



A summary of prescribing recommendations from NICE guidance

Psychosis and schizophrenia in adults

NICE CG178; 2014

This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (≥18 years) with onset before 60 years. There is a separate NICE pathway on [psychosis and schizophrenia in children and young people](#).

Definition of terms

CBT	cognitive behavioural therapy
CVD	cardiovascular disease
ECG	electrocardiogram

General principles of care – see [NICE pathway](#)

Physical health

- Offer people with psychosis or schizophrenia, especially those taking antipsychotics, a combined healthy eating and physical activity programme.
- If a person has rapid or excessive weight gain, problems with blood glucose management or abnormal lipid levels, offer interventions in line with NICE pathways on [obesity](#) and [diabetes](#) and NICE guidance on [lipid modification](#).
- Offer people help to stop smoking. Be aware of the potential impact of reducing cigarette smoking on the metabolism of other drugs, e.g. clozapine and olanzapine.
- Consider one of the following to help people stop smoking:
 - > nicotine replacement therapy, **OR**
 - > varenicline*, **OR**
 - > bupropion* †.
- Warn people taking bupropion or varenicline there is an increased risk of adverse neuropsychiatric symptoms and monitor them regularly, particularly in the first 2 to 3 weeks. See NICE pathways: [smoking prevention and cessation](#), [smoking cessation in secondary care](#).

Referral from primary care

Possible psychosis

- Refer a person without delay to a specialist mental health service or early intervention in psychosis service if they are distressed, have a decline in social functioning and:
 - > transient or attenuated psychotic symptoms, **OR**
 - > other experiences or behaviour suggestive of possible psychosis, **OR**
 - > a first-degree relative with psychosis or schizophrenia.
- A consultant psychiatrist or a trained specialist with experience in at-risk mental states should carry out the assessment.
- If a person is considered to be at increased risk of developing psychosis offer:
 - > individual CBT with or without family intervention **AND**
 - > interventions recommended in NICE pathways on: [generalised anxiety disorder](#), [social anxiety disorder](#), [depression](#), [personality disorders](#), [alcohol-use disorders](#) and [drug misuse](#).
- **Do NOT** offer antipsychotic medication to people considered to be at increased risk of developing psychosis **or** with the aim of decreasing the risk of or preventing psychosis.

*See Summary of Product Characteristics for full prescribing information.

†Bupropion is contraindicated in people with bipolar disorder. It is not recommended for people with psychosis unless they have a diagnosis of schizophrenia.

Monitoring and follow up

- If after treatment the person continues to have symptoms, impaired functioning or is distressed, but a diagnosis of psychosis cannot be made, monitor regularly for changes in symptoms and functioning for up to 3 years using a structured and validated assessment tool. Determine frequency and duration of monitoring by:
 - > severity and frequency of symptoms,
 - > level of impairment and/or distress,
 - > degree of family disruption or concern.
- If a person asks to be discharged from the service, offer follow-up appointments, the option to self-refer in future and ask their GP to monitor changes in their mental state.

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis.
- Assess people without delay. If the early intervention in psychosis service cannot provide urgent intervention, refer to a crisis resolution and home treatment team. Referral may be from primary or secondary care or self or carer-referral.

Assessment in secondary care – see [NICE pathway](#)

Treatment and management

Initial episode

- **Do NOT** start antipsychotic medication in primary care unless in consultation with a consultant psychiatrist.
- Offer:
 - > oral antipsychotic medication **AND**
 - > psychological interventions; family intervention and individual CBT.
- If the person wishes to try psychological interventions alone, advise that these are more effective when delivered in conjunction with antipsychotic medication. If the person still wishes to try psychological interventions alone:
 - > offer family intervention and CBT,
 - > agree a time (≤1 month) to review treatment options, including introducing antipsychotic medication
 - > continue to regularly monitor symptoms, distress, impairment and level of functioning including education, training and employment.

Subsequent acute episodes

- Offer crisis resolution and home treatment teams if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention services or other community teams to effectively manage it.
- If a person needs hospital care, consider the impact on them, their carers and family members. Ensure the setting is suitable for the person's age, gender and level of vulnerability.
- Offer:
 - > oral antipsychotic medication, **AND**
 - > psychological interventions; family intervention and 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 and side effects associated with current and previous medication.

Psychosis and schizophrenia in adults continued...

NICE CG178: 2014

How to choose and deliver interventions

Psychological interventions

- ◆ CBT should be delivered on a one-to-one basis over at least 16 planned sessions – see [NICE pathway](#)
- ◆ Family intervention – see [NICE pathway](#)

Antipsychotic medication

- ◆ The choice of antipsychotic medication should be decided between the person and healthcare professional, taking into account the views of the carer if the patient agrees.
- ◆ Provide 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:
 - > discuss and record the side effects that the person is most willing to tolerate,
 - > record the indications, expected benefits and risks, 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 BNF or SPC.
 - > if doses above the range given in the BNF 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 each week or as appropriate. Check if doses exceed the maximum specified in the BNF 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*

- ◆ Offer clozapine to people who have not responded adequately to treatment despite sequential use of at least two different antipsychotics. At least one of the drugs should be a non-clozapine second-generation antipsychotic.
- ◆ If response to clozapine is inadequate, consider further review, including measuring therapeutic drug levels, before adding a second antipsychotic to augment treatment with clozapine. Choose a drug that does not potentiate the common side effects of clozapine.
- ◆ A trial of augmentation may need to be up to 8 to 10 weeks.

Depot/long-acting injectable antipsychotic

- ◆ Consider in people:
 - > who would prefer this treatment after an acute episode,
 - > where avoiding covert non-adherence (either intentional or unintentional) is a clinical priority.
- ◆ Initially use a small test dose as set out in the BNF or SPC.

Baseline investigations

Before starting antipsychotic medication

- ◆ Undertake and record the following baseline investigations:
 - > weight,
 - > waist circumference,
 - > pulse and blood pressure,
 - > fasting blood glucose, HbA1c, blood lipid profile and prolactin levels,
 - > assessment of any movement disorders,
 - > assessment of nutritional status, diet and level of physical activity.
- ◆ Offer an ECG if:
 - > specified in the SPC,
 - > a physical examination has identified specific cardiovascular risk e.g. high blood pressure,
 - > there is a personal history of CVD or
 - > the service user is being admitted as an inpatient.

Monitoring

Antipsychotics

- ◆ Monitoring should be the responsibility of the secondary care team for at least the first 12 months or until the person's condition has stabilised. It can then be transferred to primary care as a shared care agreement.
- ◆ Monitor and record the following regularly throughout treatment, but especially during titration:
 - > response to treatment, including changes in symptoms and behaviour,
 - > side effects of treatment,
 - > the emergence of movement disorders,
 - > weight; weekly for 6 weeks, at 12 weeks, at 12 months then annually (plotted on a chart),
 - > waist circumference; annually (plotted on a chart),
 - > pulse and blood pressure; at 12 weeks, at 12 months then annually,
 - > fasting blood glucose, HbA1c, and blood lipid levels at 12 weeks, at 1 year and then annually,
 - > adherence and physical health.

Psychological interventions – see [NICE pathway](#)

Behaviour that challenges – see [NICE pathway](#)

Stopping antipsychotic medication

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

Promoting recovery and possible future care – see [NICE pathway](#)

Return to primary care

- ◆ Offer people whose symptoms have responded to treatment and remain stable the option to return to primary care for further management. If a person wishes to do this, record this in their notes and coordinate transfer of responsibilities through the care programme approach.

Relapse and re-referral to secondary care

- ◆ 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.

*See Summary of Product Characteristics for full prescribing information.