

World Fellowship for Schizophrenia and Allied Disorders

Second Quarter 2005

Treatment and Care

by **Diane Froggatt**

In this issue we focus on medications and treatment for schizophrenia. This is timely given the publication last year in the U.S. of the American Psychiatric Association Practice guideline for the Treatment of Schizophrenia (second edition) and the Patient Outcome Recommendations for the Treatment of Schizophrenia, known in the U.S. and elsewhere as PORT. In these pages we have reported some of the highlights of the APA Guideline and will give readers more information on the PORT Recommendations in the next issue.. We hope that this introduction to these results based on research in the U.S. will encourage our readers to delve more fully into this vast subject which concerns us all.

We recognize that most of our readers are not in the United States and may live somewhere with a completely different system of service delivery for the treatment of mental disorders. However, recognition that the treatment of schizophrenia can have guidelines to help physicians and other mental health professionals towards evidence-based practice is important, not only to American professionals but to any professionals in the field worldwide.

AVAILABILITY AND COST

There is a vast variation of availability of medicines and of treatment across the world. While many people in developed countries consider full health care almost a birthright offered by their governments to the whole population, people in other countries find that health care is an out-of-pocket expense and/ or one for which they must insure themselves, if that option is available.

The picture of mental health care can be very depressing. Global mental health resources are grossly inadequate compared to the needs. The World Health Organization Atlas project

(http://www.who.int/mental_health/evidence/atlas/) reveals that Tanzania has one psychiatrist for over 2 million people. Other African countries as well as India and parts of Asia have statistics that are equally staggering. Over a quarter of the world’s countries have no budget for mental health and of the third that admit to a budget, it represents

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This newsletter is an international bulletin published by the World Fellowship for Schizophrenia and Allied Disorders (WFSAD). Our goal is to provide information to the world self-help movement for schizophrenia and allied disorders that includes national local organizations, individuals coping with illness and friends and professionals.

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Developing the habit of taking medications

The following helpful information is excerpted from “How to get the best results from medicines – II Developing the habit of taking medicines every day” – a unit in the educational program developed by **Dr. Ian Falloon** and called **Optimal Treatment Project**. This program is recommended as a best practice treatment model by WFSAD. Many health professionals have taken the course.

The Benefits Of Taking Medication

...Continuing to take medicine helps us stay well. As well as helping reduce the symptoms of illness these antipsychotic medications also help prevent major episodes occurring after a person has recovered. Continuing to take medication regularly halves the risk of having another major episode during the year after recovery. The risk of relapse is reduced from 70% if medicine is taken irregularly to 30% if medication is taken regularly.

The Disadvantages Of Taking Medication

Successful use of medication is achieved only when the medicine is taken regularly in the dose that suits each person. This sounds very simple. But requires very close cooperation among patients, doctors and carers. Surveys show that optimal medication is achieved in less than half the people who are receiving treatment from medical and psychiatric outpatient clinics. There are many reasons for this, most of which can be overcome without much difficulty.

The Problem of Taking Medication Regularly

Most people will find it difficult to take medicine regularly, even medicine that they know has great benefits for them, and few side effects. Taking medicine is not a natural thing for people to do. It is something that needs a special effort, until we get into the habit of taking it. Even then we may need help to make sure that this habit continues throughout all the ups and downs of our lives. There is not only one way to get the best out of taking medication. Each person needs to discover the way that is best for him/her.

Making clinic appointments

Many people do not keep their appointments at mental health clinics. There are many reasons for this, from obvious practical matters, such as lack of instructions on how to get to the clinic, lack of understanding of the need to continue medication after recovering from a major episode or anxiety about attending a mental health clinic and waiting in crowded clinic rooms.

Improvements in the organization of clinics that make them more welcoming and minimize waiting may help. Some people can get their medicine from family doctors, which is par-

ticularly helpful when appointments can be made outside working hours.

Forgetfulness

...Most medicines can be taken only once a day. Simplifying the dose in this way makes the task of remembering easier. Some people have found that they can link their tablet taking to a regular habit, such as mealtimes, taking a bath or brushing their teeth. Some people find that keeping a week’s supply of tablets in a pill-box with sections for each day helps them remember the tablets to be taken.

