CLINICAL PRACTICE RECOMMENDATIONS

TREATMENT DURING THE ACUTE PHASE

GOALS OF TREATMENT

The goals of treatment during the acute phase are reduction in symptoms and improvement in role functioning. Establishing contact with the family with a view to involve them in the treatment process, and establishing an alliance which can continue throughout this process, is another important objective. Formulating a plan for further short or long-term treatment is the final goal of this phase.

ASSESSMENT

Before proceeding on to treatment all patients need a detailed and comprehensive assessment, which considers the psychiatric, physical/medical, as well as social/familial aspects of the situation.

PSYCHIATRIC ASSESSMENT

Psychiatric evaluation during the acute phase is needed-

- to establish the diagnosis
- to assess the severity of illness particularly in terms of risk of harm to self and others
- to detect comorbid conditions such as substance abuse

A diagnosis of schizophrenia should be made according to structured diagnostic criteria, wherever possible. Such a diagnosis is more reliable, facilitates communication between clinicians, and allows for better applicability of research recommendations regarding treatment.

A definitive diagnosis may need time. Further, because of the enormous psychosocial consequences a diagnosis of schizophrenia needs to be made with great caution and sensitivity. A medication-free observation period in the hospital has been recommended in doubtful cases, but needs to be balanced against the risks of delaying treatment or the potential for harm in acutely ill patients.

Efforts should be made to obtain information from all sources, particularly the family.

If a second opinion is asked for by the family, or felt necessary by the treatment team, this should always be sought.

The list of conditions mimicking schizophrenia is long. Those that need to be commonly considered are organic brain disorders, substance-induced psychotic disorders, acute psychotic conditions, and mood disorders with psychotic symptoms. Careful history taking physical and mental state assessments will help in ruling out most of these conditions. Investigations such as drug screens, EEG, neuroimaging etc. can be used whenever required.

The risk of harm to self and others secondary to delusions and hallucinations or suicidal ideas needs to be particularly looked into. If present, appropriate precautions will need to be taken.

Standardized rating scales are reliable and accurate ways of assessing severity. Wherever possible, unstructured assessments need to be supplemented by ratings on such scales.

A high index of suspicion coupled with thorough assessment will be able to detect most patients with comorbid substance abuse/dependence. Urine or blood screens (with prior consent) can be used to confirm the existence of comorbid substance abuse/dependence, wherever such facilities are available.

PHYSICAL ASSESSMENT

Patients with schizophrenia are more likely than the general population to have lifestyle risk factors for cardiovascular disease and mortality. People with schizophrenia are also less likely to exercise or take a proper diet, and more likely to neglect heath problems (McCreadie et al., 2003). The

higher physical morbidity and mortality of patients with schizophrenia must be considered in all assessments. Particular attention should be paid to the risk of metabolic and cardiovascular disease. An effort should also be made to establish the state of the patient's physical condition through detailed examinations, routine investigations, and special tests wherever required. The physical status of the patient needs to be reviewed from time to time.

ASSESSMENT OF FAMILY PARAMETERS

Much of this will be a part of the psychiatric assessment. Economic and living conditions, needs and expectations from treatment, knowledge about illness, attitudes towards patient etc., also need to be focused on.

CHOICE OF TREATMENT SETTING

Although the decision to admit the patient may hinge on several clinical and social factors the principal reasons for hospitalisation are

- risk of harm to self/others
- inability to care for self
- presence of comorbid physical or psychiatric conditions
- requirement for more intensive treatment

Alternatives to hospitalisation are outpatient treatment and a range of intermediate facilities or modalities such as day hospitalisation, home-care, ACT etc. These are feasible and efficacious alternatives as demonstrated by research data from the West, and to a lesser extent from India. However the virtual absence of such facilities in India means that the only practical alternative to hospitalisation in this country is outpatient care.

ANTIPSYCHOTIC TREATMENT

Antipsychotic medications are indicated for nearly all patients with acute episodes of schizophrenia. Antipsychotic therapy should be initiated as part of a comprehensive package of care that addresses the patient's clinical, emotional and social needs, as well as the needs of his/her family.

CHOICE OF DRUG

In general the choice of an antipsychotic is guided by the side-effect profile of the drug, prior response patterns, patient preferences and the preferred route of administration (oral versus parenteral).

SGAMs have several advantages in the treatment of schizophrenia. These drugs have significant effects in reducing positive symptoms, in which aspect they are equal, if not superior to FGAMs. The evidence for their efficacy against negative, cognitive and affective symptoms though less firm, is still compelling. They are efficacious in patients with aggressive or suicidal impulses, and have proved useful in relapse prevention. Their greatest advantage, however, is the lower risk of EPSEs, particularly TD. They seem to be more acceptable to patients, and lead to improved adherence and quality of life. They are, therefore, universally recommended as first-line treatments in schizophrenia, and should be used preferentially in first-episode patients (except clozapine). They are also the preferred choice in treatment of patients with parkinsonism, EPSE sensitivity, and those with TD. They should also be considered in patients who develop unacceptable side effects with first-generation drugs. However, patients who are well controlled on FGAMs and are not experiencing significant side effects should not be switched to second-generation antipsychotics. FGAMs can also be useful in the management of acute agitation and floridly psychotic patients (Sartorius et al., 2003).

