combination with antipsychotics (such as anticholinergics, antidepressants and laxatives).</p> |
| <p>7 Advance directives (1)</p> <p>Care plans contain advance directives detailing the individual's treatment choices in the event of an acute episode of illness which may require rapid tranquillisation.</p> | <p>100% of individuals with schizophrenia.</p> | <p>The individual with schizophrenia who is not able to participate in an informed discussion with the clinician responsible for treatment at the time and an advocate or carer is not available.</p> | <p>The care programme approach (CPA) documentation contains an advance directive that describes preferred treatment choices in the event of the individual experiencing an acute episode of illness.</p> <p>The term 'treatment choices' refers to the choice of oral antipsychotic, lorazepam or other treatments that may be used without the service users consent.</p> |

| Criterion | Standard | Exception | Definition of terms |
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| <p>8 Advance directives (2)</p> <p>In the event of an acute episode of illness, the CPA co-ordinator ensures that the individual's advance directive is notified to the clinicians responsible for their care during the acute phase. The receipt of the advance directive is recorded in the individual's notes.</p> | <p>100% of individuals with schizophrenia experiencing an acute episode of illness have advance directives in their notes where appropriate.</p> | <p>No advance directive has been made.</p> | <p>The notes indicate that the advance directive was received by the clinician responsible for the care of the individual during the acute episode of illness.</p> |
| <p>9 Information</p> <p>Individuals and their families receive written material about their illness and treatment from the health care professionals who care for them, including a copy of the NICE schizophrenia guideline produced for people with schizophrenia, their advocates and carers, and the public.</p> | <p>100% of individuals with schizophrenia and their families.</p> | <p>None</p> | <p>Local services should agree what information is to be made available, by whom, and when.</p> <p>Service users and their carers should report satisfaction with the accessibility and quality of information.</p> |

| Criterion | Standard | Exception | Definition of terms |
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| <p>10 Occupational needs</p> <p>Individuals have a comprehensive assessment of occupational status and potential, and vocational aspirations.</p> | <p>100% of individuals with schizophrenia.</p> <p>100% of individuals on enhanced CPA to receive an assessment not less than once a year.</p> | <p>Individuals who are employed, or who do not want an occupational assessment.</p> | <p>Local CPA documentation should include review of occupational status and potential, and vocational aspirations. The CPA documentation should indicate that this is reviewed, or if a person is employed, or if a person does not want to be assessed.</p> |
| <p>11 Case registers in primary care</p> <p>Individuals are identified and recorded on a case register in primary care.</p> | <p>100% of individuals with schizophrenia within primary care are recorded on a case register.</p> | <p>Individuals who refuse to be included in a case register.</p> | <p>The case register is used as the basis of monitoring the physical health needs and routine screening for people with schizophrenia, and for auditing the implementation of this guideline in primary care.</p> |

| Criterion | Standard | Exception | Definition of terms |
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| <p>12 Physical health in primary care</p> <p>Individuals have a physical health check at regular intervals. The frequency of health checks will be agreed between the GP and the service user and documented in the notes.</p> | <p>100% of individuals with schizophrenia who are registered with a GP are offered physical health screens within primary care.</p> | <p>Those individuals who refuse physical health care in primary care or those who wish to receive it from secondary services.</p> | <p>The notes document the agreed frequency of health checks, and the frequency is matched by the checks being carried out.</p> <ol style="list-style-type: none"> 1) Health checks should include blood pressure monitoring, screening for diabetes, blood lipids testing in people with raised blood pressure, screening for smoking, alcohol and drug use. 2) Health promotion advice is offered, for example advice on smoking, alcohol and drug use, and exercise. 3) Screening for side effects of drug treatments, including sexual dysfunction, lethargy, weight gain, extrapyramidal side effects (including tardive dyskinesia). |

| Criterion | Standard | Exception | Definition of terms |
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| <p>13 Second opinion</p> <p>The individual with an initial diagnosis of schizophrenia who requests a second opinion should be supported in doing so.</p> | <p>100% of individuals with an initial diagnosis of schizophrenia.</p> | <p>None</p> | <p>The notes document that following a first episode where a diagnosis has been given the GP or psychiatrist has offered a referral for a second opinion if requested by the service user.</p> <p>Service users should report satisfaction with the support that they received when asking for a second opinion.</p> |

