National Institute for Health and Clinical Excellence

Issue date: March 2009

Schizophrenia

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

This is an update of NICE clinical guideline 1

NICE clinical guideline 82
Developed by the National Collaborating Centre for Mental Health

NICE clinical guideline 82
Schizophrenia

Ordering information

You can download the following documents from www.nice.org.uk/CG82

- The NICE guideline (this document) – all the recommendations.
- A quick reference guide – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1823 (quick reference guide)
- N1824 ('Understanding NICE guidance').

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This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

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This clinical guideline updates and replaces:

- Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002).
- Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia. NICE technology appraisal guidance 43 (2002).

Introduction

This guideline covers the treatment and management of schizophrenia and related disorders[1] in adults (18 years and older) with an established diagnosis of schizophrenia with onset before age 60. The guideline does not address the specific treatment of young people under the age of 18, except those who are receiving treatment and support from early intervention services.

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. Each person with the disorder will have a unique combination of symptoms and experiences. Typically there is a prodromal period often characterised by some deterioration in personal functioning. This includes memory and concentration problems, unusual behaviour and ideas, disturbed communication and affect, and social withdrawal, apathy and reduced interest in daily activities. These are sometimes called 'negative symptoms'. The prodromal period is usually followed by an acute episode marked by hallucinations, delusions, and behavioural disturbances. These are sometimes called 'positive symptoms', and are usually accompanied by agitation and distress. Following resolution of the acute episode, usually after pharmacological, psychological and other

[1] This includes schizoaffective disorder, schizophreniform disorder and delusional disorder.

interventions, symptoms diminish and often disappear for many people, although sometimes a number of negative symptoms may remain. This phase, which can last for many years, may be interrupted by recurrent acute episodes, which may need additional intervention.

Although this is a common pattern, the course of schizophrenia varies considerably. Some people may have positive symptoms very briefly while others may experience them for many years. Others have no prodromal period, the disorder beginning suddenly with an acute episode.

Over a lifetime, about 1% of the population will develop schizophrenia. The first symptoms tend to start in young adulthood, but can occur at any age, usually at a time when people are trying to make the transition to independent living. The symptoms and behaviour associated with schizophrenia can have a distressing impact on family and friends.

The diagnosis of schizophrenia is still associated with considerable stigma, fear and limited public understanding. The first few years after onset can be particularly upsetting and chaotic, and there is a higher risk of suicide. Once an acute episode is over, there are often other problems such as social exclusion, with reduced opportunities to get back to work or study, and problems making new relationships.

Recently, there has been a new emphasis in services on early detection and intervention, a focus on long-term recovery and promoting people’s choices about the management of their condition. There is evidence that most people will recover, although some will have persisting difficulties or remain vulnerable to future episodes. Not everyone will accept help from statutory services. In the longer term, most people will find ways to manage acute problems, and compensate for any remaining difficulties.

Carers, relatives and friends of people with schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments. This guideline uses the term ‘carer’

to apply to everyone who has regular close contact with the person with schizophrenia, including advocates, friends or family members, although some family members may choose not to be carers.

Schizophrenia is commonly associated with a number of other conditions, such as depression, anxiety, post-traumatic stress disorder, personality disorder and substance misuse. This guideline does not cover these conditions. NICE has produced separate guidance on the management of these conditions (see section 6).

The guideline will assume that prescribers will use a drug's summary of product characteristics (SPC) to inform their decisions for individual patients.

Person-centred care

This guideline offers best practice advice on the care of people with schizophrenia.

Treatment and care should take into account service users' needs and preferences. People with schizophrenia should have the opportunity to make informed decisions, including advance decisions and advance statements, about their care and treatment, in partnership with their healthcare professionals. If service users do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines (available from www.dh.gov.uk). Healthcare professionals should also follow the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk).

