Psychosis/Schizophrenia
Integrated Care Pathway

For use by all professionals working in Mental Health Services and Partner Agencies, for all people with a diagnosis of Psychosis/Schizophrenia in Lanarkshire
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1. Introduction

Schizophrenia is a serious and common mental illness and includes a cluster of disorders characterised by psychotic symptoms that alter a person’s perceptions, and affect their thinking, emotions, behaviours and relationships. If untreated the person can withdraw socially, neglect their personal needs and show marked cognitive difficulties with problems in memory and concentration.

A diagnosis of schizophrenia is still associated with considerable stigma, fear and limited public understanding (NICE, 2009). The first few years after developing psychotic symptoms can be particularly distressing and chaotic and following an acute episode there can be subsequent difficulties with social exclusion, fewer opportunities to return to work/study and challenges in forming new relationships. Typically, when a specialist makes the diagnosis, the symptoms have persisted for at least one month, with a coexistent change in functioning over the preceding 6 months, and these symptoms are not a result of alcohol or drugs. For some people a diagnosis of schizophrenia takes longer.

In adults (16-65 years) there are particular phases that include:

1. **Prodromal phase** which occurs directly before an acute phase when changes in functioning are apparent. Some prodromal features include reduced concentration and attention, depressed mood and lack of motivation and energy, sleep disturbance, anxiety, social withdrawal, suspiciousness, deterioration in role function, irritability.

2. **Acute phase (psychotic episode)** characterised by loss of contact with reality, confusion, perplexity and can include hallucinations, delusions and disorganised speech as well as negative symptoms (odd affect, poverty of speech) or repetitive purposeless stereotypical behaviour. This acute episode requires urgent intervention and treatment, and recent guidance from the DVLA has clarified that those diagnosed with an acute psychotic episode should not drive (see [https://www.dft.gov.uk/dvla/medical/ataglance.aspx](https://www.dft.gov.uk/dvla/medical/ataglance.aspx) ‘At a Glance Guide to the Current Medical Standards of Fitness to Drive’, Feb 2010, p32-35).

3. **Recovery phase** when the person is clinically stable, but could still be at risk of further relapses. The recovery process may be expected to take some time. Recovery in symptoms usually occurs quicker than recovery in functioning.

The exact cause of schizophrenia is unknown but it is felt to be a combination of genetic, neurobiological, personality vulnerability and the environment. It is also associated with considerable physical ill health, with increased risk of diabetes and other cardiovascular difficulties as well as increased risk of suicide.

Schizophrenia usually begins in early adult life and usually earlier in males than females. There are various risk factors for developing schizophrenia, and these include a family history, obstetric complications, neurological infections, cannabis abuse and acute life events. The course of schizophrenia is quite variable with 15-20% of people recovering fully after a single episode. A similar percentage will never fully recover from the first episode with persisting symptoms and/or social disabilities. The remaining 60-70% will have a partial recovery with either a relapsing course and/or some loss of social and personal functional ability.
Scotland’s society is aging. The population based on 2006 figures for the period 2006-2031 for people 65-74 years is projected to rise by approximately 46.7% (GRO, 2009). Therefore a rise in older adults with schizophrenia living longer is also projected.

Many people have found ways to manage their acute difficulties/symptoms and compensate for any remaining problems. Debate however still continues as to how long the duration of anti-psychotic treatment should be, but most studies identify that patients in remission, whether they have suffered a single or multiple episodes, should be followed up for a minimum of 2 – 5 years.

Research carried out by the Royal College in 2002 showed that patients with Schizophrenia are more likely to misuse alcohol and they are 6 times more likely to use illicit drugs, mainly amphetamine based drugs including heroin, ecstasy, cocaine, amphetamine and cannabis. In particular newer research has identified the increased risks of smoking high potency cannabis in the development of psychoses (Forti et al BJ Psych Dec 2009). When patients have a coexistent drug and alcohol abuse problem we refer to these individuals as patients with dual diagnosis problems. Having a dual diagnosis of drug and alcohol problems as well as schizophrenia can increase the risk of suicide and it is important to identify this problem and to ensure that treatment approaches address this risk quickly.

Studies show as many as 1 person in 20 with schizophrenia will complete suicide but identifying and recognising risk factors for suicide in patients with schizophrenia has been shown to have the greatest impact in reducing the risk. The following risk factors are associated with completed suicide:

♦ Recent suicidal ideation
♦ Fear of the impact of the illness on mental functioning
♦ Depression.

Interventions that actively treat affective symptoms, improving adherence to treatment and maintaining vigilance regarding risk factors are important.

Although the majority of treatment for schizophrenia is managed by secondary care, GPs have a vital role in contributing to the management of this complex disorder. Screening and detection as well as physical health monitoring are important components in reducing ill health. Regular updating and monitoring of the primary care register of people with severe mental illness (SMI) is an important measure to ensure people receive opportunities for early detection of physical health problems and to advise on lifestyle choices including diet, exercise and stopping smoking.

Interest in the early detection of psychotic episodes and newer research which has shown that the duration of untreated psychoses is related to predicting a poorer outcome, has stimulated the development of tools to aid detection and to ensure quick referral to secondary care services. In particular, new research has focussed on the detection of the prodrome, mainly the period of illness before full blown psychotic symptoms are evident as being important in reducing future morbidity and improving prognosis. This exciting development in Schizophrenia research has ensured that there is a more positive outlook on this illness and is discussed further in the ICP.
In Lanarkshire the promotion of a recovery-focused approach in psychosis and schizophrenia includes advice on compliance with medication and keeping well plans that are tailored to the individual’s needs and which take account of the social and family supports available. Relatives, friends, and carers of people with psychosis or schizophrenia are important during the assessment process and in the long term successful delivery of effective treatments. With a focus on long term recovery and promoting people’s choices about their management, some of the more debilitating problems associated with this diagnosis may be prevented from developing.

Psychological techniques that promote adherence, including CBT and relapse prevention, as well as education of the individual and carers are also recommended to reduce relapses and to promote periods of remission and well-being. As continuous or maintenance medication could protect individuals by preventing, delaying or modifying the risk of psychotic relapse (with the greater choice of medications including typical and atypical antipsychotic drugs available), discussion with the psychiatrist as to the medication options forms part of the ongoing negotiation with patient and doctor.

Lastly, approximately 30% of patients will develop treatment resistance in that there are still ongoing symptoms of psychoses, even after 2 antipsychotic medications have been tried at therapeutic doses. In these instances Clozapine has superior benefit to patients and advice as to the introduction of Clozapine and blood monitoring that is required is also discussed in the ICP.

1.1 Rationale for Developing the ICP

The ICP was developed from the NHS QIS standards for mental health integrated care pathways, which specify both generic and schizophrenia-specific care standards. The generic standards are contained in the NHS Lanarkshire Generic ICP and the condition specific standards in this Psychosis/Schizophrenia ICP. These condition specific standards specify care and interventions we would generally expect to be considered for people who may be at risk of developing with a diagnosis of psychosis or schizophrenia and focus on early intervention; psycho-educational, psychological and psychosocial therapies; and medication. The ICP has been put together by a local development group consisting of NHS staff, service users and carers, local authorities, voluntary organisations and the independent sector (see Appendix 1, Psychosis/Schizophrenia ICP Development Group Members). In Lanarkshire various terms are used to describe the people who use mental health services which include, “clients”, “patients” and “service users” and to simplify this we have used the single term “patients” in the Generic ICP and this condition-specific ICP.

1.2 How to use the Lanarkshire Psychosis/Schizophrenia ICP

The Generic ICP will automatically be used for people accessing mental health services in Lanarkshire (with the exception of those people with depression who do not require specialist assessment and treatment in which case only the condition-specific ICP for depression will be used). For all others the Generic ICP will apply and if appropriate, this condition specific ICP will also be used as required.
These ICPs are based on a stepped model of care as described in the Lanarkshire Mental Health Strategy. They encompass a culture and values which aim to enable person-centred recovery and strengths-based focus with a move towards positive management of individual risk, maximising choice and access to evidence-based interventions (see Appendix 2, Guidance and Policy Base).

This ICP is designed to be used for any person over the age of 16 who presents with first episode psychosis/at risk of developing psychosis or a primary diagnosis of schizophrenia. Additionally, people with learning disabilities can access services via the Lanarkshire Learning Disabilities Service. For young people aged 16 or under services can be accessed through the Lanarkshire Child and Adolescent Mental Health Service. The ICP should not be used for patients where the primary diagnosis is something other than psychosis or schizophrenia, e.g. puerperal psychosis, psychotic depression, severe personality disorder or indeed where there are other physical causes to explain the psychotic symptoms.

