NICE National Institute for Health and Care Excellence

Psychosis and schizophrenia in adults: treatment and management

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NICE clinical guideline 178

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Contents

Introduction

This guideline updates and replaces 'Schizophrenia' (NICE clinical guideline 82). The recommendations are labelled according to when they were originally published (see About this guideline for details).

This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term 'psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. The recognition, treatment and management of affective psychoses (such as bipolar disorder or unipolar psychotic depression) are covered by other NICE guidelines. The guideline does not address the specific treatment of young people under the age of 18 years, except those who are receiving treatment and support from early intervention in psychosis services; there is a separate NICE guideline on psychosis and schizophrenia in children and young people.

Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences.

Typically there is a prodromal period, which precedes a first episode of psychosis and can last from a few days to around 18 months. The prodromal period is often characterised by some deterioration in personal functioning. Changes include the emergence of transient (of short duration) and/or attenuated (of lower intensity) psychotic symptoms, memory and concentration problems, unusual behaviour and ideas, disturbed communication and affect, and social withdrawal, apathy and reduced interest in daily activities. The prodromal period is usually followed by an acute episode marked by hallucinations, delusions and behavioural disturbances, usually accompanied by agitation and distress. Following resolution of the acute episode, usually after pharmacological, psychological and other interventions, symptoms diminish and often disappear for many people, although sometimes a number of negative symptoms remain. This phase, which can last for many years, may be interrupted by recurrent acute episodes that may need additional pharmacological, psychological and other interventions, as in previous episodes.

Although this is a common pattern, the course of schizophrenia varies considerably. Some people may have positive symptoms very briefly; 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 psychosis and schizophrenia. The first symptoms tend to start in young adulthood, at a time when a person would usually make the transition to independent living, but can occur at any age. The symptoms and behaviour associated with psychosis and schizophrenia can have a distressing impact on the individual, family and friends.

Psychosis and schizophrenia are 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 forming new relationships.

In the last decade, there has been a new emphasis on services for early detection and intervention, and 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 psychosis and 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 people with psychosis and schizophrenia, including advocates, friends or family members, although some family members may choose not to be carers.

Psychosis and schizophrenia are 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 related NICE guidance).

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

Patient-centred care

This guideline offers best practice advice on the care of adults with psychosis and schizophrenia.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences; in Wales services have a legal duty to meet these through the Mental Health Measure. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If someone does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent, the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in Patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All healthcare professionals and social care practitioners working with people using adult NHS mental health services should follow the recommendations in Service user experience in adult mental health.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

Preventing psychosis

- If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):
  - offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7) **and**
  - offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. **[new 2014]**

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. **[new 2014]**
- Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in Post-traumatic stress disorder (NICE clinical guideline 26). **[new 2014]**
- The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:
  - metabolic (including weight gain and diabetes)
  - extrapyramidal (including akathisia, dyskinesia and dystonia)

  - cardiovascular (including prolonging the QT interval)
  - hormonal (including increasing plasma prolactin)
  - other (including unpleasant subjective experiences). **[2009; amended 2014]**

- Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication). **[2009]**

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

- Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**
- Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

Promoting recovery and possible future care

- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes. **[new 2014]**
- Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic. **[2009]**

- Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment. **[new 2014]**

1 Recommendations

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See About this guideline for details.

1.1 Care across all phases

1.1.1 Service user experience

1.1.1.1 Use this guideline in conjunction with Service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and:

- 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. **[2009; amended 2014]**

1.1.2 Race, culture and ethnicity

The NICE guideline on service user experience in adult mental health (NICE clinical guidance 136) includes recommendations on communication relevant to this section.

1.1.2.1 Healthcare professionals inexperienced in working with people with psychosis or schizophrenia from diverse ethnic and cultural backgrounds should seek advice and supervision from healthcare professionals who are experienced in working transculturally. **[2009]**

1.1.2.2 Healthcare professionals working with people with psychosis or 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 psychosis or 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 psychosis or schizophrenia
- conflict management and conflict resolution. **[2009]**

1.1.2.3 Mental health services should work with local voluntary black, Asian and minority ethnic 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. **[2009]**

1.1.3 Physical health

1.1.3.1 People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider. **[new 2014]**

1.1.3.2 If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see Obesity [NICE clinical guideline 43], Lipid modification [NICE clinical guideline 67] and Preventing type 2 diabetes [NICE public health guidance 38]). **[new 2014]**

1.1.3.3 Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine. **[new 2014]**

1.1.3.4 Consider one of the following to help people stop smoking:

- nicotine replacement therapy (usually a combination of transdermal patches with a short-acting product such as an inhalator, gum, lozenges or spray) for people with psychosis or schizophrenia **or**
- bupropion[1] for people with a diagnosis of schizophrenia **or**
- varenicline for people with psychosis or schizophrenia.