Good communication between healthcare professionals and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user with mental capacity to do so agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Key priorities for implementation

Access and engagement

- Healthcare professionals working with people with schizophrenia should ensure they are competent in:
  - assessment skills for people from diverse ethnic and cultural backgrounds
  - using explanatory models of illness for people from diverse ethnic and cultural backgrounds
  - explaining the causes of schizophrenia and treatment options
  - addressing cultural and ethnic differences in treatment expectations and adherence
  - addressing cultural and ethnic differences in beliefs regarding biological, social and family influences on the causes of abnormal mental states
  - negotiating skills for working with families of people with schizophrenia
  - conflict management and conflict resolution.

- Mental health services should work in partnership with local stakeholders, including those representing black and minority ethnic (BME) groups, to enable people with mental health problems, including schizophrenia, to access local employment and educational opportunities. This should be sensitive to the person's needs and skill level and is likely to involve working with agencies such as Jobcentre Plus, disability employment advisers and non-statutory providers.

- Healthcare teams working with people with schizophrenia should identify a lead healthcare professional within the team whose responsibility is to monitor and review:
  - access to and engagement with psychological interventions
  - decisions to offer psychological interventions and equality of access across different ethnic groups.

Primary care and physical health

- GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year. Focus on cardiovascular disease risk assessment as described in 'Lipid modification' (NICE clinical guideline 67) but bear in mind that people with schizophrenia are at higher risk of cardiovascular disease than the general population. A copy of the results should be sent to the care coordinator and/or psychiatrist, and put in the secondary care notes.

Psychological interventions

- Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase[2] or later, including in inpatient settings.
- Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase[3] or later, including in inpatient settings.

Pharmacological interventions

- For people with newly diagnosed schizophrenia, offer oral antipsychotic medication. Provide information and discuss the benefits and side-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional together, considering:
  - the relative potential of individual antipsychotic drugs to cause extrapyramidal side effects (including akathisia), metabolic side effects (including weight gain) and other side effects (including unpleasant subjective experiences)
  - the views of the carer where the service user agrees.

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[2] CBT should be delivered as described in recommendation 1.3.4.12.
[3] Family intervention should be delivered as described in recommendation 1.3.4.13.

- Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).

Interventions for people with schizophrenia whose illness has not responded adequately to treatment

- For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:
  - review the diagnosis
  - establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration
  - review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families
  - consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.

- Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic.

1 Guidance

The following guidance is based on the best available evidence and applies to all healthcare professionals[4] working with people with schizophrenia and, if appropriate, to their carers. The full guideline (www.nice.org.uk/CG82fullguideline) gives details of the methods and the evidence used to develop the guidance.

1.1 Care across all phases

1.1.1 Optimism

1.1.1.1 Work in partnership with people with schizophrenia and their carers. Offer help, treatment and care in an atmosphere of hope and optimism. Take time to build supportive and empathic relationships as an essential part of care.

1.1.2 Race, culture and ethnicity

The following recommendations apply to all people with schizophrenia and their carers. However, people from black and minority ethnic (BME) groups with schizophrenia are more likely than people from other groups to be disadvantaged or to have impaired access and/or engagement with mental health services. Their particular needs may be addressed by the following recommendations.

1.1.2.1 When working with people with schizophrenia and their carers:

- avoid using clinical language, or keep it to a minimum
- ensure that comprehensive written information is available in the appropriate language and in audio format if possible
- provide and work proficiently with interpreters if needed

[4] Where the guideline refers to 'healthcare professionals', this includes professionals from social care if appropriate.

- offer a list of local education providers who can provide English language teaching for people who have difficulties speaking and understanding English.

1.1.2.2 Healthcare professionals inexperienced in working with people with schizophrenia from diverse ethnic and cultural backgrounds should seek advice and supervision from healthcare professionals who are experienced in working transculturally.

1.1.2.3 Healthcare professionals working with people with schizophrenia should ensure they are competent in:

- assessment skills for people from diverse ethnic and cultural backgrounds
- using explanatory models of illness for people from diverse ethnic and cultural backgrounds
- explaining the causes of schizophrenia and treatment options
- addressing cultural and ethnic differences in treatment expectations and adherence
- addressing cultural and ethnic differences in beliefs regarding biological, social and family influences on the causes of abnormal mental states
- negotiating skills for working with families of people with schizophrenia
- conflict management and conflict resolution.