The ICP is intended to provide a standard model of good care based on the current evidence base and expert opinion. It is important to note that the ICP is a guide to good care but it should never replace sound professional judgement. The professionals’ assessment and judgement will always override the advice of the tool where this is necessary. The ICP is part of the patient record and as with all such records, it will be private and confidential with access governed by the usual rules of confidentiality.

By using this ICP we will be able to produce data about the care and interventions provided to people in Lanarkshire with psychosis/schizophrenia. This information (variance data), will allow us to compare the actual care and interventions given with those planned in the ICP and enable us to identify areas where the ICP should be modified to improve the quality of care provided. The variance information will also identify resource issues, gaps in service availability and future staff training and supervision requirements.
2. Early Intervention

2.1 Algorithm for Early Detection and Intervention of Psychosis

Initial presentation to Primary or Secondary Care Services by individual or concerned family members

Multidisciplinary assessment including Psychiatric, Psychological and Physical health which should involve an assessment of capacity
Also address 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 (NICE 2005)

Possibly at risk of developing psychosis? Screening for At Risk Mental State (ARMS) using assessment tool, e.g. CAARMS

At risk of developing psychosis?

NO

First Episode Psychosis?

Inclusion/exclusion criteria, i.e. age, LD, sig. brain injury, neurological disorder

Immediate Risk?

NO

CMHT/Crisis Service

YES

Offer the following in a low stigma environment (IEPA, 2005) within Primary Care:

1. Engage and assess.
2. Offer regular monitoring of mental state and offer support.
3. Offer specific treatment for syndromes (i.e. depression, anxiety or substance misuse) and assistance with problem stresses such as interpersonal, vocational and family stress if present.
4. Provide psycho-education and encourage to develop coping skills for sub-threshold psychotic symptoms.
5. Offer family education and support.
6. Provide information in a flexible, careful, and clear way about risks for mental disorders as well as about existing syndromes.
7. Possible consideration of low dose atypical medications on a therapeutic trial basis for a limited period as a last line of treatment.

Transition to psychosis?

YES

NO

First episode more than 3 years ago?

Refer back to referer or refer on to appropriate service

If physical signs consider:

- Substance misuse
- Liver function abnormalities
- Systemic infection
- Nutritional deficiencies
- CNS abnormalities
- Metabolic disorders
- Gambling abnormalities
- Drug toxicity

(See: French and Morrison, 2004)

Offer the following interventions (NICE, 2005; IEPA, 2005) within Secondary/Tertiary Care:

1. Urgent referral to a local community based secondary mental health service (early intervention service or CMHT).
2. Carry out full assessment and develop a care plan which should include a crisis plan.
3. Offer early intervention services to all people with a first episode or first presentation of psychosis irrespective of age or duration of untreated psychosis.

Initial Treatment:

1. Atypical antipsychotics (start low, go slow). Offer ECG first under certain circumstances.
2. Monitor and record efficacy, side effects of treatment, adherence, and physical health.
3. Record the rationale for continuing, changing or stopping medication and the effects of such changes.
4. Carry out a trial of the medication at optimum dosage for ≥6 weeks.
5. Cognitive Behavioral Therapy (CBT)
6. Family Therapy may be indicated when there is a high degree of distress in the family.
7. Supportive crisis plans to be put in place in order to facilitate recovery.
8. Specific psychosocial strategies should be employed when poor adherence, family stressors, and increased suesite risk and substance misuse occur.
9. Provide a flexible and practical support to families.
10. Structured group programmes tailored to the current needs of the patient should be available.

Recovery (6-18 months — critical period of 5 years):

1. Psychological and Psychosocial Treatments should be core elements in the critical period.
2. Families should be provided with ongoing support and information.
3. Strategies offered within a case management model may include supportive psychotherapy, with an outline problem solving orientation, and negotiating occupational pursuits, including employment and/or education (note that there is no evidence base for supportive psychotherapy alone).
4. Multi-family groups which have a psycho-educational focus should be provided.
5. Depression, suicide risk, substance misuse and social anxiety in the patient should be identified and actively treated.
6. Early warning signs of relapse should be discussed with the patient and family.
7. Involuntary community treatment may be unavoidable in certain circumstances and should be considered to be time limited, subject to frequent review and include a planned termination date.
8. Patients should remain in comprehensive, multidisciplinary, specialist mental healthcare throughout the early years of psychosis and, once their acute symptoms improve, not be discharged or transferred to primary care without continuing specialist involvement.
9. For a subgroup of patients long-term psychotherapy may be indicated.
10. Individuals and families with recent experience of early psychosis should be encouraged to participate in the development and monitoring of early psychosis services.
2.2 Background, Rationale and Benefits of Early Intervention

**QIS Schizophrenia ICP Care Standard 30:** In the early stages of schizophrenia an early intervention model of care is delivered.

It is recognised that Schizophrenia causes a high degree of disability and active psychosis was ranked as the third most disabling condition worldwide (WHO, 2001). It was classed as more disabling than paraplegia and blindness and was considered to be less disabling only to quadriplegia and dementia. To address this difficulty the World Health Organisation and the International Early Psychosis Association (IEPA) developed an international consensus statement (WHO & IEPA, 2002) which states:

“Yet, in spite of the availability of interventions that can reduce relapses by 50% not all affected individuals have access to them, and when they do, it is not always in a timely and sustained way. Among the goals of care to these people, the identification of the illness and its treatment, as early as possible, represents a high priority.”

In Scotland we are beginning to recognise that early intervention in psychosis is important and this is evidenced through ESTEEM services (for 16-35 year olds) and the EDIE2i trial in Glasgow, and there is an early psychosis support service at the young people’s unit in Edinburgh which is available to 14-19 year olds. However at the moment Lanarkshire does not provide these specialist services and within generic adult mental health services few people experiencing early psychosis are referred to psychological services. Similarly few, if any clinicians in Lanarkshire are trained in delivering treatments to individuals with early psychosis.

Early intervention in psychosis, whether it be within specialist or generic services, follows the clinical staging model seen in other areas of healthcare. Conditions such as Diabetes and Coronary Artery Disease provide useful models where health professionals have significantly shifted their focus towards health promotion, early intervention, and collaborative management (Lester & Shiers, 2009). Aims of early intervention in first episode psychosis include:

♦ Reducing the Duration of Untreated Psychosis (DUP). Studies have established that longer DUP is a marker and independent risk factor for poor outcome (IEPA, 2008).

♦ Reducing the likelihood of hospital readmissions. Given that schizophrenia has been classed as the third most disabling condition worldwide and that the more episodes people experience as well as longer duration of untreated psychosis leads to poor outcomes, it makes sense to target the earliest stages to prevent onset and where this is not possible, to prevent re-hospitalisation.

Early intervention for psychosis focuses on the detection and intervention of the initial symptoms of psychosis. Individuals who experience psychotic symptoms are described as being in the ‘psychotic phase’ during the time that they experience their first psychotic symptoms (NICE, 2009). Early detection and intervention within this stage are important to reduce the duration of untreated symptoms and improve outcomes.
Early intervention also relates to the prevention of psychosis in a separate group of people who are considered at ‘ultra high risk’ (UHR) of developing psychotic symptoms. Those who meet criteria for the UHR stage are described as having an ‘At Risk Mental State’ (ARMS) and are often described as being in the ‘prodromal phase’ – before symptoms of an acute psychosis are apparent when a preventative approach can be used. Individuals who meet ARMS criteria can be seen within primary care or specialist services by people who have been trained within this specialist area. GPs play an important role in the early detection of both groups.

**Benefits of Early Intervention:** If effective interventions are provided early, potential benefits include reduction in:

- Disruption to the family
- Disruption to employment or education
- Need for inpatient care
- Need for high doses of antipsychotic medication
- Risk of relapse
- Risk of suicide
- Total cost of treatment

Delays in access to treatment can be caused by lack of recognition of the prodromal phase of psychosis, poor recognition of psychotic symptoms, lack of knowledge of services available, stigma associated with psychosis and fears around treatment.
3. Primary Care Management

3.1 Screening, Prevention, and Detection

When individuals initially present to primary care services or their families express concern, an initial assessment is carried out. Identification of early psychosis is important to reduce the duration of untreated psychosis. Training for GP’s on identifying early psychosis has been proposed within Lanarkshire.

If after the assessment is completed early psychosis is identified or suspected, the individual should be urgently referred to a specialist team (Early Intervention Service or CMHT) trained in early psychosis within secondary/tertiary care.

