



Chronic (persistent) psychotic disorders

Chronic (persistent) psychotic disorders* - F29# (Clinical term: Schizophrenia Eu20). Includes schizophrenia, schizoaffective disorders, schizotypal disorder, persistent delusional disorders, induced delusional disorder, other non-organic psychotic disorders

* Chronic psychosis has become a pejorative term: persistent psychosis embraces the possibility of recovery.

Presenting complaints

Many patients will have an established history of psychosis; others, however, may be unknown to specialized services, particularly those with more insidious presentations or those who have disengaged or are homeless.

Patients may present with the following:

- difficulties with thinking or concentrating (eg they think that the television is talking to them, or that their thoughts are being read)
- reports of hearing voices or seeing visions
- strange beliefs (eg having supernatural powers or being persecuted)
- extraordinary physical complaints (eg strange sensations or having unusual objects inside their body)
- problems or questions related to antipsychotic medication
- problems in managing work, studies or relationships
- physical health care problems (eg weight, respiratory or cardiac problems)
- lack of energy or motivation and an inability to feel emotion
- depression or suicidal thinking.

Families might seek help because of apathy, withdrawal, poor hygiene, or strange behaviour.

Diagnostic features

Persistent problems with the following features:

- social withdrawal and/or poor social integration
- low motivation, interest or self-neglect
- disordered thinking (exhibited by strange or disjointed speech).

Periodic episodes of:

- depression (co-existing depression is a common, and is sometimes a serious consequence of persistent psychosis; there is a serious risk of suicide)
- agitation or restlessness
- bizarre behaviour
- hallucinations (false or imagined perceptions, eg hearing voices)



- delusions (firm beliefs that are often false, eg patient is related to royalty, receiving messages from the television, being followed or persecuted)
- intense fear, anxiety and distress.

It can be difficult to ask patients about strange thoughts and hallucinations. Useful questions include, 'Have you had the feeling lately that people are talking or plotting about you, or trying to hurt you?', 'Is there anything special about you that would make anyone want to do that?' 'Have there been times lately when you have heard noises or voices or seen strange things when no one else was about and there was nothing else to explain it?'

Differential diagnosis and co-existing conditions

- Depression - F32# (if low or sad mood, pessimism and/or feelings of guilt; co-morbid depression is common).
- Bipolar disorder - F31 (if symptoms of mania excitement, elevated mood, exaggerated self-worth is prominent).
- Alcohol misuse - F10 or Drug use disorders - F11#. Chronic intoxication or withdrawal from alcohol or other substances (stimulants, hallucinogens) can cause psychotic symptoms.
- Patients with persistent psychosis might misuse drugs and/or alcohol.

Essential information for patient and family

- Agitation and strange behaviour can be symptoms of a mental disorder.
- Symptoms may come and go over time.
- Medication should be part of an overall holistic and multi-axial approach to care and can help by reducing current difficulties and the risk of relapse.
- Stable living conditions (eg stable accommodation, adequate income, daily work or activities) are a pre-requisite for effective rehabilitation and recovery.
- It is important for family/carers to work with the doctors to learn to recognise early warning signs of relapse and for an advance agreement to be established with the patient and family/carers on how crises should be managed.
- Voluntary organizations can provide valuable information, support and self-management courses to the patient and carers.

General management and advice to patient and family

- Remain optimistic and emphasize the patient's strengths and abilities rather than deficits.
- Recovery often takes place in small steps and, for the patient, being engaged in an activity that is meaningful to them might be as important as symptom control.
- Discuss a treatment plan with the patient, in line with NICE good practice; (ref 1) provide information on the condition, treatment choices and informed discussion. The treatment plan should include recognition of early warning signs and the agreed management of crises should be clearly recorded in the medical records. A copy of the plan should be given to the patient and, with their permission, to the family/carers.
- Explain that drugs help prevent relapse, and discuss information on effects and side-effects with the patient.