Warn people taking bupropion or varenicline that there is an increased risk of adverse neuropsychiatric symptoms and monitor them regularly, particularly in the first 2–3 weeks. **[new 2014]**

1.1.3.5 For people in inpatient settings who do not want to stop smoking, offer nicotine replacement therapy to help them to reduce or temporarily stop smoking. **[new 2014]**

1.1.3.6 Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report. **[new 2014]**

1.1.3.7 Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators. **[new 2014]**

1.1.4 Comprehensive services provision

1.1.4.1 All teams providing services for people with psychosis or schizophrenia should offer a comprehensive range of interventions consistent with this guideline. **[2009]**

1.1.5 Support for carers

1.1.5.1 Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs,

give a copy to the carer and their GP and ensure it is reviewed annually. **[new 2014]**

1.1.5.2 Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this. **[new 2014]**

1.1.5.3 Give carers written and verbal information in an accessible format about:

- diagnosis and management of psychosis and schizophrenia
- positive outcomes and recovery
- types of support for carers
- role of teams and services
- getting help in a crisis.

When providing information, offer the carer support if necessary. **[new 2014]**

1.1.5.4 As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers, and respects their individual needs and interdependence. **[new 2014]**

1.1.5.5 Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer. **[new 2014]**

1.1.5.6 Include carers in decision-making if the service user agrees. **[new 2014]**

1.1.5.7 Offer a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should:

- be available as needed

- have a positive message about recovery. **[new 2014]**

1.1.6 Peer support and self-management

1.1.6.1 Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers. **[new 2014]**

1.1.6.2 Consider a manualised self-management programme delivered face-to-face with service users, as part of the treatment and management of psychosis or schizophrenia. **[new 2014]**

1.1.6.3 Peer support and self-management programmes should include information and advice about:

- psychosis and schizophrenia
- effective use of medication
- identifying and managing symptoms
- accessing mental health and other support services
- coping with stress and other problems
- what to do in a crisis
- building a social support network
- preventing relapse and setting personal recovery goals. **[new 2014]**

1.2 Preventing psychosis

1.2.1 Referral from primary care

1.2.1.1 If a person is distressed, has a decline in social functioning and has:

- transient or attenuated psychotic symptoms **or**
- other experiences or behaviour suggestive of possible psychosis **or**
- a first-degree relative with psychosis or schizophrenia

refer them for assessment without delay to a specialist mental health service or an early intervention in psychosis service because they may be at increased risk of developing psychosis. **[new 2014]**

1.2.2 Specialist assessment

1.2.2.1 A consultant psychiatrist or a trained specialist with experience in at-risk mental states should carry out the assessment. **[new 2014]**

1.2.3 Treatment options to prevent psychosis

1.2.3.1 If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):

- offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7) **and**
- offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. **[new 2014]**

1.2.3.2 Do not offer antipsychotic medication:

- to people considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1) **or**
- with the aim of decreasing the risk of or preventing psychosis. **[new 2014]**

1.2.4 Monitoring and follow-up

1.2.4.1 If, after treatment (as described in recommendation 1.2.3.1), the person continues to have symptoms, impaired functioning or is distressed, but a clear diagnosis of psychosis cannot be made, monitor the person regularly for

changes in symptoms and functioning for up to 3 years using a structured and validated assessment tool. Determine the frequency and duration of monitoring by the:

- severity and frequency of symptoms
- level of impairment and/or distress **and**
- degree of family disruption or concern. **[new 2014]**

1.2.4.2 If a person asks to be discharged from the service, offer follow-up appointments and the option to self-refer in the future. Ask the person's GP to continue monitoring changes in their mental state. **[new 2014]**

1.3 First episode psychosis

1.3.1 Early intervention in psychosis services

1.3.1.1 Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. **[new 2014]**

1.3.1.2 People presenting to early intervention in psychosis services should be assessed without delay. If the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self- or carer-referral. **[new 2014]**

1.3.1.3 Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline. **[2014]**

1.3.1.4 Consider extending the availability of early intervention in psychosis services beyond 3 years if the person has not made a stable recovery from psychosis or schizophrenia. **[new 2014]**