♦ If after assessment is carried out an At Risk Mental State (ARMS) is suspected a referral should be made to a primary care team for assessment.
♦ If an At Risk Mental State is detected then appropriate treatment should be carried out as recommended below within a primary care team.
♦ If the individual has experienced a first episode of psychosis in the past 3 years or it is the individual’s first presentation to services, they should be referred to a secondary or tertiary care team trained in working with first episode psychosis (NIMHE, 2008).

3.2 Treatment Recommendations

Treatment Environment: It is recommended that early intervention services should be provided within a low stigma environment (IEPA, 2005). The international consensus statement states that care should be given in the community and strategies should be developed to minimise the use of involuntary treatments in early psychosis (WHO & IEPA, 2002). Research has shown consistent evidence that specialist early intervention services produce clinically significant benefits for a number of critical outcomes including relapse, re-hospitalisation, symptom severity, satisfaction and quality of life when compared with standard care at 18-24 months follow up (NICE, 2009).

Staff Training, Supervision and Support: Identifying first episode psychosis can be challenging and helping GP’s identify this will help to reduce the duration of untreated psychosis which leads to poorer outcomes. Working effectively with young people with early psychosis can be challenging and requires a high level of expertise. Ongoing staff training, supervision and support is essential to maintain clinical standards as research rapidly advances within this area (Orygen Research Centre, 2004).

At Risk Mental State: Treatment recommendations suggest that patients meeting ARMS criteria should be offered Cognitive Behavioural Therapy (CBT) as described by French & Morrison (2004) for symptoms of depression and anxiety, which they commonly experience. Monitoring of their symptoms within the context of a possible transition to psychosis may also help reduce duration of untreated psychosis (Morrison et al., 2004). Identification of this group requires training. Questionnaires are available and the most reliable and widely used one of these is the Comprehensive Assessment of At Risk Mental States (CAARMS) (Yung et al., 2005).
Psychological treatments for people at risk of psychosis should be provided by Clinical/Counselling Psychologists and Psychological Therapists working at a ‘high intensity’ level with clinical groups suffering from difficulties of a moderate severity within specialist primary care or specialist ARMS services (The Matrix, 2009). Treatments suggested for those at risk (NIMHE, 2008) include:

- First line treatments should comprise less intrusive treatment including psychological interventions or medication which targets presenting problems such as sleep, anxiety and depression.
- First stage intervention may be monitoring of difficulties to help reduce duration of untreated psychosis should transition to psychosis occur.
- If symptoms and distress continue, the next option would be targeting presenting problems with psychological interventions and/or pharmacological interventions.
- If the individual continues to move towards psychosis, despite these interventions, antipsychotic medication should then be considered. If transition to psychosis does occur, a referral should be made to the specialist team trained in early psychosis.

The most common co-morbid problems experienced by those at ultra high risk of developing psychosis are social anxiety, generalised anxiety, panic disorder, obsessive-compulsive symptoms, post traumatic symptoms and substance use (Patterson et al., in Addington et al., 2006). If any of these difficulties are present, they should be addressed and treated. In addition, depression should always be seen as a major target for therapeutic intervention. Treating attenuated symptoms is important within at-risk individuals and French & Morrison (2004) developed a cognitive approach to addressing these symptoms (Bowe et al., in Addington et al., 2006).

If the assessment reveals symptoms of psychosis, an urgent referral should be made to secondary or tertiary care teams who are trained to work with this client group. Treatment should be offered as recommended by the NICE and IEP clinical guidelines (see early intervention algorithm). If there are other risk factors such as suicide risk or illicit drug use, they should be taken into account and treated in an appropriate way. To assess suicide risk, use the Lanarkshire Suicide Assessment and Treatment Pathway.

### 3.3 Physical Health Monitoring

GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia (via practice registers) at least once a year (NICE 2009). Work is being currently being carried out with primary and secondary care services to ensure a consistent approach to physical monitoring.

### 3.4 Management in Primary Care

NICE suggest that people whose symptoms have responded to treatment should have the option to be managed in primary care services and be able to be referred to secondary care should issues arise such as:

- poor treatment response
- non-adherence to medication
- intolerable side effects from medication
- comorbid substance misuse
- risk to the person or others.
4. Secondary Care Management

4.1 Assessment, Diagnosis and Treatment of First Episode Psychosis

Assessment is carried out using the NHS Lanarkshire Generic ICP with the following condition specific considerations:

♦ Diagnostic uncertainty characterises the early phase of psychosis and a complete multidisciplinary clinical assessment adopting a bio/psycho/social approach is crucial.

♦ If psychosis is not apparent but that person fulfils at risk criteria for developing psychosis, a referral should be made to a primary care team for an ‘at risk’ assessment.

If the patient is experiencing symptoms of psychosis, a multidisciplinary bio/psycho/social care plan should be developed to meet the needs of the patient and his/her family members, and should include a crisis plan. If care is provided from generic services, there should be strong links between child and adult services to ensure a smooth transition between services for those developing psychosis before the age of 16, and strong links with local authority services such as back to work services should exist. The early psychosis team should provide input for at least the first three years.

There are difficulties in determining an accurate diagnosis and although assessment may not lead to a diagnosis treatment should not be delayed. It may be difficult to assess an individual who is in an acute psychotic state and in this case they should be adequately contained. However, if an assessment can be carried out safely and effectively without containment, it may take place in the person’s home, in a community based clinic, or other location acceptable to them.

Ideally, the assessment of first episode psychosis should be completed before antipsychotic medication is administered. Wherever the patient is being managed, there should be a 24 hour period at least where the client is free of medication so that continued assessments are made in terms of the evolving mental state and to allow for routine biological investigations. This reduces the possibility of a misdiagnosis and inappropriate treatment and allows for psycho-education about psychosis. In addition, it ensures that the message is given to the patient and family that decisions about treatment are thoughtful and considered. It can be useful to conduct more than one assessment by different clinicians to ensure a comprehensive assessment summary. This should be arranged in a way that maintains the patient’s sense of continuity of care without causing confusion.

The assessment should take into account the phase of psychosis, level of insight, negative symptoms, cognitive function, comorbidity, level of psychosocial functioning, home environment, family dynamics, adaptive response of the family to the illness, and cultural factors. It is important that a risk assessment is carried out which involves assessment of suicide, risk of violence and aggression (especially where coexisting substance abuse is occurring) and other risk. To assess suicide risk, use the Lanarkshire Suicide Assessment and Treatment Pathway.
**Features of Early Psychosis:** people experiencing a first episode tend to be:
- Aged between 15-30
- Less informed about mental illness
- Agitated or distressed by unfamiliar symptoms which can be frightening and confusing
- Unaware of mental health services that are available, and how they operate
- More likely to deny the existence of an illness and have a sense of invulnerability
- Exhibiting normal adolescent behaviours which can mask symptoms
- Experiencing an illness which is still evolving, making diagnosis more difficult
- Uncertain about or afraid of treatment including medication and hospital admission
- More susceptible to side effects of psychotropic medication due to lack of previous exposure to these medications.

**Physical Investigations** - recommended before commencing antipsychotic medication:
- Urine tests; drug screen, urine microscopy.
- Blood tests; full blood examination, ESR, fasting blood glucose, renal function tests, electrolytes, serum calcium and phosphate, liver function tests, thyroid function tests.
- Body Mass Index.
- CT brain scan or, ideally, MRI (usually preferable to wait until the psychosis has settled so that clients can tolerate the procedure).
- EEG (should be used if there is a history of epilepsy, birth trauma, head injury, learning disability or significant findings on CT or MRI).

**Diagnosis/Formulation** - following assessment, a multidisciplinary team (MDT) formulation should be developed and treatment should be based on the formulation. It is recommended that a Clinical Psychologist lead the MDT formulation (Clark, 2010).

**Early Psychosis Treatment in Lanarkshire:** Currently, psychiatric teams in Lanarkshire provide a service to individuals who experience first episode psychosis, and where possible, patients needs are identified proactively, with referral to appropriate clinicians including psychologists, psychiatrists, community nursing and occupational therapy facilitated. Training has been recently delivered within Lanarkshire amongst Clinical Psychologists on early warning signs monitoring for psychosis. Treatment recommendations (NICE, 2009; IEPA, 2005) for people who experience their first episode of psychosis are:

1. **Medication - Low dose typical antipsychotics**
2. **Psychological therapies such as CBT and Family Therapy.**

**Initial Treatment in the acute phase**

“Clients and their families/carers need to be seen as partners in care rather than as passive recipients” (Orygen research centre, 2004).

