CHAPTER EIGHT – SCHIZOPHRENIA AND BIPOLAR DISORDERS

Helping the Consumer Manage Schizophrenia and Bipolar Disorder

Key Definitions

Definition - Psychoses
The term psychosis refers to when an affected individual experiences a loss of touch with reality, characterised by delusions (false beliefs) and/or hallucinations (false or distorted perceptions) of objects or events, including sensations of sight, sound, taste, touch and smell, typically with a powerful sense of their reality. Psychosis is most commonly associated with the mental illness schizophrenia, but can be experienced as part of mania (bipolar disorder), as part of psychotic depression (see Chapter Five), or in association with certain organic brain syndromes (such as arising from drug or alcohol abuse). Although the symptoms of psychosis in these conditions may appear similar on initial presentation, careful history and examination will usually clarify the primary condition. This is very important as treatment approaches differ. In this chapter schizophrenia is taken as the ‘model’ of a psychotic disorder. General approaches to care (the Five Cs) are relevant to all psychotic disorders. In addition, the guide for clinicians includes a section on managing acute emergencies in schizophrenia (p. 131) the principles of which are also appropriate for emergency management of acute psychotic symptoms associated with bipolar disorder. However, there are unique features to the clinical management of bipolar disorder which are addressed in a guide to clinicians which follows the sections on schizophrenia. These two conditions are the major contributors to the burden of disorder from psychotic conditions.

Definition - Schizophrenia
Schizophrenia is a psychotic disorder with the presence of both positive and negative symptoms. It is a poorly understood illness and affects approximately one in every 100 people across the world. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. However initially it may be harder to engage the consumer due to symptoms relating to the illness (eg) suspiciousness, paranoia and blunted affect. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important.

Definition – Bipolar Disorder
Bipolar disorder is a mood disorder and may present with depression. As noted in the sections on that condition (see Chapter five), serious depressive illness may have psychotic features – psychotic depression (see p 76). However, in bipolar disorder patients also experience episodes of hypomania or mania (see below). Untreated, mania often is associated with psychotic symptoms and presents unique challenges in terms of rapport building, treatment and long-term management.
Aiming to Achieve the Five Cs

Consumer and carer

Schizophrenia is a psychotic disorder with the presence of both positive and negative symptoms. It is a poorly understood illness and affects one in every 100 people across the world. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. However initially it may be harder to engage the consumer due to symptoms relating to the illness (e.g.) suspiciousness, paranoia and blunted affect. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important.

Developing a therapeutic alliance involves the health professional/worker and the consumer gaining a common understanding of issues so that they can set goals and agree strategies. Respect and trust are key ingredients. Respect for the consumer is one of the most important ingredients for developing a sound relationship. True respect enables providers to let consumers make decisions for themselves and to make, and learn from, their own mistakes.

While conducting assessments and organising immediate interventions the health professional/worker must ensure that they explain as much as they can to the consumer on a frequent basis and seek approval from the consumer. Using words like “is this clear to you?”, “do you understand?”, “is this what you want to happen?” are just some examples.

Consumers may require constant reassurance due to experiencing derogatory auditory hallucinations (hearing unkind voices), visual hallucinations (seeing things), delusions, feeling tense/agitated. It is important not to inflict judgmental views on the consumer due to possible issues of shame and guilt and the threat of future reluctance to engage. Being non-judgmental also requires that service providers be uncritical of factors affecting many consumers over which they have little control.

Carer involvement in consumer treatment programs is vitally important due to their “lived” experience with the consumer but we still have to recognise the consumer’s right to confidentiality and obtaining consent prior to engaging a carer is vital. However when a consumer develops symptoms of psychosis, they may not want their carer/family involved. This may be due to a paranoid delusion (unfounded belief) that their care/family wants to hurt them or suspiciousness that their carer/family does not have their best interests at heart. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. For example: the consumer expresses homicidal intent towards a carer/family member because they have a delusional belief that that person wants to poison them; or the consumer is experiencing command hallucinations (voices ordering them to carry out an action) telling them to kill somebody. It is in these types of situations that consent can be overridden to protect the consumer and others. However we must remember that this does not mean that all aspects of the patient’s care should be disclosed. Based on context of the community (e.g. communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis to the importance of seeking an appropriate (suitable/reliable) other is essential.

Consumers suffering from schizophrenia are sometimes more likely to express reluctance at carer/family involvement in their care. However, as we have discussed, this is more likely due to reasons related to their symptoms (e.g. suspiciousness,
paranoia, delusions, auditory/command hallucinations) rather than a genuine reasoning for the same. This request for total confidentiality usually alters as the consumer receives treatment for the symptoms and their mental state improves. A health professional/worker should also clarify at regular intervals if the consumer wants others involved in their care. It is sometimes good to get written consent from the consumer.

Hints for consumer involvement include:

• Seek clarification from the consumer about the level and degree of involvement permitted for the carer. Determine if you are permitted to engage with the carer privately or only in the presence of the consumer.
• Determine if all treatment information can be disclosed and if long-term liaison is permitted.
• Encourage the consumer to engage carers/family in treatment plans and options.
• Avoid over engagement with carers at the expense of the therapeutic relationship with the consumer. This means that building a positive relationship with the consumer is the most important goal and we have to be careful not to sacrifice this when we seek background history from the carer/family. The aim is to empower the consumer in their care while actively involving the carers.
• Provide regular information to the consumer/carer on their treatment and progress, utilising treatment specific material (eg) brochures, handouts, user friendly materials.
• Provide information on available community resources (eg) mental health nurse/service, life promotions officer, available community services, consumer support group, and carer support group.
• Actively involve the consumer/carer in the development of Care Plans that are specific to their mental health needs and encompasses regular review and updating as the goals change. It is important to regularly review and seek input from the consumer and carer about what the important issues or difficulties are from their perspective.

It is also important to provide emotional and social support to the carer/family. This is especially important where consumers’ symptoms may negatively affect or place undue strain on the household or the overall family environment. Carer/family members are better equipped to help the consumer when they have a better knowledge of the consumer’s illness and the reason why it can affect them in different ways:

• Give information on schizophrenia explaining signs and symptoms (eg differences between positive and negative symptoms, how they affect the consumer’s presentation.
• Provide information on treatments explaining what the medication does and if there are any side effects.
• Give reassurance about concerns they may have about ongoing symptoms and management issues.
• Be available to support them and offer education to them as the principal caregiver.

Context of community
When working in Indigenous settings, we must aim to listen and learn from the people we are working with to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of psychosis but due to cultural issues could provide a more logical explanation. Examples include:
• The consumer reports seeing visual hallucinations (seeing things) of a dead relative on a regular basis. It is important to determine from a culturally appropriate person in the community to what extent the presentation is seen as acceptable in the community.

• Certain questions or the manner in which they are asked by the health professional/worker may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude. The consumer has almost no eye contact with the health professional/worker with little warmth and is not willing to communicate. Are they paranoid/suspicious of your questioning because of delusional beliefs, cultural issues or because of shyness or shame? Again it is important to determine from a culturally appropriate person if this is acceptable behaviour in this community.

• Where it is necessary to address sensitive issues (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

Remember to respect cultural and health beliefs and recognise the historical and cultural factors that affect people’s health and wellbeing. Acknowledge and utilise the local community’s expertise and work in partnership.

**Continuity of care**

It is vitally important that consumers presenting with schizophrenia are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing positive or negative symptoms, self-harming or suicidal ideation, and side effects to medication and compliance with it in the community setting.

Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with schizophrenia and discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and providing a safe environment while establishing the consumer on an appropriate form of treatment, mainly stabilisation on medication. This does not mean that other symptoms of the illness are not still present on discharge (these symptoms may be triggered for the consumer by being removed from a controlled in-patient setting back into the environment where the illness began).

When a consumer is discharged from an in-patient setting it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

• The health professional/worker can offer immediate support and reassurance for the consumer. Many consumers suffering from schizophrenia remain vulnerable to relapse thus immediate contact is vitally important to prevent this from occurring.

• The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may initially feel isolated, unsupported and more vulnerable on discharge from the in-patient setting to the community thus heightening the recurrence of symptoms of the illness.

• Allows an assessment of the overall living environment and supports in place.

• Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on the illness/diagnosis and determining the issues and concerns that family/carers may have. For example, are there
still risk factors; what does the medication do and what happens if the consumer stops taking medication?

- It is important to determine the consumer's degree of insight as this will have a bearing on ongoing care, compliance with treatment and level of follow-up/intervention. The consumer may decide that because they feel better following discharge from hospital that there is no longer a need to continue taking prescribed medications or that due to side effects (e.g., over sedation) medications are limiting them in their level of daily functioning.

- Provision of education and monitoring of prescribed medications is important to promote compliance. This is also a good opportunity to observe the client for any side effects relating to the medication. As with most medications, there may be side effects with antipsychotics. Some examples are: sedation, muscle stiffness, tremor, drooling and sexual problems. It is important that any side effects are acknowledged immediately to avoid any unnecessary discomfort for the consumer. Some consumers express reluctance in taking prescribed medications or are non-compliant with them as a result of experiencing bad side effects.

- Drafting of a community Care Plan must commence at the nearest available opportunity. This should incorporate the consumer's/carer's perspective, primary health care staff, the local mental health team and any local organisations that may be involved in the consumer's care (e.g., ATODs, life promotions officer, sports and recreation officer). However, this depends on available resources in the community.

Continuity of Care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for that consumer to be supported by their Primary Health Care Service relating to their mental health issues. However, some emphasis should be placed on continuity of care in relation to preparing and empowering the consumer in aspects of their care, the opportunity for consumers to take control of these aspects of care are vitally important. Sharing responsibility requires a willingness on the part of the health professional/worker to view continuity as a partnership where all parties have shared control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer, and the family/carer. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for schizophrenia**

- Assessment of consumer’s mood and mental state. This can be utilised to determine the stage of treatment/recovery the consumer is at in relation to their illness and can also determine if there are any other underlying symptoms of illness. The presence of positive symptoms (e.g., hearing voices or paranoid delusions) may indicate that the immediate focus of care should be around the level of acuity of the consumer. That is: how distressed they are by the symptoms; how it is impacting on their daily routine, relationships with family members or risk to self or others. For example: Bob has reported that he sometimes still experiences auditory hallucinations telling him to harm others. The voices are distressing him but he feels that he would not act on these voices’ instructions. The immediate focus of care should be to address the existing positive symptoms. This would suggest an increase in medications and an immediate assessment of the risk factors involved.

- It should be developed or altered accordingly relating to risk factors whether that be a consumer’s risk to self, others or risk from others. Is there a risk of
self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors and just because there are no risk factors does not mean that there is not an ongoing underlying problem. In Bob’s case, he is experiencing voices that are telling him to harm people, however he feels that he would not act on these. There is an immediate risk to Bob’s own reputation if he were to act on the instructions and a risk to other people when he is experiencing these voices. Are carer/family members aware of the immediate risk to themselves and others? If not they should be informed. Sometimes a short stay in hospital is required even though this may not be what the consumer wants.

- The Care Plan should incorporate positively (avoid negative comments) the consumer’s goals or achievements. Focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner. (Bob has disclosed that he is hearing voices telling him to harm other people. He has talked about this with staff and he is encouraged to continue informing them when he experiences these voices. He is advised to seek help if he is having trouble coping with these voices.)

- It should be concise and to the point, using simple language that the consumer and carer can understand. Avoid clinical jargon. For example, instead of: Bob will utilise talking therapies when experiencing derogatory auditory hallucinations; try: Bob will talk to a support person when he hears bad voices over the next seven days.

- Place emphasis on achievable goals, as overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing even if these issues are important in the consumer’s overall care. With psychosis it is important to address the acute crisis issues first. In Bob’s case we would look at the risk factors and ensure that Bob and others were safe. We also look at the auditory hallucinations and the distress they are causing Bob.

- Use realistic timeframes and ensure the Care Plan is regularly updated emphasising the consumer’s achievements. Positive reinforcement of these is important so that the consumer is aware of the progress being made. (For example, Bob will aim to control his bad voices over the next 48 hours. This is not achievable and the consumer is being placed under undue pressure. It is highly unlikely that positive symptoms would respond so quickly to treatment with medications. Response to antipsychotic medications can take up to six weeks so the Care Plan should focus on strategies to reduce distress during this period. For example, use of benzodiazepines for agitation and sleep disturbance if necessary; daily contact with the mental health team; coping strategies [listening to music], regular risk assessments and education about the symptoms of the illness.)

- Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example, the consumer’s mother states that Bob’s presentation at interview with the mental health nurse is incongruent (different) with how he is at home. Bob informs us that he is experiencing voices telling him to harm others but he would not act on these and would not harm anybody. However Bob’s mother informs that Bob becomes extremely agitated when at home. He has become violent and damaged furnishings and on one occasion has locked himself in a room with a knife. When he is agitated, he screams at people to stay away or he will harm them. The consumer may not recall these episodes of agitation due to mental
impairment at that time. It also indicates that the level and degree of risk is far greater than may have previously been believed.

- Also ensure the Care Plan is split into sections emphasising the role of each individual involved in the consumer’s care. This gives all involved parties a sense of ownership in the recovery process, gives the consumer a sense of support and safety and reinforces to the consumer that they are not alone. For example, the consumer will participate in regular 1:1 sessions with the mental health nurse. The carer will offer the consumer support with daily activities. The health worker will visit the consumer at home every three days for a chat and provide further medications. The mental health nurse will provide weekly follow-up.

- A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer’s file.

The frequency of visits/supportive follow-up for the consumer (daily, weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer’s mental health. Please refer to Chapter 5 for a list of these factors.

Ideally a consumer should have regular follow-up if any or all of these factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary, care and understanding should be given not to alienate the consumer. The emphasis should be on rapport building in a non-intimidating environment with awareness of some consumers’ belief about shame and stigma attached to mental illness.

Checking for change
Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. Ideally a set of outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the Care Planning document. However it is important that the consumer/carers have an understanding of the principles surrounding the measurements and that these are used taking into consideration cultural issues relating to Indigenous consumers.

