Schizophrenia in adults 2: treating acute episodes and promoting recovery

Exploring the new and updated aspects in NICE guidance on schizophrenia, focusing on treating acute episodes and recovery, and preventing relapse

INTRODUCTION
Part 2 in this unit on the NICE (2009) guideline update on schizophrenia focuses on ongoing treatment for acute episodes and interventions for promoting recovery. After an initial episode of schizophrenia, 14–20% of people recover fully, while others improve but go on to have further acute episodes. Common causes of relapse include increased stress, social adversity and isolation. The guideline highlights the importance of continuing pharmacological and psychological interventions as well as social support to help prevent relapse.

ACUTE EPISODES
People with schizophrenia or first-episode psychosis commonly present with an acute episode in which the positive symptoms (hallucinations and/or delusions) and behavioural disturbances (such as agitation or impaired functioning) can cause much distress and risks to them and others.

The services that are likely to be involved are community mental health teams, crisis resolution and home treatment teams, and acute day hospitals as an alternative to inpatient services. Nurses form the majority of the staff in these services, and work as part of a multidisciplinary team.

During an acute episode, clients need a range of therapeutic inputs and support adapted to meet their individual needs. Because acute episodes can be disruptive and distressing for clients and their families/carers, a comprehensive person-centred care plan should be developed, which should identify clients’ needs and priorities and resolve the episode as soon as possible. Nurses should be actively involved in helping to resolve it.

After each acute episode, it is helpful for clients to write an account of their illness to identify the treatments that were effective, help them recognise the early signs of an episode and understand their illness.

Psychological interventions
Psychological interventions are an important component of treatment for people with an acute episode, although they can also be started later, including in inpatient settings.

Cognitive behavioural therapy (CBT) should be offered oral antipsychotic medication for long-term treatment. The decision about which drug to use should be based on how well symptoms have responded to a drug before and any side-effects. The guidance for initiating treatment in part 1 should be followed.

Clients should be advised that there is a high risk of relapse if medication is stopped within 1–2 years. When medication is discontinued, it should be done gradually and monitoring for signs and symptoms of relapse continued for at least two years. If clients pose an immediate threat to themselves or others, rapid tranquillisation may be considered. For this, healthcare staff should follow the NICE (2005) guideline on violence.

After rapid tranquillisation, clients should be given the opportunity to discuss what has happened with a health professional and write an account of their experience. Practitioners should explain why rapid tranquillisation was used.

If a client has self-harmed, healthcare staff should follow the NICE (2004) guideline on this issue. Mental health nurses can be called on to conduct a comprehensive assessment, integrating needs and risk within the process to understand the social, psychological and motivational factors behind self-harm.

Clients will need to be supported to explore and consider alternative ways of coping and minimising the impact of self-harm.

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ABSTRACT

This second in a two-part unit on updated NICE guidance on schizophrenia looks at treating acute episodes and promoting recovery. Part 1 examined detection, assessment and starting treatment.

LEARNING OBJECTIVES
1. Identify the evidence-based psychosocial interventions for people with schizophrenia and their families/carers for acute episodes
2. Describe social interventions to optimise clients’ recovery

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Mental health | Psychosis | Schizophrenia

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Specialist mental health nurses can provide these interventions on a one-to-one basis. When CBT and family intervention are provided, the guideline recommends using a well-recognised treatment manual. Therapists should monitor auditable clinical outcomes in relevant areas, including client satisfaction.

Counselling, supportive psychotherapy and social skills training should not usually be offered as specific interventions because the evidence shows that they are not as effective as CBT, family intervention or arts therapies. However, if the latter are not available locally, counselling and supportive psychotherapy may be considered if clients ask for them. Moreover, clients should not usually be offered adherence therapy as a specific intervention because there is no good evidence that it is effective.

Trusts should provide training for healthcare staff to acquire the competencies to deliver CBT, family intervention and arts therapies. All teams should identify a lead practitioner in the team or service to monitor and review access to and engagement with psychological interventions, especially regarding equality of access in ethnic groups. This person may be a specialist nurse therapist or consultant nurse, or other leading mental health professional with psychological expertise.

**PROMOTING RECOVERY**

**Primary care**

Many people with schizophrenia are at risk of developing physical health problems (such as significant weight gain and diabetes) from some antipsychotics and for other reasons associated with having the condition, such as changes in lifestyle.

Clients’ physical health should be monitored at least once a year in primary care. Since people with schizophrenia are at a higher risk of cardiovascular disease than the general population, it is important to focus on risk assessment (following the NICE (2008) guideline on lipid modification). For those with established physical disease, including cardiovascular disease and diabetes, the appropriate NICE guideline should be followed (see www.nice.org.uk).

Nurses in primary care will be involved in physical health checks, while their counterparts in acute care should ensure, as part of care programme approach planning, that clients receive physical healthcare from primary care.

Good liaison between primary and acute care, using practice case registers, will enhance access for this group to physical health care.

Primary care staff should consider re-referral to acute care if the client: is not responding well to treatment; is not taking medication as prescribed; has intolerable side-effects; has a substance misuse disorder; is a risk to themselves or others; or is having a suspected relapse.

**Pharmacological interventions**

Decisions about which antipsychotic to use to promote recovery and prevent relapse should be based on how well symptoms have previously responded to a drug, side-effects and the guidance in part 1.

In the long term, there are particular issues to consider, such as the need to use medication continuously and not just during the early stages of relapse or worsening of symptoms; however, this does depend on the client’s preference. Depot or long-acting injectable antipsychotics may be a long-term option.

**Psychological interventions**

CBT, family intervention and arts therapies can all help clients to stay well.

CBT is useful for people with ongoing positive and negative symptoms and those in remission; family intervention can be helpful for families of people who have recently relapsed, are at risk of relapse or have ongoing symptoms; and arts therapies can provide support for those with negative symptoms.

**Interventions where illness has not responded adequately to treatment**

If a client’s schizophrenia has not responded adequately to pharmacological and psychological treatment, professionals should: review the diagnosis; establish adherence to medication; review engagement and use of psychological interventions; and consider other causes of non-response (for example, physical illness or misuse of alcohol or illicit substances).

Following this review, and with good evidence that they have complied with adequate courses of the correct dose of at least two antipsychotics, clients should be offered clozapine.

**Employment, education and occupational activities**

To optimise recovery, clients need support in and access to employment, education and occupational activities to help them integrate into their usual social context and role and realise their aspirations.

Mental health services should work with stakeholders, including those representing BME groups, to enable clients to access employment, educational and occupational opportunities.

Nurses should take a leading role, working alongside clients to help identify their needs, strengths and aspirations, and seeking out opportunities beyond the statutory services.

**CONCLUSION**

This guided learning unit summarises and explores the key priorities in the updated NICE (2009) guideline on schizophrenia. It also examines the clinical implications and how they affect nurses’ professional development.

Despite the strong evidence base for the interventions, there is a long way to go in terms of implementing the guidance in routine services and in reducing clients’ social exclusion.

Increased awareness of the guideline among nurses should help improve implementation across organisational boundaries.

**REFERENCES**


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