1. **Medication** - see algorithm for First Episode Psychosis in Medication Section:
   - Ideally no prescribing of antipsychotics within the first 24-48 hours in a young person with first episode psychosis so that a more accurate assessment of the symptoms can be carried out.
   - Atypical antipsychotics (‘start low, go slow’). Offer ECG first under certain circumstances.
Monitor and record efficacy, side effects of treatment, adherence, and 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.

Guidelines as to the dosage of medication used to treat an acute episode is contained within the Royal College of Psychiatrists Consensus Statement 2006 (see http://www.rcpsych.ac.uk/files/pdfversion/CR138.pdf).

2. Psychological interventions - should be core elements in the critical period. Psychological interventions can help to reduce the severity of acute psychotic symptoms (World Health Organisation, 1997).

- Cognitive Behavioural Therapy (CBT) e.g. as described by Morrison et al., (2004) or Chadwick (2006).
- Family Therapy may be indicated when there is a high degree of distress in the family.
- Behavioural Family Therapy (BFT) - a service user ‘family’ centred psychological treatment. The general aim of BFT (which is also called Family Focused Therapy in some countries) is to assist the family address and solve a range of issues, to minimise stress, enhance coping and therefore reduce the frequency of relapse and re-hospitalisation.

In Lanarkshire training in Behavioural Family Therapy has been provided for a number of years to professionals working in mental health. Relapse prevention strategies have been recommended for people who experience First Episode Psychosis (IEPA, 2005; WHO & IEPA, 2002). Training has been recently delivered in Lanarkshire amongst Clinical Psychologists on early warning signs monitoring for psychosis. (See Psycho-education, Psychological and Psychosocial Section for further information on therapies).

Family interventions in the acute phase can involve a crisis intervention model where the focus is on education to reduce carers stress and confusion while maximising their support of the patient (Kulkami and Power, 1999). Mental health professionals should remain sensitive to trans-cultural and language issues and respond appropriately (EPPIC, 1997). Families may experience a lot of blame during this time and therefore it may be helpful not to have a detailed examination of any precipitating and perpetuating factors until the acute episode has settled. Interventions include:

- Supportive Crisis Plans put in place in order to facilitate recovery.
- Specific psychosocial strategies employed when poor adherence, family stresses, increased suicide risk and substance misuse occur.
- Providing emotional support and practical advice to families.
- Structured group programmes tailored to the immediate needs of the patient. Group interventions can be offered once an acute episode has started to resolve. Group programs such as described by the EPPIC manual ‘working with groups in early psychosis’ (2000) and by Miller & Mason (1998).
Home based treatment versus Hospital treatment

Patients should be cared for in the least restrictive setting that is likely to be safe and to allow for effective treatment (American Psychiatric Association, 1997). Clinicians should not assume that every patient with first episode psychosis will need to be admitted to hospital (Orygen Research centre, 2004). The following guidelines were taken from a briefing (23) paper (The Sainsbury Centre for Mental Health, 2003):

♦ Wherever possible, acute and crisis care should be provided at home.
♦ Where needs indicate a period of care away from the home, this should be provided in a suitable, safe, age appropriate environments, which are not unnecessarily restrictive.
♦ The use of the Mental Health Act should be avoided where possible.

If resources are available and the person’s family or carers are coping, then treatment can be initiated safely in the community. This avoids the anxiety, loss of control, increased stigma and trauma which can accompany hospitalisation (Orygen Research Centre, 2004). However, a significant proportion of patients with a first episode of psychosis will need urgent intensive care in hospital to minimise serious risks of self harm or violence (McGorry and Power, 1999).

Transition to the Recovery Phase

Services should ideally provide integrated care from the early stages to the late stages of recovery. Most young people who experience early psychosis will recover from the initial acute episode but remain at risk of relapse. A positive transition from acute care to continuing care will help improve the chance that such a relapse does not occur or that, if it does, the individual seeks early help. Early assignment of a case manager will assist in facilitating transition from one phase of care to another, and ensures that the client feels that continuous care is being provided (Orygen Research Centre, 2004).

4.2 Psychosis Recovery Phase (6-18 months - critical period of 5 years)

The focus of management in the recovery phase is to assist people who have experienced psychosis to understand psychosis and to develop a range of skills which will enable them to achieve their goals for the future (EPPIC, 2001). The recovery phase can be considered in two parts:

1. Early Recovery (first 6 months following acute treatment)
   ♦ Medication as per First Episode Psychosis algorithm and notes in Medication Section.
   ♦ Support for the patient and family, with continuing psycho-education. The idea of potential relapse should be introduced, through identifying possible early warning signs of relapse which were experienced or perceived during the initial prodrome. Early warning signs should be identified at this stage and an action plan drawn up as is described by Smith (2008).
   ♦ It can be helpful to establish an area of functioning that has not been adversely affected and use this as a base for re-establishing recreational or occupational skills and other strengths.
Coping strategies which increase the patient’s sense of mastery, such as distraction and relaxation techniques, can be taught, and explanatory models such as stress vulnerability further explored.

It is important in a young person who is developing their own identity that the psychosis they experienced is differentiated from who they are as people.

Focus on prevention and treatment of secondary morbidity (see the Matrix).

Increase the perception of control over the psychosis. This can be done within a CBT framework as described by Morrison et al., (2004) or Chadwick (2006).

Continuing involvement of the case manager from the acute to the recovery phase allows monitoring of progress and an opportunity to understand the patient’s experience of psychosis.

2. **Late Recovery** (typically extending to 18 months)

- Consider ceasing medication. Note that medication should not be terminated at the same time as case management is withdrawn.

- Preventing and treating comorbidity including substance misuse, treating psychosis symptoms, adaptation to illness, preventing future episodes of psychosis, increasing sense of self and self esteem.

- Cultural issues should be taken into account.

- Strategies offered within a case management model may include supportive psychotherapy (supportive psychotherapy is not a therapy in its own right and should only be used in addition to other psychological therapies), with an active problem solving orientation, and negotiating occupational pursuits, including employment and/or education.

- Multi family groups which have a psycho-education focus should be provided.

- Depression, suicide risk, substance misuse and social anxiety in the patient should be identified and actively treated.

- Early warning signs of relapse should be discussed with the patient and family and an action plan developed.

- Involuntary community treatment, although undesirable may be required in certain circumstances and should be considered to be time limited, subject to frequent review and include a planned termination date.

- Patients should remain in comprehensive, multidisciplinary, specialist mental healthcare throughout the early years of psychosis and, once their acute symptoms improve, not be discharged or transferred to primary care without continuing specialist involvement.

- Individuals and families with recent experience of early psychosis should be encouraged to participate in the development and monitoring of early psychosis services.


- Individual family work such as BFT as described previously.

- Other therapies such as CAT and ACT have been implicated in the recovery phase of psychosis and have a developing evidence base. Other therapies too may develop a sound evidence base and should be recognised as such when included in national and international guidelines.

- For a subgroup of patients long-term psychological therapy may be indicated. (Also see Section 7: Recovery and Keeping Well).
3.3 Diagnosis of Schizophrenia (from NICE)

About 15-20% of people do not go onto have any further episodes, but seven out of 10 people have at least two acute episodes. Of these people, some recover completely between episodes while others have ongoing symptoms and a number of people (15-20%) are never free of symptoms. Many people are unsure about their diagnosis and may need help with this and they should be supported if they seek a second opinion on the diagnosis.

Most people with schizophrenia will be offered long term input from secondary care mental health services. Treatment interventions during the first 5 years of illness may have the largest impact on the course and outcome, however at all stages and throughout the range of recovery, physical, psychological and social treatment interventions may be of considerable benefit to patients and their carers.
5. Delivery of psycho-educational, psychological and psychosocial therapies

QIS Schizophrenia ICP Care Standard 31: Psycho-educational, psychological and psychosocial therapies, which should include cognitive behavioural therapy (CBT) where indicated, are offered and delivered in a timely manner.

5.1 Psycho-education

Patients and families should have ongoing support and information. Education about psychosis is essential from the earliest stages of a psychotic disorder and should include the following (WHO, 1997):

♦ This is well recognised and familiar to mental health professionals.
♦ Help is available and accessible.
♦ Current anxiety can be relieved, usually rapidly.
♦ Recovery is to be expected.
♦ No-one is to blame for the psychosis.
♦ It is important to minimise stress and stimulation during acute episodes.
♦ Agitation, strange beliefs and strange behaviour are linked with the psychosis. Families and carers can be helpful by not arguing with strange beliefs or trying to convince individuals they are wrong and avoiding confrontation with and criticism of the individual.