It is important to remember that if a health professional/worker is going to use the measurement tools they must first have formal training to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring an item.

This can be done by:
- Liaising with another worker who has outcomes training
- The local mental health clinician/worker
- The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer’s experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments. When using the outcome measures to assess a consumer
presenting with schizophrenia, it is always important to keep in mind certain specific issues. Some of these are:

- Application of the fourth principle guiding outcomes ratings with Indigenous people who may have schizophrenia or who may be experiencing socially and culturally acceptable experiences associated with funerals, religious or traditional activities that could be mistaken for psychotic experiences, is extremely important. The principle guides you to consult with a family member/carer and a local Indigenous health or mental health worker to determine consistency in form, intensity and duration with accepted beliefs, experiences and behaviours.

- Principle four also guides you to rate significant distress or potential danger associated with behaviours, beliefs and experiences, regardless of whether the cause is deemed to be a psychotic episode or an experience consistent with accepted cultural experience.

- If the consumer’s self-care appears to be very poor the health professional/worker should determine its duration (how long) and whether it is within acceptable standards for that community. Poor self-care might indicate that the consumer has stopped caring for themselves and they may be experiencing some negative symptoms of schizophrenia.

- When assessing a consumer’s mood do not confuse shyness or shame with sadness or as evidence of blunted affect.

- Use simple language and do not assume that everybody’s first language is English. A lack of response may be simply because the consumer cannot understand you and not evidence of slow or impaired cognitive functioning or refusal to engage.

- Remember that illicit substances can alter a person’s presentation and they can also induce psychosis. It is virtually impossible to obtain a clear picture of a consumer’s mental state when under the influence of these substances. A consumer presenting with blunted affect may just be “stoned” from THC use, however it is vitally important to determine that there are no symptoms of psychosis when the consumer is drug free. The consumer may be self-medicating with illicit substances as a coping strategy for other mental health problems and excessive use could precipitate a psychotic episode.

- Excessive alcohol consumption can also alter a consumer’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state. Alcohol consumption sometimes causes impulsive behaviours or acts sometimes manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated this usually (not always though) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing until further assessment can be performed when the consumer is not under the influence. There is every chance that the consumer’s frequent alcohol intoxication may be a self-medicating strategy for symptoms of schizophrenia. Excessive alcohol intake can sometimes have a negative impact on antipsychotic medications and the symptoms that they are used to treat.

Any information/data collected from the outcomes measures relating to the consumers care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered Clinical Care**

With the Fifth “C” it is important that clinicians should consider, but not be limited to, the recommendations. The guidelines should not necessarily be interpreted as absolute standards of practice. Mental health professionals care for patients with schizophrenia in different settings, including isolated and challenging settings, where it isn’t feasible to apply all recommendations.
Psychosis

What is Psychosis?

People who are hearing voices, and who have jumbled thoughts may have an illness called psychosis.

They might

Act strangely
Walk round all night
See things not there

What makes me psychotic?

These things can cause psychosis

Poor physical health
Loss or bereavement
Too much stress
Too much Alcohol or Gunja or other drugs
Family History (someone else in the family has the illness)
Stopping usual treatments
Breaking Law

Feel afraid
Think of dying
Sit down alone
What change helps if you are hearing voices or have jumbled thoughts inside?

OUTSIDE CHANGES
- Family support
- Elders
- Traditional Healer
- Clinic Mob
- Mental Health Mob
- Antipsychotic tablets with dosette or Webster pack
- Hunting, fishing, dance
- Going to country
- Stopping gunja, alcohol or Other drugs

INSIDE CHANGES
- Know about treatment
- Remember totems, family, elders
- Think with your head not with your heart

How do you make change?

- Everyone can make change – when they are ready
- There are lots of different ways to change
- Telling people they SHOULD change doesn’t help
- Letting them know you think they CAN change does help
- Everyone changes in his or her own time
- Small steps can lead to big changes

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Schizophrenia: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Eoin Killackey, Patrick McGorry and Kathryn Elkins, for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and is not as a substitute for clinician advice.

Introduction
This document is an adaptation of the RANZCP guidelines developed for adults and young people with or suspecting they have schizophrenia, and is intended for the use of primary care workers as well as consumers and carers. It has been written to provide information about schizophrenia and its treatment, based on the best research evidence to March 2003.

There have been many advances in treatment recently. Research into effective therapies for schizophrenia is booming. There is already excellent knowledge about treatment but unfortunately, a lot of this knowledge is not being fully utilised. It is the responsibility of health professionals to ensure that they are up to date with current best practice approaches for the illnesses their clients have.

The current treatments for schizophrenia are the most effective yet and should provide hope that a comprehensive treatment approach will reduce the suffering that schizophrenia can bring.

What is schizophrenia?
Schizophrenia is a poorly understood illness in the general community. There is much misinformation and stigma associated with it. For instance, it is NOT true that a person suffering from schizophrenia has “multiple personalities”. It is also NOT true that people with schizophrenia will be violent. If they receive appropriate treatment they are no more likely than people in the general population to commit crimes.

Schizophrenia is one of a group of mental disorders known as psychosis. A person experiencing psychosis has a loss of contact with reality. These disorders are characterised by difficulties with the thinking process. This can include seeing or hearing things which other people cannot see or hear. Such experiences are called hallucinations.

Psychosis can also include holding beliefs that are very odd or not true. These beliefs are called delusions. People with psychosis often feel that they want to withdraw from the outside world. Their energy and emotions are affected. They may feel a loss of vitality. They may also feel depressed or irritable.

Who gets schizophrenia?
Anyone can get schizophrenia. Schizophrenia affects one in 100 people across all countries, social classes and cultures. Schizophrenia usually begins when people are aged between 15 and 25, although it can also emerge later in life. Men and women are affected equally, although men tend to have an earlier onset.

What are the first signs something is wrong?
Most people experience changes in behaviour and perception. When these occur together they are called a “prodrome”. The prodromal symptoms include:
- Changes from normal behaviour, e.g. worsening of usual work or school performance;
- Social withdrawal;
- Emerging unusual beliefs; and
- Changes in perception such as experiencing brief instances of hearing sounds not heard by others.

The prodromal period lasts approximately two years on average. After this time clearer symptoms of psychosis become evident. The prodrome is best thought of as a warning but it does not mean that the person experiencing a prodrome is necessarily going to develop a psychosis.

What are the symptoms of schizophrenia?
Health professionals talk about two main types of symptoms in relation to schizophrenia. These are positive symptoms and negative symptoms. Positive symptoms are experiences that happen in addition to normal experience. These include symptoms such as hallucinations (positive because they are additional perceptions). Negative symptoms incorporate a loss or decrease in normal functioning. They include experiences such as loss of pleasure or interest in normal activities, loss of motivation and loss of interest in socialisation. Symptoms vary from person to person, but commonly include:

**Negative symptoms**
- Feeling unmotivated
- Not feeling social
- Feeling apathetic
- Not feeling any emotions

**Mood**
- Irritability
- Suicidality
- Depression
- Elevated mood

**Positive symptoms**
- Delusions
- Hallucinations
- Disorganised thoughts
- Feeling tense and agitated

Schizophrenia appears cyclical, worsening in periods known as relapse, but improving or disappearing completely during remission. People with schizophrenia can have periods of stable emotional health. However, during the acute or psychotic phase, when delusions and hallucinations may occur or worsen, many have trouble with everyday tasks like thinking clearly, managing feelings, solving problems, making decisions or relating to family, friends or professionals.

What causes schizophrenia?
It is now accepted that schizophrenia is a syndrome (cluster of symptoms) produced by a complex change in brain functioning. This change interferes with intellectual processes and produces unusual experiences and emotional changes.

The causes of schizophrenia are multiple. They involve a combination of genetic risk factors and other contributors such as complications during pregnancy and early life,
and almost certainly other problems with brain development during adolescence. It is probable that a different mix of causes can occur from person to person. While in some people it is possible to show subtle changes in brain structure using tests such as magnetic resonance imaging scans (MRI), in most people these changes seem to reflect the way the brain is functioning when that person is unwell. This is why treatment with anti-psychotic drugs seems to restore normal central nervous system/brain functioning. However, a great deal still needs to be learned about this complex disorder of the central nervous system.

What other problems do people with schizophrenia face?
People with schizophrenia may also face other problems. Anxiety and depression are very common. The rates of substance use (cigarettes, alcohol and cannabis especially) can be up to ten times higher than in the general community. Because symptoms, if left untreated, affect relationships, many people with schizophrenia are single and unemployment can be a problem. People can also have accommodation problems and may withdraw from family and friends. Isolation and loneliness can be common. Thus people with schizophrenia may need assistance for several problems when seeking professional help. They should be assured that it is OK to ask for help for any of these problems to improve the chance of recovery.

How is schizophrenia diagnosed?
While there is currently no test for schizophrenia, some other medical tests may be necessary to rule out other possible illnesses, both physical and mental, which have symptoms similar to those of schizophrenia. Getting a correct diagnosis can be difficult because psychiatric diagnoses are still based on descriptions of behaviour. Sometimes there are difficulties in getting timely help because the person may be fearful and feel reluctant to describe their symptoms or see a health professional. However, it is advised that a psychiatrist who is qualified and experienced in confirming the diagnosis and planning treatment be consulted.

Is there a cure?
There is currently no cure for schizophrenia. However, many treatments that aid recovery have been developed. Although some people who are diagnosed as having schizophrenia will recover completely, most will remain vulnerable to relapse and may have sustained disability. Despite this, good quality of life is possible, and with improvements in the quality of treatment and support, the goal of treatment should be recovery – return to leading a full life.

Prevention: can the prodrome be treated?
The prodrome is the period before an acute episode of psychosis that indicates that a psychotic episode may be about to occur. People showing signs of a prodrome who have never had an episode of psychosis, are encouraged to develop a relationship with a mental health professional or a doctor with a knowledge of this prodromal period.

Individuals with a parent or sibling with psychosis have more risk of developing schizophrenia. If there is any change in level of functioning at school or work, or if symptoms of depression or strange thinking occur, it is a good idea for these individuals to go to their local health care centre to be thoroughly assessed. By being monitored in this manner, if clear psychotic symptoms emerge (and there is no guarantee that they will), early specific treatment is readily available. This can avoid the need for hospitalisation and minimise the impact of a potential psychotic episode.

Evidence from research indicates that assessment and provision of low levels of medication in the prodromal period may reduce the risk of eventual psychotic symptoms in some people.
Treatment: what to expect

When should treatment begin?
The sooner a person with schizophrenia gets help for their symptoms the better chance they have of receiving effective treatment. Research shows it is important to get help early for the first and for all subsequent episodes. In most cities a specialist “early intervention team” provides care during the first episode and offer follow-up for the one or two years. In towns and remote areas this is probably not available, but getting help early is still possible and important.

The first task is to undertake a thorough assessment to understand more about the young person’s life, like accommodation, finances, symptoms and physical health. A thorough investigation is required to make sure that there is no underlying physical condition that may better account for the symptoms. Once a medical check has been completed, a referral can be made to an appropriate mental health service. There may be significant social, cultural or religious issues that need to be considered in treatment and these should be identified.

How is care organised?
When receiving care through a public mental health service, it is usual practice to be allocated a case manager (sometimes called a key worker) and a doctor. The case manager organises the assessment, treatment plan and ongoing treatment. This includes information and education for the family or partner, or carers. They also arrange links to other services such as community agencies, employment services, social security and accommodation agencies. The case manager also prepares the treatment plan that encompasses all aspects of care: medication, psychotherapy, education, support and other treatment or services required.

How to advocate for improving care?
People being treated for schizophrenia should be confident they are receiving the level of care they need. They should be informed about this and encouraged to speak out if they are dissatisfied. They should be encouraged to talk to their case manager, or the clinic manager.

Location
A range of treatment settings is available and the choice of which one to use is made on the basis of severity of illness. Where possible people with schizophrenia are treated in the community to reduce the distress and disruption to their lives. The case manager should do home visits and provide support in crisis situations.

Consumers in recovery or remission can be treated with regular outpatient appointments. However, if there is a risk of harm to self or others, or if the patient is extremely distressed, the best option may be a short stay in hospital. Sometimes this may be necessary even though it may not be what the person wants at the time.

When the consumer is well, arrangements for what will happen in the event of a relapse can be put in place in advance. This gives her or him more control and an ability to have a say in treatment planning.

How is schizophrenia treated?
Treatment should include medication, psychological treatment and community support. The combination of treatments is crucial.
Medication
Medication is essential for effective treatment of schizophrenia for most people. However, it works best when integrated with good quality psychosocial treatment.

It is necessary to find the right type and dosage of medication to treat symptoms with the least side effects. Generally, a single medication will be used. However, in some cases it may be helpful to combine drug therapies. The main type of medicines used to treat schizophrenia are called antipsychotics. There are two groups of antipsychotics. The older group, “typical” antipsychotics, include drugs such as chlorpromazine and haloperidol. The newer group are called “atypical” antipsychotics. These include olanzapine, risperidone, clozapine, and quetiapine. Older medications work, but often have more side effects, especially if used in excessive doses.

Safe dose range information can be found in drug product information, or in standard manuals of medication such as MIMS or the Therapeutic Guidelines. Both of these are also available on the Queensland Health website through the Clinician’s Knowledge Network under “Drug Information”. The choice of medication should be carefully explained and the patient given written information on the drugs prescribed, including any side effects that may occur.

Does the medication work?
All of the drugs used have gone through rigorous international testing and have been shown to reduce the symptoms of psychosis. They are not addictive. There are several types of medication and the psychiatrist or medical officer should choose the one to best address each particular patient’s symptoms. Patients should be encouraged to ask about the reasons a specific medication was chosen and about benefits and risks. In recommended doses, anti-psychotic medication is safe. However, excessive doses can result in a range of disturbing side effects.