1.3.2 Primary care

1.3.2.1 Do not start antipsychotic medication for a first presentation of sustained psychotic symptoms in primary care unless it is done in consultation with a consultant psychiatrist. **[2009; amended 2014]**

1.3.3 Assessment and care planning

1.3.3.1 Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains:

- psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history)
- medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis
- physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)
- psychological and psychosocial, including social networks, relationships and history of trauma
- developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions)
- social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer)
- occupational and educational (attendance at college, educational attainment, employment and activities of daily living)
- quality of life
- economic status. **[2009; amended 2014]**

1.3.3.2 Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in Post-traumatic stress disorder (NICE clinical guideline 26). **[new 2014]**

1.3.3.3 Routinely monitor for other coexisting conditions, including depression, anxiety and substance misuse particularly in the early phases of treatment. **[2009; amended 2014]**

1.3.3.4 Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional who made the referral and the service user. **[2009; amended 2014]**

1.3.3.5 For people who are unable to attend mainstream education, training or work, facilitate alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment. **[new 2014]**

1.3.4 Treatment options

1.3.4.1 For people with first episode psychosis offer:

- oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with
- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

1.3.4.2 Advise people who want to try psychological interventions alone that these are more effective when delivered in conjunction with antipsychotic medication. If the person still wants to try psychological interventions alone:

- offer family intervention and CBT

- agree a time (1 month or less) to review treatment options, including introducing antipsychotic medication
- continue to monitor symptoms, distress, impairment and level of functioning (including education, training and employment) regularly. **[new 2014]**

1.3.4.3 If the person's symptoms and behaviour suggest an affective psychosis or disorder, including bipolar disorder and unipolar psychotic depression, follow the recommendations in Bipolar disorder (NICE clinical guideline 38) or Depression (NICE clinical guideline 90). **[new 2014]**

1.3.5 Choice of antipsychotic medication

1.3.5.1 The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences). **[2009; amended 2014]**

1.3.6 How to use antipsychotic medication

1.3.6.1 Before starting antipsychotic medication, undertake and record the following baseline investigations:

- weight (plotted on a chart)
- waist circumference
- pulse and blood pressure

- fasting blood glucose, glycosylated haemoglobin (HbA_{1c}), blood lipid profile and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity. **[new 2014]**

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

- specified in the summary of product characteristics (SPC)
- a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure)
- there is a personal history of cardiovascular disease **or**
- the service user is being admitted as an inpatient. **[2009]**

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

- Discuss and record the side effects that the person is most willing to tolerate.
- 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.
- 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. **[2009; amended 2014]**

1.3.6.4 Monitor and record the following regularly and systematically throughout treatment, but especially during titration:

- response to treatment, 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) and impact on functioning
- the emergence of movement disorders
- weight, weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually (plotted on a chart)
- waist circumference annually (plotted on a chart)
- pulse and blood pressure at 12 weeks, at 1 year and then annually
- fasting blood glucose, HbA_{1c} and blood lipid levels at 12 weeks, at 1 year and then annually
- adherence
- overall physical health. **[new 2014]**

1.3.6.5 The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements. **[new 2014]**

1.3.6.6 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. **[2009]**

1.3.6.7 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. **[2009]**

1.3.6.8 'As required' (p.r.n.) prescriptions of antipsychotic medication should be made as described in recommendation 1.3.6.3. 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. **[2009]**

1.3.6.9 Do not use a loading dose of antipsychotic medication (often referred to as 'rapid neuroleptisation'). **[2009]**

1.3.6.10 Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication). **[2009]**

1.3.6.11 If prescribing chlorpromazine, warn of its potential to cause skin photosensitivity. Advise using sunscreen if necessary. **[2009]**

1.3.7 How to deliver psychological interventions

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

- follow a treatment manual[2] 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. **[2009]**

1.3.7.2 Family intervention should:

- include the person with psychosis or 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 psychosis or schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work. **[2009]**

1.3.8 Monitoring and reviewing psychological interventions

1.3.8.1 When providing psychological interventions, routinely and systematically monitor a range of outcomes across relevant areas, including service user satisfaction and, if appropriate, carer satisfaction. **[2009]**

1.3.8.2 Healthcare teams working with people with psychosis or 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. **[2009]**

1.3.9 Competencies for delivering psychological interventions

1.3.9.1 Healthcare professionals providing psychological interventions should:

- have an appropriate level of competence in delivering the intervention to people with psychosis or schizophrenia