5.2 Psychological interventions for Psychosis/ Schizophrenia

The delivery of Psychological Interventions in Lanarkshire is based on the principle of matched care, whereby individuals referred into the service are matched to the appropriate level of treatment for the level of complexity of their difficulties (NHS Lanarkshire Psychological Therapies Strategy, August 2009). In addition the recently published Matrix document from the Scottish Government provides health boards with a comprehensive review of the evidence base for psychological interventions and guidance as to how these should be delivered (i.e. level of training required to deliver therapy, amount of supervision required) (see Appendix 3, Matrix Schizophrenia evidence base).

This diagram shows the stages involved in the delivery of therapies which include a thorough psychological assessment and formulation and refomulation throughout the course of therapy.
Several psychological therapies/interventions are evidence based for psychosis/schizophrenia and are detailed below. The availability of these interventions in Lanarkshire (together with the training and supervision requirements), will be determined through the ongoing implementation of the Psychological Therapies Strategy.

1. **Prodromal Monitoring** - Prodromal Monitoring, which can also be called early warning signs monitoring/detection of relapse, is a specialised assessment and intervention carried out with the person experiencing psychosis, and family member or carer. The general aim is to assist them to identify the earliest and most reliable signs and symptoms that occur before a relapse i.e. becoming unwell. Once these have been identified an action plan is prepared which lists agreed actions which will be taken to minimise the possibility of (or prolong the time to) a relapse. To assist the patient use the action plan, a daily diary is developed and the reliable signs and symptoms can be monitored each day. With the patient’s consent the action plan is shared with everyone involved in their care.

2. **Behavioural Family Therapy (BFT)** - BFT is a patient ‘family’ centred psychological treatment focusing on:
   a) Providing information to the family
   b) Enhancement of specific skills in particular communication skills and problem solving
   c) Identification of individual goals
   d) Arranging family meetings/discussions
   e) Monitoring the reliable signs and symptoms prior to relapse.

   The general aim of BFT (also called Family Focussed Therapy) is to assist the family to address and solve a range of issues, to minimise stress, enhance coping and therefore reduce the frequency of relapse and re-hospitalisation.

3. **Cognitive Behavioural Therapy (CBT)** - CBT is one of a range of psychological therapies which targets a patient’s problems and difficulties. The focus is on monitoring their thoughts, emotions, behaviours, beliefs and experiences and evaluating these systematically to bring about positive change. CBT for psychosis involves developing a shared formulation with the patient about their difficulties and identifying shared goals for their therapy. Morrison et al. 2004 describe in detail a formulation based approach to CBT for psychosis.

5.3 **Other psychological interventions**

There are other psychological interventions which are developing an evidence base in working with psychosis/schizophrenia. One example of this is:

- **Acceptance and Commitment Therapy (ACT)** (described by Hayes et al. 1999) is being increasing developed for use with individuals and groups who have experienced psychotic symptoms and the evidence base appears to be growing for this form of therapy (Bach and Hayes, 2002; Gaudiano and Herbert, 2006). ACT takes a stance of acceptance and committed action helping individuals to develop a more mindful approach to their psychotic/unusual experiences and belief systems and to develop more commitment to their values and take actions towards more value based behaviours. ACT can help individuals to develop more psychological flexibility towards their difficulties/experiences and enable a more value-based recovery.
Psychological Therapy – Psychological therapy can also be provided to patients with psychosis/schizophrenia (where appropriate their families and carers) for personal problems which may or may not adversely affect their experience of psychosis/schizophrenia, e.g. history of abuse in childhood, Post Traumatic Stress Disorder, anxiety states, substance misuse. Boxes 1 and 2 below describe the questions to consider for use of Psychological Therapy.

Box 1. Questions for Patients
1. Could the patient have difficulty adjusting to their diagnosis?
2. Could anxiety/depression be affecting them?
3. Could there be underlying cognitive impairments?
4. Could substance misuse be causing problems?
5. Are there stressful family dynamics or home circumstances that could be affecting the patient?
6. Are there problems with engagement with services or adherence to the care plan?
7. Are there frequent crises?
8. Do the patient’s symptoms worsen readily or are they relapse prone?
9. Are there difficulties with social interaction/social skills?
10. Has there been early trauma giving rise to ongoing difficulties?
11. Are there challenging behaviours?

Box 2. Questions for Family Member and Carers
1. Do carers have adequate information about the patient’s difficulties?
2. Do carers have difficulty in accepting the diagnosis or care plan/treatment advice?
3. Do carers need help to manage aspects of the patient’s behaviour or relationship with them?

A Psychological/Psychosocial Interventions Record Form has been developed to record all interventions offered/recommended and details commencement and completion dates and their outcome (see Appendix 4).

5.4 Occupational Therapy based Psychosocial and Psychological Interventions
In a person’s journey to recovery from psychosis they should have the opportunity to access psychosocial interventions at the earliest opportunity. In community teams and acute inpatient wards this role is often carried out by occupational therapists. Occupational therapy is a collaborative approach and aims to build on strengths of people in order to achieve recovery. The patient and the occupational therapist will identify goals for occupational therapy intervention. Standardised assessments such as the Assessment of Motor and Process Skills (AMPS), Occupational Therapy Self-Assessment and the Canadian Occupational Performance Measure are used to guide and evaluate interventions provided.

The areas which are considered for occupational therapy intervention are:
- Self care (primarily safety in personal care and domestic activities)
- Leisure (increasing social inclusion)
- Work (vocational rehabilitation)
Interventions are tailored to the needs of the individual and may take place on a one-to-one or group setting.
People who experience psychosis/schizophrenia generally suffer from reduced occupational performance. Studies show that health and well-being is influenced by the person’s capacity to engage in life’s occupations. Withdrawal or reduction in occupational performance can lead to increased dependency; lack of confidence, reduced self-esteem and increased distress. Occupational therapy intervention is aimed at restoring or enhancing an individual’s ability to be independent and exercise choice and control over his or her daily activities which has been proven to increase productivity and life satisfaction.

Vocational rehabilitation is an area of occupational therapy specialty. People who experience psychosis and schizophrenia as a population are less likely to be in paid employment. Occupational therapists having knowledge of psychiatric, psychological and physical conditions are able to provide a holistic intervention aimed at gaining and maintaining employment. The occupational therapist achieves this by using activity which is meaningful to the person to achieve recovery. Occupational therapists are trained to analyse activity and provide interventions which are within the capabilities of the person. Research shows that occupational therapy intervention improves social skills and enables people to return to education or employment. This is achieved through adapting cognitive and psychosocial activities to facilitate functional performance in the community (Gutman et al 2009).

Occupational therapists also deliver interventions such as Mindfulness Based Cognitive Therapy which has a developing evidence base for reducing distress and problematic belief convictions caused by psychotic symptoms (auditory hallucinations) (Taylor et al 2009). Occupational therapists work to develop innovative, cost effective practical services that allow people with psychosis/schizophrenia to take care of themselves and live satisfying and purposeful lives in their communities.

5.5 Arts Therapies

NICE has reviewed the evidence for the use of art therapies in providing psychosocial interventions in relation to the care and treatment of people with schizophrenia. The review found that arts therapies demonstrate consistent efficacy in the reduction of negative symptoms in both inpatients and outpatients. NICE further notes that the therapeutic benefits of arts therapies were shown to last at least up to 6 months following treatment (and was even enhanced). An economic analysis has also shown arts therapies to be cost effective (NICE, 2009).

NICE recommends that arts therapies should be provided by a Health Professions Council registered arts therapist with previous experience of working with people with schizophrenia. The interventions 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 patient. They can be offered to all people with schizophrenia either during the acute phase or later, including in inpatient settings and can assist in promoting recovery. The aims of these therapies should include: enabling people to experience themselves differently and develop new ways of relating to others; helping people express themselves and organise their experience into a satisfying aesthetic form; helping people accept and understand feelings that may have emerged during the creative process at a pace suited to the person.
6. Medication

6.1 Medication for First Episode Psychosis/Newly Diagnosed Schizophrenia

**QIS Schizophrenia ICP Care Standard 32: Medication, including for drug treatment-resistant schizophrenia is recorded.**

Medication for people with psychosis/schizophrenia may be prescribed in either primary care (by GPs with experience in treating or managing this condition) or in secondary care (NICE 2009). It may be necessary to offer antipsychotic medication to people with a first episode of psychosis and an antipsychotic should be offered to people with newly diagnosed schizophrenia. This should be a single oral antipsychotic. Regular combined antipsychotics should not be used except for short periods when changing medication.