What symptoms are helped by medication?
The positive symptoms of psychosis, such as hallucinations and delusions have been the main focus of medication treatment. Newer antipsychotic medication may also be helpful in treating negative symptoms, particularly problems with mood, thinking and socialising. Feelings of anxiety and agitation are also helped by anti-psychotic medication.

Does the medication work for everyone?
A small number of people do not respond well to initial treatment and may need to try several antipsychotics as well as other therapies to gain control over their symptoms. A drug such as clozapine has been found to be effective for people whose symptoms are resistant to initial atypical anti-psychotic medications.

Relapse prevention and medication
Individuals who have experienced a psychosis previously should consult their mental health team to prevent a further episode. This may include restarting or increasing medication, adding a different medication in combination with psychosocial treatment and regular monitoring.

What are the side effects from medication?
As with most medications, there may be side effects when taking antipsychotics. It is very important to communicate any changes or new symptoms to your doctor, as these may be side effects of your medication. A table of drugs and side effects is in Appendix 2 of the guide for clinicians which follows.
Movement disorders
Common side effects include movement disorders, in particular dystonia (muscle spasm); Parkinsonism (tremor, slow movements); and akathisia (restlessness). These side effects may be more prevalent on the older typical antipsychotics.

No one should have to experience these side effects these days! Doctors can treat these side effects by using low doses of antipsychotics or prescribing medicines to reduce these movement symptoms. The newer or atypical antipsychotics have been found in studies to be effective at treating symptoms, and to cause fewer movement disorders. While newer drugs in general have fewer effects on muscle tone and movement, they are more likely to cause weight gain, loss of libido (sex drive), and hormonal side effects.

Tardive dyskinesia
Another effect often seen with anti-psychotic medication is tardive dyskinesia (TD). This involves uncontrollable muscle spasms resulting in a twisting of the body or neck. TD will occur in 5% of patients who take typical antipsychotics. Studies have found that risperidone and clozapine (two of the atypical antipsychotics) have much lower rates of TD. Evidence is not yet available for the newest atypical antipsychotics (olanzapine and quetiapine), however it is expected that the risk for TD will be quite low.

Patients should be encouraged to ask for and obtain as much information as possible about symptoms, side effects and other problems. Patients have a right to expect the best treatment possible. They should be instructed carefully and encouraged to take all medications as prescribed. In general, if a drug works well - stick with it - don't chop and change. These drugs take a little while to start working and should not be stopped unless under good medical supervision.

Other side effects
Other side effects include sedation, galactorrhea (stimulation of milk secretions in females), sexual problems in males, and rarely, liver disorder.

Clozapine has been associated with a small chance (less than 1%) of agranulocytosis (loss of production of white blood cells that are involved in defending the body from infection). This can lead to an increased chance of experiencing life-threatening infections. To prevent this, assessment of white cells is conducted weekly which aims to prevent the mortality risk.

Clozapine has been associated with seizures, sedation, drooling and increased heart rate. However, with careful monitoring, and encouragement to report any difficulties or side effects, these symptoms can usually be managed.

Risperidone in low doses has very few non-movement disorder side effects. In higher doses some movement disorder side effects have been noted. Users have also reported some gastric distress and mild sedation.

Olanzapine has few movement disorder side effects, but has been associated with non-movement disorder side effects such as sexual dysfunction, weight gain, and possible mild liver dysfunction. Quetiapine has been associated with side effects such as drowsiness, dizziness, and headaches but there is a significantly lower incidence of distressing symptoms such as movement disorder symptoms and less restlessness.
Amisulpride may cause side effects including weight gain and drowsiness. Amisulpride may be more likely to cause changes in the breast, such as increased milk flow and changes in males than other antipsychotics although these are very rare, but may be less likely to cause sedation and movement disorder side effects. Patients should be encouraged to talk to the doctor about the advantages and disadvantages of using these new medications, particularly the possible impact of side effects.

**What is the treatment for side effects?**
Psychiatrists often use a medication called an anticholinergic such as benzotropine (Cogentin) to treat movement disorders caused by older antipsychotics.

Anticholinergic medications may lead to dry mouth, constipation, or impaired memory skills. Many side effects, such as sedation, improve with time, or by changing the dose, changing the type of anticholinergic, or adding another medication. Some non-medication strategies may also be helpful. For example reviewing diet and exercise habits may assist with minimisation of weight gain. Depot medication can be a useful strategy for a small number of individuals, at least as a time-limited strategy.

Anyone receiving these medications should be told that if they experience anything which may be a side effect, the doctor should be informed as soon as possible. It may be that the symptom is not a side effect, but it is better to be sure.

**What is depot medication?**
Depot medication is a form of anti-psychotic medication given by injection, which slowly releases the drug over one to four weeks (depending on which drug is given). A doctor or nurse will usually give the injection. Some people prefer depot medication as they find remembering to take pills every day difficult. However, depot medication can cause the same side effects as mentioned above for the forms of these drugs taken orally.

Sometimes people with schizophrenia are ordered to take medication under government laws such as the *Mental Health Act*. In this situation, depot medication is often used. An order to be treated (often called a Community Treatment Order or CTO) and to take medication made under mental health legislation must be reviewed at regular intervals and patients may appeal against the CTO.

*Patients who have been put on an order to receive treatment under the Mental Health Act should be given appropriate information regarding their rights and how to represent their interests.*

**What about other medications?**
There are several groups of medications often used with anti-psychotic drugs. The doctor or psychiatrist may consider prescribing other medications along with an anti-psychotic medication to treat the symptoms of schizophrenia or other problems. There are many medications that may be used in conjunction with antipsychotic medication. They include:

- Anti-anxiety agents which are used to treat distress or agitation;
- Mood stabilising agents to treat mood symptoms when they occur in psychosis (Lithium, Tegretol (Carbamazapine) and Sodium Valproate);
- Sleeping tablets (hypnotics) to help insomnia;
- Side effect medication (anticholinergics, or anti-parkinsonian drugs) used to reduce movement disorders; and
- Anti-depressants used to treat depression.
There are a number of points to consider. Accepting the need for regular medication is a challenge for anyone. Taking medications long-term requires some lifestyle change. Just as with arthritis and diabetes, having a psychotic condition also requires this approach. Making lifestyle and mindset changes is not easy. Furthermore, drugs are often seen as mind altering rather than mind restoring. This view is especially so when taking the drugs includes unpleasant experiences such as sedation, “numbing” or slowed down thinking, movement or body problems or sexual side effects.

However, medications are a very powerful protector against a second or further breakdown. Taking medication as it is prescribed makes it five times less likely that a relapse will occur. Sometimes it takes more than one episode for people to accept that medication is necessary.

How much is needed?
Anti-psychotic medications are administered at the dose that proves most appropriate for each individual patient. For many medications, the doctor will start with a low dose and increase very slowly to reach the level where symptoms stop, before side effects start to be present. Doses differ according to the potency of the medication used and cannot easily be compared against one another.

For example:

100 milligrams (mg) of chlorpromazine is approximately equal to:
- 2mg of Haloperidol, OR
- 2mg of Risperidone, OR
- 7.5-10mg of Olanzapine

How long should medication be taken?
Some people will require anti-psychotic medication for long periods. Usually the medication is continued for one to two years after the person has achieved excellent recovery from their first episode, and is stable in life with regard to relationships, work or accommodation.

In the early years there is a high risk of relapse and if the person experiences another episode they may need anti-psychotic medication for two to five years before ceasing use. For those who have multiple episodes, they may need to use medication for much of their life.

What if the medications don’t work?
If one or two anti-psychosis medications have been tried and symptoms have not improved a thorough review is necessary. First, the health practitioner will need to check that the medication was taken as prescribed and that the dose was correct, and that there are not other factors involved such as a medical problem or using cannabis or other drugs.

The mental health team may suggest that psychological therapy, described below, be offered to help cope with the symptoms and that other medicines be added to help. A third atypical medication may be tried. Clozapine, a medication showing good results when other treatments are not successful may be offered. However, clozapine requires a considerable side effect monitoring scheme.

What about pregnancy and breastfeeding?
Many anti-psychotic medications have not been tested on pregnant women. Unborn babies are very sensitive to drugs and it is very important to check if a patient who is prescribed these medications is pregnant. They should be warned carefully (particularly if they are taking anticonvulsant drugs which are sometimes used to treat mental health disorders and which are known to harm the developing foetus) and told
to inform the health team immediately if they become pregnant or plan to do so. They should be encouraged to talk to their doctor about the safest choices to use during pregnancy and/or breastfeeding.

**Psychosocial treatment**
Psychosocial treatments should be tailored to the needs of the individual. Medications aim to reduce symptoms, while psychosocial treatment helps adapt to psychosis and helps the patient strive for good quality of life, despite the illness. One important feature of all psychosocial treatment is developing a relationship with the health professional that is trusting and optimistic. Preferably, they should extend this relationship to include family, partner or carer. There are several kinds of psychosocial treatment that may benefit recovery.

**Psychoeducation**
This therapy provides education to individuals and their carers about their illness, either individually or in a group. It works by increasing understanding of symptoms and treatment options, services available and recovery patterns. Information and education may be given via videos, pamphlets, websites, meetings or discussions with the case manager or doctor.

**Family therapy**
Not all patients want their family involved in their care. That is their right and it should be respected (as long as they are 18 years or older). However, there are good reasons why the family, partner or some other key individual might be involved in planning and providing care. For a majority of people, their family is the primary source of long-term support. Secondly, even if the patient doesn't initially want their family directly involved, the family may wish to talk to a professional about their experience of the patient's illness and how they might help. It can be very distressing to see a loved one become unwell. Thirdly, the family can be an important source of information to help in clarifying the diagnosis, and in supporting treatment. However, the patient should be heard out and unless there are very clear reasons not to do so, their wishes should be respected.

Research shows that recovery is aided if treatment of schizophrenia is a collaboration between the patient, family, doctor and case manager. The purpose of this collaboration is to work together towards recovery. Good communication exists when they talk about the choice of treatments so that everyone learns the same information and can move towards the same goal.

Clinicians should offer family members or carers frequent support when the patient is acutely unwell, and on an ongoing basis as needed. Ideally, printed or other information on medications, therapy or group activities should be made available for the patient’s family members or partner.

Support groups are designed for patients and families where experiences with services or treatment are shared. Sometimes the family may be able to help in other ways: identification of early warning signs; keeping records of the effectiveness of medication at treating symptoms in the past; and in assisting in accessing care. They also play an important role in encouraging and supporting return to social, academic and vocational activities.

**Cognitive Behavioural Therapy**
One form of psychotherapy, which has been found to be effective in psychosis is, called Cognitive Behavioural Therapy or CBT. It may be recommended depending on needs and phase of illness. Research suggests that CBT can improve coping
strategies, help the patient learn new ways to manage stressful situations, improve thinking and memory skills, learn to socialise, reduce the level of positive symptoms, and to manage ongoing symptoms. Research has also shown that CBT is a treatment of choice for depressive and anxiety symptoms. It may also be effective in reducing drug abuse. These are very common experiences for people going through a psychotic episode. It is also more common for people experiencing psychosis to have suicidal thoughts and feelings. They are at a greater risk than the general community for self-harm and suicide. This risk can be reduced through supportive psychotherapy and use of expertly conducted CBT. It works by reducing depressive thoughts and severity and hopelessness, which can be experienced by some people with schizophrenia.

**Vocational and social rehabilitation**
Rehabilitation focuses on social and occupational skills that may be absent or underdeveloped due to illness. Depending on needs, rehabilitation can be undertaken in a group or individually. It’s about getting life back on track and not just the management of symptoms.

**Group activities**
People with schizophrenia may benefit from participating in groups with other people who also have schizophrenia. The focus of these groups can vary. They may provide information; teach coping skills for dealing with mental illness; provide opportunities for formal or informal exercise; help to develop relationships; help to learn to become independent again; improve confidence; enhance study or work skills; or just be fun.

**Self-help groups**
Self-help groups are not really considered “treatment”. Rather, they are there for support and information. They may be beneficial because they provide support, facilitate information exchange and provide resources. Often self-help provides opportunities for new friendships. Self-help groups may also work to foster understanding of people with schizophrenia by the wider community. They can also give the chance to help people recovering benefit from hearing of each other’s experiences.

Advocacy is important. There is much known about the optimal treatments for psychosis, however, access to these optimal treatments is not as easy as it should be. Through self-help groups patients and families can lobby for better services or more research.

**Crisis support**
A system of mobile clinical support is available in most cities 24 hours a day. Public mental health crisis assessment teams (often called “CAT”) are trained mental health professionals linked with a local service who can speak with patients over the phone about their situation, current treatment and symptoms and when necessary visit or arrange follow-up. This may not be available in small towns and communities. However, the local primary care centre should be able to make contact with a psychiatrist or the CAT team at any time and should have those details available for after-hours staff. Consumers and their families should be encouraged to contact the primary care team early if they believe there is a problem.

**Counselling**
Talking to someone is an important part of treatment. Your case manager and mental health team will provide general counselling and support during and after an episode of psychosis.
Isolation and loneliness are related to poorer and slower recovery. Group activities counteract these problems.

**Coping with bad times**
Suicide is one of the main causes of death for people with schizophrenia, most likely due to the depressive symptoms especially early on in people’s experiences of psychosis. Here are some messages for patients to help them deal with “bad times”:

- If you are feeling down, depressed, demoralised or thinking about suicide it is VITAL that you talk to someone about it;
- Suicidal thinking is temporary, but it is dangerous to try to cope with on your own;
- Depression can be overcome. Most people have a good recovery even if things have been a bit rocky for a while. Tell the patient that the key steps to surviving depression and suicidal thoughts in schizophrenia are:
  - Tell someone - your doctor, case manager, relatives, friends
  - Seek help - your doctor or case manager can help you manage your low feelings
  - Don’t remain alone – keep company around you and perform some positive activity.

Research shows that combined treatments work best, rather than choosing only one treatment. It is important to choose both medication and psychosocial treatments together to progress recovery.

