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MRCPsych General Adult Psychiatry

Psychosis 3

Developing people
for health and
healthcare

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Objectives

To develop an understanding of:

- the biopsychosocial management of schizophrenia
- evidence based treatment

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Expert Led Session

Schizophrenia:
biopsychosocial management and evidence-based treatment

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Overview

- introduction
- pharmacological interventions
- NICE guidelines
- non-pharmacological interventions
- summary

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Introduction

- antipsychotics
- psychosocial interventions
- psychotherapy

Biopsychosocial approach

- complexity of schizophrenia
- any single therapeutic approach inadequate to deal with the multifactorial disorder

Primary goals of hospitalisation

- diagnostic purposes
- medication stabilization
- safety of patients and others
- grossly disorganized behaviour
- effective association between patients and community support systems

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Treatment in hospital

Focus

- self-care
- quality of life
- employment
- social relationships

Aftercare facilities

Pharmacotherapy

- chlorpromazine 1952

- placebo-controlled clinical trials of antipsychotics in the acute phase of schizophrenia consistently demonstrated that the active drug is significantly more effective

- pharmacological properties
  - all share capacity to anatagonise postsynaptic dopamine receptors, with consistent level of dopamine blockade within few days

- some side effects in most patients

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Different types of antipsychotics

- pharmacology
- kinetics
- overall efficacy/effectiveness
- tolerability

1st vs 2nd generation antipsychotics

- typicals or first generation (FGAs)
- atypicals or second generation (SGAs)
- difference = size of therapeutic index in relation to acute EPSEs
- e.g.
  - haloperidol has a very narrow index <0.5 mg/day
  - olanzapine has a wide index 20-40mg/day

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Evidence

CATIE & CUtLASS

- 51 FGAs vs 11 SGAs
- no convincing evidence to support advantage for SGAs over FGAs (possible exception of clozapine & 0lanzapine)

Leucht S et al. comparative efficacy & tolerability of 15 antipsychotic drugs in schizophrenia: multiple treatment metanalysis lancet 2013

- ranking: clozapine 1st, amisulpride 2nd and olanzapine 3rd
- difference is small but potentially substantial enough to be clinically important

Side effects

- for both FGAs & SGAs
- common reason for treatment discontinuation
- psychiatrists' views of prevalence & importance of adverse effects differs markedly from patients' experience

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Acute phase

- average duration 4-8 weeks
- immediate attention
- alleviate psychotic symptoms
- manage agitation
- longer duration of untreated psychosis (DUP) = worse prognosis

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First episode psychosis

- early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis

- choice of antipsychotic medication should be made by the patient and healthcare professional together, taking into account the views of the carer, if the service user agrees

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First episode psychosis

- initiate antipsychotic at low licensed dosage range
- first-episode psychosis responds to lower doses of antipsychotic medication than those required for the treatment of established schizophrenia
- document review of change in symptom and side effects in the clinical records, with the rationale for any change in medication or its continuation
- adequate trial: optimum dosage with good compliance for 4 weeks

First episode psychosis

- for FGAs: medium or low-potency drug rather than high potency drug

- anticholinergic agents should only be used for emergent extrapyramidal problems (not prophylactically)

Pharmacotherapy

- many respond to antipsychotic drugs initially
- around 80% relapse within five years (discontinuation of medication, side effects)
- 75% recurrently relapse, leading to disability, but there is a moderately good long term global outcome in over half

Risk of relapse within a year

- 16%-23% on treatment
- 53%-72% without treatment

- patients with one episode have a 4:5 chance of relapsing

- stopping antipsychotics increases this risk 5 folds

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Length of treatment with antipsychotic after the first episode

- consensus guidelines recommend continued antipsychotic medication for 1–2 years (Buchanan et al., 2010; National Institute for Health and Clinical Excellence,2009b)

- recent data suggest 1-2 years maintenance is not enough
- some recommend treatment for at least 5 years; other indefinitely

Non-compliance

- very high rate
- up to 25% partially or non compliant at 10 days post discharge up to 50% at 1 year; up to 75% at 2 years
- increased risk of relapse, severity of relapse, duration of hospitalization, suicide attempts by four-fold

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Long-acting depot injection

- active drug in an oily suspension
- associated with a reduced risk of relapse and re-hospitilisation
- FGAs & SGAs

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Treatment resistant schizophrenia

- failure to respond to two or more antipsychotic medications given in therapeutic doses for 6 weeks or more
- approx 30% of patients respond poorly to antipsychotics
- about 7% show total non-response

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Treatment resistant schizophrenia- management

- clarify diagnosis
- address comorbidity
- consider non-compliance
- pharmacology: clozapine, then augment
- rehabilitation

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Relapse prevention

- continued prescription of antipsychotics to prevent relapse, maintain long-term control of symptoms/behaviour and improve quality of life
- individuals achieving greater improvement in symptoms with optimal pharmacotherapy benefit more from psychosocial interventions
- small number of longer-term, relapse prevention trials
- data insufficient to allow assessment of the relative merits of individual antipsychotics