1.1.2.4 Mental health services should work with local voluntary BME groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds.

1.1.3 Getting help early

1.1.3.1 Healthcare professionals should facilitate access as soon as possible to assessment and treatment, and promote early access throughout all phases of care.

1.1.4 Assessment

1.1.4.1 Ensure that people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment. The assessment should also address the following:

- accommodation
- culture and ethnicity
- economic status
- occupation and education (including employment and functional activity)
- prescribed and non-prescribed drug history
- quality of life
- responsibility for children
- risk of harm to self and others
- sexual health
- social networks.

1.1.4.2 Routinely monitor for other coexisting conditions, including depression and anxiety, particularly in the early phases of treatment.

1.1.5 Comprehensive services provision

1.1.5.1 All teams providing services for people with schizophrenia should offer a comprehensive range of interventions consistent with this guideline.

1.1.5.2 All teams providing services for people with schizophrenia should offer social, group and physical activities to people with schizophrenia (including in inpatient settings) and record arrangements in their care plan.

1.1.6 Working in partnership with carers

1.1.6.1 When working with carers of people with schizophrenia:

- provide written and verbal information on schizophrenia and its management, including how families and carers can help through all phases of treatment
- offer them a carer's assessment
- provide information about local carer and family support groups and voluntary organisations, and help carers to access these
- negotiate confidentiality and information sharing between the service user and their carers, if appropriate
- assess the needs of any children in the family, including young carers.

1.1.7 Consent, capacity and treatment decisions

1.1.7.1 Before each treatment decision is taken, healthcare professionals should ensure that they:

- provide service users and carers with full, patient-specific information in the appropriate format about schizophrenia and its management, to ensure informed consent before starting treatment
- understand and apply the principles underpinning the Mental Capacity Act, and are aware that mental capacity is decision specific (that is, if there is doubt about mental capacity, assessment of mental capacity should be made in relation to each decision)

- can assess mental capacity, if this is in doubt, using the test set out in the Mental Capacity Act.

These principles should apply whether or not people are being detained or treated under the Mental Health Act and are especially important for people from BME groups.

1.1.7.2 When the Mental Health Act is used, inform service users of their right to appeal to a first-tier tribunal (mental health). Support service users who choose to appeal.

1.1.8 Advance decisions and statements

1.1.8.1 Advance decisions and advance statements should be developed collaboratively with people with schizophrenia, especially if their illness is severe and they have been treated under the Mental Health Act. Record the decisions and statements and include copies in the care plan in primary and secondary care. Give copies to the service user and their care coordinator, and their carer if the service user agrees.

1.1.8.2 Advance decisions and advance statements should be honoured in accordance with the Mental Capacity Act. Although decisions can be overridden using the Mental Health Act, healthcare professionals should endeavour to honour advance decisions and statements wherever possible.

1.1.9 Second opinion

1.1.9.1 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.

1.1.10 Transfer between services

1.1.10.1 Discuss transfer from one service to another in advance with the service user, and carer if appropriate. Use the care programme approach (CPA) to help ensure effective collaboration with other care providers during transfer. Include details of how to access services in times of crisis.

1.2 Initiation of treatment (first episode)

1.2.1 Early referral

1.2.1.1 Urgently refer all people with first presentation of psychotic symptoms in primary care to a local community-based secondary mental health service (for example, crisis resolution and home treatment team, early intervention service, community mental health team). Referral to early intervention services may be from primary or secondary care. The choice of team should be determined by the stage and severity of illness and the local context.

1.2.1.2 Carry out a full assessment of people with psychotic symptoms in secondary care, including an assessment by a psychiatrist. Write a care plan in collaboration with the service user as soon as possible. Send a copy to the primary healthcare professional who made the referral and the service user.

