Demystifying schizophrenia management guidelines

Despite the myths and pessimism surrounding schizophrenia, effective treatments are available. Early intervention and comprehensive, sustained care by a multidisciplinary team is essential.

STEPHEN CARBONE
MB BS

PATRICK McGORRY
MB BS, PhD, FRANZCP

Dr Carbone is a General Practitioner, Dianella Community Health Service, Broadmeadows, Vic. Professor McGorry is Executive Director, ORYGEN Youth Health and ORYGEN Research Centre, Department of Psychiatry, University of Melbourne, Parkville, Vic.

Schizophrenia affects around 1% of people worldwide and is one of the most misunderstood mental disorders. Myths about it abound among the lay public and health professionals alike. Among the most detrimental of these myths is the belief that prognosis in schizophrenia is inevitably bleak. Nothing could be further from the truth.

Outcomes for schizophrenia are, in fact, quite heterogenous. About 25% of people with the condition will have only one or two episodes in their lifetime; about 50% will experience a relapsing and remitting course, with varying degrees of impairment between episodes but a tendency for improvement over time; and fewer than 25% will experience chronic, persistent illness.[1] Furthermore, effective treatments for schizophrenia are available, including an increasing number of atypical antipsychotic medications and continually evolving and improving psychosocial treatments.

Tragically, the pessimism that surrounds schizophrenia continues to take its toll. Delays in the detection and treatment of first episode psychosis are common, and only a third of people with an established illness receive treatment; fewer still receive the recommended evidence-based care on a sustained basis. The challenge is to dispel the myths and pessimism surrounding schizophrenia so that early intervention can be promoted and the number of people receiving optimum treatment can be increased.

Key features

Schizophrenia is characterised by the presence of various positive and negative symptoms and cognitive difficulties (Table 1). Comorbidity with other psychiatric disorders, including anxiety, depression and substance abuse, is very common.[2]

Diagnosis

The onset of schizophrenia typically occurs in adolescence or early adult life. While schizophrenia may start abruptly, usually the first psychotic episode is preceded by a prodromal period that may occur over weeks, months or even years. Symptoms during this phase vary considerably but typically include significant dysphoria, deterioration in

IN SUMMARY

- **Early detection of schizophrenia is vital. Long periods of untreated psychosis are associated with significantly poorer outcomes.**
- **A team approach to care is preferable.**
- **Treatment aims to achieve remission of active psychotic symptoms, promote functional and social recovery, and prevent relapse and secondary mental and physical health problems. Addressing comorbid substance use is important.**
- **Successful outcomes depend on the combined use of antipsychotic medication and active individual and family psychosocial support.**
- **Atypical antipsychotics should be used as first line therapy. Clozapine should be introduced early if symptoms persist despite an adequate trial of two different antipsychotic medications.**
- **The affected person's physical health remains a prime focus of attention.**

Table 1. Characteristic features of schizophrenia

Positive symptoms
Delusions
Hallucinations
Thought disorder

Negative symptoms
Blunted or inappropriate affect
Poverty of speech
Loss of motivation
Reduced goal directed activity

Cognitive difficulties
Inattention
Impaired memory
Impaired decision making

Other associated symptoms
Dysphoria
Sleep disturbance
Agitated or disorganised behaviour
Social withdrawal
Impaired functioning in study, work and relationships

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psychosocial functioning and some attenuated or fleeting positive psychotic symptoms. The significance of the prodromal period is usually only apparent in hindsight, after a young person develops a full-blown psychotic episode.

In recent years researchers have attempted to use this knowledge about the prodrome to detect people who may be at heightened risk of psychosis, so intervention can occur before the onset of the acute psychotic phase. Using ultrahigh risk predictive criteria, they have been able to define cohorts with high rates of transition to psychosis. In the members of one such cohort, the use of very low doses of antipsychotics and focused psychological therapies have been shown to at least delay the onset and ameliorate the impact of psychosis.[3] However, the approach is still experimental, and at present a definitive diagnosis and a sound basis for antipsychotic medication can only be made following progression of a patient to the initial acute psychotic phase. Nevertheless, potentially prodromal patients should be actively engaged, monitored and supported until their course declares itself one way or the other.