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Monitoring of antipsychotic medication-NICE

- responsibility of secondary care team to monitor service users' physical health and effects of antipsychotic medication for at least the first 12 months or until condition stabilized

- afterwards, the responsibility may be transferred to primary care under shared care arrangements

Non-pharmacological interventions

- address impairments in social, vocational, and educational functioning
- focus

-physical health, smoking cessation

-patient and family education

-skills training

-supported employment

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Psychological therapies NICE

- CBT to all people with psychosis or schizophrenia
- family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the patient
- consider arts therapies to all people with psychosis or schizophrenia (alleviation of negative symptoms)

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CBT for psychosis

- 1:1 basis over at least 16 sessions
- establishes links between thoughts, feelings or actions and current/past symptoms, and/or functioning
- re-evaluation of people's perceptions, beliefs or reasoning relating to the target symptoms

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CBT for psychosis

Factors for successful CBT

- early work with acutely psychotic inpatients (Drury et al)
- female gender (Drury et al, Brabban et al)
- shorter duration of untreated illness (Drury et al)
- less severe symptoms (Tarrier et al)
- low level of conviction in delusions (Brabban et al)

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Evidence for CBT for psychosis

Jones et al. (2005) - systematic review of 30 papers: 19 trials of CBT for schizophrenia

- CBT was a promising but under-evaluated intervention for schizophrenia and other psychotic illnesses

SoCRATES trial (Lewis et al., 2002): 5-week course of CBTp for people recently admitted to hospital

- more rapid improvement in symptoms for the group that received CBT
- relatively modest effect size

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Evidence for CBT for psychosis

Wykes et al. (2008) meta-analysis of 34 trials of CBT

- significant inverse relationship between effect size and trial quality
- smaller, older and poorly funded trials showed a larger effect size
- rigorous CBTp studies had a moderate effect size (around 0.4)

Move away from generic CBT for psychosis towards a symptom specific approach (Steel, 2008) e.g. CBT for command hallucinations

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Family intervention

- family includes people who have a significant emotional connection to the individual, such as parents, siblings and partners
- 3 months to 1 year
- at least 10 planned sessions
- consider family's preference for either single family intervention or multi-family group intervention
- consider relationship between main carer and the person with psychosis

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Family therapy for schizophrenia

- 16 trials (857 participants): family intervention may reduce the frequency of relapse among patients
- 8 trials (481 patients): family intervention may reduce hospital admissions
- 7 trials (369 patients): family intervention may encourage compliance with medication
- 6 trials (481 patients): it does not apparently effect the tendency of individuals and families to drop out of care

(Family intervention for schizophrenia (review) PHAROAH F., et al Publisher:John Wiley and Sons , 2006, 107p., bibliog, Chichester)

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Support for carer

- as early as possible negotiate with patient and carer about how information about the service user will be shared
- offer carer an assessment
- offer carer focused education and support programme

Summary

- antipsychotics do not “cure” schizophrenia
- some antipsychotic drugs are more effective than others
- range of antipsychotics are available; different drugs suit different patients
- long-term treatment is generally required to prevent relapses
- antipsychotics should never be stopped suddenly
- psychological and psychosocial interventions increases the chances of staying well

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Any Questions?

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MCQs

1. Which one of the following led a trial that proved Clozapine's effectiveness in treating resistant schizophrenia?

A Kretschmer

B Cade

C Kraepelin

D Kane

E Bleurer

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MCQs

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MCQs

2. Choose the correct match from the following pairs:

A Risperidone: dibenzoxapine

B Droperidol: butyrophenones

C Aripiprazole: benzisothiazole

D Thioridazine: diphenyl butyl piperidine

E Flupentixol: dihydroindole

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MCQs

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MCQs

3. Which of the following atypical agents have the shortest half life?

A Quetiapine

B Aripiprazole

C Olanzapine

D Clozapine

E Risperidone

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MCQs

3. Which of the following atypical agents have the shortest half life?

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MCQs

4. The patients who are prescribed clozapine or olanzapine should have their serum lipids measured every:

A 6 days whilst on treatment

B One year whilst on treatment

C 3 months for the first year of treatment

D 6 weeks for the first year of treatment

E 6 months for the first year of treatment

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MCQs

4. The patients who are prescribed clozapine or olanzapine should have their serum lipids measured every:

A 6 days whilst on treatment

B One year whilst on treatment

C 3 months for the first year of treatment

D 6 weeks for the first year of treatment

E 6 months for the first year of treatment

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MCQs

5. What percentage of patients develop Tardive Dyskinesia with every year of typical antipsychotic exposure?

A More than 50%

B 2-5%

C 5-10%

D 20-25%

E 10-20%

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MCQs

5. What percentage of patients develop Tardive Dyskinesia with every year of typical antipsychotic exposure?

A More than 50%

B 2-5%

C 5-10%

D 20-25%

E 10-20%

Insert name of the module

Any Questions?

Thank you.

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References

- Psychosis and Schizophrenia in adults

The NICE guideline on treatment and management updated edition 2014

- SPMM Course HiYield Paper A(2)