## Provision of information

✓ When a diagnosis is made, professionals should ensure that service users and families/carers are informed and that clear information is given about what the diagnosis means and why it has been made.

## Access and engagement

✓ Comorbid substance misuse should not exclude people with schizophrenia from services or interventions. Management of severe and complex problems may require a joint consultative approach between mental health and substance use services.

### Early intervention services

**A** **Individuals in the first episode of psychosis should receive treatment within the context of a specialist early intervention model of care. This should be multidisciplinary and encompass**

- **engagement/assertive outreach approaches**
- **family involvement and family interventions**
- **access to psychological interventions and psychologically informed care**
- **vocational/educational interventions**
- **access to antipsychotic medication.**

### Assertive community treatment

**B** **Assertive outreach should be provided for people with serious mental disorders** (including for people with schizophrenia) **who make high use of inpatient services, who show residual psychotic symptoms and who have a history of poor engagement with services leading to frequent relapse and/or social breakdown** (for example homelessness).

## Pharmacological and related approaches

### Antipsychotic tolerability

✓ Healthcare professionals and service users should work together to find the most appropriate medication and the lowest effective dose. There should be detailed discussion with service users outlining the potential benefits and harms of individual medications. Service user preference should be elicited and taken into account.

✓ Local arrangements for physical health monitoring should be put in place at the time of antipsychotic prescribing.

### Management of adverse effects

| Concern and/or risk | | Consider |
|---|---|---|
| EPSE | B | SGAs or low-potency FGAs |
| tardive dyskinesia | B | SGA |
| sedation | B | haloperidol or aripiprazole |
| weight gain | A | haloperidol, aripiprazole or amisulpride |
| weight gain on antipsychotic medications | A | lifestyle interventions |
| | B | metformin |

## Pharmacological and related approaches

### Initial treatment in first episode psychosis

**D** **Following initiation of an antipsychotic medication for service users in the first episode of psychosis, the medication should be continued for at least two weeks unless there are significant tolerability issues. Assessment of dose and response should be monitored during the early phase of prescribing.**

**D** **Where there is poor response to medication there should be an assessment of medication adherence and inter-current substance misuse before the lack of response can be definitively established.**

**D** **If there is no response to medication after four weeks, despite dose optimisation, a change in antipsychotic should be considered.**

**D** **Where there is partial response, this should be re-assessed after eight weeks unless there are significant adverse effects.**

**D** **Minimum effective dose of either first- or second-generation antipsychotics should be used in individuals in the first episode of schizophrenia.**

**D** **Following remission of the first episode of schizophrenia, the duration of maintenance treatment with antipsychotics should be at least 18 months.**

### Treating acute exacerbation or recurrence

**A** **In service users with an acute exacerbation or recurrence of schizophrenia prescribers should consider amisulpride, olanzapine or risperidone as the preferred medications with chlorpromazine and other low-potency first-generation antipsychotics providing suitable alternatives. Consideration should be given to previous response to individual antipsychotic medications and relative adverse effect profiles.**

**D** **Following initiation of an antipsychotic medication for acute exacerbation of schizophrenia, the medication should be continued for at least four weeks unless there are significant tolerability issues.**

**D** **Where a partial response is seen after review at four weeks, the medication should be re-assessed after eight weeks unless there are significant adverse effects.**

### Treatment to prevent relapse during remission

**A** **Individuals with schizophrenia which is in remission should be offered maintenance treatment with an antipsychotic medication.**

**B** **For maintenance treatment, prescribers should consider amisulpride, olanzapine or risperidone as the preferred medications with chlorpromazine and other low-potency first-generation antipsychotics providing suitable alternatives.**

**A** **Individuals with schizophrenia which is in remission should be offered maintenance treatment with antipsychotic medication for a minimum of two years.**

**B** **Individuals with schizophrenia who request depot and those with medication adherence difficulties should be offered maintenance treatment with depot antipsychotic medication.**

## Pharmacological and related approaches

### Treatment-resistant schizophrenia

**A** **Clozapine should be offered to service users who have treatment-resistant schizophrenia.**

**B** **Clozapine should be considered for service users whose schizophrenia has not responded to two antipsychotics including a second-generation antipsychotic medication.**

**C** **A trial of clozapine augmentation with a second SGA should be considered for service users whose symptoms have not responded adequately to clozapine alone, despite dose optimisation. Treatment should be continued for a minimum of ten weeks.**

**B** **A trial of clozapine augmentation with lamotrigine may be considered for those service users whose symptoms have had an insufficient response to clozapine alone.**

✓ The decision to switch antipsychotic medication should take into account the risk of destabilisation and adverse effects and the dose of medications should be gradually cross tapered.

