ORIGINAL ARTICLE

ANALYSIS OF THE CORE INTERVENTIONS IN THE MANAGEMENT OF SCHIZOPHRENIA IN SECONDARY CARE USING NICE GUIDELINES

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ABSTRACT

OBJECTIVE

Study was conducted by analysing case notes of 66 patients suffering from Schizophrenia retrospectively to find out whether the NICE management guidelines were followed in outpatient clinics in Milton Keynes primary care trust.

SUBJECTS AND METHODS

Case notes of 66 patients were randomly selected from East, West recovery teams who attended the service between January and December 2007.

INCLUSION CRITERIA

All patients with the diagnosis of schizophrenia in the age range of 18-65 and who had received treatment at the Milton Keynes primary care trust, England within the past 12 months were included in the study.

EXCLUSION CRITERIA

Patients admitted to psychiatric ward at the time of study were excluded from the study.

RESULTS

8% patients received family therapy and 9% received CBT. 18% were engaged with AOT while only 5% patients and their relatives received information on their illness. In about 38% progress was recorded, 48% were on depot medication and 85% were on mono therapy. No information was found on the reasons for poly pharmacy while the drugs combined were not in line with the NICE guidance.

CONCLUSION

The findings of the study were mixed where recommendations from the NICE guidance had not been followed consistently in providing the core interventions set out in the NICE guidance. There is a case for the individual trusts to identify the reasons for non adherence to the guidelines and take appropriate measures ensuring implementation of the guidance in its totality.

KEY WORDS

Schizophrenia, NICE Guidelines, Schizophrenia Audit

INTRODUCTION

Schizophrenia is a term used to describe a major psychiatric disorder that alters an individual's perception, thoughts, affect and behaviour. The Symptoms of schizophrenia 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. Whatever the pattern of illness, schizophrenic disorders have a strong tendency for recurrence: because of several reasons including social isolation, stigma, and comorbid substance misuse, the effect of symptom domains on adherence, both the positive and negative symptoms, lack of insight, depression, and cognitive impairment. Approximately half of people with schizophrenia treated in standard services will relapse and require readmission within the first 2 years; although about a quarter will have no further admissions[1]. Recurrence, or relapse, can be affected by home circumstances: relapse rates can be higher for people living in stressful relationships, especially with family members[2,3]. It is likely that relapse rates will also be affected by other life stresses, such as those related to finance and employment. However, this appears to be partly reversed in some developing countries[4], suggesting that the relationship between incidence, recovery rates and cultural and economic factors is more complex than a simple correspondence with socio-economic deprivation[5].

The effects of schizophrenia on a person's life experience and opportunities are considerable; service users and care givers need help and support to deal with their future and to cope with the changes the illness brings. The mean incidence of schizophrenia reported in epidemiological studies, when the diagnosis is limited to core criteria and corrected for age, is 0.11 per 1000 (range 0.07–0.17 per 1000); if broader criteria are used, this figure doubles to 0.24 per 1000 (range 0.07–0.52 per 1000)[4].

Today, within both hospital and community settings, antipsychotic medicines remain the primary treatment for schizophrenia. There is well-established evidence for the efficacy of antipsychotic drugs in both the treatment of acute psychotic episodes and relapse prevention over time[6]. However, despite the effectiveness of these drugs, considerable problems remain and a significant proportion, perhaps upto 40% has a poor response to conventional antipsychotic drugs[7]. In response to the limited effectiveness and extensive side-effects of conventional antipsychotic drugs, considerable effort has gone into developing pharmacological treatments for schizophrenia that produce fewer or less disabling side-effects. The main advantage of these newer, 'atypical' antipsychotic has been a lower liability to EPS. Moreover, it has also been argued that certain atypical drugs, particularly Clozapine, can produce therapeutic gains in people with schizophrenia who do not respond well to conventional antipsychotic[8].

