

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

SCOPE

Clinical guideline title: Psychosis and schizophrenia in adults: treatment and management

Quality standard title: Psychosis and schizophrenia in adults

1 Introduction

1.1 Clinical guidelines

Clinical guidelines are recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS. They are based on the best available evidence.

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider.

This is a partial update of '[Schizophrenia](#)' (NICE clinical guideline 82). See section 3.3.1 for details of which sections will be updated. We will also carry out an editorial review of all recommendations to ensure that they comply with NICE's duties under equalities legislation.

This update is being undertaken because new evidence has emerged on service-level interventions, interventions that improve the ability of people to undertake employment (including supported employment and pre-vocational training) and cognitive remediation therapy (in particular, its combination with pre-vocational training). In addition, the scope has been broadened to include psychosis because it was recognised that service-level interventions are not generally limited to people with a diagnosis of schizophrenia.

1.2 Quality standards

Quality standards are a set of specific, concise quality statements and measures that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

For this clinical guideline a NICE quality standard will be produced during the guideline development process, after the development of the clinical guideline recommendations.

This scope defines the areas of care for which specific quality statements and measures will (and will not) be developed.

The guideline and quality standard development processes are described in detail on the NICE website (see section 7).

2 Need for guidance

2.1 Epidemiology

- a) Psychosis is a broad category that includes schizophrenia. 'Psychosis' is a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behaviour. The symptoms of psychosis are usually divided into positive symptoms, including hallucinations and delusions, and negative symptoms, such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect. Nevertheless, people who develop psychosis and schizophrenia will have their own unique combination of symptoms and experiences, the precise pattern of which will be influenced by their own particular circumstances and which may call for flexibility in services' response.
- b) The symptoms and experience of psychosis and schizophrenia are often distressing and the effects of the illness are pervasive, with a significant number of people experiencing long-term disability. Psychosis and schizophrenia can have a major detrimental effect

on people's personal, social and occupational functioning, placing a heavy burden on individuals and their carers, dependents and extended families, as well as making potentially large demands on the social and healthcare system.

- c) A recent systematic review found that in England the pooled incidence of broadly defined psychotic disorder was 31.72 per 100,000 person-years. The pooled estimate of the annual prevalence rate of psychosis was 4.1 per 1000, the same rate as for schizophrenia. It should be noted that in this review there was considerable variation between study estimates.

2.2 Current practice

- a) Since the 1950s there have been significant changes in the way psychosis is treated. Following de-institutionalisation service users were often treated in outpatient clinics, however since the 1970s there have been moves towards treatment in home- and community-based settings.
- b) Services in England and Wales have a range of teams available for the treatment of people with psychosis and schizophrenia, which may include Assertive Community Treatment teams, early intervention teams, crisis resolution and home treatment teams and community mental health teams. Other service-level interventions include case management, acute day hospitals and crisis houses.
- c) Available pharmacological treatments usually have limited effects on cognitive impairments associated with schizophrenia. Cognitive remediation is specifically focussed on basic cognitive processes such as attention, working memory or executive functioning, and aims to improve performance in these areas in order to improve outcomes for daily living and social or vocational skills. Limited evidence for cognitive remediation has been found although there is additional US-based evidence for combined cognitive

remediation and vocational training programmes; however, there is a lack of longer-term follow-up data in this area.

- d) The cumulative cost of the care of individuals with psychosis and schizophrenia is high. In 2004/05, the total annual societal cost of schizophrenia in England was £6.7 billion, made up of £2 billion in the direct cost of treatment and an estimated £4.7 billion in indirect costs. The cost of lost productivity owing to unemployment, absence from work and premature death accounted for 72% of the total indirect cost.
- e) Two UK studies found that after the first episode of illness, unemployment rates for people with schizophrenia increased from on average 42% to 63%. Other UK studies have found that unemployment rates may be as high as 96% for people with schizophrenia in some areas. Carers also have a very significant burden socially, financially and personally. There are work-related interventions for people with psychosis and schizophrenia, including supported employment, pre-vocational training and other approaches to enhance employment prospects in the longer term.
- f) A systematic review of ethnic variations in use of specialist mental health services in the UK found higher rates of inpatient admission among African-Caribbean service users than white service users. In addition, African-Caribbean people on inpatient units were four times more likely to experience a compulsory admission than white people. Variations in gaining access to mental health services may explain some of these differences. Furthermore, other studies suggest that there may be variation in response to treatment among people with psychosis and schizophrenia from different ethnic groups.
- g) Some people with schizophrenia and psychosis may have exceptionally difficult lives, facing stigma and with high levels of need for health and social care. The care and treatment of people

with schizophrenia has improved since the first NICE guideline was published in 2002; however, the treatments they receive and the fact that they continue to be subject to compulsory admission, at relatively high levels, highlights the stigma and social exclusion they often have to face. The need for a quality standard to enhance the ability of the NHS to meet their needs remains a top priority.