1.2.1.3 Include a crisis plan in the care plan, based on a full risk assessment. The crisis plan should define the role of primary and secondary care and identify the key clinical contacts in the event of an emergency or impending crisis.

1.2.2 Early intervention services

1.2.2.1 Offer early intervention services to all people with a first episode or first presentation of psychosis, irrespective of the person's age or

the duration of untreated psychosis. Referral to early intervention services may be from primary or secondary care.

1.2.2.2 Early intervention services should aim to provide a full range of relevant pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline.

1.2.3 Early treatment

1.2.3.1 If it is necessary for a GP to start antipsychotic medication, they should have experience in treating and managing schizophrenia. Antipsychotic medication should be given as described in section 1.2.4.

1.2.4 Pharmacological interventions

1.2.4.1 For people with newly diagnosed schizophrenia, offer oral antipsychotic medication. Provide information and discuss the benefits and side-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional together, considering:

- the relative potential of individual antipsychotic drugs to cause extrapyramidal side effects (including akathisia), metabolic side effects (including weight gain) and other side effects (including unpleasant subjective experiences)
- the views of the carer if the service user agrees.

How to use oral antipsychotic medication

1.2.4.2 Before starting antipsychotic medication, offer the person with schizophrenia an electrocardiogram (ECG) if:

- specified in the SPC
- a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure)

- there is personal history of cardiovascular disease, or
- the service user is being admitted as an inpatient.

1.2.4.3 Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial. Include the following:

- Record the indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British National Formulary (BNF) or SPC.
- Justify and record reasons for dosages outside the range given in the BNF or SPC.
- Monitor and record the following regularly and systematically throughout treatment, but especially during titration:
  - efficacy, including changes in symptoms and behaviour
  - side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia, for example the overlap between akathisia and agitation or anxiety
  - adherence
  - physical health.
- Record the rationale for continuing, changing or stopping medication, and the effects of such changes.
- Carry out a trial of the medication at optimum dosage for 4–6 weeks.

1.2.4.4 Discuss any non-prescribed therapies the service user wishes to use (including complementary therapies) with the service user, and carer if appropriate. Discuss the safety and efficacy of the

therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.

1.2.4.5 Discuss the use of alcohol, tobacco, prescription and non-prescription medication and illicit drugs with the service user, and carer if appropriate. Discuss their possible interference with the therapeutic effects of prescribed medication and psychological treatments.

1.2.4.6 'As required' (p.r.n.) prescriptions of antipsychotic medication should be made as described in recommendation 1.2.4.3. Review clinical indications, frequency of administration, therapeutic benefits and side effects each week or as appropriate. Check whether 'p.r.n.' prescriptions have led to a dosage above the maximum specified in the BNF or SPC.

1.2.4.7 Do not use a loading dose of antipsychotic medication (often referred to as 'rapid neuroleptisation').

1.2.4.8 Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).

1.2.4.9 If prescribing chlorpromazine, warn of its potential to cause skin photosensitivity. Advise using sunscreen if necessary.

1.3 Treatment of the acute episode

1.3.1 Service-level interventions

1.3.1.1 Consider community mental health teams alongside other community-based teams as a way of providing services for people with schizophrenia.

1.3.1.2 Crisis resolution and home treatment teams should be used to support people with schizophrenia during an acute episode in the

community. 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 may benefit from early discharge from hospital following a period of inpatient care.

1.3.1.4 Acute day hospitals should be considered alongside crisis resolution and home treatment teams as an alternative to acute admission to inpatient care and to help early discharge from inpatient care.

1.3.2 Pharmacological interventions

1.3.2.1 For people with an acute exacerbation or recurrence of schizophrenia, offer oral antipsychotic medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see section 1.2.4). Take into account the clinical response and side effects of the service user's current and previous medication.

1.3.3 Rapid tranquillisation

1.3.3.1 Occasionally people with schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines (see recommendations 1.3.3.2 and 1.3.3.5).

1.3.3.2 Follow the recommendations in 'Violence' (NICE clinical guideline 25) when facing imminent violence or when considering rapid tranquillisation.

