THE NICE CLINICAL GUIDELINES FOR THE TREATMENT AND MANAGEMENT OF SCHIZOPHRENIA IN PRIMARY AND SECONDARY CARE

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In December 2002 a team of healthcare professionals, service users and researchers in the UK published the "NICE Clinical Guidelines for the treatment and management of schizophrenia in primary and secondary care" after careful consideration of the best available clinical evidence and with the aim to assist clinicians to provide high quality care for people with schizophrenia and their families.

The main recommendations of the guidelines are summarised and presented in this paper along with a brief discussion on the challenges in implementing these guidelines.

Key words: schizophrenia management, clinical guidelines, National Institute of Clinical Excellence.

What is NICE?

In the United Kingdom local National Health Service (NHS) organisations are responsible for delivering high quality healthcare. This is done through ´clinical governance´ (a framework through which NHS organisations are accountable for continuously improving standards of care), which is supported by modernised self-regulation of health professionals and continuing professional education (Department of Health, 1997, 1998).

As part of this process the National Institute for Clinical Excellence (NICE) was established in 1999 as a Special Health Authority by the Department of Health. NICE makes national recommendations and provides guidance on best practice in medical treatment and care. It also publishes national clinical guidelines which are ´systematically developed statements that assist clinicians and patients in making decisions about appropriate treatment for specific conditions´ (Department of Health, 1996).

There is a considerable amount of evidence of unacceptable inequalities and inefficiencies in health care in the UK, as elsewhere in the world, including variations in the use of interventions of proven value and the too eager adoption of interventions with no established clinical benefits[6]. NICE guidance is covering medication, interventions for diagnosis and treatment, as well as clinical practice and healthcare promotion campaigns. It does not assess all new treatments or medicines; only those where there is a lack of clarity and wide discrepancies in care across the country (´postcode prescribing´), or doubt about the effectiveness of a treatment. Once NICE clinical guidelines are published, health professionals are expected to take them into account when making clinical decisions. However, NICE guidelines do not replace the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient.

NICE attempts to assess the evidence of all health-related benefits of an intervention in a wide sense and this may include impact on quality of life, relief of pain or disability, impact on length of life and associated costs in order to reach a judgement on whether this intervention can be recommended as a cost-effective use of NHS resources. NICE follows a transparent and well-structured process for its appraisals. It allows all participants the opportunity to submit evidence, to comment on draft recommendations, and to appeal to an independent panel in cases of disagreement. NICE consists of a wide network of people who work in and use the NHS -practitioners, patient and carer groups- as well as academics, professional bodies and government experts. It has recently reinforced the voice of the general public by establishing a ´Citizen´s Council´ of lay people.

The development of the NICE guideline for schizophrenia

The methodology used for this NICE guideline reflects current international consensus on the appropriate practice for guideline development (AGREE: Appraisal of Guidelines for Research and Evaluation Instrument; www.agreecollaboration.org) ensuring the collection and selection of the best research evidence available, and the systematic generation of treatment recommendations.

The guideline was commissioned by NICE and developed by the National Collaborating Centre for Mental Health (NCCMH). The NCCMH is led by a partnership between the Royal College of Psychiatrists´ Research Unit and the British Psychological Society´s equivalent unit. Members of the NCCMH come from thirteen organisations[1] representing allied health professions, national service user associations, academic bodies and health economics experts. The guideline was published in December 2002.

Parallel, plain English, version "Understanding NICE guidance - information for service users, their advocates and carers, and the public" was also published at the same time to explain in jargon-free language what people can expect in terms of the services available, the treatments offered, and the approach that staff should take with them.

The NCCMH has also developed a training website (www.rcpsych.ac.uk/cru/sts/index.htm) that gives information on how to understand and use the NICE schizophrenia guideline. The full document "Schizophrenia: Full national clinical guideline on core interventions in primary and secondary care" is published by Gaskell and The British Psychological Society and can be purchased via the website of The Royal College of Psychiatrists (www.rcpsych.ac.uk).

Following, the main points of the NICE guidance for schizophrenia will be summarised under the original headings of the guidance and with the addition of footnotes explaining service related terminology. At the end, the difficulties in implementing the guidance in everyday routine clinical practice will be discussed.