DOSE

The recommended dose of FGAMs is in the range of 300 - 1000 mg chlorpromazine equivalents per day (APA, 1997; 2004; NICE, 2002).

Standard recommendations for SGAMs are also available.

Lower than recommended doses are usually recommended for first-episode patients.

The use of high or mega doses of antipsychotics, if required, may be used with caution in exceptional circumstances.

It is likely that Indian patients require lower doses of antipsychotic drugs. Although this is suggested by clinical experience and pharmacokinetic studies of Asian patients, there is little evidence for, or against this supposition from clinical trials.

ROUTE OF ADMINISTRATION

Parenteral administration is often required in acutely agitated patients to achieve rapid control of behavioural disturbance. Liquid or mouth-dissolving formulations are helpful in non-compliant patients. Depot preparations are generally not used during the acute phase. The use of one drug by one route is recommended in order to minimise drug interactions and simplify clinical observations.

DURATION OF TREATMENT

The minimum recommended duration of treatment for all drugs is 4- 6 weeks, with the exception of clozapine, where the minimum period of treatment should be 3 months (APA, 1997; 2004; NICE, 2002).

RESPONSE.

Antipsychotics are known to produce a significant remission of positive symptoms. This could thus be a reasonable goal of treatment. Effects on negative symptoms are less impressive, therefore a mild to moderate reduction in negative symptoms is often acceptable. Response indicators for other aspects of the illness (e.g. cognitive symptoms) are not clear (Miller et al., 1999). Regular monitoring is required for determining the degree of response and the emergence of side effects.

NON-RESPONSE

In case of non-response, non-compliance, which is highly prevalent among patients, should be suspected first. If this is confirmed the causes should be looked for, and appropriate steps taken to handle the problem. Clozapine is recommended after failure of sequential trials of 2 antipsychotics (at least one of which is a SGAM), in patients who are violent/at risk for suicide and not responding to their current medication, or in patients who have intolerable side effects with two different classes of antipsychotics (APA, 1997; 2004; NICE, 2002).

COMBINING ANTIPSYCHOTICS

The evidence for the efficacy of combining antipsychotics is limited and anecdotal. Combinations of antipsychotics should be normally avoided, except in patients not responding to clozapine (NICE, 2002). 6

COST OF TREATMENT

Whether patients can actually afford the drugs being prescribed should always be enquired about. In certain situations the cost of the drug could be an important determinant of the choice of the antipsychotic to be used.

ADJUNCTIVE MEDICATIONS

Lithium and other mood stabilizers can be added in agitated, overactive patients or those with affective symptoms responding poorly to their current drug. Adjunctive benzodiazepines can be useful in controlling agitation and in those with sleep disturbance. The role of antidepressants in treating depressive symptoms during the acute psychotic phase, as opposed to the post-psychotic phase, is not clear. Prophylactic anticholinergic treatment is generally required in situations of high risk for EPSEs, predisposition to EPSEs, or possible detrimental effects of EPSEs on compliance (APA,

1997; 2004; NICE, 2002; Kusumi & Koyama, 1999).

ECT

ECT can be used for patients with catatonic or affective symptoms and in certain situations where rapid control of symptoms is required.

PSYCHOSOCIAL INTERVENTIONS

In the acute phase psychosocial treatments with the patient are aimed at reducing over stimulating or stressful conditions, while providing a safe and structured environment. The interventions are kept relatively simple. Information about the nature and treatment of illness can be provided depending on the patient's ability to handle such information. There should be opportunities for recreational and simple therapeutic activities. Input from social workers, nurses and psychologists may be required to deal with non-psychotic symptoms or difficult behaviours.

An effort is also made to involve and engage the family in the process of treatment. Relatives need to be seen regularly for this purpose. The aim is to educate the family in understanding the illness. Simple and brief explanations about the nature of the patient's illness, treatments, likely side effects, likely length of treatment etc. can be offered. Relatives also need to be given time to confront the painful fact of the illness, and what it entails for the patient and the family as a whole. It is important that professionals are careful and considerate, but clear and thorough in their use of clinical language and in the explanations they provide. No blame should be attached to the family. Treatment adherence will be another main objective at this stage; family members will need assistance in dealing with various problems it presents e.g. continued use of medication to control symptoms, issues of non-compliance, dealing with distressing side effects etc.

PLANNING FOR FURTHER TREATMENT

At the end of the acute phase the treating team, family members and the patient whenever possible, should jointly decide on a plan for further treatment. Issues such as follow-up, medication management, preventing psychosocial stress etc. could be discussed. To ensure continuity of care it is preferable for the same team member(s) to be involved in the future care of the patient.