1.3.3.3 After rapid tranquillisation, offer the person with schizophrenia the opportunity to discuss their experiences. Provide them with a clear

explanation of the decision to use urgent sedation. Record this in their notes.

1.3.3.4 Ensure that the person with schizophrenia has the opportunity to write an account of their experience of rapid tranquillisation in their notes.

1.3.3.5 Follow the recommendations in 'Self-harm' (NICE clinical guideline 16) when managing acts of self-harm in people with schizophrenia.

1.3.4 Psychological and psychosocial interventions

1.3.4.1 Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase[5] or later, including in inpatient settings.

1.3.4.2 Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase[6] or later, including in inpatient settings.

1.3.4.3 Consider offering arts therapies to all people with schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.

1.3.4.4 Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with schizophrenia. However, take service user preferences into account, especially if other more efficacious psychological treatments, such as CBT, family intervention and arts therapies, are not available locally.

1.3.4.5 Do not offer adherence therapy (as a specific intervention) to people with schizophrenia.

[5] CBT should be delivered as described in recommendation 1.3.4.12.
[6] Family intervention should be delivered as described in recommendation 1.3.4.13.

1.3.4.6 Do not routinely offer social skills training (as a specific intervention) to people with schizophrenia.

Principles for providing psychological interventions

1.3.4.7 When providing psychological interventions, routinely and systematically monitor a range of outcomes across relevant areas, including service user satisfaction and, if appropriate, carer satisfaction.

1.3.4.8 Healthcare teams working with people with schizophrenia should identify a lead healthcare professional within the team whose responsibility is to monitor and review:

- access to and engagement with psychological interventions
- decisions to offer psychological interventions and equality of access across different ethnic groups.

1.3.4.9 Healthcare professionals providing psychological interventions should:

- have an appropriate level of competence in delivering the intervention to people with schizophrenia
- be regularly supervised during psychological therapy by a competent therapist and supervisor.

1.3.4.10 Trusts should provide access to training that equips healthcare professionals with the competencies required to deliver the psychological therapy interventions recommended in this guideline.

1.3.4.11 When psychological treatments, including arts therapies, are started in the acute phase (including in inpatient settings), the full course should be continued after discharge without unnecessary interruption.

Delivering psychological interventions

1.3.4.12 CBT should be delivered on a one-to-one basis over at least 16 planned sessions and:

- follow a treatment manual[7] so that:
  - people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning
  - the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms
- also include at least one of the following components:
  - people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
  - promoting alternative ways of coping with the target symptom
  - reducing distress
  - improving functioning.

1.3.4.13 Family intervention should:

- include the person with schizophrenia if practical
- be carried out for between 3 months and 1 year
- include at least 10 planned sessions
- take account of the whole family's preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.

1.3.4.14 Arts therapies should be provided by a Health Professions Council (HPC) registered arts therapist, with previous experience of working with people with schizophrenia. The intervention should be provided in groups unless difficulties with acceptability and access

[7] Treatment manuals that have evidence for their efficacy from clinical trials are preferred.

and engagement indicate otherwise. Arts therapies should combine psychotherapeutic techniques with activity aimed at promoting creative expression, which is often unstructured and led by the service user. Aims of arts therapies should include:

- enabling people with schizophrenia to experience themselves differently and to develop new ways of relating to others
- helping people to express themselves and to organise their experience into a satisfying aesthetic form
- helping people to accept and understand feelings that may have emerged during the creative process (including, in some cases, how they came to have these feelings) at a pace suited to the person.

1.3.5 Early post-acute period

In the early period of recovery following an acute episode, service users and healthcare professionals will need to jointly reflect upon the acute episode and its impact, and make plans for future care.

1.3.5.1 After each acute episode, encourage people with schizophrenia to write an account of their illness in their notes.

1.3.5.2 Healthcare professionals may consider using psychoanalytic and psychodynamic principles to help them understand the experiences of people with schizophrenia and their interpersonal relationships.