- be regularly supervised during psychological therapy by a competent therapist and supervisor. **[2009]**

1.3.9.2 Trusts should provide access to training that equips healthcare professionals with the competencies required to deliver the psychological therapy interventions recommended in this guideline. **[2009]**

1.4 Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

1.4.1 Service-level interventions

1.4.1.1 Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it. **[new 2014]**

1.4.1.2 Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals. **[new 2014]**

1.4.1.3 Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need. **[new 2014]**

1.4.1.4 If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender and level of vulnerability, support their carers and follow the recommendations in Service user experience in adult mental health (NICE clinical guidance 136). **[new 2014]**

1.4.2 Treatment options

1.4.2.1 For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer:

- oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with
- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

1.4.3 Pharmacological interventions

1.4.3.1 For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication. **[2009; amended 2014]**

1.4.4 Psychological and psychosocial interventions

1.4.4.1 Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

1.4.4.2 Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

1.4.4.3 Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

1.4.4.4 Arts therapies should be provided by a Health and Care Professions Council registered arts therapist with previous experience of working with people with psychosis or schizophrenia. The intervention should be provided in groups unless difficulties with acceptability and access 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 psychosis or 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. **[2009]**

1.4.4.5 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. **[2009]**

1.4.4.6 Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with psychosis or 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. **[2009]**

1.4.4.7 Do not offer adherence therapy (as a specific intervention) to people with psychosis or schizophrenia. **[2009]**

1.4.4.8 Do not routinely offer social skills training (as a specific intervention) to people with psychosis or schizophrenia. **[2009]**

1.4.5 Behaviour that challenges

1.4.5.1 Occasionally people with psychosis or 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 1.4.5.2 and 1.4.5.5). **[2009]**

1.4.5.2 Follow the recommendations in Violence (NICE clinical guideline 25) when facing imminent violence or when considering rapid tranquillisation. **[2009]**

1.4.5.3 After rapid tranquillisation, offer the person with psychosis or 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. **[2009]**

1.4.5.4 Ensure that the person with psychosis or schizophrenia has the opportunity to write an account of their experience of rapid tranquillisation in their notes. **[2009]**

1.4.5.5 Follow the recommendations in Self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia. **[2009]**

1.4.6 Early post-acute period

1.4.6.1 After each acute episode, encourage people with psychosis or schizophrenia to write an account of their illness in their notes. **[2009]**

1.4.6.2 Healthcare professionals may consider using psychoanalytic and psychodynamic principles to help them understand the experiences of people with psychosis or schizophrenia and their interpersonal relationships. **[2009]**

1.4.6.3 Inform the service user that there is a high risk of relapse if they stop medication in the next 1–2 years. **[2009]**

1.4.6.4 If withdrawing antipsychotic medication, undertake gradually and monitor regularly for signs and symptoms of relapse. **[2009]**

1.4.6.5 After withdrawal from antipsychotic medication, continue monitoring for signs and symptoms of relapse for at least 2 years. **[2009]**

1.5 Promoting recovery and possible future care

1.5.1 General principles

1.5.1.1 Continue treatment and care in early intervention in psychosis services or refer the person to a specialist integrated community-based team. This team should:

- offer the full range of psychological, pharmacological, social and occupational interventions recommended in this guideline
- be competent to provide all interventions offered
- place emphasis on engagement rather than risk management
- provide treatment and care in the least restrictive and stigmatising environment possible and in an atmosphere of hope and optimism in line with Service user experience in adult mental health (NICE clinical guidance 136). **[new 2014]**

1.5.1.2 Consider intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services. **[new 2014]**

1.5.1.3 Review antipsychotic medication annually, including observed benefits and any side effects. **[new 2014]**

1.5.2 Return to primary care

1.5.2.1 Offer people with psychosis or 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 care programme approach. **[2009]**

1.5.3 Primary care

Monitoring physical health in primary care

1.5.3.1 Develop and use practice case registers to monitor the physical and mental health of people with psychosis or schizophrenia in primary care. **[2009]**

1.5.3.2 GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes. **[new 2014]**

1.5.3.3 Identify people with psychosis or schizophrenia who have high blood pressure, have abnormal lipid levels, are obese or at risk of obesity, have diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or are physically inactive, at the earliest opportunity following relevant NICE guidance (see Lipid modification [NICE clinical guideline 67], Preventing type 2 diabetes [NICE public health guidance 38], Obesity [NICE clinical guideline 43], Hypertension [NICE clinical guideline 127], Prevention of cardiovascular disease [NICE public health guidance 25] and Physical activity [NICE public health guidance 44]). **[new 2014]**

