



A summary of prescribing recommendations from NICE guidance

Psychosis and schizophrenia in children and young adults

NICE CG155; 2013

This guideline covers the recognition and management of psychosis and schizophrenia in children and young people up to the age of 18.

Definition of terms

CAMHS	child and adolescent mental health services (up to the age of 17 years)
CBT	cognitive behavioural therapy
CVD	cardiovascular disease
SPC	Summary of Product Characteristics
ECG	electrocardiogram

General principles of care

- Health and social care professionals working with children/young people with psychosis or schizophrenia should be trained and competent to work with children/young people with mental health problems of all levels of learning ability, cognitive capacity, emotional maturity and development.

Referral from primary care

Possible psychosis

- When a child/young person experiences transient or attenuated psychotic symptoms (such as possible or fleeting hallucinations or delusions) or other experiences suggestive of possible psychosis, **refer** without delay to a specialist mental health service such as CAMHS or an early intervention in psychosis service (≥ 14 years).

First episode psychosis

- Urgently refer all children/young people with a first presentation of sustained psychotic symptoms (lasting ≥ 4 weeks) to a specialist mental health service, either CAMHS or an early intervention in psychosis service (≥ 14 years).

Referral in crisis and challenging behaviour – see full guideline.

Assessment - see full guideline or [NICE Pathway](#)

Treatment and management

Most antipsychotic medicines are unlicensed for use in children/young people.

- Obtain and document informed consent.

Possible psychosis

- When transient or attenuated psychotic symptoms or other mental state changes associated with distress, impairment or help-seeking behaviour are not sufficient for a diagnosis of psychosis or schizophrenia:
 - consider individual CBT with or without family intervention, **AND**
 - offer treatments recommended in NICE guidance for children/young people with anxiety disorders, depression, emerging personality disorder or substance misuse.
- Do NOT** give antipsychotic medication:
 - for psychotic symptoms or mental state changes that are not sufficient for a diagnosis of psychosis or schizophrenia, **OR**
 - with the aim of decreasing the risk of psychosis.

First episode psychosis

- In primary care, antipsychotic medication should not be started unless in consultation with a consultant psychiatrist with training in child and adolescent mental health.
- Give:
 - oral antipsychotic medication, **AND**
 - psychological interventions; family intervention with individual CBT.
- If the child/young person and their parents/carers wish to try psychological interventions alone, advise that psychological interventions are more effective when delivered in conjunction with antipsychotic medication.
- If the child/young person and their parents/carers still wish to try psychological interventions alone:
 - offer family intervention with individual CBT,
 - agree a time limit (≤ 1 month) for reviewing treatment options, including introducing antipsychotic medication,
 - continue to regularly monitor symptoms, level of distress, impairment and level of functioning, including educational engagement and achievement.

Treatment of subsequent acute episodes

- Give:
 - oral antipsychotic medication, **AND**
 - psychological interventions; family intervention with individual CBT.
- Choice of drug should be influenced by the same criteria recommended for starting treatment (see next page). Take into account the clinical response to and side effects associated with current and previous medication.
- Aripiprazole is recommended as an option for the treatment of schizophrenia in people aged 15 to 17 years who are intolerant or have a contraindication to risperidone, or whose schizophrenia has not been adequately controlled with risperidone. See [NICE TA213](#).

Inadequate response to treatment

- For psychosis or schizophrenia that has not responded adequately to pharmacological or psychological interventions:
 - review the diagnosis,
 - check adherence to antipsychotic medication - ensure this has been prescribed at an adequate dose and for the correct duration,
 - review engagement with and use of psychological interventions; if family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for children/young people in close contact with their families,
 - consider other causes of non-response, such as comorbid substance misuse (including alcohol), concurrent use of other prescribed medication or physical illness.
- Offer clozapine – see Box 1.

Visit the [NICE Pathway: Psychosis and schizophrenia in children and young people](#)

Psychosis and schizophrenia in children and young people

NICE CG155:2013

How to choose and deliver interventions

Psychological interventions

- ◆ Family intervention should:
 - > include the child/young person 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 or multi-family group intervention,
 - > take account of the relationship between the parent or carer and the child/young person,
 - > have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.
- ◆ CBT should be delivered on a one-to-one basis over at least 16 sessions.