"Care across all phases and optimism"

At the opening section it is stated that the aim of the guideline is to improve outcomes of care for people with schizophrenia. These outcomes are defined as the degree of symptomatic recovery, quality of life, personal autonomy, access to work, quality of living accommodation, degree and quality of social integration, financial independence and the experience and impact of side effects.

To achieve this improvement the guideline suggests that the assessment of needs for health and social care for people with schizophrenia must be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues. An additional key message is that health professionals should work in partnership with service users and carers, offering help, treatment and care in an atmosphere of hope and optimism.

The essential role of the families of people with schizophrenia is acknowledged in the guidelines. It is said that parents of people with schizophrenia often feel to blame, either because they have ´passed on´ the genes causing schizophrenia, or because they are ´bad parents´. Therefore it is recommended that clear and accessible information is made available to service users and their families about schizophrenia, its possible causes and treatment and about the role of families in promoting recovery and reducing relapse.

"First episode of Schizophrenia"

NICE guidelines recommend that early intervention services[2] are developed across the country to provide pharmacological, psychological, social, occupational and educational interventions to people suffering a first episode of schizophrenia. Also the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine at the lower end of the standard dose range are considered as first-line treatments for people with newly diagnosed schizophrenia.

Given the considerable personal and social consequences of having a diagnosis of schizophrenia it is suggested that a decision to seek a second opinion on the diagnosis should be supported. The guideline also recommends that towards the end of an acute episode, service users and carers should be offered help to understand better the period of illness, and given the opportunity to write their account in their notes.

"Ongoing assessment of health and social care needs"

This part of the NICE guideline aims to safeguard the physical health of people with schizophrenia. It is advised that healthcare workers monitor regularly physical health at a frequency jointly decided between service users and clinicians. The agreed frequency should be recorded in the patient´s notes. Physical health checks should pay particular attention to endocrine disorders, such as diabetes and hyperprolactinaemia, cardiovascular risk factors, such as obesity, blood pressure and lipids, side effects of medication, and lifestyle factors such as lack of exercise and smoking. These must also be recorded in the notes.

Regarding the social care of people with schizophrenia the guideline advocates regular and full assessment including assessment of accommodation and quality of life. The agreed frequency of assessment should be documented in the care plan. Family members and other non-professional carers should also have an assessment of their caring, physical and mental health needs, at an agreed and recorded frequency.

"Service–level interventions"

At the ″service level intervention″ section of the guideline there is an attempt to describe the services best suited to meet the diverse needs of people with schizophrenia. The services most likely to help people who are acutely ill include crisis resolution and home treatment teams[3], early intervention teams, community mental health teams and acute day hospitals. Inpatient treatment is only recommended when these teams are unable to meet the needs of a service user, or if the Mental Health Act is used (compulsory admission).

The role of the Community mental health teams, as outlined in the NICE guidance, is to organise community care and co-ordinate and integrate other community based teams providing services for people with schizophrenia. Crisis resolution and home treatment teams should be used to manage crises for service users and deliver high-quality acute care. Particular attention must be paid to risk monitoring as a high-priority routine activity. Also the above teams should be considered both as an alternative to acute admission and to facilitate early discharge from inpatient care.

It is acknowledged in the NICE recommendations that some people with schizophrenia have high needs for care and tend to be lost from ordinary services. It is suggested that assertive outreach teams[4] (or assertive community treatment – ACT) should be provided for people with schizophrenia, who make high use of inpatient services and have a history of poor engagement with services leading to frequent relapse and social breakdown. In addition, integrating and coordinating the care of people with schizophrenia who receive services from different teams should be carefully

considered. The Care Programme Approach[5] is proposed as the main mechanism by which the care of individuals across services is managed and integrated.

"Pharmacological interventions"

Regarding the use of medication the guidelines highlight the need for maintaining antipsychotic treatment for 1 to 2 years after an acute episode to minimise the risk of relapse. Antipsychotic medication should be part of a comprehensive package of care that addresses the individual´s clinical, emotional and social needs. The doctor responsible for treatment should monitor therapeutic progress and tolerability of the drug on an ongoing basis. Monitoring is particularly important when individuals have just changed from one antipsychotic to another.