The diagnosis of schizophrenia, within the spectrum of first episode psychosis, is purely a clinical one, although physical examination and certain laboratory and imaging investigations are important to exclude organic causes of psychosis such as drug intoxication, endocrine disorders and brain pathology. Recommended investigations before starting medication include those listed in Table 2.

A comprehensive history and thorough mental state examination are critical. Key issues to cover in a mental state examination are appearance, behaviour and rapport, affect and mood, speech and thought, perception, cognition, and insight and judgement.

Early detection is essential as long durations of untreated psychosis contribute to slower and less complete recovery and a greater risk of future relapse.[4] Given that most GPs will encounter only one or two people a year with first-onset psychosis, a high index of suspicion is required to make the diagnosis. It is important to consider the possibility of schizophrenia in any adolescent or young adult presenting with persistent psychological symptoms and deterioration in psychosocial functioning,

Table 2. Schizophrenia: important investigations

Laboratory tests

FBE and ESR
Vitamin B_{12}
Folate
Electrolytes and urea
Calcium
Phosphate
Thyroid stimulating hormone
Liver function tests
Urine drug screen
Fasting glucose
Fasting lipids

Imaging

ECG
CT scan

especially if there is a positive family history of psychotic disorder. Although depression, anxiety disorders and/or substance abuse will be the most likely explanations, it is important to actively exclude psychosis. GPs should, therefore, ask specifically about psychotic symptoms, as these are usually not directly volunteered.

If there are significant concerns or any uncertainty about the person's mental state or safety, questions about depression, illicit drug use, psychotic symptoms and suicide risk should be asked at the first assessment. If the situation is less urgent and the GP wishes to build greater rapport before asking these more sensitive questions, then it is reasonable to arrange a follow up appointment to conduct a more thorough mental state examination. It is also important to obtain information from family or other informants (such as teachers) when possible, as some individuals minimise or deny their problems. A carefully planned home visit is often helpful in determining the diagnosis.

A team approach to management

While GPs are pivotal to the successful management of schizophrenia, this disorder perhaps more than any other is best managed using a team approach that involves the patient, his or her carers, the GP, specialist clinicians and workers in psychosocial support services. Such an integrated biopsychosocial approach is particularly important in the early 'critical period' of the illness (the first five years), during which functional impairment typically develops. Comprehensive, intensive and sustained treatment in this period can produce significant long term benefits.[2]

The aims of treatment are to:

- achieve remission of active psychotic symptoms
- promote functional and social recovery
- prevent relapse and secondary mental and physical health problems.

Long term success depends on the formation of strong, collaborative relationships between the patient, carers and treating team. It also depends on an approach to care that balances the need for the patient to learn how to manage the condition in his or her own way with the need for assertive or involuntary interventions if necessary to manage a serious risk of harm or deterioration.

Pharmacotherapy

Antipsychotic medication remains an essential component of the treatment of schizophrenia. An extensive range of typical (or conventional) antipsychotics and newer atypical (or novel) antipsychotics are available to treat schizophrenia. Both typical and atypical antipsychotic medications have proven efficacy in alleviating positive psychotic symptoms. However, atypical agents are often better subjectively tolerated than typical agents, are generally associated with fewer extrapyramidal side effects, and may have a more favourable impact on negative symptoms, cognition and relapse rates. Some atypical medications, though, are associated with serious weight gain and metabolic complications. Overall, the increased benefits seen with the atypical antipsychotics may only be modest and some key studies have questioned their value;[5] however, provided metabolic side effects are screened for, they do still represent a substantial advance in the quality of care.

Current guidelines produced by the Royal Australian and New Zealand College of Psychiatrists state that people with newly diagnosed schizophrenia should be started on an oral atypical antipsychotic medication such as risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), amisulpride (Solian) or aripiprazole (Abilify).[2] The prescribing of medication in first episode psychosis is summarised in the box on page 29.