The Medication Algorithm for First Episode Psychosis should be followed.

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Information should be provided on the benefits and side effects of each antipsychotic and these should be discussed with the patient. The decision as to which antipsychotic should be used should be agreed with the patient and the carer (if the patient agrees). When deciding on the most suitable antipsychotic to use, consider the relative potential of individual antipsychotics to cause extrapyramidal side effects, metabolic side effects and other side effects.
A chart is available at the Choice and Medication website which provides a comparison of antipsychotics, how they work and their relative side effects and provides a focal point for these discussions with the patient and/or carer. At this point consideration should be given to other medication (both prescribed and non-prescribed, including complementary) and possible interference with proposed treatment. Discuss alcohol, tobacco and illicit drugs with the patient and the effect this may have on illness and treatment. Treatment with antipsychotic medication should be considered as an individual therapeutic trial. The indications, expected benefits and risks and the expected time for a change in symptoms and for possible side effects to occur should all be recorded. The Physical Parameter Monitoring form summarises the physical parameters that should be monitored for people taking antipsychotic medication. Ensure that baseline measurements/tests are taken and results recorded in the clinical notes prior to starting antipsychotic. If this cannot be done the reason should be recorded in the notes.

Start with a dose at the lower end of the licensed range and titrate slowly within the dose range specified in the BNF or SPC. The plan for dose titration should be recorded and recording changes to this plan should be on-going, as the patient’s response and side effects dictate. Justify and record reasons for doses outside the specified ranges. Antipsychotic should be assessed over a 6-8 week period. If effective continue at optimal dose and assess effectiveness and tolerability at regular appropriate intervals which should be pre-determined and recorded in notes. Ensure physical parameters are being monitored as specified in SPC and the Physical Parameter Monitoring guideline chart. Use one of the self rating side effect scales, GASS or LUNSERS to aid assessment of subjective side effects. LAPSAC is an aid to assessing side effects through discussion with carers in people who have difficulties with communication.

If not effective consider compliance and the reasons for non-compliance. (intentional or non-intentional). Increase concordance to medication by further discussions on choice of medication and management of side effects and change antipsychotic with patient’s agreement if appropriate. The comparison of antipsychotics chart at the Choice and Medication website should be re-visited with the patient. The reasons for changing drug, expected benefits and risks and the expected time for a change in symptoms and for possible side effects to occur should all be recorded as before.

If ‘as required’ medication is necessary, the same considerations for choice of drug, monitoring and the recording of these should be followed as for regular medication. The clinical indications, frequency of administration, therapeutic benefits and side effects should be reviewed each week or as appropriate. Intended review intervals should be recorded.

“As required” antipsychotics are often given when a patient is acutely ill. Great care should be taken over this because it is often a time of high risk for several reasons. A complete formulation of the patient’s problems may not have been made, the history of recent drug ingestion (including illicit drugs) may not be known, there may be occult physical problems and the patient is likely to be in a state of high arousal. It should be remembered that antipsychotic effect evolves over days at minimum. It will often be safer and more helpful to give “as required” benzodiazepines especially if additional “as required” antipsychotics are likely to lead to a cumulative dose above the maximum advised daily dose.
6.2 Acute Exacerbation or Relapse of Psychosis or Schizophrenia

For people with an **acute exacerbation or relapse of psychosis or schizophrenia** current medication should be reviewed by following the Medication Algorithm for Acute Relapse Psychosis or Schizophrenia.

### Treatment Algorithm

**(full adherence to medication confirmed)**

- Investigate social or psychological precipitants
- Provide appropriate support and/or therapy
- Continue usual drug treatment

**Add short-term sedative or Switch to a different, acceptable antipsychotic if appropriate**

**Assess over at least 6 weeks**

- Treatment ineffective

**Confused or disorganised**

- Simplify drug regimen
- Reduce anticholinergic load
- Consider compliance aids*

**Lack of insight or support**

- Discuss with patient
- Consider compliance therapy or depot antipsychotic

**Poor tolerability**

- Discuss with patient
- Switch to acceptable drug

**Treatment ineffective**

- Try different antipsychotic or see Treatment Resistant Schizophrenia Algorithm

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* Compliance aids are not a substitute for patient education. The ultimate aims should be to promote independent living, perhaps with the patient filling their own compliance aid, having first been given support and training. Note that such compliance aids are of little use unless the patient is clearly motivated to adhere to prescribed treatment. Note also that some medicines are not suitable for storage in compliance aids.

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Algorithm for Treatment for Relapse or Acute Exacerbation of Psychosis/Schizophrenia, page 1 of 1
Approved by NHS Lanarkshire Mental Health Drugs and Therapeutics Committee 18th August 2008.
(Amended 22nd Feb 2010). Review August 2010
Adapted from Maudsley Guidelines, 9th Edition

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psychosis/schizophrenia integrated care pathway
Adherence to medication at an adequate dose/duration should always be considered and the reasons for non-adherence investigated as indicated on the algorithm. Refer to Nice Clinical Guideline 76 on Medicines adherence for useful information on increasing patient concordance with medicines. Again the comparison of antipsychotics at the Choice and Medication website should be revisited to provide a focal point for discussions on the choice of antipsychotic if switching drug is appropriate. One of the self rating side effect assessment scales GASS or LUNSERS can be used to help assess the tolerability of the antipsychotic (or LAPSAC if appropriate).

If extrapyramidal side effects are troublesome the ESPE Management chart provides guidance to their management. Anticholinergics should not be used routinely and should be reviewed regularly if they are used. Some antipsychotics can produce anticholinergic side effects themselves and the combination can greatly increase confusion and physical side effects like constipation. Again discuss with the patient alcohol, tobacco and illicit drugs and the effect this may have on illness and treatment and consider if this could be a factor in the relapse. Consider other medication (both prescribed and non-prescribed, including complementary) and possible interference with current treatment.

If it is agreed that changing the antipsychotic is the most appropriate course of action, the reasons for this and the choice of antipsychotic should be recorded. Ensure that baseline measurements/tests are taken, as specified in SPC or Physical Parameter Monitoring chart, and results recorded in the clinical notes prior to starting antipsychotic. If this cannot be done the reason should be recorded in the notes.

The aim of treatment should again be monotherapy. Either withdraw one drug before commencing the other or cross-titrate. During cross-titration, start with a dose at the lower end of the licensed range and titrate slowly within the dose range specified in the BNF or SPC as the previous drug is being withdrawn. Ensure the process of discontinuation is completed. The plan for dose titration and dose reduction should be recorded and recording changes to this plan should be ongoing, as the patient’s response and side effects dictate. Justify and record reasons for doses outside the specified ranges. The Antipsychotic Equivalents chart provides a useful tool to indicate the dose of the new drug that may be necessary to achieve a similar response, particularly for the conventional antipsychotics. However this only provides a rough estimate and should not replace regular review of actual response and side effect monitoring.

Rapid Tranquillisation is sometimes necessary in people who pose an immediate threat to themselves or others during an acute episode of psychosis. Rapid tranquillisation is the administration of medicine to control severe behavioural disturbance by producing a state of calm or light sedation when other less coercive techniques, such as verbal de-escalation, have failed. If this is considered necessary, the Lanarkshire Rapid Tranquillisation Policy should be followed in adults under 65 years of age, including those with a Learning Disability and the Rapid Tranquillisation Policy for People over 65 years followed for those in this age group. The reasons for the use of rapid tranquillisation and the positive and negative effects observed should be recorded. After rapid tranquillisation it should be explained why it was used and the patient should also be given the opportunity to discuss or write an account of their experience. This should be recorded in their notes.
6.3 Treatment Resistant Schizophrenia

People with Treatment Resistant Schizophrenia should be considered for treatment with Clozapine. Patients with a diagnosis of schizophrenia whose symptoms have not responded adequately to treatment despite the confirmed adherence to at least two different antipsychotics (at least one of which is 2nd generation) at adequate doses, each one for at least 6 weeks, may be considered to be Treatment Resistant.

A drug history should be taken to ensure that previous treatment has been adhered to and that the doses and duration of treatment have been appropriate. Interactions with prescribed and non-prescribed medicines should be eliminated. Co-morbid substance abuse and physical illness should be eliminated or investigated. The diagnosis of schizophrenia should also be confirmed and psychological treatments reviewed before a patient is considered drug resistant.