1.3.5.3 Inform the service user that there is a high risk of relapse if they stop medication in the next 1–2 years.

1.3.5.4 If withdrawing antipsychotic medication, undertake gradually and monitor regularly for signs and symptoms of relapse.

1.3.5.5 After withdrawal from antipsychotic medication, continue monitoring for signs and symptoms of relapse for at least 2 years.

1.4 Promoting recovery

1.4.1 Primary care

1.4.1.1 Develop and use practice case registers to monitor the physical and mental health of people with schizophrenia in primary care.

1.4.1.2 GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year. Focus on cardiovascular disease risk assessment as described in 'Lipid modification' (NICE clinical guideline 67) but bear in mind that people with schizophrenia are at higher risk of cardiovascular disease than the general population. A copy of the results should be sent to the care coordinator and/or psychiatrist, and put in the secondary care notes.

1.4.1.3 People with schizophrenia at increased risk of developing cardiovascular disease and/or diabetes (for example, with elevated blood pressure, raised lipid levels, smokers, increased waist measurement) should be identified at the earliest opportunity. Their care should be managed using the appropriate NICE guidance for prevention of these conditions[8].

1.4.1.4 Treat people with schizophrenia who have diabetes and/or cardiovascular disease in primary care according to the appropriate NICE guidance[8].

1.4.1.5 Healthcare professionals in secondary care should ensure, as part of the CPA, that people with schizophrenia receive physical healthcare from primary care as described in recommendations 1.4.1.1–1.4.1.4.

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[8] See ‘Lipid modification’ (NICE clinical guideline 67), ‘Type 1 diabetes’ (NICE clinical guideline 15), ‘Type 2 diabetes’ (NICE clinical guideline 66). Further guidance about treating cardiovascular disease and diabetes is available from www.nice.org.uk

1.4.1.6 When a person with an established diagnosis of schizophrenia presents with a suspected relapse (for example, with increased psychotic symptoms or a significant increase in the use of alcohol or other substances), primary healthcare professionals should refer to the crisis section of the care plan. Consider referral to the key clinician or care coordinator identified in the crisis plan.

1.4.1.7 For a person with schizophrenia being cared for in primary care, consider referral to secondary care again if there is:

- poor response to treatment
- non-adherence to medication
- intolerable side effects from medication
- comorbid substance misuse
- risk to self or others.

1.4.1.8 When re-referring people with schizophrenia to mental health services, take account of service user and carer requests, especially for:

- review of the side effects of existing treatments
- psychological treatments or other interventions.

1.4.1.9 When a person with schizophrenia is planning to move to the catchment area of a different NHS trust, a meeting should be arranged between the services involved and the service user to agree a transition plan before transfer. The person's current care plan should be sent to the new secondary care and primary care providers.

1.4.2 Service-level interventions

1.4.2.1 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).

1.4.3 Psychological interventions

1.4.3.1 Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.4.12.

1.4.3.2 Offer family intervention to families of people with schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.4.13.

1.4.3.3 Family intervention may be particularly useful for families of people with schizophrenia who have:

- recently relapsed or are at risk of relapse
- persisting symptoms.

1.4.3.4 Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.

1.4.4 Pharmacological interventions

1.4.4.1 The choice of drug should be influenced by the same criteria recommended for starting treatment (see section 1.2.4).

1.4.4.2 Do not use targeted, intermittent dosage maintenance strategies[9] routinely. However, consider them for people with schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.

[9] Defined as the use of antipsychotic medication only during periods of incipient relapse or symptom exacerbation rather than continuously.

1.4.4.3 Consider offering depot/long-acting injectable antipsychotic medication to people with schizophrenia:

- who would prefer such treatment after an acute episode
- where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.

1.4.5 Using depot/long-acting injectable antipsychotic medication

1.4.5.1 When initiating depot/long-acting injectable antipsychotic medication:

- take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)
- take into account the same criteria recommended for the use of oral antipsychotic medication (see section 1.2.4), particularly in relation to the risks and benefits of the drug regimen
- initially use a small test dose as set out in the BNF or SPC.