1.5.3.4 Treat people with psychosis or schizophrenia who have diabetes and/or cardiovascular disease in primary care according to the appropriate NICE guidance (for example, see Lipid modification [NICE clinical guideline 67], Type 1 diabetes [NICE clinical guideline 15], Type 2 diabetes [NICE clinical guideline 66], Type 2 diabetes – newer agents [NICE clinical guideline 87]). [2009]

1.5.3.5 Healthcare professionals in secondary care should ensure, as part of the care programme approach, that people with psychosis or schizophrenia receive physical healthcare from primary care as described in recommendations 1.5.3.1–1.5.3.4. **[2009]**

Relapse and re-referral to secondary care

1.5.3.6 When a person with an established diagnosis of psychosis or 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. **[2009]**

1.5.3.7 For a person with psychosis or 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. **[2009]**

1.5.3.8 When re-referring people with psychosis or 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. **[2009]**

Transfer

1.5.3.9 When a person with psychosis or 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. **[2009]**

1.5.4 Psychological interventions

1.5.4.1 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 1.3.7.1. **[2009]**

1.5.4.2 Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2. **[2009]**

1.5.4.3 Family intervention may be particularly useful for families of people with psychosis or schizophrenia who have:

- recently relapsed or are at risk of relapse
- persisting symptoms. **[2009]**

1.5.4.4 Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms. **[2009]**

1.5.5 Pharmacological interventions

1.5.5.1 The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). **[2009]**

1.5.5.2 Do not use targeted, intermittent dosage maintenance strategies[3] routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity. **[2009]**

1.5.5.3 Consider offering depot /long-acting injectable antipsychotic medication to people with psychosis or 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. **[2009]**

1.5.6 Using depot/long-acting injectable antipsychotic medication

1.5.6.1 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 sections 1.3.5 and 1.3.6), 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. **[2009]**

1.5.7 Interventions for people whose illness has not responded adequately to treatment

1.5.7.1 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. **[2009]**

1.5.7.2 Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic. **[2009]**

1.5.7.3 For people with schizophrenia whose illness has not responded adequately to clozapine at an optimised dose, healthcare professionals should consider recommendation 1.5.7.1 (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. **[2009]**

1.5.8 Employment, education and occupational activities

1.5.8.1 Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment. **[new 2014]**

1.5.8.2 Mental health services should work in partnership with local stakeholders, including those representing black, Asian and minority ethnic groups, to enable people with mental health problems, including psychosis or schizophrenia, to stay in work or education and to access new employment (including self-employment), volunteering and educational opportunities. **[2009; amended 2014]**

1.5.8.3 Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes. **[2009]**

[1] At the time of publication (February 2014), bupropion was contraindicated in people with bipolar disorder. Therefore, it is not recommended for people with psychosis unless they have a diagnosis of schizophrenia.

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

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

2 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.

2.1 Peer support interventions

What is the clinical and cost effectiveness of peer support interventions in people with psychosis and schizophrenia?

Why this is important

Service users have supported the development of peer support interventions, which have recently proliferated in the UK, but current evidence for these interventions in people with psychotic disorders is not strong and the studies are mainly of very low quality. Moreover the content of the programmes has varied considerably, some using structured interventions, others providing more informal support. There is therefore an urgent need for high-quality evidence in this area.

The programme of research would be in several stages. First, there should be development work to establish what specifically service users want from peer support workers, as opposed to what they want from professionals, and what the conditions are for optimal delivery of the intervention. This development work should be co-produced by exploring the views of service users, experienced peer support workers and developers of peer support interventions, and suitable outcome measures should be identified reflecting the aims of peer support. Second, the intervention, delivered as far as possible under the optimal conditions, should be tested in a high-quality trial. Further research should test structured and manualised formats versus unstructured formats (in which service user and peer decide together what to cover in the session). Benefits and adverse effects experienced by peer support workers should also be measured.

2.2 People who choose not to take antipsychotic medication

What is the clinical and cost effectiveness of psychological intervention alone, compared with treatment as usual, in people with psychosis or schizophrenia who choose not to take antipsychotic medication?