**Other treatments and treatment issues**

**What is the role of hospitalisation?**
A range of treatment settings should be available to people with schizophrenia. Treatment should occur in the least restrictive environment possible and hospitals used only when absolutely necessary. This may be when patients need a place away from major stresses, when medications need major review or when treatments are needed that can only be delivered in hospital.

Going to hospital can be distressing. Everybody has ideas about what a psychiatric ward will be like. Most of these ideas are based on outdated stereotypes, and fiction. Patients have a right to be treated with respect and to have things explained in a way and language that they understand. Sometimes it is necessary for family or friends to stay with the patient while she or he is admitted and getting settled in. Hospitalisation should also offer access to non-medication treatment options such as those discussed previously.

**Other issues**
Patients may want to know: what can I do to help myself? They should be told that they can contribute to their wellbeing by staying informed about schizophrenia and its treatments. Tips for patients for good health practices include:

- Following a sensible diet;
- Having regular exercise;
- Avoid all illicit drugs as they have a strong negative impact on recovery;
- Tobacco, as for all individuals, is discouraged, as it acts on the liver and may mean higher doses of medication are required;
- Moderate use of alcohol and caffeine is advised;
- Developing good sleep habits;
- Learning and using stress management techniques;
• Try and build an honest and open relationship with professionals involved in care. It will make it easier for them to understand the situation and provide appropriate help;
• Pay attention to changes in your body and in your thinking and report them as soon as practical to your treating team. This includes collaborating with your doctor to find a medication that gives you the most benefit and use it as recommended;
• It is wise to develop a plan to monitor early signs of relapse. You may want to ask close friends or family to help; and
• Finally, it is important to nurture all the positive relationships you have in your life to ensure you have support throughout treatment and a positive outlook for the future.

**Encourage optimism in the future. It is possible to live well with, and after having had, schizophrenia!**
**Schizophrenia: a Guide for Clinicians**

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Management of Schizophrenia” (2003) published in *Australasian Psychiatry* by Patrick McGorry, Eoin Killackey, Kathryn Elkins, Martin Lanbert and Tim Lambert for the RANZCP Clinical Practice Guideline Team for the Treatment of Schizophrenia (McGorry, Killackey et al 2003). These are, in turn, an abbreviated form of the full guidelines review published in the *Australian and New Zealand Journal of Psychiatry* (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders 2005). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

*Introduction*

Schizophrenia is a complex and misunderstood illness with a poor public image. It usually emerges during the critical period of transition to adulthood. Recognition and treatment is often suboptimal, yet over the past decade schizophrenia has become more treatable than ever. A new generation of drug therapies, a renaissance of psychological and psychosocial interventions and a first generation of reform within Australia’s and New Zealand’s specialist mental health systems have combined to create an evidence-based climate of realistic optimism. Neuroscientific advances hold out the strong possibility of more definitive biological treatments in the near future. This potential for greatly improved outcomes and quality of life contrasts starkly with the day-to-day reality for many people with schizophrenia. There is a large gap between the proven efficacy of treatments for schizophrenia and the effectiveness achieved in the “real world”.

Clinicians should consider, but not be limited to, the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals care for patients with schizophrenia in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
TABLE 1: KEY RECOMMENDATIONS… Foundations for effective care include:

General
- Optimism and partnership;
- A stable and secure social environment, including a pleasant home environment, family and peer support, financial security and a meaningful social role; and
- Therapeutic engagement and continuity of care.

Specific
- Early detection and comprehensive treatment of first episodes of schizophrenia is a priority because it can minimise the psychosocial – and possibly biological – impact of illness and may improve long-term outcomes.
- Comprehensive and sustained intervention should be provided during the initial years following diagnosis because the course of illness is strongly influenced by what occurs during this “critical period”. Patients should not have to “prove chronicity” before they gain consistent access to specialist mental health services.
- Antipsychotic medication is the cornerstone of treatment but there is great scope for further improvement in the expert use of these medications. The treatment of choice for most patients is the atypical antipsychotic medications because of their superior tolerability, probable greater efficacy in relapse prevention and, in particular, reduced risk of tardive dyskinesia. In first-episode psychosis atypical agents should be used as first-line therapy.
- Conventional antipsychotic medications in low dosage may still have a role to play in a small proportion of patients, where there has been full remission and good tolerability, where atypicals are poorly tolerated, or where depot medication is unavoidable. However, the indications are shrinking progressively.
- Clozapine should be prescribed early, if there is incomplete remission of positive symptoms following treatment with at least two other antipsychotic medications (this should be done by a psychiatrist).
- Clozapine may also be considered where there are pervasive negative symptoms or a significant and persistent risk of suicide.
- Psychosocial interventions should be available routinely for all patients within an integrated hospital and community service, and provided by appropriately trained mental health professionals. Appropriate interventions include family interventions, CBT, vocational rehabilitation and therapy for comorbid conditions, particularly substance use disorders.
- Interventions should be tailored to the phase and stage of illness, and to the gender and cultural background of the person.
- Consumers and relatives should be closely involved in their own care.
- Maintenance of good physical health and the prevention and early treatment of medical illness in people with schizophrenia has been neglected. Actively focus on general medical care for people with schizophrenia.
- General practitioners should be closely involved in the care of people with schizophrenia in a “shared care” model. Sole care by a GP with minimal or no specialist involvement is not an acceptable standard of practice, despite the challenges of Australia’s geography.

(CBT, cognitive behavioural therapy; GP, general practitioner)

An overview of schizophrenia

What is schizophrenia?
Schizophrenia is a psychotic disorder that is defined in terms of a variable confluence of positive and negative symptoms without the sustained presence of major mood disturbance. Cognitive impairment and disability are common additional concomitants. The boundaries and validity of the concept, especially in the onset phase, remain problematic. Schizophrenia overlaps with other psychotic disorders phenotypically and in terms of underlying risk factors.
The diagnosis of schizophrenia

Two diagnostic frameworks are commonly used by mental health professionals: the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV) and the Mental Health Manual of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10AM). The latter is now standard within Queensland Health and the diagnostic guidelines for schizophrenia are presented in Appendix 1.

Diagnosis is complicated in cross-cultural settings. For instance, in Aboriginal and Torres Strait Islander populations positive symptoms must be carefully differentiated from certain culturally informed experiences. These may be accompanied by negative symptoms from the baneful effects of unrelenting social disadvantage that is common in many Indigenous settings and which is often complicated by substance use. These difficulties are compounded by clinical contexts in which communication may be fraught with uncertainty and miscommunication, emphasising the importance of informed Indigenous collateral informants (Hunter 2004).

Aetiological basis of schizophrenia

Schizophrenia arises from a combination of risk factors, mainly in genetically vulnerable people. The genetic vulnerability is complex and is now regarded as involving a variable combination of multiple genes of small effect. Environmental risk factors are also necessary and some operate early in life, creating a neurodevelopmental vulnerability state. Other contributory risk factors include gender, socioeconomic disadvantage and urban birth. Recently it has become clearer that risk factors and pathophysiological processes operating closer to the onset of the syndrome are also required. This second set of factors is believed to involve either endogenous central nervous system (CNS) processes such as increased neuronal dysfunction with reduced connectivity, or extrinsic candidates such as substance abuse, viral infections and developmental stress. How specific these risk factors are for schizophrenia is not clear. There is now extensive evidence of mild structural and significant functional abnormalities in the CNS of people with schizophrenia, although none of these are specific and there is still no laboratory test to confirm the diagnosis of schizophrenia.

Impact of schizophrenia

The lifetime prevalence is approximately 1% and it occurs in all known cultures. The course of illness is highly variable, although despite much better recovery rates than generally appreciated, significant disability does occur in a large subgroup and life expectancy is substantially reduced by suicide and chronic medical diseases.

Psychotic disorders appear to be more common in Aboriginal and Torres Strait Islander populations. The standardised mortality ratio for deaths due to mental and behavioural disorders for the period 1999 to 2001 for Queensland, South Australia, Western Australia and the Northern Territory was 4.1 and 1.9 for Indigenous males and females compared to non-Indigenous males and females respectively. Hospital separation rate ratios for 2000 to 2001 for schizophrenia, schizotypal and delusional disorders was 2.3 and 2.1 for Indigenous males and females compared to non-Indigenous males and females. While these elevated rates are influenced by a wide range of factors substance use is clearly important. From the same data the hospital separation rate ratios for mental disorders due to psychoactive substance use for Indigenous vs non-Indigenous males and females was 4.8 and 3.6 respectively (McLennan and Madden 2003).
Current treatment evidence
The management of schizophrenia is best considered in stages or phases: the prepsychotic or prodromal phase, first-episode psychosis, recurrent or persistent schizophrenia (including prevention and treatment of relapse), maintenance therapies, and treatment-resistant schizophrenia.

Prepsychotic or prodromal phase
Background
In most patients a prolonged period of symptoms and increasing disability, commonly termed the "prodrome", occurs before the onset of severe and persistent positive psychotic symptoms that are sufficient to allow the diagnosis of schizophrenia or first-episode psychosis. Such psychosocial damage is always difficult to reverse. Recently it has also been shown that active neurobiological change may occur during this period. While more evidence is required before definitive guidelines can be developed the following recommendations are offered.

Recommendations
1) The possibility of psychotic disorder should be considered in any young person who is becoming more socially withdrawn, performing more poorly for a sustained period of time at school or at work, behaving in an unusual manner for them, or becoming more distressed or agitated yet unable to explain why [V-1].
2) Subthreshold psychotic features combined with the onset of disability, especially if there is a family history, indicate very high risk. The young person and the family should be actively engaged in assessment and regular monitoring of mental state and safety. This should be carried out in a home, primary care or office-based setting if possible, to reduce stigma [V-1].
3) Concurrent syndromes such as depression and substance abuse, and problem areas such as interpersonal, vocational and family stress, should be appropriately managed [III-3].
4) Information about the level of risk should be carefully provided, conveying a sense of therapeutic optimism. It should emphasise that current problems can be alleviated, that progression to psychosis is not inevitable, and if psychosis does occur then effective and well-tolerated treatments are readily available. Engagement at this early stage will help to reduce any subsequent delay in accessing treatment for first-episode psychosis [III-3].
5) The use of antipsychotic medication during the prodrome is the subject of research. At present it should be reserved for patients who are clearly psychotic [V-1].

First-episode psychosis
Background
Two key issues in first-episode psychosis (FEP) are the timing of intervention (and thus the duration of untreated psychosis (DUP)) and its quality (the sustained provision of comprehensive phase-specific treatment). There are often prolonged delays in initiating effective treatment for first-episode psychosis. Prolonged DUP is associated with poorer response and outcome. Early identification of people in the earliest phases of psychotic disorders combined with optimal treatment is very likely to reduce the burden of disease while it is active. Any improvements in long-term outcome should be seen as a bonus, rather than as a prerequisite for improving clinical standards during early illness. First-episode psychosis tends to be more responsive to treatment than subsequent episodes and later phases of illness but it can be more demanding because of the range of clinical issues to be addressed. Syndromes, and hence diagnoses, tend to be unstable and may evolve over time. The umbrella term “psychosis” allows this syndromal flux and comorbidity to be
accommodated, and treatment commenced for all prominent syndromes, before a stable diagnosis such as schizophrenia needs to be applied. Whether or not core "schizophrenia" can be diagnosed or not is not crucial for effective treatment in FEP. Treatment-relevant syndromes are positive psychosis, mania, depression, substance abuse and the negative syndrome. Cannabis use in particular is common in FEP and can cause confusion and delay in treating the psychotic episode. Significant cannabis use appears to be a risk factor for onset of schizophrenia as well as an aggravating factor for subsequent course.

**Recommendations**

1) Strategies to improve the treatment of FEP include better mental health literacy, more informed primary care, and greater responsiveness of public and private psychiatry to possible cases. Community-wide education systems should be developed to improve understanding of how psychotic disorders emerge in a hitherto healthy person and how to seek and obtain effective advice, treatment and support [III-1].

2) A high index of suspicion and a low threshold for expert assessment should be set for FEP [V-1].

3) Entry and retention within specialist mental health services is often based on a reactive crisis-orientated model in which individuals must reach a threshold of behavioural disturbance, risk, disability or chronicity. This creates unnecessary trauma, demoralisation and therapeutic nihilism in-patients, families and clinicians. Instead, services should aim for proactive retention of patients throughout the first 3–5 years of illness, combining developmental (youth) and phase-specific perspectives [III-3].

4) Initial treatment should be provided in an outpatient or home setting if possible. Such an approach can minimise trauma, disruption and anxiety for the patient and family, who are usually poorly informed about mental illness and have fears and prejudices about in-patient psychiatric care. In-patient care is required if there is a significant risk of self-harm or aggression, if the level of support in the community is insufficient, or if the crisis is too great for the family to manage, even with home-based support [V-1].

5) In-patient care should be provided in the least restrictive environment.

6) Pharmacological treatments should be introduced with great care in medication-naive patients, to do the least harm while aiming for the maximum benefit. Appropriate strategies include graded introduction, with careful explanation, of low dose antipsychotic medication plus antimanic or antidepressant medication where indicated. Skilled nursing care, a safe and supportive environment, and regular and liberal doses of benzodiazepines are essential to relieve distress, insomnia and behavioural disturbances secondary to psychosis, while antipsychotic medication takes effect [III-3, V-1].

7) The first-line use of atypical antipsychotic medication is recommended on the basis of better tolerability and reduced risk of tardive dyskinesia. In the longer term, the risk–benefit ratio may change for some patients, for example if weight gain or sexual side effects associated with the atypical agents develop. Typical antipsychotic medications may then be one of the options considered [I]. Appendix 2 lists the characteristics of currently available antipsychotics.

8) A baseline physical examination, electrocardiogram (ECG), weight (body mass index; BMI) and fasting serum glucose should be included in the initial assessment [V-1]. Where possible a neurological examination including a neurocognitive screen for movement disorder should be undertaken and if the patient is hospitalised a baseline CT scan is recommended.
9) Psychosocial interventions, especially cognitive behavioural therapy (CBT), are an important component of early treatment, providing a humane basis for continuing care, preventing and resolving secondary consequences of the illness, and promoting recovery. Cognitive behavioural therapy may also be helpful for comorbid substance use, mood and anxiety disorders and improving treatment adherence [III-3].