In different regions of the world, practice guidelines have been developed to improve schizophrenia care. Nevertheless, it remains unresolved how a core set of universally valid secondary and tertiary psychiatric care recommendations can be defined which could easily be used to develop national or regional mental health guidelines without disregarding local health systems or cultures. Wolfgang Gaebel et al. measured the scientific quality of practice guidelines[9], selecting an instrument developed by an international group of guideline experts, the Appraisal Guideline Research and Evaluation Europe (AGREE) rating scale[10]. The AGREE instrument assesses both the quality of reporting and the quality of the guideline development process. They evaluated 24 guidelines from 21 countries and showed that many national guidelines were difficult to apply and majority of these didn't consider local psychiatric care system or cultural or socioeconomic issues. They found that NICE had the highest methodological quality and the highest scores in 5 out of 6 domains. In United Kingdom the national institute of excellence (NICE) have developed a guideline for treating schizophrenia and recommends that all patients diagnosed with schizophrenia must have access to a whole range of services including family therapy, Cognitive Behaviour Therapy, Assertive Outreach programme, Occupational Therapy and pharmacotherapy .

This guideline addresses the major treatments and services for people with Schizophrenia and assist clinicians and others to provide high-quality care for people with schizophrenia and their families, while also emphasizing the importance of the experience of care for service users and care givers. An earlier independent audit in the trust (2006) had shown that NICE guidelines were inconsistently followed in the treatment of Schizophrenia especially very little use was made of the CBT and Family interventions. Present study was designed to analyse the Core interventions offered to individuals suffering with schizophrenia in the outpatient setting and the authors hypothesized that NICE guidelines were consistently followed while offering these core interventions.

SUBJECTS AND METHODS

Participants

Case notes of 66 patients were randomly selected from East, West recovery teams who attended the service between January and December 2007. The Inclusion criteria was defined as following;

1. All patients diagnosed with schizophrenia and who were still with the secondary mental health services at Milton Keynes primary care trust, England were included in the study.
2. Patients between the age range of 18-65 were included who had received treatment from one of the recovery teams (formerly community mental health team-CMHT).

Exclusion Criteria was defined as following;

1. Patients on the ward at the time of study were excluded from the study.
2. Patients were also excluded where access was not possible to complete record including case notes and the hospital data base.

Procedure

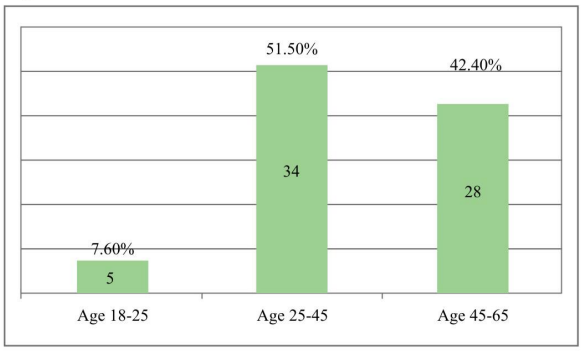
Case notes of 66 patients currently receiving treatment from either the East or West Recovery Teams, at Milton Keynes primary care trust, England mental health services were analysed using manual record and the hospital computer database. Information on these core interventions were obtained mainly from the clinician's assessment at the outpatient clinics, clinic letters to GP's, Care Programme approach (CPA) forms and paper work provided by other professionals involved in their care. Psychology department database was also accessed on Information on family therapy and CBT with the help of a consultant psychologist working in the hospital psychology department.

RESULTS

Total 66 case notes were studied of which 8 were females and 58 were males. 5 patients were between age 18-25, 34 patients were between 25- 45, while 27 between 45-65 (figure 1). Four were Asians, 5 were Africans while 57 were Europeans.

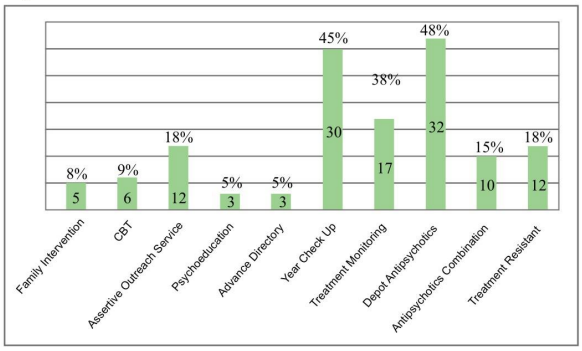
Apart from Depot medication and Yearly physical Check up most of the other interventions offered were provided to less than 10% of the patients (figure 2).