Why this is important

The development of alternative treatment strategies is important for the high proportion of people with psychosis and schizophrenia who choose not to take antipsychotic medication, or discontinue it because of adverse effects or lack of efficacy. There is evidence that psychological interventions (CBT and family intervention) as an adjunct to antipsychotic medication are effective in the treatment of psychosis and schizophrenia and are cost saving. However, there is little evidence for family intervention or CBT alone, without antipsychotic medication.

The programme of research should compare the clinical and cost effectiveness of psychological intervention alone (CBT and/or family intervention) with treatment as usual for people with psychosis or schizophrenia who choose not to take antipsychotic medication, using an adequately powered study with a randomised controlled design. Key outcomes should include symptoms, relapse rates, quality of life, treatment acceptability, social functioning and the cost effectiveness of the interventions.

2.3 The physical health benefits of discontinuing antipsychotic medication

What are the short- and long-term benefits to physical health of guided medication discontinuation and/or reduction in first episode psychosis and can this be achieved without major risks?

Why this is important

There is growing concern about the long-term health risks, increased mortality and cortical grey matter loss linked to cumulative neuroleptic exposure in people with psychosis. The majority of young adults discontinue their medication in an unplanned way because of these risks. A Dutch moderately-sized open trial has reported successful discontinuation of medication in 20% of people without serious relapse; at 7-year follow-up there was continuous benefit for guided

reduction in terms of side effects, functioning and employment, with no long-term risks. If replicated, this would mark a significant breakthrough in reducing the long-term physical health risks associated with antipsychotic treatment and improving outcomes.

The programme of research should use an adequately powered, multicentre, double-blind, randomised controlled design to test the physical health benefits, risks and costs of discontinuing or reducing antipsychotic medication among young adults with first episode psychosis who have achieved remission. The primary outcomes should be quality of life and metabolic disorder, including weight gain; secondary outcomes should include side effects, serious relapse, acceptability and user preference.

2.4 Maintaining the benefits of early intervention in psychosis services after discharge

How can the benefits of early intervention in psychosis services be maintained once service users are discharged after 3 years?

Why this is important

Early intervention in psychosis services deliver evidence-based interventions in a positive, youth-friendly setting, improve outcomes, are cost effective and have high service user acceptability and engagement. Once people are transferred to primary care or community mental health services these gains are diminished. The guideline recommends that trusts consider extending these services. However, the extent to which gains would be maintained and who would benefit most is not known. The successful element of early intervention in psychosis services might be incorporated into mainstream services for psychosis, but how this would function, and its cost effectiveness, needs to be determined.

The suggested programme of research should use an adequately powered, multi-centre randomised trial comparing extending early intervention in psychosis services (for example, for 2 years) versus providing augmented (step-down) care in community mental health services versus treatment as usual to determine whether the gains of early intervention can be maintained and which service users would benefit most under each condition. The primary outcome should be treatment/service engagement and secondary outcomes should include relapse, readmission, functioning and user preference.

2.5 Interventions for PTSD symptoms in people with psychosis and schizophrenia

What is the benefit of a CBT-based trauma reprocessing intervention on PTSD symptoms in people with psychosis and schizophrenia?

Why this is important

PTSD symptoms have been documented in approximately one-third of people with psychosis and schizophrenia. The absence of PTSD symptoms in this context predicts better mental health outcomes, lower service use and improved life satisfaction. Two-thirds of the traumatic intrusions, observed in first episode and established psychosis, relate to symptoms of psychosis and its treatment (including detention). One study has demonstrated proof-of-principle in first episode psychosis for trauma reprocessing, focusing on psychosis-related intrusions. Replication of the study will fill a major gap in treatment for this population and may have other benefits on psychotic symptoms and service use.

The suggested programme of research would use an adequately powered, multi-centre randomised trial to test whether a CBT-based trauma reprocessing intervention can reduce PTSD symptoms and related distress in people with psychosis and schizophrenia. The trial should be targeted at those with high levels of PTSD symptoms, particularly traumatic intrusions, following first episode psychosis. The follow-up should be up to 2 years and the intervention should include 'booster' elements, extra sessions of CBT-based trauma reprocessing interventions, and a health economic evaluation.

3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

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 section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

3.2 Related NICE guidance

Details are correct at the time of publication of the guideline (February 2014). Further information is available on the NICE website.