10) Families and, whenever possible and appropriate, other members of the person’s social network should be actively supported and progressively educated about the nature of the problem, the treatment and the expected outcomes. If there are frequent relapses or slow early recovery, a more intensive and prolonged supportive intervention for families is required [I].

11) If recovery is slow and remission does not occur despite sustained adherence to two antipsychotic medications (at least one of which is an atypical medication) for 6 weeks each, early use of clozapine and intensive CBT should be seriously considered [I].

12) Early use of clozapine should also be considered if suicide risk is prominent or persistent [II].

Recommended interventions in FEP are summarised in Table 2. Appendix 2 lists the characteristics of currently available antipsychotics.
TABLE 2: RECOMMENDED INTERVENTIONS IN FIRST-EPISODE PSYCHOSIS

Pharmacological interventions: First-episode non-affective psychosis

- 24–48 h observation (no antipsychotics, but use benzodiazepines for anxiety and sleep disturbance) [V-1].
- Start low dose atypical [II] Increase within 7 days to initial target dose (risperidone 2 mg, olanzapine 10 mg, quetiapine 300 mg, amisulpride 400 mg) and hold for next 3 weeks [III-2, V-1].
- If no response increase dose slowly over next 4 weeks (8 weeks in total) to 4 mg, 20 mg, 800 mg and 800 mg respectively [III-2, V-1].
- If response occurs, continue for 12 months, and if remitted stop gradually over a few months with close follow-up.
- Side effects (e.g., weight gain) may be grounds to consider switch to typical agent.
- If no response, assess reason. For poor adherence, discuss, analyse reasons, optimise dose, try compliance therapy [V-2].
- Non-response: switch to another atypical and assess over 6–8 weeks [V-1].
- If no response or poor adherence, or persistent suicide risk, positively recommend clozapine, informing patient and family of benefits and risks. If reluctant, further trials of atypicals or typicals may be justified. An injectable atypical preparation, namely risperidone, has recently become available [V-2].
- If no response or poor adherence with frequent relapse, try low dose typical depot trial for 3–6 months. Currently, unless specifically preferred by the patient, this is a last resort option because of reduced tolerability, greater restrictiveness and associated stigma. This recommendation may partially change with the availability of atypical injectables [V-2].

Pharmacological interventions: First-episode schizoaffective psychosis

- 24–48 h observation (no antipsychotics, but use benzodiazepines for anxiety and sleep disturbance) [V-1].
- If manic type: start with mood stabiliser plus low-dose atypical antipsychotic (add benzodiazepine if sedation required) [V-1].
- If no response switch to another atypical [V-1].
- If depressed type: Start with low dose atypical and SSRI [V-1].
- If response, continue for 12 months and discontinue gradually [V-1].
- If cyclothymic or family history of bipolar add mood stabiliser [V-1].
- If no response switch to another atypical. If no response to SSR1 try SNRI [V-1].
- If still no response try tricyclic antidepressant then consider ECT [V-1].

Psychosocial interventions

Prepsychotic period

- Engagement.
- CBT [V-1].
- Stress management [V-1].
- Vocational rehabilitation [V-1].
- Family intervention [V-1].
- NB – SSRIs where indicated.

First episode acute phase

- CBT [II]
- Psychoeducation and emotional support for both the patient and family/carers [V-1].
- Debriefing for patient and carers (especially where the admission involved traumatic events) [V-2].
- Address comorbidity (e.g., substance use, mood and anxiety disorders, trauma) [V-1].
- Case management aimed at coordinating care, reversing downward social drift, vocational repair, reduction in environmental stressors, engagement in and acceptance of treatment, lifestyle and social environment [V-1].

CBT - cognitive behavioural therapy; SNRI- selective noradrenaline re-uptake inhibitor; SSRI - selective serotonin re-uptake inhibitor.
Recovery and relapse: treating schizophrenia in the critical period

Background
Relapses are common during the first 5 years after a first episode of psychosis, a phase that has been termed the “critical period”. Young people naturally find it difficult to accept the lifestyle change of taking daily medication, especially if they have substantially recovered. Poor adherence often contributes to one or more relapses, which are risky, disruptive and may confer an increased chance of treatment resistance. Secondary consequences such as worsening substance abuse, vocational failure, family stress and homelessness are common during this phase, as the social fabric of the young person’s life is put under severe strain. It is essential that high quality and intensive biopsychosocial care be provided continuously and assertively during this critical period. In practice, though, patients are rapidly discharged to primary care and may experience acute relapse, a suicide attempt or manifest severe disability and collateral psychosocial damage. This minimalist model is highly inappropriate for the needs of patients during this often-stormy critical period of illness.

Recommendations: recovery from first-episode psychosis

1) In fully remitted patients, antipsychotic medication should be continued for at least 12 months and then an attempt made to withdraw the medication over a period of at least several weeks. Close follow-up should be continued with specialist review for a further period of at least 12 months, and any relapse rapidly identified and treated [V-1].

2) Approximately 10–20% of patients fail to fully remit after a trial of two antipsychotic medications. They should be considered as manifesting treatment resistance (see specific guidelines following [III-3]).

3) Even in fully remitted patients, a range of psychological, family and vocational issues need to be addressed. Comorbidity, especially substance abuse, depression, posttraumatic stress disorder (PTSD) and social anxiety, is common and should be treated [V-1].

4) Every patient has the right to a safe, secure and agreeable home environment [V-1].

5) Family support and intervention should be consistently provided during this phase [I].

6) Suicide risk must be actively monitored and addressed [II].

7) Vocational recovery interventions should be offered once a stable clinical state has been achieved [II].

8) Most patients should be closely monitored by a specialist mental health team throughout the early years of illness [V-2].

Recommendations: managing acute relapse

Table 3 summarises strategies for acute relapse. A solid therapeutic relationship and a staged approach are essential. Good adherence to antipsychotic medication and specific psychosocial interventions, particularly family interventions, can reduce the risk of relapse. A significant advantage of an atypical antipsychotic over a typical agent in the prevention of relapse has recently been demonstrated. Poorly engaged, frequently relapsing patients benefit most from intensive case management or assertive community treatment (ACT) models of care. Comorbid substance abuse commonly contributes to relapse, and interventions based on CBT and motivational interviewing show early promise, although this is likely to remain a challenging issue. Appendix 2 lists the characteristics of currently available antipsychotics.
TABLE 3: RECOMMEND INTERVENTIONS IN ACUTE RELAPSE

Pharmacological interventions: Oral
- CBT: cognitive behavioural therapy. Ascertain reason for relapse. Distinguish between relapse linked to poor adherence and relapse despite good adherence [V-1].
- Optimise medication dose and review polypharmacy [V-1].
- Re-start medication if relapse due to non-adherence after understanding the reasons [I].
- If on typical antipsychotic, switch to atypical if response not optimal or if there are tolerability problems. If relapse has occurred despite good adherence, switch to an atypical medication. If patient has been in remission with good quality of life and has no tolerability problems with typical agent, re-start or continue the typical medication. If tolerability problems with the atypical, especially weight gain, offer switch to another atypical or typical [II].
- If on depot, consider relapse as a learning experience and an opportunity to review need for depot within a psychoeducational framework [V-1].
- Consider depot as a last resort only, unless patient prefers this. Atypical depot may offer distinct advantages [V-2].
- If treatment resistance is evident, and two antipsychotic agents (at least one an atypical) have been tried, consider psychiatric evaluation for trial of clozapine [I].

Pharmacological interventions: Depot
- Prior to starting or continuing depot consider potential reversible factors in current relapse (eg extrapyramidal side effects) [V-1].
- Where possible consider use of atypical depot preparations and obtain psychiatric consultation before switching from typical to atypical preparations.
- If a depot is considered essential, consider using the lowest dose possible and maximum dosing interval.
- Depot should be used in conjunction with psychosocial interventions [I].
- Short-term benzodiazepine or oral neuroleptic supplementation may be required [II].

Psychosocial interventions
- Support and counselling for consumer and carers about relapse, especially for a second episode [I].
- Structured family interventions [I].
- Address comorbidities using CBT [II].
- Psychoeducation [III-1].
- Compliance therapy [II].
- Case management [V-1].
- Assertive community treatment [I].
- Vocational rehabilitation [I].
- Relapse prevention [I].
- Harm minimisation for substance use disorders [II].
Prolonged schizophrenia: maintenance treatment and care

**Background**

Long-term issues in schizophrenia include lifestyle problems and the physical and mental consequences of chronic illness, such as poverty, poor housing, a strained relationship with family members, social isolation and unemployment. Clinical issues include ongoing relapse prevention, reducing the demoralising effects of persistent psychotic symptoms, depression and suicide, substance abuse, smoking, family relationships and vocational rehabilitation. The personal relationship with the patient is critical and a staged approach to recovery essential. Hence psychosocial intervention is always an essential element in addition to pharmacotherapy. Monotherapy with atypical antipsychotic medication, following consultation with the patient and family, is the treatment of choice, unless there has been full remission and good tolerability with a typical agent, or the atypical medications have produced unacceptable side-effects. Physical morbidity must not be neglected. The emergence of obesity, impaired glucose tolerance, tardive dyskinesia, hypertension and cardiovascular disorders should be regularly considered. Although the risk of tardive dyskinesia has been reduced with the atypical antipsychotics, the risk of obesity, diabetes mellitus and sexual side effects has increased and is of particular relevance with Indigenous patients. Preventive health care should be offered early and consistently. No conclusive evidence could be found at this stage to support more widespread introduction of cognitive remediation or social skills training programs.

**Recommendations [all V-1]**

1) Actively maintain and enhance the patient’s social environment and social capital within a case management framework, addressing issues such as access to paid work or pension support, housing, social relationships. Attend to clinical issues such as active personal and family support, medication adherence, depression, monitoring suicide risk and substance use.

2) In conjunction with general practitioners, ensure full annual physical check-ups that cover weight, blood pressure, lipid profile, ECG and fasting blood glucose, and usual preventive medicine activities such as appropriate screening for cervical, breast, bowel, skin and prostate cancer.

3) Encourage smoking cessation and reduction or cessation of substance misuse, and promote exercise and a healthy diet.

4) Regularly review sexual function.

5) Regularly (6-monthly) examine for signs of tardive dyskinesia.

6) Check for signs of late remission and review the need for continuing antipsychotic medication.

7) Actively encourage and facilitate meaningful social role development and maintenance, especially through “*in vivo***” vocational rehabilitation.

**Treatment-resistant schizophrenia**

**Background**

Symptoms persist in a substantial minority of people with schizophrenia despite apparently adequate treatment. It is important for clinicians to remain hopeful of positive change rather than becoming nihilistic, and recognize that late remissions can occur despite treatment resistance. Treatment resistance can be defined narrowly in terms of persistent positive symptoms, or more broadly to include the persistence of negative symptoms and disability. Complacency, therapeutic nihilism and service gaps have meant that many such patients have not been exposed to clozapine, CBT or active psychosocial interventions. Conditions that may resemble “treatment resistance” include marked but subtle extrapyramidal symptoms, unrecognised depression, inadequate psychosocial rehabilitation, poor adherence, substance abuse, drug interactions and inappropriate drug therapy.
**Recommendations**

1. Identify and address contributing factors such as poor adherence, extrapyramidal side effects, depression, substance abuse, polypharmacy, or poor social environment and support [V-2].

2. Ensure that the patient has received two adequate trials (at least 6 weeks of maximum well-tolerated dose) of antipsychotics, of which at least one should be atypical [V-1].

3. Clozapine is the treatment of choice for clearly defined treatment resistance [I].

4. Depot antipsychotics can be considered if there has been poor adherence and atypicals are the preparations of choice (clozapine should be considered because the required monitoring often enhances adherence) [V-1].

5. Cognitive behavioural therapy should be offered either in conjunction with clozapine or as an interim alternative to it if the patient is unwilling to consent to clozapine. In this situation every effort should be made to inform the patient and family of the disabling consequences of the illness if symptoms do not remit, restate the risks and benefits of clozapine and evidence for its use, and enable them to reach an informed choice.

6. If treatment resistance persists despite treatment with clozapine, reinstate the best previous antipsychotic and try an appropriate adjunctive therapy, such as lithium. Cognitive behavioural therapy should always be provided should clozapine fail. There is no firm evidence that combining antipsychotics in such patients is useful and tends to increase the side-effect burden [V-2].

7. Personal, family and social support, vocational rehabilitation and a safe and fulfilling lifestyle are critical for this group of patients, who are at risk of being marginalised and demoralised [I].

**Managing acute emergencies in schizophrenia**

**Background**

Key goals in managing emergencies involving patients with schizophrenia are summarised in Table 4.

**Key recommendations**

1. A range of preventive strategies aimed at reducing the likelihood, severity and sequelae of acute emergencies should be actively promoted.

2. Use typical antipsychotics only as a last resort in emergency tranquillisation because of the extremely high risk of extrapyramidal side effects. Even in multiphase patients, the doses of typical neuroleptics required for tranquillization greatly exceeds the threshold for extrapyramidal side effects (EPS).

3. If the patient is non-combative, try oral therapy with benzodiazepines (diazepam 5–10 mg stat with second dose after 1 hr if required to a max. of 20 mg in 24 hours) followed by oral olanzapine, preferably wafers, but if not available, tablet form (5–10 mg stat, after consultation with MO may repeat in 2 – 4 hours according to clinical response up -20 mg in 24 hours) as the next option. High doses of benzodiazepines may be required for some patients, especially those with severe substance dependence. The use of haloperidol is very difficult to justify because it is non-sedative and is associated with severe EPS and dysphoria in most cases.