Antipsychotics may take some time to have their full effect, with maximal impact expected around six to eight weeks after initiating therapy, and dose adjustments should be done gradually. The mantra is to start low and go slow to reduce the risk of adverse reactions such as dystonias, excess sedation and weight gain sedation that may impact on patient adherence to treatment in the long term. Secondary symptoms such as agitation or insomnia may be treated for brief periods with benzodiazepines (for example, diazepam 5 to 10 mg three times daily). Prominent affective symptoms, such as mania or severe depression, require specific treatment with mood stabilisers or antidepressants. Substance abuse should be tackled and ceased wherever possible.

If a person has a poor response to adequate doses of one atypical antipsychotic that has been given over a sufficient period of time, he or she should be trialled on another atypical agent. If there are significant metabolic complications, a switch to a typical agent may be considered. Patients who have not experienced symptom remission after a trial of two or more different antipsychotics or who are at persistent risk of suicide should be considered for a trial of clozapine (Clopine, Clozapine Synthon, Clozaril). This will require referral to an approved clozapine prescriber. People who experience relapsing remitting or persistent problems beyond the

first episode usually require slightly higher doses of medication. However, dosages above the recommended range rarely offer much benefit and greatly increase the side effect burden.

People who have been previously stabilised on typical medications and are not experiencing significant negative symptoms or side effects may continue on these medications; otherwise, they should be switched to an atypical medication under close specialist review.

Depot medications should be reserved for people who voluntarily opt for this approach to treatment or for people in whom medication use remains a continuing problem despite active education and support to promote adaptation and adherence. It is particularly appropriate in patients in whom the consequences of relapse could be serious and involve substantial risk to the patient or others. Injectable atypical antipsychotics are now available (risperidone [Risperdal Consta], olanzapine [Zyprexa IM].

There is no clear-cut evidence regarding the optimal duration of treatment with antipsychotic medications. It is generally suggested that patients continue with antipsychotics for at least 12 months after remission of a first psychotic episode and then the medication is slowly withdrawn under supervision. Many will not experience a repeat episode. If a person experiences two or more repeat episodes, medication should be maintained for at least five years (some would say even longer) if he or she has no symptoms, but may be required long term if relapses or persistent psychotic episodes occur.

Psychosocial treatment

Psychosocial treatments are an essential adjunct to the promotion of full functional recovery. Psychoeducation is a key component that helps the person gain an accurate understanding of the nature of his or her condition and how to manage it. The stress–vulnerability model provides a useful framework that can be used to help the affected person understand the impact of various genetic and neurobiological predisposing factors for schizophrenia and the potential trigger factors for psychosis onset and relapse. In addition, it can be used to dispel myths about personal blame or faulty parenting.

A generic diagnosis

In a patient with first episode psychosis it is usually best to frame the diagnosis broadly in a syndromal way, stating that the person has developed psychosis or a psychotic disorder. It should be explained that these are umbrella terms covering a range of symptom patterns with a variety of possible outcomes that are difficult to predict accurately. Also explain that the more specific diagnosis schizophrenia tends to be easier to charaterise later as it may only become apparent over time. The schizophrenia concept and definition contain prognostic as well as diagnostic components, and can be threatening and overwhelming for a young patient and his or her family. The generic psychosis diagnosis is usually well accepted, but it too can be distressing and hence it is important to counteract feelings of denial or demoralisation with factual information and an attitude of pragmatic optimism.

Empowering the patient

As with any condition that is potentially relapsing–remitting, the affected person needs to be empowered and learn how to monitor and manage his or her psychotic illness. Discussions about the importance of medication adherence, stress management and the avoidance of substance or alcohol misuse are important, and may need to be regularly reinforced. In some people, particular symptoms that indicate an incipient psychotic relapse can be identified. It may be useful to develop a healthy lifestyle plan and relapse management plan

Prescribing medication in first episode psychosis – a summary of the RANZCP guidelines[2]