The guidelines also emphasise that the choice of antipsychotic drug should be made jointly by the individual and the doctor based on a discussion of the relative benefits of the drugs and their side-effect profiles. If a service user is unable to make his or her preference known, an atypical should be prescribed. It is best to use a single drug, using doses within the British National Formulary (BNF, Royal Pharmaceutical Society of Great Britain) dose range and not to use high or loading doses.

More specifically, the guidance dictates, the dosage of conventional antipsychotics for an acute episode should be in the range of 300–1000 mg chlorpromazine equivalents per day for a minimum of 6 weeks. Reasons for dosage outside this range should be justified and documented and the minimum effective dose should be used. Massive loading doses of antipsychotic medication, known as ´rapid neuroleptization´, should not be used.

The atypical antipsychotic drugs (amisulpride, olanzapine, quetiapine, risperidone, zotepine) are considered as treatment options for a first episode of schizophrenia or for people currently on conventional antipsychotic drugs experiencing unacceptable side effects. It is not advised that individuals change from conventional to atypical antipsychotics if they are achieving good control of their condition without unacceptable side effects. In case that a potential to cause weight gain or diabetes has been identified for an atypical antipsychotic, there should be routine monitoring at an agreed and recorded frequency.

"Rapid tranquillisation"

The guidance covers also the issue of rapid tranquillisation. It is stated that for the majority of service users rapid tranquillisation is not necessary during an acute illness and should not be resorted to routinely. Staff on inpatient units should be trained to assess and manage potential and actual violence using de-escalation techniques, restraint, seclusion and rapid tranquillisation. Staff should also be trained to undertake cardiopulmonary resuscitation. Mental health professionals should identify environmental and social factors that increase the likelihood of violence and aggression in inpatient settings such as overcrowding; lack of privacy; lack of activities; long waiting times and poor communication between service users and staff.

Oral medication should be offered before parenteral medication but if it proves necessary, the intramuscular route (IM) should be preferred over the intravenous. Vital signs must be monitored after parenteral treatment is administered. Blood pressure, pulse, temperature and respiratory rate should be recorded at regular intervals. If the service user appears to be asleep, more intensive monitoring is needed. According to the guidelines resuscitation equipment and medication, including flumazenil, must be available and easily accessible where rapid tranquillisation is used. The minimum effective dose should be used and the prescription of unusually high doses or ´drug cocktails´ is not advised. Service users who are heavily sedated or using illicit drugs or alcohol should not be secluded. The IM preparations recommended by NICE for use in rapid tranquillisation are lorazepam, haloperidol and olanzapine. Wherever possible, a single agent is preferred to a combination. When rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam should be considered. IM chlorpromazine or IM diazepam are not recommended. An anticholinergic agent should be given to reduce the risk of dystonia and other extrapyramidal side effects of IM conventional antipsychotics.

"Treatment–resistant schizophrenia"

This part of the guidelines is devoted to the management of treatment resistant schizophrenia (TRS). TRS is possible when there is no satisfactory clinical improvement despite the sequential use of the recommended doses for 6 to 8 weeks of two antipsychotics (at least one atypical). The first step in the management of TRS is to establish that antipsychotic drugs have been sufficiently tried in terms of dosage and duration. Then other causes should be considered such as co-morbid substance misuse, poor treatment compliance or physical illness. When there is evidence of TRS, it is recommended that clozapine is introduced at the earliest opportunity. The addition of a second antipsychotic to clozapine may be useful for people with TRS for whom clozapine alone has proved insufficiently effective.

"Psychological interventions"

The NICE guidelines place much emphasis on psychological interventions which are described as an essential part of the treatment options available for people with schizophrenia and their families. Those quoted to be supported by the best evidence of effectiveness are cognitive behavioural therapy (CBT) and family interventions. These should be used to prevent relapse, to reduce symptoms, increase insight and promote compliance with medication. Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia. CBT is considered for persisting psychotic symptoms and as a treatment option to assist in the development of insight and the management of poor compliance. Longer treatments with CBT are regarded more effective than shorter ones, which

may improve depressive symptoms but are unlikely to improve psychotic symptoms. NICE recommends that an adequate course of CBT should be of more than 6 months´ duration and include more than ten planned sessions.