Clozapine treatment should be considered subject to following the Medication Algorithm for Treatment Resistant Schizophrenia and registration with the current Clozapine supplier/manufacturer. For the current Clozapine manufacturer website see the link on Pharmacy (Mental Health) website on the NHS Lanarkshire Intranet (First Port). Refer to the Clozapine section in the NHSL Guide for Mental Health Prescribers for current local procedures relating to Clozapine prescribing.

Consideration must also be given to patient concordance with the strict blood monitoring necessary for Clozapine therapy and this should be discussed fully with the patient including the post discharge logistics of blood sampling and supply of Clozapine. Early contact with pharmacy, preferably prior to initiation, to discuss the logistics of supply is essential. Mental Health Pharmacy contact details are available on the Pharmacy (Mental Health) website on First Port.

The algorithm also gives advice on prescribing if Clozapine monotherapy provides an inadequate response.
High Dose Antipsychotic Therapy (HDAT) occurs when an antipsychotic is prescribed at a dose higher than the manufacturer’s recommended maximum dose or the sum of the percentages of the maximum doses of two or more antipsychotics is 100% or more. If High Dose antipsychotics are prescribed, the **High dose Antipsychotic Protocol** must be followed. All patients on high-dose antipsychotic treatment must be monitored. The protocol attempts to clarify the identification of patients on high-dose antipsychotics, factors to be taken into account before such prescribing and the documentation required when antipsychotics are prescribed in high-dose.

‘As required’ antipsychotics should be taken into account when calculating if a patient is on high dose antipsychotic therapy. Note that high dose antipsychotic prescribing should be a carefully considered clinical strategy, not an inadvertent outcome of routinely prescribing “as required” antipsychotics.

The **Antipsychotic High Dose Calculator** is a tool for calculating if a patient is on high dose antipsychotic therapy. Doses above the BNF maximum are more likely to occur with the co-prescription of depot and oral medication or typical and atypical drugs. Once it has been determined a patient is “high dose” the **High dose Antipsychotic Monitoring Form** should be completed and filed in the notes. Monitoring required consists of ECG measurements (to assess QTc interval) and urea and electrolyte levels every 3 months. Blood pressure, pulse, temperature and hydration should also be monitored on a frequent basis. If there is a difficulty in obtaining any of the specified monitoring parameters in Adults with Incapacity, this should be documented in notes and the **Alternative Health Recordings** form filled out. Attempts should continue be made to comply with the High Dose Antipsychotic Therapy Protocol at the specified intervals.

It is the prescriber’s responsibility to notify the patient’s consultant psychiatrist when high dose antipsychotic therapy is prescribed. The guideline should be followed whenever a patient, being prescribed antipsychotic drugs is prescribed in the high-dose range, regardless of his/her location – hospital or community or of the status of the prescriber, GP or Psychiatrist.

**Antipsychotics**

- **Adhere**: inform, discuss and agree with patient on choice
- **Record**: decisions and reasons on choice, plans, changes and monitoring
- **Monitor**: response and side effects from baseline

All algorithms, guidelines and policies can be found on First Port – Clinical Services on the Pharmacy (Mental Health) website in the Psychosis folder. This website also contains other useful links relating to medication and the contact details for the Mental Health Pharmacists in Lanarkshire.
7. Recovery and Keeping Well

7.1 Recovery (from the Scottish Recovery Network)

In recent times one of the most important and positive developments in psychosis/schizophrenia and in mental health in general, has been the concept of recovery. This has provided a more optimistic view of the person’s journey from mental ill health to mental well-being. While recovery is a unique and individual experience it is possible to identify key themes and ideas in relation to the experience. The following list, while not exhaustive, highlights some of the most commonly identified elements.

♦ **Recovery as a journey:** The recovery journey can have ups and downs and some people describe being in recovery rather than recovered to reflect this.

♦ **Hope, optimism and strengths:** Hope is widely acknowledged as key to recovery. There can be no change without the belief that a better life is both possible and attainable. One way to realise a more hopeful approach is to find ways to focus on strengths.

♦ **More than recovery from illness:** Some people describe being in recovery while still experiencing symptoms. For some it is about recovering a life and identity beyond the experience of mental ill health.

♦ **Control, choice and inclusion:** Taking control can be hard but many people describe how it important it is to find a way to take an active and responsible role in their own recovery. Control is supported by the inclusion of people with experience of mental health issues in their communities. It is reduced by the experience of exclusion, stigma and discrimination.

♦ **Self management:** One way to gain more control over recovery is to develop and use self management techniques.

♦ **Finding meaning and purpose:** We all find meaning in very different ways. Some people may find spirituality important, while others may find meaning through employment or the development of stronger interpersonal or community links. Many people describe the importance of feeling valued and of contributing as active members of a community.

♦ **Relationships:** Supportive relationships based on belief, trust and shared humanity help promote recovery.

For more information about Recovery and the Scottish Recovery Network see their website at: [http://www.scottishrecovery.net/Key-themes-of-recovery/key-themes-of-recovery.html](http://www.scottishrecovery.net/Key-themes-of-recovery/key-themes-of-recovery.html)

To assist people in Lanarkshire with psychosis/schizophrenia in recovery we have a number of support methods and tools available (should the person wish to choose them) which include:

♦ **Recovery Plans and workbooks such as My RAP (copies on Elament -see below)**

♦ **Advance Statement**

♦ **Medication management/monitoring (see Medication Section)**

♦ **Service User and Carer support networks such as Lanarkshire Links [http://www.lanarkshirelinks.org.uk/](http://www.lanarkshirelinks.org.uk/)**

♦ **Elament** - an online mental health and wellbeing information website: [http://www.lanarkshirementalhealth.org.uk/](http://www.lanarkshirementalhealth.org.uk/).
8. ICP Monitoring

Monitoring of the service provided to each person will take place using:

♦ **Variance Analysis** - questions to be agreed in conjunction with ICP development groups and national QIS ICP programme team.

♦ **Staff, Patient and Carer Surveys** - to be developed in conjunction with ICP development groups, national QIS public involvement group, etc.
### Appendix 1: Psychosis/Schizophrenia ICP Development Group Members

| Lesley Dewar, Clinical Pharmacist Learning Disability, NHS Lanarkshire |
|------------------------|---------------------------------------------------------------------|
| Gerry Dunn, Senior Charge Nurse, NHS Lanarkshire                     |
| Ann Jane Garvie, Charge Nurse, NHS Lanarkshire                        |
| David Henderson, Community Psychiatric Nurse, NHS Lanarkshire         |
| Louise Holland, Service User/Carer, Lanarkshire Links                  |
| Karen Livingstone, Clinical Psychologist, NHS Lanarkshire             |
| Kay McGregor, Adult Protection Co-ordinator, North Lanarkshire Council |
| David McCorrison, Team Leader CMHT, South Lanarkshire Council         |
| Aileen McGonnigle, Charge Nurse, NHS Lanarkshire                       |
| Christopher McMahon, Senior Occupational Therapist, NHS Lanarkshire   |
| Caroline Mitchell, Consultant Psychiatrist, NHS Lanarkshire           |
| Wendy Prentice, Chartered Clinical Psychologist, NHS Lanarkshire       |
| Pasna Sallis, Senior Occupational Therapist, NHS Lanarkshire          |
| Ann Michelle Skilling, Senior Charge Nurse, NHS Lanarkshire            |
| Alison Thom, Consultant Psychiatrist/Lead Clinician, NHS Lanarkshire  |
| (Chair)                                                              |
| Linda Waddell, ST6, NHS Lanarkshire                                  |
| Theresa Watson, Senior Nurse for Clinical and Professional Practice  |
| (Mental Health), NHS Lanarkshire                                      |

**ICP Team:**  
| Patricia Kent, ICP Manager | Janis Dickson, Mental Health ICP Project Assistant |
Appendix 2: Guidance and Policy Base to Support Values

Guidance and Policy Base to Support Values (2010)

The Mental Health (Care and Treatment) (Scotland) Act 2003 is underpinned by the Milan principles of reciprocity, respect for equality and diversity in a non-discriminatory manner.

The 10 Essential Shared Capabilities for Mental Health promotes working in partnership, challenging inequalities (social inequality and exclusion), promoting recovery, providing service user centred care and making a difference.

The Scottish Recovery Indicator states the service should provide interventions designed specifically to promote participation in life’s roles, to self-manage illness, and to enhance relationships with others.

NHS Lanarkshire’s Organisational Values which commit to quality, patient focused services; quality healthcare environment; continuous improvement; involvement; communication; respect, fairness and consistency; competence and continuous learning.