1.4.6 Interventions for people with schizophrenia whose illness has not responded adequately to treatment

1.4.6.1 For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:

- review the diagnosis
- establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration
- review engagement with and use of psychological treatments and ensure that these have been offered according to this

guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families

- consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.

1.4.6.2 Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic.

1.4.6.3 For people with schizophrenia whose illness has not responded adequately to clozapine at an optimised dose, healthcare professionals should consider recommendation 1.4.6.1 (including measuring therapeutic drug levels) before adding a second antipsychotic to augment treatment with clozapine. An adequate trial of such an augmentation may need to be up to 8–10 weeks. Choose a drug that does not compound the common side effects of clozapine.

1.4.7 Employment, education and occupational activities

1.4.7.1 Supported employment programmes should be provided for those people with schizophrenia who wish to return to work or gain employment. However, they should not be the only work-related activity offered when individuals are unable to work or are unsuccessful in their attempts to find employment.

1.4.7.2 Mental health services should work in partnership with local stakeholders, including those representing BME groups, to enable people with mental health problems, including schizophrenia, to access local employment and educational opportunities. This

should be sensitive to the person's needs and skill level and is likely to involve working with agencies such as Jobcentre Plus, disability employment advisers and non-statutory providers.

1.4.7.3 Routinely record the daytime activities of people with schizophrenia in their care plans, including occupational outcomes.

1.4.8 Return to primary care

1.4.8.1 Offer people with schizophrenia whose symptoms have responded effectively to treatment and remain stable the option to return to primary care for further management. If a service user wishes to do this, record this in their notes and coordinate transfer of responsibilities through the CPA.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from www.nice.org.uk/CG82

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (third edition, published April 2007), which is available from www.nice.org.uk/guidelinesprocess or from NICE publications (phone 0845 003 7783 or email publications@nice.org.uk and quote reference N1233).

3 Implementation

The Healthcare Commission assesses how well NHS organisations meet core and developmental standards set by the Department of Health in 'Standards for better health' (available from www.dh.gov.uk). Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that NHS organisations should take into account national agreed guuidance when planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CG82).

- Slides highlighting key messages for local discussion.
- Costing tools:

- national costing statement – gives some financial background and context to the guideline
- costing template to estimate the local costs and savings involved.

- Audit support for monitoring local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see section 5).

4.1 Clozapine augmentation

For people with treatment-resistant schizophrenia whose illness has shown only a partial response to clozapine, is augmentation of clozapine monotherapy with an appropriate second antipsychotic clinically and cost effective?

Why is this important?

Clinicians commonly use a second antipsychotic to augment clozapine when the response has been unsatisfactory, but the findings from clinical trials so far are inconclusive. There is some indication that an adequate trial of such a strategy may be longer than the 6–8 weeks usually considered adequate for a treatment study of an acute psychotic episode. The pharmacological rationale for the choice of a second antipsychotic should be tested, that is:

- potent dopamine D2 receptor blockade, as a hypothesised mechanism of pharmacodynamic synergy, and
- a low liability for compounding the characteristic side effects of clozapine.

4.2 Family intervention

For people with schizophrenia from BME groups living in the UK, does ethnically adapted family intervention for schizophrenia (adapted in

consultation with BME groups to better suit different cultural and ethnic needs) enable more people in BME groups to engage with this therapy, and show concomitant reductions in patient relapse rates and carer distress?

Why is this important?
Family intervention has a well-established evidence base from the last 30 years, and proven efficacy in reducing relapse rates in schizophrenia. However, most recent studies applying cultural modification to the intervention have been conducted in non-UK service settings and set against relatively undeveloped treatment as usual services. Thus, the efficacy of culturally adapted family intervention has not been established within UK NHS settings. BME groups are over-represented in schizophrenia diagnoses, and in some inner city settings make up at least 50% of admissions and crisis care. These groups are also less likely to be offered psychological interventions and may thus remain more vulnerable to relapse, despite larger networks and potentially more family support, than those who are living with family carers. Engaging BME families in suitable adaptations of family intervention would expand the evidence base for family intervention in the UK and be an important way to improve experiences and outcomes for both carers and service users.