**D** **Prescribing high dose antipsychotics should only be considered after adequate trials of antipsychotic monotherapy and augmentation, including a trial of clozapine, has failed.**

### Specific clinical issues

| Concern and/or risk | | Consider |
|---|---|---|
| treatment-resistant schizophrenia with irritability, hostility and aggression | D | clozapine |
| cognitive dysfunction | B | acetylcholinesterase inhibitors |
| persistent negative symptoms | B | augment original antipsychotic (eg clozapine) with antidepressant, lamotrigine, or sulpiride |

### Medication effects on comorbidities

✓ Individuals with schizophrenia which is in remission who have comorbid anxiety symptoms may benefit from a sedative antipsychotic medication.

✓ Individuals who meet criteria for:

- an anxiety state should be treated according to relevant clinical practice guidelines for anxiety and panic disorders.
- depressive disorder should be treated according to relevant clinical practice guidelines for depression, including the use of antidepressant medication.

**B** **Second-generation antipsychotics should be considered for individuals with schizophrenia which is in remission who have comorbid depressive symptoms.**

## Psychological therapies

### Cognitive behavioural therapy for psychosis

**A** **Individual CBTp should be offered to all individuals diagnosed with schizophrenia whose symptoms have not adequately responded to antipsychotic medication and where persisting symptoms and/or depression are being experienced. CBTp can be started during the initial phase, the acute phase or recovery phase including inpatient settings.**

**B** **The minimum dose of CBTp should be regarded as 16 planned sessions.**

✓
- CBTp should be delivered according to an established treatment manual by appropriately trained therapists receiving regular supervision.

✓
- The therapy should be delivered in a collaborative manner.

### Cognitive remediation

**B** **Cognitive remediation therapy may be considered for individuals diagnosed with schizophrenia who have persisting problems associated with cognitive difficulties.**

### Family intervention

**A** **Family intervention should be offered to all individuals diagnosed with schizophrenia who are in close contact with or live with family members and should be considered a priority where there are persistent symptoms or a high risk of relapse. Ten sessions over a three month period should be considered the minimum effective dose. Family intervention should encompass:**

- **communication skills**
- **problem solving**
- **psychoeducation.**

✓ Delivery of family intervention should take account of the whole family's preference for either single-family intervention or multi-family group intervention and should not exclude offspring.

### Social skills training

**B** **Social skills training may be considered for individuals diagnosed with schizophrenia who have persisting problems related to social skills.**

## Perinatal issues

✓ Healthcare professionals should be aware that women with schizophrenia have an increased risk of relapse of illness in the postpartum period, which is increased further if they are unwell during pregnancy.

### Interventions to reduce risk of relapse of illness

**D** **Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, GP, health visitor, mental health services and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand held records. The plan should identify what support should be in place and who to contact if problems arise, together with their contact details** (including out-of-hours)**, and address decisions on medication management in late pregnancy, the immediate postnatal period and with regard to breast feeding.**

### Effects of antipsychotic medication on fetal and infant outcomes

**D** **All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.**

**C** **Women taking antipsychotics during pregnancy should be treated as high risk for gestational diabetes and monitored for blood glucose abnormalities.**

### Breast feeding

**D** **Women who are taking clozapine should not breast feed.**

✓ All breastfed infants should be monitored for sedation and extra-pyramidal adverse effects where mothers are taking antipsychotic medications.

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 131 Management of schizophrenia.** Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk.

This Quick Reference Guide is also available as part of the SIGN Guidelines app.

Available on the App Store

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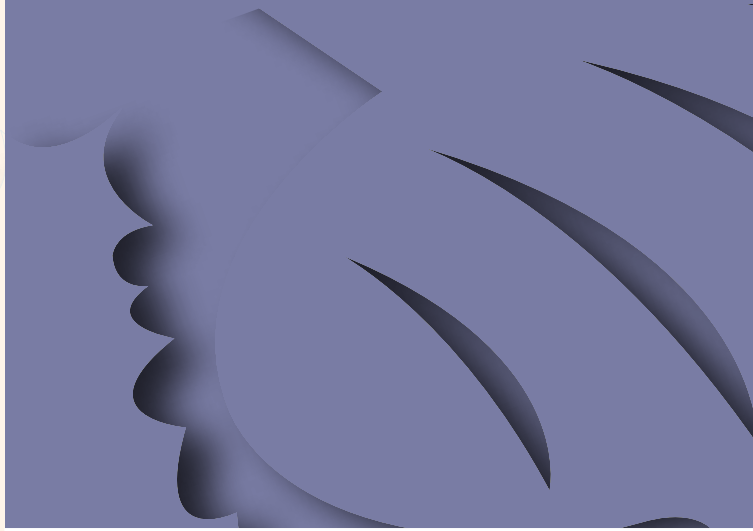

# SIGN 131 • Management of schizophrenia

*Quick Reference Guide* *March 2013*

Evidence