Whenever possible we suggest that it is best for people to take responsibility for their own tablet taking. Nagging by concerned carers often discourages people. Carers may benefit from learning more constructive ways of prompting, as well as ways to praise the person for taking their medicine regularly....

How to keep the Habit of Taking Medicine Regularly

Once we have got into the habit of taking our medicine regularly, it is important that this habit continues. People who do not have any symptoms for several months may feel that there is little benefit from continuing to take the medication. We may be tempted to cut down, and to miss doses. A recurrence does not usually occur immediately, so we may feel that our actions make sense, and think that the doctors are wrong.

Rewards for regularly taking medicines

Rewarding people for taking their medicines regularly will help them keep up their good habits, even when they cannot see many benefits. Giving praise and compliments to that person may be sufficient. Additional rewards, such as a special meal, recreational outing or small gift to express appreciation at less frequent intervals may help. One clinic organized a party every three months for all those people who had taken their medicine at least 75% of the time...

New Injectable Second Generation Medication

Janssen Pharmaceutica has recently introduced an injectable version of its medication Risperdal under the name Risperdal Consta. This will be the first second generation injectable medication. It is hoped that it will prove beneficial for those who have trouble taking tablets regularly. It is already available in many countries.



Treatment and Care (Continued)

less than 1% of their total health spending.

Twenty percent of countries do not have even the most basic psychotropic drugs at primary level and the figure is greater in the African region. Where patients have access to these medications another difficulty arises in the cost of the second generation (atypical) compounds. In Nigeria, for instance, a month's supply of the second generation medication risperidone costs more than twice the minimum monthly wage in the public service.¹

In India first and second generation psychotropic medicines are available, and often easily available as it is quite possible to buy them without prescription. Prices vary from place to place and from manufacturer to manufacturer. First generation psychotropic medicines, plus one second generation medicine, risperidone, are distributed under the government's free-distribution system. In December of 2004 India became a signatory to the World Trade Organization Patent Ordinance. As a result second generation psychotropic medications may be available but not affordable in the future, as copying drugs that are under patent will be illegal.

FIRST VERSUS SECOND GENERATION MEDICATIONS

It is of interest to note that clozapine, which has been off patent for some years, is not recommended by the APA as a first-line medication. Neither is it considered an essential drug under the WHO's essential drugs list. Nevertheless, for patients who have not had any benefit or limited benefit from the other medications, clozapine holds out a lot of hope and is recommended in the guideline. Some years ago an article in Time Magazine touted it as a miracle drug returning people to a normal life after years of disability. In general, however, families report that clozapine

has vastly improved their relative's ability to function within the family, and even to take up work, but that some symptoms do remain. What many families are looking for is a "son of clozapine", a medication which would be as effective but without the 1% risk of a fatal blood condition. Until that time it is good to know there is a medication with only a small risk of tardive dyskinesia, and one that can be helpful in reducing the incidence of suicide.

In these pages we are pleased to reproduce the PORT table of recommended antipsychotic dosage ranges for the treatment of schizophrenia (page 10).

One thing that the 2nd generation medications have brought about is the change in the way people think of schizophrenia.

After reading the full APA Guideline I could find no indication that second generation medications are considered more effective than the old ones. Nevertheless, they have fewer unpleasant side effects (extrapyramidal) at recommended doses and are being used as first line medications for patients newly diagnosed with the disorder. The National Institute of Clinical Excellence in the UK² recommends that "2nd generation drugs be considered in the choice of

first-line treatments and for patients showing or reporting unacceptable adverse effects caused by 1st generation medications".

One thing that the 2nd generation medications have brought about is the change in the way people think of schizophrenia. Treatment used to be considered successful when the patient's voices (hallucinations) and delusions were reduced or eliminated. This is no longer the case. Clinicians are looking for their patients to be able to think more clearly and have better judgment. This must have been brought about by clinicians beginning to see these improvements happen in their patients, even if in only a small percentage. Is it the new medications; is it the re-

vised dosing for the old medications, or is it the recognition that psychosocial and psychoeducational support must be offered to patients and families?