4.3 Cultural competence training for staff

For people with schizophrenia from BME groups living in the UK, does staff training in cultural competence at an individual level and at an organisational level (delivered as a learning and training process embedded in routine clinical care and service provision) improve the service user's experience of care and chance of recovery, and reduce staff burnout?

Why is this important?
Culture is known to influence the content and, some would argue, the form and intensity of presentation of symptoms; it also determines what is considered illness and the remedies people seek. Cultural practices and customs may create contexts in which distress is generated – for example,

where conformity to gender, age, and cultural roles is challenged. It is important that professionals are not only careful and considerate, but clear and thorough in their use of clinical language and in the explanations they provide, not just to service users and carers, but also to other health professionals. It is important that all clinicians are skilled in working with people from diverse linguistic and ethnic backgrounds, and have a process by which they can assess cultural influences and address cumulative inequalities through their routine clinical practice. Addressing organisational aspects of cultural competence and capability is necessary alongside individual practice improvements.

Although cultural competence is now recognised as a core requirement for mental health professionals, little evaluative work has been done to assess the effects of cultural competence at both an individual and organisational level, on service user, carer and mental health professional outcomes. A recent systematic review (Bhui et al. 2007)[10] suggested that staff cultural competence training may produce benefits in terms of cultural sensitivity and staff knowledge and satisfaction; however, the included studies did not assess the impact on service users and carers, and all were conducted outside the UK, thus limiting their generalisability to UK mental health settings.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care (update)' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from www.nccmh.org.uk, our website

[10] Bhui KS, Warfa N, Edonya P et al. (2007) Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research 31: 7–15

(www.nice.org.uk/CG82fullguideline) and the National Library for Health (www.library.nhs.uk).

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CG82quickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1823).

5.3 'Understanding NICE guidance'

Information for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CG82publicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1824).

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about schizophrenia.

6 Related NICE guidance

Published

Medicines adherence. NICE clinical guideline 76 (2009). Available from www.nice.org.uk/CG76

Lipid modification. NICE clinical guideline 67 (2008). Available from www.nice.org.uk/CG67

Type 2 diabetes (update). NICE clinical guideline 66 (2008). Available from www.nice.org.uk/CG66

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from www.nice.org.uk/CG52

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from www.nice.org.uk/CG51

Depression (amended). NICE clinical guideline 23 (2007). Available from www.nice.org.uk/CG23

Anxiety (amended). NICE clinical guideline 22 (2007). Available from www.nice.org.uk/CG22

Obesity. NICE clinical guideline 43 (2006). Available from www.nice.org.uk/CG43

Bipolar disorder. NICE clinical guideline 38 (2006). Available from www.nice.org.uk/CG38

Statins for the prevention of cardiovascular events. NICE technology appraisal guidance 94 (2006). Available from www.nice.org.uk/TA94

Obsessive-compulsive disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/CG31

Post-traumatic stress disorder. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/CG26

Violence. NICE clinical guideline 25 (2005). Available from www.nice.org.uk/CG25

Self-harm. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG16

Type 1 diabetes. NICE clinical guideline 15 (2004). Available from www.nice.org.uk/CG15

Eating disorders. NICE clinical guideline 9 (2004). Available from www.nice.org.uk/CG9

Guidance on the use of electroconvulsive therapy. NICE technology appraisal guidance 59 (2003). Available from www.nice.org.uk/TA59

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

- Depression in chronic physical health problems (partial update of CG23). NICE clinical guideline (publication expected September 2009).
- Depression in adults (partial update of CG23). NICE clinical guideline (publication expected September 2009).
- Alcohol use disorders: management of alcohol dependency. NICE clinical guideline (publication expected December 2010).
- Psychosis with substance misuse. NICE clinical guideline (publication expected March 2011).

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Carer Representative

Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

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Karen Cowley
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