4. If the patient is openly combative, remains aggressive while consistently refusing oral medication, if the initial response to oral medication is inadequate, or if rapid tranquillization is required because of escalating aggression, then parenteral medication will be necessary. Start with clonazepam 1-2mg stat, this should be repeated only under MO supervision to a maximum of 4mg in 24 hours. Under the direct and continuing on-site supervision of a medical officer midazolam 5mg
i.m. may be considered (this should only be used when there is access to the benzodiazepine reversal agent, flumazenil. As when any parenteral medication is administered, resuscitation facilities must be available and the patient must be directly observed for at least 2 hours).

5. If the aforementioned steps have been ineffective, consider the following:
   - after an oral benzodiazepine and atypical antipsychotic, try haloperidol 5-10mg orally or chlorpromazine 25–100 mg orally;
   - after i.m. therapy, consider haloperidol 5-10mg IM. Access to cardiopulmonary resuscitation (CPR) and defibrillation must be assured;
   - further sedation should be under psychiatric supervision. Consideration may be given in District hospital settings to zuclopenthixol acetate (use low doses, especially in patients not previously treated with antipsychotics, because EPS are very common);
   - after parenteral tranquilization, monitor temperature, pulse, blood pressure and respiratory rate every 5–10 min for 1 hour, then half-hourly until the patient is ambulatory.

6. After remission of symptoms, the patient should normally be maintained on the lowest effective dose of an atypical antipsychotic. Debriefing for patients, staff, family members or other caregivers should always be provided.

Table 4: Key goals in managing emergencies
- Primary prevention of emergency situations and the need for restraint.
- Prevention of physical harm to the patient, other patients or staff.
- Prevention of psychological trauma to patients and staff arising from the management of emergencies.
- Prevention of adverse events from physical or pharmacological restraint during emergencies.
- Prevention of sequelae of emergency restraint.

Conclusion
These guidelines are inevitably a “work in progress”. The evidence base continues to grow steadily and, despite gaps and the lack of uniform level I evidence, is relatively clear as judged by the degree of consensus between these guidelines and those from other countries that have produced similar documents. Treating schizophrenia inadequately is already a costly exercise.
## Diagnostic Criteria for Schizophrenia in ICD-10 and DSM-IV

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Characteristic Symptomatology:</strong></td>
<td><strong>A.</strong> <strong>Characteristic symptoms:</strong> Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):&lt;br&gt;1. Delusions;&lt;br&gt;2. Hallucinations;&lt;br&gt;3. Disorganised speech (frequent derailment or incoherence);&lt;br&gt;4. Grossly disorganised or catatonic behaviour;&lt;br&gt;5. Negative symptoms, ie, affective flattening, alogia or avolition. <strong>Note:</strong> Only one criterion A symptom required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.</td>
</tr>
<tr>
<td>1. One month or more, in which a significant portion of time is taken up one very clear symptom or 2 less clear:&lt;br&gt;<strong>A.</strong> Passivity phenomena&lt;br&gt;<strong>B.</strong> Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;&lt;br&gt;<strong>C.</strong> Voices commenting or other types of hallucinatory voices coming from some part of the body;&lt;br&gt;<strong>D.</strong> Persistent bizarre delusions. <strong>Or</strong>&lt;br&gt;2. At least two of the following:&lt;br&gt;<strong>E.</strong> Persistent hallucinations every day for 1 month when accompanied either by fleeting or half-formed delusions without clear affective content;&lt;br&gt;<strong>F.</strong> Thought stopping/blocking AND incoherence or irrelevant speech, or neologisms;&lt;br&gt;<strong>G.</strong> Catatonic behaviour;&lt;br&gt;<strong>H.</strong> Negative symptoms;&lt;br&gt;<strong>I.</strong> A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.</td>
<td><strong>B. Social/Occupational functioning</strong>&lt;br&gt;For significant portion of time, since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to onset (or when the onset is in childhood or adolescence, the failure to achieve expected level of interpersonal, academic, or occupational achievement).</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td><strong>C.</strong> Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (ie, active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (eg, odd beliefs, unusual perceptual experiences).</td>
</tr>
<tr>
<td>One of 1 or two of 2 present for one month</td>
<td></td>
</tr>
<tr>
<td>Exclusion:</td>
<td>ICD-10</td>
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<td>-------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>The diagnosis is not made in presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedated the affective disturbance. The disturbance is not due to substance intoxication, dependence or withdrawal, or overt brain disease.</td>
<td><strong>D. Schizoaffective and Mood Disorder exclusion:</strong> Schizoaffective Disorder and Mood Disorder with Psychotic features have been ruled out because either (1) no Major depressive, Manic, or Mixed episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.</td>
</tr>
<tr>
<td><strong>E. Substance/general medical condition exclusion:</strong> The disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.</td>
<td><strong>F. Relationship to a pervasive developmental disorder:</strong> If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).</td>
</tr>
</tbody>
</table>
# APPENDIX 2 MEDICATION GUIDE

Usual therapeutic doses and intensity of common side effects of antipsychotic medications (Based on and adapted from Therapeutic Guidelines (Psychotropic) Version 4)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg)</th>
<th>IM Dose interval</th>
<th>Sedation</th>
<th>Postural Hypotension</th>
<th>ACh</th>
<th>EPS</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newer Oral Agents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clozapine</td>
<td>100-600</td>
<td></td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+[1]</td>
<td>+++</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5-20</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+[1]</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Quetiapine</td>
<td>300-700</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+[1]</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>0.5-6.0</td>
<td>+</td>
<td>++(initially)</td>
<td>0</td>
<td>+[1]</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td><strong>Older Oral Agents</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>50-600</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>0.5-12</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Pericyazine</td>
<td>25-75</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Pimozide</td>
<td>2-12</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>10-50</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
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<td></td>
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<tr>
<td><strong>Acute Parenteral Agents</strong></td>
<td></td>
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</tr>
<tr>
<td>Chlorpromazine</td>
<td>25-50</td>
<td>+(?)----</td>
<td>+++(?)----</td>
<td>+++(?)</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>2-10</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>Zuclopenthixol acetate</td>
<td>50-150</td>
<td>2-3d [2]</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Depot Agents</td>
<td>[3] (weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone Consta</td>
<td>25-50</td>
<td>2</td>
<td>?---</td>
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<td></td>
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<tr>
<td>Fluoxetine decanoate</td>
<td>12.5-50</td>
<td>2-4</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Fluphenazine decanoate</td>
<td>20-40</td>
<td>2-4</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Haloperidol decanoate</td>
<td>50-200</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Zuclopenthixol decanoate</td>
<td>200-400</td>
<td>2-4</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>

ACh = anticholinergic effects;  EPS = extrapyramidal effects;  0 = Negligible or absent;  + = Mild;  ++ = Moderate;  +++ = Marked;  NA = not applicable  
[1] Rarely a problem at usual therapeutic doses; [2] single dose, not to be repeated for 2 or 3 days; [3] An initial test dose recommended for depot agents especially if not previously exposed to this type of agent (but not if switching from zuclopenthixol acetate to decanoate
Mania

What is mania?

People who are full of energy, are acting strangely happy, and who have very fast thoughts and speech may have an illness called mania.

They might

Think they are the best or special in some way
Walk round all night – no sleep
Have strange or silly or very happy behaviour
Get angry too quickly
Talk too much and too fast and jumbled up
Have so much energy that they can’t stop

What makes me manic?

These things can cause mania

Poor physical health
Loss or bereavement
Too much stress
Stopping usual treatments
Breaking Law
Family History (someone else in the family has the illness)

People with mania or depression can also have psychosis as well – and will usually need treatment for both problems – see the psychosis pamphlet
What change helps if you are hearing voices or have jumbled thoughts inside?

**OUTSIDE CHANGES**
- Family support
- Elders
- Traditional Healer
- Clinic Mob
- Mental Health Mob
- Antipsychotic tablets with dosette or Webster pack
- Hunting, fishing, dance
- Going to country
- Stopping gunja, alcohol or Other drugs

**INSIDE CHANGES**
- Know about treatment
- Remember totems, family, elders
- Think with your head not with your heart

How do you make change?

- Everyone can make change – when they are ready
- There are lots of different ways to change
- Telling people they SHOULD change doesn’t help
- Letting them know you think they CAN change does help
- Everyone changes in his or her own time
- Small steps can lead to big changes

This information sheets is produce by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Bipolar Disorder: a Guide for Primary Care Workers, Consumers and Carers

Please refer to the definitions and discussion on achieving the 5 Cs for schizophrenia when working with someone with bipolar disorder:

- Consumer and carer centred approach;
- Context of community;
- Continuity of care;
- Checking for change; and
- Considered clinical care.

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers”, by Phillip Mitchell, Gin Malhi, Bernette Redwood and Jillian Ball for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and is not as a substitute for clinician advice.

Introduction

Aim and purpose of the guide

This document is an adaptation of the RANZCP Bipolar Disorder Treatment Guide for Consumers and Carers released in May 2003 and is a research summary of what is known about bipolar disorder and its treatment. It is also a plain English version of the Australian and New Zealand Clinical Practice Guideline for the Treatment of Bipolar Disorder written for mental health professionals by the same authors for the RANZCP Clinical Practice Guideline Treatment Team for Bipolar Disorder (Mitchell, Malhi et al 2003). Information relating to the NH&MRC-defined levels of evidence on which the clinical guidelines were based is published (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process.

What this guide covers

Its purpose is to provide information on best practice in the assessment, diagnosis and treatment of bipolar disorder. It is important that its recommendations are not taken as absolute. First, we cover why comprehensive assessment and diagnosis is so important. We then outline treatments by each phase of the illness:

- Acute treatment of mania and mixed episodes
- Acute treatment of depression
- Preventative continuing treatment of mania and depression

What is bipolar disorder?

Bipolar disorder is a mood disorder. Figure 1 on the following page shows the criteria for diagnosing Bipolar Disorder according to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV). Queensland Health uses the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). A comparison of these two diagnostic frameworks is provided in Appendix 4. Bipolar Disorder is characterised by periods of mania or hypomania, depression, and “mixed episodes” (or “dysphoric mania” — a mixture of manic and depressed symptoms). According to DSM-IV, the illness is commonly subdivided into:

- Bipolar I disorder — at least one lifetime manic episode or at least one mixed episode
- Bipolar II disorder — only periods of a major depression accompanied by at least one hypomanic (not manic) episode.
Most people experience multiple episodes at an average of one episode each two to three years, with each phase lasting about three to six months. If a person has four or more episodes in a 12-month period, their condition is termed “rapid cycling” bipolar disorder.

**Treatment of mania and mixed episodes**
This section discusses the initial clinical assessment, how bipolar disorder presents when people first experience it and the main treatment approaches, mood stabilising and antidepressant medications.

*Initial diagnosis*
When people with bipolar disorder experience acute mania, immediate referral to a specialist psychiatric service is usually necessary.

Diagnosing bipolar disorder can be very complex and the first assessment may not provide a definitive diagnosis. To confirm the diagnosis, a mental health professional (usually a psychiatrist) should undertake a comprehensive assessment. This should include information from relatives and other local informants.

It is necessary to conduct a full psychiatric history, mental state assessment and physical examination to confirm the diagnosis, to exclude any underlying organic cause (such as a prescription drug or substance-induced manic state) and identify any physical complications (such as dehydration). Assessment should also include determining if there is any risk to the person’s safety or to others, a key consideration in deciding how best to manage the condition.

Mania refers to elevated mood that is characterised by high-risk behaviour of either: aggression, excessive spending, or engaging in what is called, “disinhibited behaviour”. This is behaviour that is likely to severely damage the patient’s reputation, such as sexual indiscretions. Insight and judgment are usually impaired early in the episode of illness. Some people may develop delusions, or fixed false beliefs. These are symptoms of psychosis. The presence or absence of psychosis will be taken into account in treating bipolar disorder.
FIGURE 1: THE CRITERIA FOR DIAGNOSIS BIPOLAR DISORDER

The Diagnostic and Statistical Manual (DSM-IV) criteria are:

**Bipolar 1:** Occurrence over a lifetime of at least one manic episode or at least one mixed episode.

**Bipolar 2:** One or more major depressive episodes accompanied by at least one hypomanic episode (not manic episodes).

**Hypomania and Mania (DSM-IV Criteria)**
A distinct period of abnormally and persistently elevated, expansive or irritable mood. Mania lasts at least one week (or any duration if hospitalisation is necessary). Hypomania lasts at least four days. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (eg feels rested after only three hours of sleep)
- More talkative than usual, or pressure to keep talking
- “Flight of ideas” or subjective experience that thoughts are racing
- Distractibility (ie attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually, or a mental and physical restlessness)
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

**Major Depression (DSM-IV Criteria)**
Five or more of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.

- Depressed mood as indicated by either subjective report (eg feels sad or empty) or observation made by others (eg appears tearful)
- Markedly diminished interest or pleasure in activities
- Significant weight loss when not dieting, or weight gain or decrease or increase in appetite
- Insomnia or excessive sleep
- Mental and physical slowing or restlessness
- Fatigue or loss of energy
- Feelings of worthlessness, or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

**Mixed Episodes (DSM-IV Criteria)**
The criteria are met both for mania and a major depressive episode nearly every day during at least a one week period.
**Initial management**

Figure 2 shows the approach mental health professionals usually take in the initial management of a person when they present with acute mania. Although community or outpatient treatment is always preferable, and admission with the patient’s consent is sometimes possible, involuntary hospitalisation under the relevant health legislation is often needed. Going to hospital can protect the person and their family from the damage that may result from the impaired judgment associated with the illness. The decision to go to hospital is often traumatic for the person with bipolar disorder and their family.

**FIGURE 2: INITIAL CLINICAL ASSESSMENT - HYPOMANIC/MANIC EPISODE**

**INITIAL SCREENING ASSESSMENT**

- Severity of symptoms;
- Level of functional impairment;
- Degree of insight;
- Presence/absence of psychosis;
- Risk to self (financial, sexual, reputation) or others (violence); and
- Amount/quality of family support and/or community services.

Assessment may lead to:

- Outpatient treatment, OR
- Voluntary hospitalisation, OR
- Involuntary hospitalisation.