- The DVLA must be notified in all cases. Advise patient to inform DVLA: driving should cease until patient has been stable and well for at least three years and has insight into his/her condition (LGV/PSV driver) (ref 2)
- Support patient to function in the areas that are important to him/her (eg work, recreation, relationships).
- It is important proactively to offer patients the same health promotion and prevention measures as the general population (eg smoking cessation, weight control, screening for diabetes and sexual health).
- Substance misuse (seen in over 30% of cases) will increase the chance of relapse.
- Psychological therapies for both the patient and family/carers might help prevent relapse, promote recovery, and are increasingly available in local services. Encourage the patient to engage with psychological therapies where available (eg cognitive behavioural therapy, family therapy, problem-solving interventions).
- Family interventions or problem-solving work might help improve patient and carer health.
- Therapeutic alliances build on respect and feeling valued. Encourage the patient to build relationships with key members of the practice team, for example by seeing the same doctor or nurse at each appointment. Use the relationship to discuss the treatment plan including medication advantages of medication and to review the effectiveness of the care plan.
- Acute psychotic disorder - F23. Advise on the management of agitated or excited states.
- If care is shared with the Community Mental Health Team, agree who is to do what.
- Support of the carer is essential for effective treatment and rehabilitation. An assessment of the patient's needs and those of the carer (under the Carer's Recognition and Services Act) can be requested from the local Social Services department.

Medication

- Antipsychotic medication may reduce psychotic symptoms (BNF section 4.2.1).
- Some patients remain stable on the older medications (eg trifluoperazine, chlorpromazine). If effective and well tolerated, NICE guidance suggests the drug should be continued (ref 1). If ineffective or poorly tolerated, NICE guidance suggests an atypical medication should be considered (ref 1).
- Atypical antipsychotics, for example olanzapine (5–10 mg a day) or risperidone (2–4 mg per day), should be considered as a first-line treatment (ref 1).
- Inform the patient that continued medication helps reduce risk of relapse. In general, antipsychotic medication should be continued for at least one year.
- The dose should be the lowest possible for relief of symptoms and effective daily functioning.
- If, after team support, the patient is reluctant or erratic in taking medication, injectable long-acting antipsychotic medication could be considered in order to ensure continuity of treatment and reduce risk of relapse (ref 3). It should be reviewed at 46 monthly intervals, and a weight gain and physical annual health check is essential to decrease the risk of cardiac and respiratory effects of medication and a sedentary lifestyle. Doctors and nurses who give depot injections in primary care need training to do so (ref 4). If available, specific counselling about medication is also helpful (ref 5). As part of the 'shared care plan', decide who is to contact the patient should he/she fail to attend an appointment.
- Discuss the potential side-effects with the patient. Common motor side-effects, particularly with older antipsychotics, include the following:



- Acute dystonias or spasms and parkinsonian symptoms (eg tremor and akinesia), which can be managed with antiparkinsonian drugs (eg orphenadrine [50 mg three times a day]); (BNF section 4.9)
 - withdrawal of antiparkinsonian drugs should be attempted after 2-3 months without symptoms, as these drugs are liable to misuse and may impair memory.
 - Akathisia (severe motor restlessness) can be managed with dosage reduction, or beta-blockers (eg propranolol at 30–80 mg a day) (BNF section 2.4). A change in medication might be necessary
 - Tardive dyskinesia is a particularly important side-effect for which to monitor. It is associated with longer-term use of traditional antipsychotic medication, is severely disabling and can be irreversible.
- Other side-effects can include glucose intolerance, weight gain, galactorrhoea and photosensitivity. Patients suffering from drug-induced photosensitivity are eligible for sunscreen on prescription.
 - Avoid poly-pharmacy, particularly concurrent prescribing of typical and atypical antipsychotics, and prescribing in excess of BNF guidelines.

Liaison and referral

Referral to secondary mental health services is advised:

Urgently:

- if there are signs of relapse (unless there is an established previous response to treatment and it is safe to manage the patient at home)
- if there is a risk to self or others.

Non-urgently:

- if there is a poor response to treatment
- to clarify diagnosis and ensure most appropriate treatment, including family interventions and cognitive behavioural therapy for psychosis
- if there is non-compliance with treatment, problematic side-effects, failure of community treatment or breakdown of living arrangements (eg threat of loss of home).

Patients with complex mental-health, occupational, social and financial needs are normally managed by specialist services, under the Care Programme Approach and shared care with primary healthcare teams once stable.

Community Mental Health Services should be able to provide concordance therapy, (ref 5) family interventions, (ref 6) cognitive behaviour therapy (ref 7) and rehabilitative facilities.



Special considerations in children and adolescents

- In younger teenagers, psychosis is less common than in adults, and in prepubertal children it is decidedly rare. When it does occur, however, it often takes a particularly severe and persistent form.
- For children and teenagers, family-based management and specialist education are particularly important.
- Only atypical antipsychotics should be used and depot preparations are seldom necessary or appropriate.