3 Clinical guideline

3.1 Population

3.1.1 **Groups that will be covered**

- a) Adults (18 years and older) who have a clinical working diagnosis of psychosis or schizophrenia, including schizoaffective disorder and delusional disorder, and those with an established diagnosis of schizophrenia (with onset before age 60) who require treatment beyond age 60.
- b) People in early intervention services, which may include people 14 years and older. However, the guideline will not make recommendations about the specific treatment of people under 18 years of age.

3.1.2 **Groups that will not be covered**

- a) Very late onset schizophrenia (onset from age 60 onwards).
- b) Children and young people, unless they are being treated in early intervention services. However, the guideline will not address early interventions services in Child and Adolescent Mental Health Services (CAMHS).
- c) People diagnosed with bipolar disorder.
- d) People with transient psychotic symptoms.

3.2 Healthcare settings

- a) NHS-commissioned care that is received from health and social care professionals in community settings.
- b) The guideline will also be relevant to the work of, but will not cover the practice of, A&E departments, paramedic services, prison medical services, the police and those who work in the criminal justice and education sectors.

3.3 Management

3.3.1 Key issues that will be covered

- a) Low intensity interventions specifically for people with psychosis and schizophrenia, for example, befriending, peer support, exercise and diet, smoking cessation interventions, interventions for anxiety and depression, self-management and hearing voices self-help groups.
- b) All the range of teams and service level interventions currently used in the treatment of people with psychosis and schizophrenia, including Assertive Community Treatment teams, early intervention teams, crisis resolution and home treatment teams, community mental health teams, case management, acute day hospitals and crisis houses.
- c) Key aspects of teams delivering interventions that are associated with good outcomes.
- d) Interventions that improve the ability of people to undertake employment, including supported employment and pre-vocational training.
- e) Cognitive remediation, in particular its combination with vocational rehabilitation.
- f) The psychological management of previous trauma.

3.3.2 Key issues that will not be covered

- a) Psychological (with the exception of cognitive remediation) and pharmacological interventions.
- b) Specific interventions that are delivered in primary care services.
- c) Rapid tranquillisation.
- d) The specific management of affective disorders.
- e) The treatment of people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment.
- f) The management of coexisting learning disabilities, significant physical or sensory difficulties, or substance misuse.

3.4 Main outcomes

- a) Relapse rates and days in recovery.
- b) Quality of life and functioning.
- c) Engagement with services.
- d) Symptom measures, including affective outcomes as a result of interventions.
- e) Physical health.
- f) Experience of care.
- g) Experience of carers.
- h) Rate of employment/ occupational activity.
- i) Accommodation.

3.5 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in section 8 of ['The guidelines manual'](#).

4 Quality standard

Information on the NICE quality standards development process is available on the NICE website, see section 7.

4.1 Areas of care

The areas of care of a patient's pathway used to inform the development of the quality statements are set out in section 4.1.1. The content of the quality standard statements may change during the process and may differ after consultation with stakeholders.

4.1.1 Areas of care that will be considered

- a) Service-level interventions.
- b) Initiating treatment (first episode).
- c) Treating the acute episode.
- d) Promoting recovery across all phases.
- e) Treatment in primary and secondary care
- f) Delivery of services, including the components of effective teams.

4.1.2 Areas of care that will not be considered

- a) Primary prevention.
- b) Diagnosis of schizophrenia.

- c) Schizophrenia in people with moderate to severe learning disabilities, and physical or sensory disabilities.

4.2 Economic aspects

Developers will take into account both clinical and cost effectiveness when prioritising the quality statements to be included in the quality standard. The economic evidence will be considered, and the cost and commissioning impact of implementing the quality standard will be assessed.

5 Status

5.1 Scope

This is the final version of the scope.

5.2 Timing

The development of the guideline recommendations and the quality standard will begin in February 2012.

6 Related NICE guidance

6.1.1 NICE guidance that will be incorporated in or updated by the clinical guideline

This guideline will update the following NICE guidance:

- Schizophrenia. NICE clinical guideline 82 (2009). Available from www.nice.org.uk/guidance/CG82

6.2 Related NICE guidance

This guideline will incorporate the following NICE guidance:

Published

- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011). Available from: www.nice.org.uk/guidance/CG120
- Medicines adherence. NICE clinical guideline 76 (2009). Available from www.nice.org.uk/guidance/CG76

- Violence. NICE clinical guideline 25 (2005). Available from www.nice.org.uk/guidance/CG25
- Service user experience in adult mental health. NICE clinical guideline. Publication expected October 2011. www.nice.org.uk/guidance/CG136

NICE guidance under development

NICE is currently developing the following related guidance (details available from the NICE website):

- Psychosis and Schizophrenia in Children & Young People. NICE clinical guideline. Publication expected January 2013.

7 Further information

Information on the guideline development process is provided in:

- [How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS](#)
- [The guidelines manual](#)
- [Developing NICE quality standards: interim process guide.](#)

Information on the progress of the guideline and quality standards is also available from [the NICE website](#).