**Comprehensive clinical assessment**

Clinical assessment requires patient cooperation. This may not be possible if the patient is irritable or aggressive as a result of acute mania. The comprehensive assessment is carried out after the person is more settled.

A full medical history and a mental state assessment should be performed. This includes a “risk assessment”, which assesses a person’s potential for experiencing harms associated with mania. These may include aggression, financial harm, risky sexual behaviour or vulnerability to exploitation and the possibility of contracting communicable diseases (such as HIV, Herpes or Hepatitis C) due to sexual behaviour.

The medical history should include past episodes of psychiatric problems and compliance with recommended treatment. Physical examination should exclude organic causes of the manic behaviour, such as neurological disorder, systemic disease, the misuse of alcohol or drugs or other substances, or the use of prescription medication, as well as assessing any physical consequences of mania (eg dehydration, emaciation or injuries).

Routine laboratory investigations include urea and electrolytes, full blood count, liver function tests, thyroid function tests and therapeutic drug monitoring of mood stabiliser serum concentrations. Other investigations should be carried out if needed. For example, these may include a brain scan, cognitive/dementia screen, and an EEG.
Acute treatment of manic episodes
Medications are the main way of managing an acute manic episode. The aim of the medications is to stabilise mood (Figure 3 on the following page).

There are two components to the drug management of acute mania. The first is the commencement of a mood stabiliser (lithium, sodium valproate, carbamazepine or olanzapine). Mood stabilisers act on the elevated mood but take about one week to start working for most people.

The second component is the concurrent use of an antipsychotic or benzodiazepine (or a combination of these). These medications calm or sedate the person with mania as a temporary procedure, until the mood stabiliser starts to help the person to feel better.

The research evidence that has evaluated the effectiveness of lithium when compared to placebo is strong. Studies show that carbamazepine and valproate are of similar value to lithium, although there have been few trials, particularly for carbamazepine.

Olanzapine has also been studied and has been demonstrated in controlled trials to be more effective than placebo. It is possibly more effective to valproate.

For lithium and sodium valproate, therapeutic blood concentration levels for acute mania are reasonably well established. For carbamazepine however, the plasma therapeutic range used is that applied for epilepsy. However, dosage is mainly determined by the assessment of individual response to the medication.

Management of mixed episodes of bipolar disorder
The treatment of mixed episodes involves the choice of any of these medications.
- Valproate
- Carbamazepine
- Lithium
- Olanzapine

The best evidence for the treatment of mixed states of bipolar disorder is for valproate. However, this finding is based on only one study of valproate and lithium in mania. The evidence for carbamazepine is weak and, although there are no specific studies of lithium in mixed episodes, some doctors recommend its use if anticonvulsants have not worked. Olanzapine, an antipsychotic medication, has been shown to be effective in studies that included people with both mania and mixed episodes.

If the episode does not respond to first line treatment
The timing of the decision to change treatment will depend on both clinical urgency and the degree of response, which varies from person to person. There are several options when a person does not respond to the initial medication chosen:
- Increase the dose and/or blood levels of the mood stabiliser;
- Switch mood stabilisers;
- Combine mood stabilisers; or
- Add an additional antipsychotic such as risperidone, olanzapine or haloperidol.
FIGURE 3: TREATMENT OF A MANIC EPISODE

MOOD STABILISER WITH OR WITHOUT ADDITIONAL TREATMENTS FOR OTHER SYMPTOMS

1) MOOD STABILISER
   LITHIUM
   Commence with 750 to 1000 mg daily.
   Determine serum level after 5-7 days of steady-dose treatment
   [Aim for serum concentration of 0.8-1.2 mmol/L]

   OR

   VALPROATE
   Commence with 400 to 800 mg daily.
   Determine serum level after 5 days of steady-dose treatment OR
   Use loading dose strategy commencing at 20 to 30 mg/kg
   [Aim for serum concentration of 300-800 µmol/L]

   OR

   CARBAMAZEPINE
   Commence with 200-400 mg daily.
   Determine serum levels after 5 to 7 days of treatment.
   [Aim for serum concentration of 17 to 50µmol/L].

   OR

   OLANZAPINE
   5 to 20 mg daily

WITH OR WITHOUT

2) ADDITIONAL TREATMENTS FOR OTHER SYMPTOMS
   AIMS
   • Contain aggressive / overactive / disturbed behaviour
     • Treat psychosis
     • Manage sleeping difficulties

   OPTIONS
   i) Taken orally
     • Benzodiazepines (diazepam, clonazepam, lorazepam)
     • Antipsychotics (risperidone, olanzapine, chlorpromazine, thioridazine, haloperidol)

   ii) Taken by injection (only use if oral administration is not possible or ineffective)
     • Benzodiazepines (midazolam IM, diazepam IV)
     • Antipsychotics (droperidol IM, haloperidol IM, zuclopenthixol IM)
     • Cease adjunctive treatments prior to discharge.
If there is continuing failure to respond

- Re-evaluate the diagnosis – consider alternate causes (other psychoses, organic disorders)
- Electroconvulsive therapy (ECT)

**Electroconvulsive Therapy (ECT)**

ECT is administered on an inpatient or day treatment basis by psychiatrists especially trained to administer it. It is a physical treatment and is only able to be conducted after ensuring no physical complications could arise from its use in a particular patient's case. ECT involves the use of electricity to stimulate the brain. It is a safe and painless procedure and can be life-saving for severe depression. It is now administered to very specific target areas of the brain so that side effects (such as short-term memory loss) are limited and/or of very short duration. Informed consent is mandatory.

**Continuation treatment**

Following remission of an initial episode of mania, the mood stabiliser should be continued for at least six months. This is because experience with most patients shows that this is the best way to prevent another episode. The benzodiazepine or antipsychotic should be withdrawn once the acute episode has resolved but the mood stabiliser is continued.

For those people with a well-established history of bipolar disorder, there are several recommended criteria for deciding if the person is likely to benefit from ongoing medication treatment. Most of these guidelines are based on medical consensus opinions and clinical wisdom, taking into account how often illness happens, its severity and the level of disability that it causes.

**Criteria for continuation and maintenance treatment**

**First manic episode**

- Continue treatment for at least six months

**Manic episode in established bipolar illness**

Various criteria for long-term treatment – however serious consideration should be given to long-term treatment whenever a patient has experienced two episodes of mania and/or depression. This is particularly relevant in remote settings where there are greater difficulties with follow-up monitoring. The practitioner should also consider past suicide attempts, psychotic episodes and functional disability associated with episodes.

**Treatment of bipolar depression**

**Assessment of bipolar depression**

The treatment for bipolar depression is sometimes different to how people with depression, but without bipolar disorder, are treated for depressive symptoms. This chapter discusses assessment and management of these episodes in relation to bipolar disorder depression. In established bipolar disorder, depression arises:

- In the absence of ongoing medication – a new depression
- During ongoing treatment – called “breakthrough depression”.

As shown below, a full psychiatric history, mental state and physical examination should be conducted to:

- Confirm diagnosis;
- Exclude underlying complications (such as the presence of any other illness);
- Identify physical complications; and
- Assess any risk of self-harm.
The reason for the latter is that people with bipolar disorder have much higher rates of self-harm and suicide than the general population. This is usually due to depression, sometimes due to impulsivity, and at other times can result from accidents during periods of manic behaviour. Stopping medications too soon is a common cause of depressive relapse, so the assessment will involve a full medication history and review.

**INITIAL CLINICAL ASSESSMENT OF BIPOLAR DEPRESSIVE EPISODE**

**INITIAL SCREENING ASSESSMENT**

- Severity of symptoms
- Level of functional and cognitive impairment
- Presence/absence of psychosis
- Risk to self (suicide)
- Extent of family support and/or community services

**TREATMENT CONSIDERATIONS**

Legal aspects (eg informed consent, mental capacity)

Care in least restrictive environment ensuring safety (risk of self-harm)

This may lead to:

- Outpatient care OR
- In-patient care EITHER
- Voluntary hospitalisation OR
- Involuntary hospitalisation

**COMPREHENSIVE CLINICAL ASSESSMENT OF BIPOLAR DEPRESSIVE EPISODE**

Clinical assessment requires patient cooperation and may not be possible if the patient is severely slowed physically and mentally. It is essential to obtain corroborative information especially in cases with suspected cognitive impairment.

- Suicide risk assessment
- Exclude organic causes (neurological disorder, systemic disease, substance misuse, drug induced)
- Sophisticated appraisal of possible psychotic symptoms – especially pathological/delusional guilt and hallucinations
- Check compliance with mood stabilisers
- Conduct routine haematological and biochemical investigations (urea and electrolytes, full blood count, thyroid function tests, therapeutic drug monitoring)
- Additional investigations if indicated (eg brain scan, cognitive/dementia screen).
**New depressive episode**
The first step in managing a new depressive episode is for appropriate antidepressant treatment to be started. There are two options that work for most people: using a mood stabiliser alone or mood stabiliser and antidepressant combined.

**Mood stabiliser alone**
Lithium is recommended as the first-line treatment unless it has been unsuccessful in the past or is poorly tolerated. If it has not worked before, lamotrigine (an antiepileptic drug) or valproate should be tried. The administration of a mood stabiliser minimises the risk of switching (from depression into mania). For patients who are not psychotic, suicidal or hospitalised, this may be sufficient.

Mood stabiliser medication is tailored to each individual by monitoring blood levels to ensure that the dosage of medication is adequate. Lithium is the preferred choice because it has been shown by research to be very effective. However, it has a slow onset of action and it is not as effective an antidepressant as lamotrigine. Therefore, both lithium and lamotrigine should be considered as first-line options. Valproate should be considered in rapid cycling bipolar disorder.

**Mood stabiliser and antidepressant combined**
Because the antidepressant effect of mood stabilisers can take several weeks to work, there is a risk of self-harm, simultaneous antidepressant use is advisable. The concurrent use of a mood stabiliser and antidepressant may enhance and accelerate antidepressant effectiveness and reduce the likelihood of switching moods.

**Breakthrough depression on a single mood stabiliser**
If there is “breakthrough depression” the dose and/or blood levels of the mood stabiliser should be optimised. If this is unsuccessful the addition of (i) an antidepressant; or (ii) a second mood stabiliser should be considered.

**Add an antidepressant**
Antidepressant therapy on its own may induce mania or rapid cycling, and should therefore be avoided. Selective serotonin reuptake inhibitors (SSRIs) and venlafaxine form the medications of choice (tricyclic and monoamine oxidase medications may be used but must be under close psychiatric supervision).

Upon remission or recovery of the episode, antidepressants should be tapered so as to minimise the risk of switching moods while the mood stabiliser is continued.

**Add second mood stabiliser**
Adding a second mood stabiliser is as effective as adding an antidepressant, but can have significant side effects in some people.

Lithium, valproate and carbamazepine combinations are used routinely but convincing research is only available to suggest that the combining of lithium and carbamazepine is the better option. Lamotrigine is the preferred choice when considering a second mood stabiliser. However, its dose should be reduced in combination with valproate because of the risk of serious rash. Therefore, overall, the addition of an antidepressant is the preferred choice but a second mood stabiliser can be tried, especially if combination therapy is likely to continue long-term.
Choice of antidepressant
The SSRIs are the antidepressants of choice in the treatment of bipolar depression because research shows they are superior and they seldom cause mood switching. Venlafaxine is a suitable alternative.

Choice of mood stabiliser
The choice of mood stabiliser is made on the basis of clinical indications. However, the research evidence clearly shows that lithium and lamotrigine are superior.
- Lithium
- Lamotrigine
- Olanzapine/SSRI combination

Failure of depressive episode to respond to treatment
If the depressive episode does not respond to initial treatment it is important to be sure that treatment is at the right dosage and that it is being taken as prescribed. If there is still no improvement, either or both mood stabilisers and antidepressants can be tried instead or another mood stabiliser added. By this stage, lithium should have been tried.

Any number of mood stabiliser combinations can be attempted in conjunction with antidepressants. However, if despite all reasonable efforts the patient remains depressed or only partially responds, it is important to re-evaluate the diagnosis and review therapy. Organic causes need to be ruled out. Furthermore, the impact of any additional medical or psychiatric conditions should be thoroughly re-assessed.

Finally, consideration needs to be given to psychosocial factors, such as how much support the person has, and whether or not their living circumstances are such that recovery will be promoted. Following remission of the depressive episode it is appropriate to withdraw antidepressant treatment after two to three months to avoid causing mania and/or rapid cycling. However, in every individual, it is necessary to balance the need to treat bipolar depression versus the risk of precipitating mania. It is usual to withdraw antidepressant treatment after two to three months to avoid precipitating mania / rapid cycling. If the person has recurrent depressive episodes, the antidepressant can be continued if administered with a mood stabiliser.

Most experts agree that electroconvulsive therapy is the most effective antidepressant therapy for bipolar depression. It should therefore be used when indicated and especially if it has been previously effective or there are psychotic symptoms.
FIGURE 4: SUMMARY PHARMACOLOGICAL INTERVENTION– DEPRESSIVE EPISODE

NEW DEPRESSIVE EPISODE
Initiate and optimise mood stabiliser
OR
Initiate and optimise mood stabiliser and antidepressant concurrently

BREAKTHROUGH DEPRESSIVE EPSIODE ON SINGLE MOOD STABILISER
Check blood levels
IF Inadequate blood levels – THEN optimise mood stabiliser to adequate blood levels

WHEN adequate blood levels
Add antidepressant
OR
Add second mood stabiliser

SUMMARY: FAILURE OF DEPRESSIVE EPISODE TO RESPOND TO TREATMENT
FAILURE TO RESPOND
Switch/substitute antidepressants
OR
Switch/substitute mood stabilisers
OR
Electroconvulsive therapy

CONTINUING FAILURE TO RESPOND
• Confirm correct diagnosis
• Re-evaluate psychological/social factors responsible for maintaining depression
• Consider adjunctive psychological therapies

Prevention of further episodes
Everyone with bipolar disorder has different patterns of illness. Because the illness is episodic, it can be hard to judge when to stop or when to continue treatment. If the patient ceases medication and relapses, the experience should be used to educate the patient and reinforce compliance.

