

# 31 - Summary

## Summary

Schizophrenia and related psychoses CHAPTER 1 a first admission for schizophrenia, clozapine and olanzapine fared better with respect to preventing readmission than other oral antipsychotics.<sup>23</sup> In this same study, the use of a long-acting antipsychotic injection seemed to offer advantages over oral antipsychotics, despite confounding by indication (depots will have been prescribed to those considered to be poor adherers, oral to those perceived to have good adherence).<sup>23</sup> Later studies show a huge advantage for long-acting risperidone over oral risperidone in the first episode<sup>24</sup> and a smaller but substantial benefit for paliperidone LAI over oral antipsychotics in 'recently diagnosed schizophrenia'.<sup>25</sup> In a later study, amisulpride was shown to give good outcomes and staying on amisulpride after not initially reaching remission was as successful as switching to olanzapine.<sup>26</sup> In practice, a firm diagnosis of schizophrenia is rarely made after a first episode and the majority of prescribers and/or patients will have at least attempted to stop antipsychotic treatment within one year.<sup>27</sup> Ideally, patients should have their dose reduced very gradually and all relevant family members and healthcare staff should be aware of the discontinuation (such a situation is most likely to be achieved by using LAI). It is vital that patients, carers and keyworkers are aware of the early signs of relapse and how to access help. Antipsychotics should not be considered the only intervention. Evidence-based psychosocial and psychological interventions are clearly also important.<sup>28</sup>

**Multi-episode schizophrenia** The majority of those who have one episode of schizophrenia will go on to have further episodes. Patients with residual symptoms, a greater adverse-effect burden and a less positive attitude to treatment are at greater risk of relapse.<sup>29</sup> With each subsequent episode, the baseline level of functioning deteriorates<sup>30</sup> and the majority of this decline is seen in the first decade of illness. Suicide risk (10%) is also concentrated in the first decade of illness. Antipsychotic drugs, when taken regularly, protect against relapse in the short, medium and (with less certainty) long term.<sup>3,31</sup> Those who receive targeted anti psychotics (i.e. only when symptoms re-emerge) seem to have a worse outcome than those who receive prophylactic antipsychotics<sup>32,33</sup> and the risk of TD may also be higher. Similarly, low-dose antipsychotics are less effective than standard doses.<sup>34</sup> The optimal dose to prevent relapse is 5mg/day risperidone equivalents.<sup>35</sup> Higher doses offer no benefit and ensure poorer tolerability. Depot preparations may have an advantage over oral in maintenance treatment, most likely because of guaranteed medication delivery (or at least guaranteed awareness of medication delivery). Meta-analyses of clinical trials have shown that the relative and absolute risks of relapse with depot maintenance treatment were 30% and 10% lower, respectively, than with oral treatment.<sup>3,36</sup>

**Long-acting preparations of antipsychotics** may thus be preferred by both prescribers and patients.

**Summary**

- ■ Relapse rates in patients discontinuing antipsychotics are extremely high.
- ■ Antipsychotics significantly reduce relapse, readmission and violence/aggression.
- ■ Long-acting depot formulations provide the best protection against

relapse.

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