Antipsychotic medication

- ◆ Choice of antipsychotic medication should be decided between the young person, their parents/carers and healthcare professionals.
- ◆ Provide age-appropriate information and discuss the likely benefits and possible side effects of each drug including:
 - > metabolic (including weight gain and diabetes),
 - > extrapyramidal (akathisia, dyskinesia and dystonia),
 - > cardiovascular (including prolonging QT interval),
 - > hormonal (including increasing plasma prolactin),
 - > other (including unpleasant subjective experiences).

Prescribing

- ◆ Treatment with antipsychotic medication* should be considered an individual therapeutic trial.
- ◆ Treatment with regular and 'as required' antipsychotic medication should be as follows:
 - > if the drug is **NOT** licensed for children/young people start with a dose below the lower end of the licensed range for adults,
 - > if the drug is licensed for children/ young people start with a dose at the lower end of the licensed range,
 - > slowly titrate upwards following doses in the BNF, BNFC or SPC,
 - > if doses above the range given in the BNF, BNFC or SPC are used, document the reasons for doing this,
 - > record the rationale for continuing, changing or stopping medication, and the effects of such changes,
 - > carry out a trial of the medication at optimum dose for 4 to 6 weeks.
- ◆ For 'as required' prescriptions, review clinical indications, frequency of administration, therapeutic benefits and side effects at least weekly. Check if doses exceed the maximum specified in the BNF, BNFC or SPC.
- ◆ **Do NOT** use a loading dose of antipsychotic medication.
- ◆ **Do NOT** initiate regular combined antipsychotic medication, except for short periods.

Chlorpromazine*

- ◆ Warn of its potential to cause skin photosensitivity. Advise using sunscreen if necessary.

Clozapine*

- ◆ Consider clozapine for children/young people who have not responded adequately to pharmacological treatment despite sequential use of at least two different antipsychotic drugs each used for 6 to 8 weeks.
- ◆ If response to clozapine is inadequate, consider a multidisciplinary review, including measuring therapeutic drug levels, before adding a second antipsychotic to augment treatment. Choose a drug that does not potentiate the common side effects of clozapine.
- ◆ A trial of augmentation should be up to 8 to 10 weeks.

Baseline investigations

- ◆ Before starting antipsychotic medication, undertake and record the following baseline investigations:
 - > weight and height (both plotted on a growth chart),
 - > waist and hip circumference,
 - > pulse and blood pressure,
 - > fasting blood glucose, HbA_{1c}, blood lipid profile and prolactin levels,
 - > assessment of any movement disorders, nutritional status, diet and level of physical activity.
- ◆ Offer the child/young person an ECG if:
 - > specified in the SPC,
 - > a physical examination has identified specific CV risk,
 - > there is a personal history of CVD or a family history of CVD such as premature sudden cardiac death or prolonged QT interval,
 - > the child/young person is admitted as an inpatient.

Monitoring

Antipsychotic medication

- ◆ Monitoring should be the responsibility of the secondary care team for at least the first 12 months. It can then be transferred to primary care as a shared care agreement.
- ◆ 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,
 - > the emergence of movement disorders,
 - > weight; weekly for 6 weeks, at 12 weeks then 6 monthly,
 - > height and waist/hip circumference; 6 monthly,
 - > pulse and blood pressure; at 12 weeks then 6 monthly,
 - > fasting blood glucose, HbA_{1c}, blood lipid and prolactin levels at 12 weeks then 6 monthly,
 - > adherence to treatment and physical health.
- ◆ Review antipsychotic medication annually.

Psychological interventions

- ◆ Routinely and systematically monitor outcomes across relevant areas, including the child/young person's and parents/carers satisfaction.
- ◆ Healthcare teams 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.

Promoting recovery – see full guideline

Stopping antipsychotic medication

- ◆ Inform the child/young person and parents/carers there is a high risk of relapse if medication is stopped 1 to 2 years following an acute episode.
- ◆ Withdraw medication gradually. Monitor regularly for signs and symptoms of relapse whilst withdrawing, and for at least 2 years afterwards.

Providing future care in primary care

- ◆ Monitor the physical health of children/young people with psychosis or schizophrenia at least once a year, taking into consideration that people with schizophrenia are at higher risk of CVD than the general population.
- ◆ Identify children/young people with psychosis or schizophrenia who smoke or have high blood pressure, raised lipid levels or increased waist measurement and monitor for the emergence of CVD or diabetes.

* See Summary of Product Characteristics for full prescribing information.