Better Health, Better Care, Scottish Government (2007), Better Together, Patient Experience Programme and the Quality Strategy (2010), Scottish Government. These documents set out the Six Dimensions of Quality which focus on providing safe, effective care that enhances the patient’s experience of our services:

1. Person centred: providing care that is responsive to individual personal preferences, needs and values and ensuring that patient values guide all clinical decisions
2. Safe: avoiding injuries to patients from care that is intended to help them
3. Effective: providing services based on scientific knowledge
4. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
6. Timely: reducing wait and sometimes harmful delays for both those who receive care and those who give care.

Caring and Compassionate Practice is the work of a group from the Nursing, Midwifery and Allied Health Profession (NMAHP) Practice Development Centre in NHS Lanarkshire. It sets out a list of people’s expectations accompanied by statements that set the minimum practice standards for how nurses, midwives, allied health professionals and support workers must work on a day to day basis:

- To be valued as a person
- To feel and be safe
- To be cared for with dignity
- To see NMAHPs make the best possible effort
- To experience courtesy
- To be respected
- To receive kindness.
### Appendix 3: The Matrix Evidence Table for Schizophrenia

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Cognitive Behavioural Therapy* (&gt;10 sessions or &gt; 6 months[^4])</td>
<td>A[^1-14]</td>
</tr>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Family Interventions</td>
<td>A[^3, 14, 19, 20]</td>
</tr>
</tbody>
</table>

**For those at ultra high risk for developing psychosis**

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Primary Care / Specialist Service</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>B[^21-23]</td>
</tr>
</tbody>
</table>

**For early detection and intervention for relapse**

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Detection of Relapse</td>
<td>A[^24-31]</td>
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<td></td>
<td></td>
<td></td>
<td>Cognitive Behavioural Therapy for Relapse</td>
<td>B[^32]</td>
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</table>

- Strongest evidence indicates effectiveness of CBT for those with persistent and distressing psychotic experiences, rather than those in the acute phase of psychosis[^3]

**Insufficient Evidence:**

a. There is currently insufficient evidence to recommend use of Cognitive Remediation as a Routine Therapy for Schizophrenia[^14, 33, 34]

**MATRIX SCHIZOPHRENIA REFERENCES**

14. NICe Schizophrenia: Core interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. Available at: http://www.nice.org.uk. (Accessed 30.06.08.)
**Appendix 4: Psychological and Psychosocial Interventions Record Form**

NHS Lanarkshire Mental Health Services  
Schizophrenia Integrated Care Pathway

**Psychological/Psychosocial Intervention Record**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Therapist/Worker</th>
<th>Date Referred</th>
<th>Date Commenced</th>
<th>Date Completed</th>
<th>Outcome</th>
</tr>
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<tbody>
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Patient name:  
CHI/PIMS No: *(or affix patient label)*

Please record all psychological/psychosocial interventions offered/recommended, when they were commenced/completed and their outcome. Please also record reasons for premature ending of interventions.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Therapist/Worker</th>
<th>Date Referred</th>
<th>Date Commenced</th>
<th>Date Completed</th>
<th>Outcome</th>
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<tr>
<td><strong>Glossary/Abbreviations</strong></td>
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<tr>
<td><strong>Assessment of Motor and Process Skills (AMPS)</strong></td>
<td>An innovative observational assessment that is used to measure the quality of a person's performance of domestic (instrumental) or basic (personal) activities of daily living.</td>
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<tr>
<td><strong>At Risk Mental State (ARMS)</strong></td>
<td>Psychotic disorders rarely arise 'out of the blue'. They are generally preceded by a gradual alteration in a person's sense of well-being and psychosocial functioning, often over a period of time. This period, which precedes the onset of clear-cut psychotic symptoms (such as Delusional Beliefs, Thought Disorder and Hallucinations) was previously referred to as the prodromal phase, however is now more accurately referred to as an 'At Risk Mental State'.</td>
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<tr>
<td><strong>Comprehensive Assessment of At Risk Mental States (CAARMS)</strong></td>
<td>A standardised semi-structured interview which identifies individuals who have an increased risk of psychosis.</td>
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<tr>
<td><strong>Central Nervous System (CNS)</strong></td>
<td>The part of the nervous system that processes the information received from the peripheral nervous system. The CNS consists of the brain and spinal cord. It is responsible for receiving and interpreting signals from the peripheral nervous system and also sends out signals to it, either consciously or unconsciously.</td>
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<tr>
<td><strong>Diagnostic and Statistical Manual of Mental Disorders (DSM IV)</strong></td>
<td>Psychiatric Diagnoses are categorized by the Diagnostic and Statistical Manual of Mental Disorders. The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches.</td>
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<tr>
<td><strong>Electrocardiogram (ECG)</strong></td>
<td>A test that measures the electrical activity of the heart.</td>
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<tr>
<td><strong>Family Therapy</strong></td>
<td>Family and Systemic Psychotherapy – often called Family Therapy helps people in close relationship help each other. It enables family members to express and explore difficult thoughts and emotions safely, to understand each other’s experiences and views, appreciate each other’s needs, build on family strengths and make useful changes in their relationships and their lives.</td>
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<tr>
<td><strong>Historical, Clinical, Risk Management-20 (HCR-20)</strong></td>
<td>An assessment tool that helps mental health professionals estimate a person's probability of violence. It consists of a list of 20 probing questions about the person being evaluated for violence. The clinician gathers qualitative information about the person being assessed, guided by the HCR-20, and the results are used to make treatment decisions. The HCR-20's results help mental health professionals determine best treatment and management strategies for potentially violent, mentally disordered individuals.</td>
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<tr>
<td><strong>International Classification of Diseases (ICD 10)</strong></td>
<td>This is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States.</td>
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<tr>
<td><strong>NHS Quality Improvement Scotland (QIS)</strong></td>
<td>NHS Quality Improvement Scotland was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHS Scotland. By 'improve', they mean the improving of the experiences of patient/clients and the outcomes of their treatment while in the care of NHS Scotland. They work to achieve these goals through an analysis of scientific evidence, by listening to the needs and preferences of patient/clients and carers, as well as the experiences of healthcare professionals. Web address: <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a></td>
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<tr>
<td><strong>National Institute for Clinical Excellence (NICE)</strong></td>
<td>NICE is part of the NHS. It is the independent organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales. Its guidance is for healthcare professionals and patient/clients and their carers, to help them make decisions about treatment and healthcare. NICE guidance and recommendations are prepared by independent groups that include healthcare professionals working in the NHS and people who are familiar with the issues affecting patient/clients and carers. Website address: <a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
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<td><strong>Scottish Intercollegiate Guidelines Network (SIGN)</strong></td>
<td>SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland. Its objective is to improve the quality of healthcare for patients in Scotland by reducing variation in practice and outcome, through the dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. For further information contact: <a href="http://www.sign.ac.uk">www.sign.ac.uk</a></td>
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<td><strong>Variance</strong></td>
<td>A deviation from an activity set out in an ICP.</td>
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<td><strong>World Health Organisation (WHO)</strong></td>
<td>WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.</td>
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</tbody>
</table>
Standards for Integrated Care Pathways in Mental Health, NHS Quality Improvement Scotland, 2007

International clinical practice guidelines for early psychosis, International Early Psychosis Association Writing Group, British Journal of Psychiatry (2005), 187 (suppl. 48, s120^S124)


Notes

1 The EDIE2 trial is a national trial being carried out over 5 sites (Manchester (lead site), Birmingham/Worcestershire, Cambridge, Norfolk, and Glasgow. The trial aims to reduce transition to psychosis and reduce the distress felt by help-seeking individuals. In particular the aims are to (a) investigate the effectiveness of psychological therapy (Cognitive Therapy) in reducing or delaying transition to psychosis in at-risk individuals; (b) reduce the duration of untreated psychosis for individuals who go on to make transition to psychosis; (c) develop an understanding of the pathways to care for at-risk individuals; (d) establish local data to inform future service development. This follows on from the EDIE1 trial by Morrison and colleagues in 2004. The results of the EDIE1 trial suggested that CT is an effective psychological intervention in reducing the transition rate in people at risk. CT produced a significant reduction in the likelihood of being prescribed anti-psychotic medication and produced improvements in distressing psychotic experiences, and they stated that monitoring people who are at high risk of developing psychosis is effective in reducing the DUP should transition occur.

2 Attenuated symptoms can be defined as sub-clinical levels of positive symptoms (e.g. paranoia, hearing voices).

3 The ‘critical period’ covers the first five years of illness; however, most early intervention services provide input for the first three years.

4 The early signs monitoring training is based on a package developed by Jo Smith who is based in Worcestershire and is the head of early intervention services throughout England.