- Use benzodiazepines for brief periods for anxiety and sleep disturbance.
- Initiate antipsychotic treatment with a low dose of an atypical antipsychotic, and increase dose within seven days to the initial target dose of risperidone 2 mg, olanzapine 10 mg, quetiapine 300 mg, amisulpride 400 mg or aripiprazole 15 mg. Maintain dose for the next three weeks.
- If there is no response or a poor response, increase atypical antipsychotic dose slowly over the next four weeks (eight weeks in total) to maximum of 4 mg, 20 mg, 600 mg, 800 mg and 30 mg for the medications above, respectively.
- If response occurs, continue the antipsychotic for 12 months. If the psychosis fully remits and the patient recovers socially, stop medication gradually over a few months with close follow up.
- If side effects develop, consider switching to an alternative agent (generally another atypical but switch to a typical one if metabolic syndrome develops).
- If there is still a poor response, assess the reason for this – consider whether the dose is still inadequate (increase further if no side effects) and whether adherence is satisfactory (discuss, and offer compliance therapy). If response is no better after optimising dose and adherence, switch to another atypical and assess over six to eight weeks.
- If response or adherence is still poor with another antipsychotic, or there is a persistent risk of suicide, offer a trial of clozapine. If the patient is reluctant to take clozapine, further trials of different atypicals or typicals may be justified. Injectable atypicals may be considered as alternatives to clozapine for patients with poor adherence.

Managing a patient with schizophrenia – the GP's role

- Use a generic 'psychosis' diagnosis in a patient with first episode psychosis rather than specifying 'schizophrenia', as the former is less threatening and overwhelming.
- Ideally, refer a patient with first episode psychosis for initiation of treatment and then manage his or her maintenance treatment, making adjustments as necessary.
- Maintain a practical and optimistic attitude with the patient, and provide factual information.
- Establish a multidisciplinary team to provide integrated biopsychosocial care of the patient. Team Care Arrangement plans may be used to co-ordinate shared care.
- Provide continuing patient care with regular follow up appointments for review of overall health and wellbeing, mental state, risk status and treatment adherence and side effects, as well as consideration of current needs and issues.
- Manage the patient's physical health.
- Help the patient learn how to monitor and manage his or her illness. Discuss medication adherence, stress management and use of harmful substances, and review these issues regularly. Develop a written healthy lifestyle and relapse management plan.
- Support the patient in his or her return to, and maintenance of, normal social, recreational and vocational activities.
- Refer the patient as necessary for more focused psychological intervention such as CBT.
- Involve the family in the patient's care (with his or her permission), and establish regular contact with family members.
- Provide the patient and carers with information regarding patient and carer support services and groups, psychosocial support and rehabilitation services, accommodation services, financial support services and employment support services.

that documents these early warning signs and highlights the actions the person should take (such as increasing the dose of antipsychotic medication, temporarily taking benzodiazepines for sleep disturbance or agitation, and seeking medical assistance).

The goal of psychosocial treatment is to support the person in returning to, and maintaining, normal social, recreational and vocational activities at a pace and level that suits him or her, while working to counteract excessive fear and avoidance at one extreme or noncompliance and impulsivity at the other. GPs can achieve much of this. Key skills include supportive counselling, structured problem solving and motivational interviewing.

Cognitive behaviour therapy

Many people benefit from more focused forms of psychological intervention for the treatment of persisting positive psychotic symptoms or secondary depression and anxiety symptoms. Recent research highlights the effectiveness of adjunctive cognitive behaviour therapy (CBT) in improving mental state and global functioning and reducing the risk of relapse compared to standard care alone.[2] The provision of CBT may require referral to an experienced clinical psychologist or other qualified provider. Australian Divisions of General Practice should be encouraged to include at least one clinician with this expertise in their Access to Allied Health, Better Outcomes in Mental Health Care Initiative.

Family involvement

Families are often the forgotten casualties of mental illness yet research highlights their crucial role as allies supporting patients' recovery.[6] The family is the life support system for anyone with a persistent and relapsing illness. A diagnosis of schizophrenia is a traumatic and confusing experience for the person and his or her carers alike, and both need active assistance. While some people may resist the involvement of family members in their care, most do not.