Attitude to medication and coping with side effects
Adverse side effects are not the only cause of non-acceptance of medication. The lack of feelings of general health and wellbeing, successful social interaction and intellectual activity are important considerations. People who manage to live well with bipolar disorder tend to agree that even when treatment is seemingly effective, all other life issues must be taken into account.

Weight gain is often a significant problem for people taking medication for bipolar disorder. This is especially so for lithium, sodium valproate or antipsychotics. Diet and exercise help lift depression and may assist with weight gain.

Not taking medication properly is the most common cause of relapse. A good mental health professional discuss how the patient manages their medication and their attitude and response to it, to try to prevent the possibility of relapsing. These approaches may include:
• Providing you with education about the recurrent and disabling nature of this condition and potential side effects of medications;
• Addressing the fear people with bipolar disorder often have about the potential sudden loss of control of their behaviour and the embarrassing consequences (it is sometimes only after several episodes that many individuals come to accept the diagnosis and need for ongoing medication or treatment); and
• Helping you to locate support (see Appendix 3).

**Barriers to Taking Medication**

- Doubt about the diagnosis and willingness to risk another episode to confirm it;
- Possible side effects;
- Possible enjoyment of the experience of mania and a wish to experience it again;
- Not realising that mania and depression may involve negative consequences for them or for others;
- Concerns over pregnancy or interactions with medications used for other health problems; and
- All medications cause side effects. These cause many people to stop taking medications. It is important to discuss all side effects you experience with your doctor.

**Continuity of care**

An under-acknowledged issue in the long-term management of bipolar disorder is that of continuity of care. Ongoing contact with the same mental health professional increases the likelihood of early identification of recurrences, and facilitates awareness of the impact of the illness. Unfortunately, mental health professionals change often. Research suggests that the best outcomes are achieved if there is continuity of care in terms of case management.

**How to tell if longer-term treatment is needed?**

Long-term treatment is called the “maintenance” phase of treatment or “relapse prevention”. The goal of long-term treatment for bipolar disorder is to maintain stable mood and to prevent a relapse of mania or a depressive episode. The mental health professional should discuss with the patient their pattern of illness and should suggest the appropriate maintenance strategy.

**Non rapid cycling**

There is strong evidence from clinical trials of the long-term effectiveness of lithium for bipolar disorder. While there have been studies indicating that carbamazepine works to about the same extent as lithium, there have been no long-term studies of either carbamazapine or valproate confirming their superiority over placebo.

For individuals on lithium, kidney function, serum creatinine and electrolytes should be monitored every three to six months. Thyroid function (including thyroid-stimulating hormone (TSH)) should be monitored every six to twelve months, in addition to clinical assessment.

Abrupt stopping of lithium leads to relapse of mania (or, less likely, depression) in many people with bipolar disorder within the next few months. Therefore, if lithium is to be stopped, this should be undertaken slowly over at least one to two months.
For carbamazepine and valproate, haematological and hepatic function should be monitored at least each three to six months after treatment has begun.

**Rapid cycling**

There is no convincing evidence from randomised controlled trials that any of the mood stabilisers are robustly effective in the treatment of rapid cycling bipolar disorder. Valproate has been reported to be effective in some studies but this finding is yet to be confirmed by further research. Lamotrigine was found to have mood stabilising properties in one rigorous study of a mixed group of people who had unipolar and rapid-cycling forms of bipolar disorder.

**Failure to prevent recurrences of bipolar disorder**

**Non-rapid cycling**

There is some evidence that adding a second mood stabiliser (particularly using the combination of lithium and valproate) enhances long-term mood stability.

**Rapid cycling**

First, potential causes of rapid-cycling bipolar disorder should be excluded and managed. These may include substance misuse, antidepressant medications, and possible physical conditions such as hypothyroidism.

**FIGURE 5: MEDICATIONS FOR LONG-TERM TREATMENT OF BIPOLAR DISORDER**

1) **NON-RAPID CYCLING**

   **LITHIUM**
   (Aim for serum concentration of 0.6 to 0.8 mmol/L)
   **OR**
   **VALPROATE**
   (Usual dose range 1000 to 2500 mg; serum concentration 350-700 µmol/L)
   **OR**
   **CARBAMAZEPINE**
   (Usual dose range 600 to 1200 mg; serum concentration 17 to 50 µmol/L)
   **OR**
   **LAMOTRIGINE**
   (Usual dose range 50 to 300 mg; serum concentration not useful)

2) **RAPID CYCLING**

   **VALPROATE**
   (Usual dose range 1000 to 2500 mg; serum concentration 350-700 µmol/L)
   **OR**
   **LAMOTRIGINE**
   (Usual dose range 50 to 300 mg; serum concentration not useful)
   **OR**
   **CARBAMAZEPINE**
   (Usual dose range 600 to 1200 mg; serum concentration 17 to 50 µmol/L)
   **OR**
   **LITHIUM**
   (Aim for serum concentration of 0.6 to 0.8 mmol/L)
FAILURE TO PREVENT RECURRENCES OF BIPOLAR DISORDER

NON-RAPID CYCLING
- Exclude non-compliance
- Treat any comorbid substance misuse
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate)

RAPID CYCLING
- Exclude non-compliance
- Treat any comorbid substance misuse
- Exclude antidepressant-induced affective instability
- Exclude subclinical hypothyroidism
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate).

Further treatment choices

Psychosocial treatments
So far we have reported the research evidence for the effectiveness of medications. There are further treatment choices, such as psychological and psychosocial approaches, which may also improve health outcomes. These may be used at all phases of illness along with medication. Here we discuss the role of these approaches in relation to medications, and other treatment issues.

Learning to live with a continuous illness that is episodic is a major issue for people with bipolar disorder and their families. Repeated episodes of mania and depression tend to lead to increased rates of divorce, family breakdown, unemployment, a break in social networks and education, and financial difficulties. Therefore suffering can be reduced if other steps, over and above medication, are taken to manage the condition.

While in other psychiatric illnesses, there is often an “either/or” choice between taking a medication OR using a psychological treatment, in bipolar disorder, medication remains essential rather than optional. The psychological treatments here are called, “adjunctive”, which means that they can be used in addition to medications.

Psychological treatments
People with bipolar disorder often express embarrassment because of the inappropriate behaviour, or sexual indiscretions, which might have happened when they were manic. Education about the illness and cognitive therapy can help to deal with the psychological and social stresses that the illness can cause.

These strategies therefore play an important role in any treatment plan. Cognitive therapy appears to not only help people with bipolar disorder to understand the disorder and improve coping strategies, but might also improve self-esteem. The main psychological treatments that are used are:
- Psychoeducation (education about the illness provided in groups, individually, or with family members);
- Cognitive Behaviour Therapy (CBT);
- Interpersonal and Social Rhythm Therapy (IPSRT).
Coping strategies
Consumers tend to agree that there are several strategies that can help patients improve how they cope with their illness. These are:

- Being educated about how to identify the early signs and symptoms of either mania or depression;
- Encouraging family and friends to also be able to identify such early signs;
- Staying in treatment and being aware of anything that risks not taking medication;
- Remembering to focus upon the achievement of goals, rather than letting the illness take over the patient’s life;
- Keeping a mood diary to help keep track of your treatment progress and any side effects of any medications the patient is taking; and
- Keeping support around you from family and friends.

However, support from family and friends, does not always shield the patient from the effects of life stresses. Increased levels of support may be necessary when people are required to cope with the death of family or close friends, loss or interruption to careers, or psychological and social distress of other kinds.

Complementary (non-prescribed) medications
Herbal remedies and other natural supplements have not been well studied and their effects on bipolar disorder are not fully understood. Omega-3 fatty acids (found in fish oil) are being studied to determine their usefulness for long-term treatment of bipolar disorder. St John’s Wort (hypericum perforatum) is being studied in regard to depression, but there is some evidence that it can reduce the effectiveness of some medications, can react with some prescribed antidepressants, or may cause a switch into mania.

Pregnancy and breast feeding
The period following childbirth for all women is an extremely emotional period but for women with bipolar disorder the risk of mania, depression or psychosis is particularly high. About 30% of women with pre-existing bipolar disorder will experience a manic or depressive episode following childbirth.

During pregnancy and breast-feeding the goal of treatment is to use the minimum effective dosage of medications and to limit the total number of medications while sustaining the mother’s mental health. Ensuring adequate social, emotional and psychological support is critical.

Support groups
While types of support groups vary widely, here we discuss groups run by people who themselves have experienced bipolar disorder and its treatments.

There is now a growing awareness of the benefits of support groups for people with a bipolar disorder. They have been found to influence positively: the person’s recognition of a need for practical and experiential information about the illness; the awareness of need for medications; and they have been found to assist with the interpersonal difficulties associated with this condition.

Such groups may also help people to cope with hospitalisation, understanding mental health legislation and finding other important mental health information. Some provide support over the telephone and professional referral services. Some groups also enable partners, relatives and friends to attend groups with the person experiencing bipolar disorder.
Standards Of Care
People with any kind of mental illness should expect to be treated with courtesy and compassion by health professionals. There are published *National Standards for Mental Health Services* available in both Australia and New Zealand which are a guide to what to expect from services. Currently, all public mental health services are aiming to achieve these standards over time. There are some key ideas to keep in mind:

- Evidence-based treatments have the best chance of working if delivered by skilled staff who have up-to-date training;
- Patients have a right to quality care and you also have a responsibility to work with your health professionals to get the best care outcomes; and
- There are complaints processes in mental health services and patients should be informed about how to use these processes should they have concerns regarding the quality of treatment.

Conclusion
This guide has covered what the latest research and expert and consumer opinion tell us about living with bipolar disorder and its treatments according to each phase of illness.

People who manage their bipolar disorder well provide assurance and hope that living with it and achieving a good lifestyle is possible. The wider community is now more aware and understanding of bipolar disorder, there is support and there are highly effective treatments now available.

While there remains no cure, there is no reason to think that treatments will not improve even further in the future. This guide has also discussed where research is limited or remains uncertain. Future research will aim to reduce the side effects of existing treatments and to develop better ones.
### Diagnostic Criteria for Bipolar Disorder in ICD-10-AM and DSM-IV

<table>
<thead>
<tr>
<th>ICD-10-AM Characteristic Symptomatology</th>
<th>DSM-IV</th>
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<tbody>
<tr>
<td><strong>Bipolar affective disorder</strong>&lt;br&gt;A disorder characterised by two or more episodes in which the patient’s mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classed as bipolar. Although the most typical form of bipolar disorder consists of alternating manic and depressive episodes separated by periods of normal mood, it is not uncommon for depressive mood to be accompanied for days or weeks on end by overactivity and pressure of speech, or for a manic mood and grandiosity to be accompanied by agitation and loss of energy and libido. Depressive symptoms and symptoms of hypomania or mania may also alternate rapidly, from day to day or even from hour to hour. A diagnosis of mixed bipolar affective disorder should be made only if the two sets of symptoms are both prominent for the greater part of the current episode of illness, and if that episode has lasted for at least 2 weeks.</td>
<td><strong>Bipolar 1</strong>: Occurrence over a lifetime of at least one manic episode or at least one mixed episode.&lt;br&gt;<strong>Bipolar 2</strong>: One or more major depressive episodes accompanied by at least one hypomanic episode (not manic episodes).</td>
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<td><strong>Hypomania</strong>&lt;br&gt;A disorder characterised by persistent mild elevation of mood, increased energy and activity, usually feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity and sexual energy and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the most usual euphoric sociability. Disturbance of mood and behaviour are not accompanied by hallucinations or delusions. Several of these features should be present for at least several days on end, to a degree and with a persistence greater than described for cyclothymia. Considerable interference with work or social activity is consistent with a diagnosis of hypomania, but if disruption of these is severe or complete, mania should be diagnosed.</td>
<td><strong>Hypomania and Mania</strong>&lt;br&gt;A distinct period of abnormally and persistently elevated, expansive or irritable mood. Mania lasts at least one week (or any duration if hospitalisation is necessary). Hypomania lasts at least four days. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:&lt;br&gt;- Inflated self-esteem or grandiosity&lt;br&gt;- Decreased need for sleep (eg feels rested after only three hours of sleep)&lt;br&gt;- More talkative than usual, or pressure to keep talking&lt;br&gt;- “Flight of ideas” or subjective experience that thoughts are racing&lt;br&gt;- Distractibility (ie attention too easily drawn to unimportant or irrelevant external stimuli)&lt;br&gt;- Increase in goal-directed activity (either socially, at work or school, or sexually, or a mental and physical restlessness) and&lt;br&gt;- Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).</td>
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<td><strong>Mania</strong>&lt;br&gt;Mood is elevated out of keeping with the patient’s circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character. The episode should last for at least 1 week and should be severe enough to disrupt ordinary work and social activities more or less completely. The mood change should be accompanied by increased energy and several of the symptoms referred to above (particularly pressure of speech, decreased need for sleep, grandiosity, excessive optimism).</td>
<td><strong>Major Depression</strong>&lt;br&gt;Five or more of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.&lt;br&gt;- Depressed mood as indicated by either subjective report (eg feels sad or empty) or observation made by others (eg appears tearful)&lt;br&gt;- Markedly diminished interest or pleasure in activities&lt;br&gt;- Significant weight loss when not dieting, or weight gain or decrease or increase in appetite&lt;br&gt;- Insomnia or excessive sleep&lt;br&gt;- Mental and physical slowing or restlessness&lt;br&gt;- Fatigue or loss of energy&lt;br&gt;- Feelings of worthlessness, or excessive or inappropriate guilt&lt;br&gt;- Diminished ability to think or concentrate, or indecisiveness&lt;br&gt;- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.</td>
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<td><strong>Mixed Episodes</strong>&lt;br&gt;The criteria are met both for mania and a major depressive episode nearly every day during at least a one week period.</td>
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