Family interventions are suggested for families of people with schizophrenia who have recently relapsed, are considered at risk of relapse or have persisting symptoms. The length of the intervention should be longer than 6 months´ duration and include more than ten sessions. When providing family interventions, the service user should normally be included in the sessions, as this significantly improves the outcome.

˝Employment˝

At the final part of the guideline there is an attempt to address the issue of employment for people with schizophrenia. It is suggested that baseline assessments of people with schizophrenia should include assessment of their occupational status and potential and that this should be recorded in their notes and care plans. Supported employment schemes must also be provided for those people with schizophrenia who wish to return to work or gain employment. However, other, non work-related, meaningful activities should be offered when individuals are unable to work or are unsuccessful in their attempts to find employment.

The task of implementation

Psychiatrists, other mental health professionals and the public welcomed the NICE guidelines[8]. In a recent survey the majority of participant psychiatrists felt that the guidelines were effective in improving patient care, could be used flexibly to suit individual patients and did not impinge on their clinical judgement7. Even though the guidelines were developed for England and Wales (Scotland has developed similar guidelines in 1998) they have subsequently been adopted by national mental health agencies in Italy and Australia.

However the development and dissemination of clinical guidance alone does not guarantee changes into everyday practice. A commitment to implementation and a strong lead from the highest levels of healthcare organisations is essential[9]. Although full implementation will require additional resources, current resources could be mobilised to effect change in a spirit of optimism and hope through systematic approaches and a comprehensive implementation strategy. These are likely to include continuous professional education, training events, audit and the collection of meaningful outcome data. Yet, further research is necessary to determine whether the implementation of the NICE guidelines will translate into improved outcomes for patients and their families.

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1. The National Collaborating Centre for Mental Health reference group consists of members of the following organisations: Royal College of Psychiatrists, British Psychological Society, Royal College of Nursing, National Institute for Social Work, Clinical Effectiveness Forum for the Allied Health Professions, Royal College of General Practitioners, Royal Pharmaceutical Society, Rethink Severe Mental Illness (formerly the National Schizophrenia Fellowship – NSF), Manic Depression Fellowship, MIND, Centre for Evidence Based Mental Health, Centre for Economics in Mental Health and the Institute of Psychiatry.
2. Early Intervention Services (also called “first episode or early onset teams”) have been developed in the UK as a response to evidence that long duration of untreated psychosis results in less favourable outcomes and that two thirds of suicides occur in the first five years. EIS adopt a collaborative young person–friendly approach and focus on maintaining or reclaiming social roles, support networks, employment or education. These teams also undertake assessment and treatment of co–morbid conditions especially substance misuse, depression and anxiety.
3. The Crisis Resolution or Home Treatment Teams (HTT) have evolved as a response to increased bed pressures and a requirement for 24 hour access to services in a crisis. Their main focus is on people who are acutely ill or in crisis and at imminent risk of hospitalisation (“gatekeeping”). HTT provide frequent contact and intensive intervention and remain involved until the crisis resolves. Patient contact ranges from daily to several times daily according to risk and need.
4. The development of Assertive Outreach Teams is supported by a huge literature and research base. These teams are targeting difficult to engage, chaotic, high inpatient using individuals with a high use of inpatient facilities. The Assertive Outreach Teams are multidisciplinary, based in the community, have certain features and are able to deliver a mix of evidence based psychosocial interventions and intensive practical support.
5. The Department of Health introduced the `Care Programme Approach´ (CPA) in 1991 to improve collaboration between multidisciplinary teams, other agencies such as housing departments and service users and caregivers. Each person accepted by specialist mental health services now is expected to have: a systematic assessment of their health and social care needs, an agreed package of care, a nominated care coordinator and regular reviews and monitoring of the service user’s needs and progress of the delivery of the care programme. The CPA process was updated in 1999 with the publication of “Effective Care Co–ordination in Mental Health Services. Modernising the CPA (DoH 1999).

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