Early and ongoing education and support for family members is required to provide the supportive, encouraging and low stress family environment that is essential to the person's recovery. GPs are encouraged to meet with key family members, either with the patient or separately, at the earliest possible opportunity, and to establish regular contact with them. Family members may also benefit from being in contact with other carers supporting people with schizophrenia. Carer support services and groups have been established across Australia, and may be located via local public mental health services, Sane Australia's Helpline Service (phone 1800 18 SANE (7263) or online at www.sane.org) and the Mental Illness Fellowship of Australia (www.schizophrenia.org.au).

Psychosocial support and rehabilitation services

Some people with schizophrenia may require assistance with day-to-day living skills, and each State and Territory operates its own system of psychosocial support and rehabilitation services. While useful for anyone, such services are particularly important for people with an impaired capacity for independent living. GPs have a vital role in encouraging and assisting people to access these services, some of which (those in Victoria, for example) have outreach workers who can make contact with the person in his or her usual living environment.

Many of these services can also help people to access housing and financial support services. Alternatively, referral to a Community Health Service or Centrelink social worker may prove useful. Referral to the Commonwealth Rehabilitation Service

or another specialist employment support service is also recommended for people seeking to return to the workforce once their illness is in remission.

Maintaining physical health

People with schizophrenia and other psychotic disorders are at increased risk of poor physical health, some of which is related to complications associated with certain antipsychotic medications.[7] Increased attention has been given recently to the need to monitor patients with schizophrenia for the development of the metabolic syndrome, characterised by central obesity, hypertension, impaired glucose tolerance or diabetes, and dyslipidaemia. Regular measurement of height, weight and abdominal girth and yearly review of fasting glucose and lipids are required.[8] Referral to a dietician and appropriate medical treatment may also be necessary.

Cigarette smoking and harmful use of alcohol and other drugs are also common among people with schizophrenia. These behaviours should be assessed, documented and managed accordingly. Education, motivational interviewing and problem solving techniques can be used to support a reduction in use or abstinence. Motivational interviewing aims to move people through the stages of behavioural change (from precontemplation to action to maintenance) by attempting to create dissonance between their concerns about their substance use and their longer term aspirations for physical, mental and social wellbeing, while generally encouraging and supporting their efforts to change.[9]

It is important to remember that, in many cases, the person's poor physical health is as likely to impact on quality of life and mortality as his or her mental illness. Physical health should, therefore, remain a prime focus of attention.

Follow up care

Good continuing care is essential for successful outcomes in patients with schizophrenia. Strong organisational systems and a clear framework for action are important. Depending on the person's condition, regular appointments should be scheduled every one to three months. A reminder system for missed appointments may be helpful for people who require more proactive follow up or who are prone to cease contact when relapsing. Assertive follow up has been shown to be an important component of successful treatment.

Each appointment provides an opportunity to review the person's overall health and wellbeing, reassess his or her mental state and risk status, monitor treatment adherence and side effects, conduct a targeted physical examination and deal with current needs and issues. Use of an outcome measure such as the Health of the Nation Outcome Scale (HoNOS) may help to monitor progress and guide treatment (see www.crufad.com/cru_index.htm). Team Care Arrangement plans may be used to co-ordinate shared care arrangements with psychosocial support services and specialist mental health providers.

Conclusion

Schizophrenia is best managed through an integrated, biopsychosocial approach provided by primary care and specialist providers working in collaboration. It would be disingenuous to suggest that the management of schizophrenia in general practice is straightforward. While the GP has a role to play in managing the person's mental and physical healthcare needs as part of a shared care approach, perhaps his or her greatest task is to establish a treatment team that can be relied on (see the box on page 30). Although public and private specialist mental health services are not always readily accessible or of sufficient quality and remain seriously underresourced, it is extremely beneficial to the patient and carers if the GP has taken the time to create and co-ordinate a supportive treatment team.

With early diagnosis and active and sustained use of antipsychotic medication coupled with individual and family psychosocial support, most people with schizophrenia can expect to manage their illness and experience a good quality of life. It is, therefore, quite unacceptable for anyone with schizophrenia to be abandoned to struggle alone as a result of misinformed therapeutic nihilism or a fragmented and minimalist service system. MT

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