Child and Adolescent Mental Health Services should usually be the specialist advisors for children and teenagers.

Resources for patients and families

Rethink (formerly the National Schizophrenia Fellowship)
England: 020 8974 6814 (Advice line: 10am–3pm, Monday–Friday)
Email: advice@rethink.org; website: <http://www.rethink.org>
Scotland: 0131 557 8969
Northern Ireland: 02890 402 323
Monthly social groups for clients with schizophrenia living in the community and relatives support.

Schizophrenia Association of Great Britain 01248 354 048
Email: info@sagb.co.uk; website: <http://www.sagb.co.uk>

Offers information and support to sufferers, relatives, friends, carers and medical workers.

MINDinfoLINE 08457 660 163 (9.15am–5.15pm, Monday–Friday).
Email: info@mind.org.uk; website: <http://www.mind.org.uk>
Information service for matters relating to mental health.

SANELine 08457 678 000 (helpline 12noon–2.00am)
Website: <http://www.sane.org.uk>
Helpline offering information and advice on all aspects of mental health for those experiencing illness or their families or friends.

Hearing Voices Network 0161 228 3896 (10.30am–3pm, Monday–Wednesday, Friday)
Self-help groups to allow people to explore their voice-hearing experiences.

The UK NHS Portal for Schizophrenia
Website: http://www.nelmh.org/home_schizophrenic.asp?c=10

This is a web-based information resource for people with schizophrenia and their carers. The site contains a number of user-friendly sections: Evidence-based treatment summaries; What is schizophrenia? How is schizophrenia diagnosed? Managing schizophrenia; Living with schizophrenia; Support for carers; and Legal issues.

IRIS (Initiative to Reduce the Impact of Schizophrenia) 01922 858 044
Website: <http://www.iris-initiative.org.uk>
In conjunction with Rethink, IRIS has developed clinical guidelines for practitioners and consumers.

Mental Health Care <http://www.mentalhealthcare.org.uk>



This site provides mental health information and research news from the Institute of Psychiatry and the South London and Maudsley NHS Trust in partnership with Rethink.

The Mental Health Foundation produces the information booklet Understanding Schizophrenia. Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW, UK. Tel: 020 7802 0304; website: <http://www.mentalhealth.org.uk>.

Living With Schizophrenia: a Holistic Approach to Understanding, Preventing and Recovering from Negative Symptoms by John Watkins. Hill of Content Publishing, 1996.

Working with Voices by R Coleman and M Smith. Handsell Publishing, 1997
This is a workbook to help voice hearers manage their voices.

Human Voices: A Common Human Experience by John Watkins. Hill of Content Publishing, 1998

References

1 National Institute for Clinical Excellence. Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. Clinical Guideline 1. December 2002. URL <http://www.nice.org.uk>. (A1)

2 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL <http://www.dvla.gov.uk>. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

3 Adams CE, Eisenbruch M. Depot fluphenazine for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (C1) The use of depot fluphenazine continues to be based on clinical judgement rather than on evidence from methodical evaluation within trials.

4 Kendrick T, Millar E, Burns T, Ross F. Practice nurse involvement in giving depot neuroleptic injections: development of a patient assessment and monitoring checklist. Prim Care Psychiatry 1998, 4(3): 149-154 (AIV) Of the 25% of people with schizophrenia who have no specialist contact, many have a practice nurse as their only regular professional contact. Levels of knowledge of schizophrenia and its treatment of those nurses was often no better than a lay person's.

5 Kemp R, Kirov G, Everitt B, David A. A randomised controlled trial of compliance therapy: 18-month followup. Br J Psychiatry 1998, 172: 413-419. (AII) Patients who received specific counselling regarding their attitudes towards their illness and drug treatment were five times more likely to take medication without prompting compared with controls.

6 Pharoah FM, Mari JJ, Streiner D. Family intervention for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (A1) Thirteen studies were analysed. Families receiving this intervention, which promotes a more supportive family environment, can expect the family member with schizophrenia to relapse less and to be in hospital less.

7 Cormac I, Jones C, Campbell C, Silveira da Mota Neto J. Cognitive behaviour therapy for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (A1) Thirteen studies were analysed. Four small trials show that cognitive behaviour therapy is associated with substantially reduced risk of relapse.