ASPECTS OF TREATMENT DURING THE ACUTE PHASE

- Determining goals
- Assessment (psychiatric/ physical/ psychosocial)
- Choice of treatment setting
- Antipsychotic treatment
  1. Choice of drug
  2. Dose
  3. Route of administration
  4. Duration of treatment
  5. Determining response or non-response
  6. Combining antipsychotics
- Use of adjunctive medications
- Use of ECT
- Psychosocial interventions
- Planning for further treatment

POST-ACUTE PHASE / STABILIZATION PHASE/ CONTINUATION-TREATMENT PHASE

GOALS OF TREATMENT

Goals of treatment during this phase include facilitation of continued symptom reduction and decreasing the likelihood of relapse. Stress on patients needs to be minimized, support needs to continue, and patient's adaptation to life in the community enhanced.

ASSESSMENT

Assessments for further help to minimise disability, reduce risk of relapse and improve quality of life should be routinely undertaken during recovery from the acute phase.

ANTIPSYCHOTIC DRUG TREATMENT

Though studies have not specifically examined the issue of efficacy of drugs during this phase, the data on maintenance phase efficacy of antipsychotics provide important clues. This suggests that if the patient has improved with a particular drug during the acute phase he/she should continue with the same drug at the same dose for the next 6-12 months. Failure to do so may result in a relapse relatively early.

PSYCHOSOCIAL INTERVENTIONS

Psychosocial treatments remain supportive. Engagement with family continues with further psychoeducation and support. The importance of treatment compliance is reemphasised. Patients when they are willing and able can also be taught how to manage their medication, although the family members should also supervise drug intake. A few basic skills that will help prepare the patient for life in the community can also be taught. It is important to ensure continuity of care and prevent early dropouts. Frequent outpatient appointments, ensuring that patients have ready access to treatment facilities, dealing with any emergencies that might arise, all help in this process. Home visits can also be arranged if required and when feasible.

ASPECTS OF TREATMENT DURING THE POST-ACUTE PHASE

- Determining goals
- Further assessment
- Antipsychotic treatment
- Psychosocial interventions

STABLE PHASE / MAINTENANCE TREATMENT PHASE

GOALS OF TREATMENT

The goals of treatment during this phase are to maintain or improve functioning and quality of life. Prodromal symptoms or psychotic exacerbations should be effectively treated. Adverse effects should be detected and managed.

ASSESSMENTS AND MONITORING

Further assessments may be required during this period especially if psychosocial treatments are being planned. Monitoring is required for assessing response and for side effects that may emerge. Information should be obtained both from the patients, family members, and other available sources. Whenever possible, objective ratings should be used to gauge the progress of therapy more effectively. Standardised instruments improve reliability and enhance communication. Reassessment on several parameters may need to be carried out from time to time. Frequency of contact will depend on several factors such as clinical state, the distance of the hospital from the patient's home, social support available for the patient, the type of treatment being administered etc.

ASSESSMENTS FOR DRUG TREATMENT

Ongoing assessments and monitoring are required to determine response to antipsychotics and the need for change if any, to detect side effects, and to identify the early signs of a relapse.

SUGGESTED ASSESSMENTS AND MONITORING *

Parameter	Baseline assessment	Follow-up monitoring
Vital signs (pulse, B.P., temperature etc.)	Required	As required
Height/weight/body mass index (BMI)	Required	BMI every visit for 6 months & every 3 months thereafter
Haemogram	Required	Repeated as required, particularly for those on clozapine
Biochemistry (electrolytes, renal, liver and thyroid functions etc.)	Required	Annually and as clinically indicated
Screening for infections (syphilis, HIV etc.)	Required if clinically indicated	-
Screening for substance abuse	Required if clinically indicated	-
Neuroimaging/EEG	Required if clinically indicated	-
Screening for diabetes	Required especially in those with risk factors and those on drugs with known predisposition	Fasting blood sugar or Haemoglobin A1c after 4 months of treatment & annually thereafter
(history, examination, fasting blood sugars)	Required especially in those with risk factors and those on drugs with known predisposition	At least every 5 years
Hyperlipidemia (lipid profile)	Required especially in those with risk factors and those on drugs with known predisposition	At least every 5 years
Screening for cardiovascular disorders (history, examination, ECG etc.)	Required especially in those with risk factors and those on drugs with known predisposition	ECG with every dose change or addition of new drugs & as required
Hyperprolactinemia (history & examination; prolactin level only if indicated and feasible)	Required especially in those on drugs with known predisposition	Screening for signs/symptoms of hyperprolactinemia - at each visit until on stable doses, yearly thereafter for those on drugs with known predisposition. Prolactin level only if indicated and feasible
Clinical assessment for (Acute) EPSEs	Required after starting drugs	Clinical assessment at least weekly until on stable doses, at every follow-up thereafter
Clinical assessment for Tardive dyskinesia	Required after 3 months of treatment	At least every 6 months for FGAMs & every 12 months for SGAMs

**** Extent of baseline assessments and frequency of monitoring are principally determined by the clinical situation***