Published

- Smoking cessation in secondary care. NICE public health guidance 48 (2013).
- Social anxiety disorder. NICE clinical guideline 159 (2013).
- Psychosis and schizophrenia in children and young people. NICE clinical guideline 155 (2013)
- Patient experience in adult NHS services. NICE clinical guidance 138 (2012).
- Service user experience in adult mental health. NICE clinical guidance 136 (2011).
- Self-harm: longer term management. NICE clinical guideline 133 (2011).
- Common mental health disorders. NICE clinical guideline 123 (2011).
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011).

- Alcohol use disorders. NICE clinical guideline 115 (2011).
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011)
- Depression with a chronic physical health problem. NICE clinical guideline 91 (2009).
- Depression in adults. NICE clinical guideline 90 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Medicines adherence. NICE clinical guideline 76 (2009).
- Promoting mental wellbeing at work. NICE public health guidance 22 (2009).
- Managing long-term sickness and incapacity for work. NICE public health guidance 19 (2009).
- Smoking cessation services. NICE public health guidance 10 (2008).
- Lipid modification. NICE clinical guideline 67 (2008).
- Type 2 diabetes. NICE clinical guideline 66 (2008).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Obesity. NICE clinical guideline 43 (2006).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Statins for the prevention of cardiovascular events. NICE technology appraisal guidance 94 (2006).
- Obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).

- Self-harm. NICE clinical guideline 16 (2004).
- Type 1 diabetes. NICE clinical guideline 15 (2004).
- Eating disorders. NICE clinical guideline 9 (2004).
- Guidance on the use of electroconvulsive therapy. NICE technology appraisal guidance 59 (2003).

Under development

NICE is developing the following guidance (details available from the NICE website):

- Bipolar disorders (update). NICE clinical guideline. Publication expected September 2014.
- Violence and aggression. NICE clinical guideline. Publication expected December 2014.

4 The Guideline Development Group, National Collaborating Centre and NICE project team

4.1 Guideline Development Group

The Guideline Development Group members listed are those for the 2014 update. For the composition of the previous Guideline Development Groups, see the full guideline.

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4.2 National Collaborating Centre for Mental Health

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Jasdeep Hayre
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Catharine Baden-Daintree
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Changes after publication

March 2014:

A correction has been made to the wording of recommendation 1.1.3.3 to be clear that it is the hydrocarbons in cigarette smoke that cause interactions with other drugs, rather than nicotine. The corrected recommendation reads:

Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.

February 2014: minor maintenance

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

This guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

This guideline updates and replaces NICE clinical guideline 82 (published March 2009).

Recommendations are marked as **[2009]**, **[2009, amended 2014]**, **[2014]** or **[new 2014]**.

- **[2009]** indicates that the evidence has not been reviewed since 2009.
- **[2009, amended 2014]** indicates that the evidence has not been reviewed since 2009 but changes have been made to the recommendation wording that change the meaning (see below).
- **[2014]** indicates that the evidence has been reviewed but no changes have been made to the recommendation.
- **[new 2014]** indicates that the evidence has been reviewed and the recommendation has been updated or added.

Recommendations from NICE clinical guideline 82 that have been amended

Recommendations are labelled **[2009, amended 2014]** if the evidence has not been reviewed since 2009 but changes have been made to the recommendation wording that change the meaning.

Recommendation in 2009 guideline	Recommendation in current guideline	Reason for change

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. [1.1.1.1]	Use this guideline in conjunction with Service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • 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. [2009; amended 2014] [1.1.1.1]	The GDG amended this recommendation to direct readers to the NICE guidance on service user experience, which replaces some of the recommendations from the 2009 schizophrenia guideline.

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. [1.1.4.1]	Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains: • psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history) • medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis • physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health) • psychological and psychosocial, including social networks,	The GDG amended the recommendation in line with 'Psychosis and schizophrenia in children and young people' (NICE clinical guideline 155) to ensure that the comprehensive assessment is better tailored to the needs of people with psychosis or schizophrenia and better designed for developing a care plan. The GDG considered it important to align this guideline and 'Psychosis and schizophrenia in children and young people' because the latter promotes early intervention in psychosis services (as an alternative to child and adolescent mental health services) for people aged 15 and older, some of whom (over 18) will be covered by this guideline. The GDG therefore wished to ensure that both guidelines were consistent in their key aspects.

	relationships and history of trauma • developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions) • social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer) • occupational and educational (attendance at college, educational attainment, employment and activities of daily living) • quality of life • economic status. [2009; amended 2014] [1.3.3.1]	
Routinely monitor for other coexisting conditions, including depression and anxiety, particularly in the early phases of treatment.[1.1.4.2]	Routinely monitor for other coexisting conditions, including depression, anxiety and substance misuse particularly in the early phases of treatment. [2009; amended 2014] [1.3.3.3]	The GDG judged that substance misuse should be added to the recommendation because of its prevalence in people with psychosis and schizophrenia.