Figure 1



Age distribution of the patients.

Figure 2



Interventions Offered

DISCUSSION

The study has been important and while in certain areas especially the use of single drug to treat schizophrenia and the use of Clozapine

in treatment resistant cases has mainly been in line with the NICE guidelines. For example the study provided evidence that majority of the patients 85% were on mono therapy which is an encouraging finding but 15% patients were receiving poly pharmacy, where no evidence was found for its prescription according to the NICE guidance. NICE recommends poly pharmacy only while switching over to another drug or combining Amisulpiride with Clozapine in resistant cases.

The use of family interventions and cognitive behaviour therapy has been appallingly low i.e. only 8% & 9% respectively while NICE recommends these 100% with only a few exceptions. These results are in line with an independently conducted audit during 2006 by the Milton Keynes Primary Care Trust on 250 Schizophrenia patients using the NICE guideline where they reported that fewer than 10% patients received family therapy and CBT.

Most meta-analyses concur that expert cognitive-behavioral therapy (CBT) has proven benefits in research settings in managing residual symptoms, poor insight and poor adherence to treatment regimens in schizophrenia[11].

Douglas Turkington et al 2006 conducted a 12-month follow-up study and hypothesized that there would be no difference between the two groups (CBT and usual care) in insight, overall symptoms, depression or suicidality, occupational recovery, time to and duration of hospital readmission, and psychotic or negative symptoms. The durable effects of the intervention occurred across certain but not all outcome measures. Statistically significant improvement was found for both insight and secondary negative symptoms such as apathy, reduced volition and asociality[12].

The 1980's have seen the publication of the first generation of studied of family intervention in schizophrenia. They are of profound significance since they appear to demonstrate that an illness so often regarded as malignant can be controlled through environmental interventions. This has important implication not only for the provision of service but also for the concepts which underpin our thinking about this disorder. Eighteen families who completed two years community management based upon behavioral family therapy were compared with 18 families who received patient oriented management with family support. Families receiving family management reported less disruption of activities, reductions in physical and mental Health problems and less subjective burden than those receiving the patient oriented approach. It is concluded that the benefits of family management extend beyond the reduction in clinical and social morbidity of the index patient to beneficial effects for the family as a whole[14].

Paul Lelliott conducted a 1-day census, involving 3576 psychiatric in-patients prescribed anti-psychotic medication. Half of patients were prescribed more than one anti-psychotic drug concurrently although 23.3% (n=832) of patients were prescribed a high dose, this was actually administered to only 10.4% (n=371) during the 24-hour census period. The difference was almost entirely accounted for by 'as required' medication that was written on the prescription chart but not given during the census period. Less than 1% of patients (n=34) were prescribed a single antipsychotic drug at a dose that exceeded BNF limits. For the remainder, high dose was owing to the effect of the concurrent prescription of more than one antipsychotic. Thus, only 2% of the 1769 subjects prescribed a single antipsychotic drug were prescribed a high dose compared with 44% of the 1807 subjects who were prescribed more than one antipsychotic drug[15].

CONCLUSION

The findings of the study were mixed where recommendations from the NICE guidance had not been followed consistently in providing the core interventions set out in the NICE guidance. There is a case for the individual trusts to identify the reasons for non adherence to the guidelines and take appropriate measures ensuring implementation of the guidance in its totality.

RECOMMENDATIONS

Most of the guidelines were developed in Europe and United States and as schizophrenia shows a highly variable course in different countries[4]; cross cultural differences must also be reflected in such guidelines. This could be facilitated by independent and international organisation such as the WHO and the WPA. These cores recommendations could be use for adaptations to different cultural, economic and other backgrounds in collaboration with stake holders of the respective countries and regions. In addition guideline disseminations and implementations strategies need to be developed within individual countries.

LIMITATIONS

No explicit information on how many of these patients had persistent psychotic symptoms and hence requiring CBT.
No detailed information on occupational therapy was available as the member of staff requested could not provide these details within the required time.
No information on how many had required family intervention as we could not assess their family and social support system.

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