NICE CG178 on psychosis – an evidence-based guideline?

Udayanga Perera MB BS and Mark Taylor BSc, MD, FRCPsych, FRANZCP

NICE is renowned for producing impartial and evidence-based clinical guidelines, with a rigorous development process leading to reliable and cost-effective recommendations. NICE recommendations can have far reaching implications on policy at regional and national levels. Despite this, NICE has been associated with controversy, eg the restriction of acetylcholinesterase inhibitors in moderate severity Alzheimer’s.1

In this editorial we summarise and critique NICE clinical guideline on *Psychosis and Schizophrenia in Adults: Treatment and Management* (GC178).

Psychosis or schizophrenia?

NICE CG178 replaces the previous 2009 title of ‘schizophrenia’ with ‘psychosis and schizophrenia’. In the introduction NICE defines ‘psychosis’ as a group of psychotic disorders that include schizoaffective disorder, schizophreniform disorder and delusional disorder. However, the term ‘psychosis’ is not found within either Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnostic manuals, and in some services includes bipolar I disorder. This vagueness could be misleading. Furthermore, even a casual glance through the guideline confirms the impression that it concentrates on psychosocial interventions, as though cognitive behavioural therapy (CBT) and family interventions are a panacea across all stages of the illness.

CBT as a panacea?

Comparing the evidence head to head for CBT and family intervention against pharmacotherapy for schizophrenia is beyond the scope of this article. But there is little doubt that the advent of antipsychotics in 1952 had an immense impact on the lives of people with schizophrenia. For example, a population-based study2 concluded that long-term treatment with antipsychotic drugs is associated with lower mortality compared to cases where no antipsychotic was used.

There has been increasing interest in the last three decades in CBT as an adjunct to antipsychotic medication in treatment of schizophrenia. NICE draws its recommendations on CBT based on 31 RCTs (N=3052) of CBT versus any type of control. Based on this and another review on CBT for (only) those at risk for psychosis,3 NICE recommends CBT for all people with schizophrenia or psychosis at all stages of the illness, including those at risk for psychosis. A recent larger meta-analysis concluded that CBT has a small therapeutic effect on schizophrenia symptoms and even this small effect is reduced when sources of bias, particularly masking, are controlled for.4

NICE has also taken the bold step of recommending CBT and family therapy alone for people with first-episode psychosis who wish it. The guideline acknowledges that psychosocial interventions are more effective in conjunction with antipsychotic medication, but still suggests this intervention alone for one month or less. This is controversial in view of the lack of robust supportive evidence and could potentially worsen outcomes. A related point is that in the guideline NICE seem oblivious to the fact that many patients with acute schizophrenia have impaired insight into their illness and health needs,5 and thus may not have capacity to consent to their treatment.

Failure to offer the most evidence-based treatments promptly could be viewed as breaching the duty of care by the practitioner. It is also interesting that NICE seems to have ignored patients who refuse psychotherapy and makes no recommendations on offering medication alone anywhere in the guideline.

The bias towards psychosocial interventions seems mostly based on the premise that antipsychotics are harmful. But it is vital to keep in mind that medication-related adverse effects come to light after extensive research and experience over a long duration. Therefore absence of evidence for adverse effects of psychosocial interventions should not be taken as evidence of absence, as it has been tested less rigorously. Possible adverse effects include stigma associated with prolonged psychotherapy and possible deterioration of mental state due to over-stimulation especially in taxing interventions like CBT. CBT is also costly, time consuming and is not readily available. Its effectiveness depends largely on the skill of the therapist and its fidelity and quality can be difficult to evaluate.

Are all antipsychothics the same?

Out of 110 recommendations in the guideline only 27 (24 per cent) are reserved for medication and most of these are coupled with recommendations on offering CBT and/or family intervention to all patients. It is interesting to note that a contemporary and equally evidence-based guideline, Scottish Intercollegiate Guideline Network (SIGN) 131, has 60 per cent of its recommendations devoted to pharmacological interventions alone.6

NICE CG178 makes commendable recommendations on monitoring for medication-related adverse effects, highlighting the differences between antipsychotics. NICE also implies the conventional view that all antipsychotics are equal in efficacy. By way of comparison SIGN 131 advocates considering amisulpride, olanzapine or risperidone (Risperdal) as the preferred
medications in the acute phase. This is in keeping with evidence that these medications are more efficacious for acute schizophrenia. 7

Also, NICE CG178 recommendations do not reflect the differences required in medication dosage in the first episode and the subsequent episodes. On depot or long-acting injectable antipsychotics (LAIs) NICE gives a low strength recommendation and says to ‘consider offering’ LAIs. This is not in keeping with evidence favouring LAIs over oral antipsychotics. 8, 9

Equally NICE has overlooked the need for a loading dose for the recently introduced LAI paliperidone palmitate (Xeplion), carelessly stating: ‘do not use loading doses of antipsychotic medication’. 10

Conflicts of interest?

In our view NICE CG178 promotes some psychosocial interventions, especially CBT, beyond the evidence. NICE CG178 also makes strong nonevidence-based recommendations, for instance that the course of CBT should be at least 16 planned sessions. The guideline’s research recommendations also appear to reflect the interests of the authors. Here they also note an open trial from the Netherlands reporting successful discontinuation of medication in 20 per cent of patients, which merely confirms the well-known fact that about 20 per cent of people who have an acute episode of schizophrenia recover completely.

Conclusion

NICE occupies an important position – it can validate ‘gold-standard’ treatment paradigms that can impact on policy making and research agendas. NICE CG178 should be constrained by the limits of the available evidence and it is unfortunate that the guideline appears at times to reflect the interests of its authors rather than impartial up-to-date evidence.

References


Declaration of interests

Dr Perera has none to declare. Professor Taylor was co-chair of SIGN guideline 131 and has accepted fees or hospitality from Janssen and Lundbeck in the last three years.

Dr Perera and Professor Taylor both work in Metro South Brisbane, Australia