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.[1.2.1.2]	Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional who made the referral and the service user. [2009; amended 2014] [1.3.3.4]	The first sentence has been deleted because it was replaced by the assessment recommendations in sections 1.2.2 and 1.3.3. The second sentence was amended to reflect best practice as defined by the GDG.

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. [1.2.3.1]	Antipsychotic medication for a first presentation of sustained psychotic symptoms should not be started in primary care unless it is done in consultation with a consultant psychiatrist. [2009; amended 2014] [1.3.2.1]	The GDG judged that the context in which the 2009 recommendation had been made had changed, and that it was important to emphasise that antipsychotics should not be initiated in primary care unless done with supervision from a consultant. The GDG considered it important to align this guideline and 'Psychosis and schizophrenia in children and young people' because the latter promotes early intervention in psychosis services (as an alternative to child and adolescent mental health services) for people aged 15 and older, some of whom (over 18) will be covered by this guideline. The GDG therefore wished to ensure that both guidelines were consistent in their key aspects.

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. [1.2.4.1]	The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including: • metabolic (including weight gain and diabetes) • extrapyramidal (including akathisia, dyskinesia and dystonia) • cardiovascular (including prolonging the QT interval) • hormonal (including increasing plasma prolactin) • other (including unpleasant subjective experiences). [2009; updated 2014] [1.3.5.1]	This recommendation was amended in line with 'Psychosis and schizophrenia in children and young people' (NICE clinical guideline 155). The GDG considered it important to align this guideline and 'Psychosis and schizophrenia in children and young people' because the latter promotes early intervention in psychosis services (as an alternative to child and adolescent mental health services) for people aged 15 and older, some of whom (over 18) will be covered by this guideline. The GDG therefore wished to ensure that both guidelines were consistent in their key aspects.

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	Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial. Include the following: • Discuss and record the side effects that the person is most willing to tolerate. • 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. • 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. [2009; amended 2014] [1.3.6.3]	This recommendation was amended because the GDG wished to make a separate recommendation about monitoring, in line with 'Psychosis and schizophrenia in children and young people' (NICE clinical guideline 155). Therefore the 4th bullet point of the original recommendation was used as the basis of a new recommendation (see 1.3.6.4). The GDG considered it important to align this guideline and 'Psychosis and schizophrenia in children and young people' because the latter promotes early intervention in psychosis services (as an alternative to child and adolescent mental health services) for people aged 15 and older, some of whom (over 18) will be covered by this guideline. The GDG therefore wished to ensure that both guidelines were consistent in their key aspects.

− 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. [1.2.4.3]		

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.[1.3.2.1]	For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication. [2009; amended 2014] [1.4.3.1]	This recommendation was amended in line with 'Psychosis and schizophrenia in children and young people' (NICE clinical guideline 155), to state that existing medication should be reviewed. The GDG considered it important to align this guideline and 'Psychosis and schizophrenia in children and young people' because the latter promotes early intervention in psychosis services (as an alternative to child and adolescent mental health services) for people aged 15 and older, some of whom (over 18) will be covered by this guideline. The GDG therefore wished to ensure that both guidelines were consistent in their key aspects.

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. [1.4.7.2]	Mental health services should work in partnership with local stakeholders, including those representing black, Asian and minority ethnic groups, to enable people with mental health problems, including psychosis or schizophrenia, to stay in work or education and to access new employment (including self-employment), volunteering and educational opportunities. [2009; amended 2014] [1.5.8.2]	The recommendation has been amended to reflect recent terminology relating to ethnic groups and to remove reference to specific agencies in order to ensure that the recommendation remains current for as long as possible. The GDG also wished to challenge the assumption that people with psychosis and schizophrenia are not already in employment by stating that they should be enabled to 'stay in work or education'.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also Patient-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

For updates, also include the following (delete if not applicable):

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations ending **[2009]** (see Update information above for details about how recommendations are labelled). In particular, for recommendations labelled **[2009]** the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Other versions of this guideline

The full guideline, Psychosis and schizophrenia in adults contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

The recommendations from this guideline have been incorporated into a NICE Pathway.

We have produced information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice are also available.

Your responsibility

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 summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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