POLYPHARMACY OR TAKING A COCKTAIL OF MEDICATIONS

The number of antipsychotic drugs, and the different effects they can produce in individual patients, means that the right drug for the patient cannot always be found at first. Families must be patient. Doctors may also need to prescribe other drugs simultaneously to deal with medical problems, but taking several antipsychotic drugs at the same time is not usually recommended.

Nevertheless, patients are often given more than one psychotropic medication. We note that in the APA and PORT recommendations, giving more than one antipsychotic at a time is not suggested as standard treatment, but might occur after a patient has been given a fair trial (six months or so) of several antipsychotic medications successively without result. However, when doctors discover depressive or obsessive compulsive symptoms in a patient with schizophrenia, they sometimes help alleviate these symptoms by adding an anti-anxiety or anti-depressant medication.

PSYCHOEDUCATIONAL AND PSYCHOSOCIAL INTERVENTIONS

It is clear from the APA and PORT reports that psychosocial and psychoeducational interventions are in short supply in North America. It is also not at all clear what constitutes either one. There will be many who swear that specific types of these interventions *do* reduce relapse, *do* reduce family sickness and/or burden and *do* act as a catalyst for better functioning. The difficulty is that each intervention cannot be compared to another similar *intervention*, which means that studies are not altogether a satisfactory means of finding out what type of intervention works best. WFSAD has been frustrated in its efforts to validate these interventions. As readers know, WFSAD has been promoting psychoeducation for families since 1998 when

we launched our “Families as Partners in Care” strategy under president Margaret Leggatt, in order to promote the positive involvement of families.

Since that time there has been ample evidence published that working with families does enhance both patient well-being and family well-being.³ Controlled studies also often show that any kind of intervention in which a patient gets continuous and regular attention will be beneficial to his quality of life. It is therefore valuable that the APA Guideline suggests that clinicians attend to things other than pharmacological interventions. Patients nowadays often need to discuss their plans and be offered pragmatic advice to help them function in their day to day lives.

CONCLUSION

The huge gap between the developing and developed world makes it difficult to make appropriate comments about what should happen in treatment and care. Nevertheless psychiatrists and family doctors working in the field need guidance on current methods of treatment. We particularly appreciate having the PORT table that gives an appropriate range of dosage for medications (page 10). We are also pleased to report on a book on cognitive therapy for schizophrenia. Despite the fact that this is a new mode of treatment that requires extremely skilled therapists, it points the way to another auxiliary treatment that has promise. The mystery that is schizophrenia is gradually being unraveled and we are pleased to be part of an era of new research and discovery.

1 Oye Gureje, Prof. Of Psychiatry, University of Ibadan. *International Psychiatry* (2003), 2, 10-12

2 Nat. Institute of Excellence. (2002) Health Technology Appraisal No.43, NICE, London.

3. Diane T. Marsh. A Family Focused Guide to Serious Mental Illness: Empirically Supported Interventions. Haworth Press, 2001

Diane would like to acknowledge Nirmala Srinivasan and Radha Shankar who provided information to assist in the preparation of this article.



The American Psychiatric Association Practice Guideline for the Treatment of Schizophrenia

The updated guideline for the treatment of schizophrenia was published by the American Psychiatric Association during 2004 and can be read on line at the APA website or obtained by writing. The document is comprehensive (77 pages long plus 30 pages of references). The chair of the work group producing the document is Anthony F. Lehman, MD, MSPH and the steering committee chair on practice guidelines was John S. McIntyre, MD. Because of the length and specialized nature of the document we have relied on the 5-page executive summary to bring you some of the important points that are discussed in full in the main text. We have included many elements of the report, particularly the recommendations marked with the coding system (see below). As laypersons we do not presume to prepare a synopsis but rather use the direct text in our report. We recommend that professionals read the full report and that other readers look at the Executive Summary on line at www.APA.org for comprehensive information.

OUR SUMMARY

A. Coding System

A system of priorities was applied to recommendations. [I] recommended with substantial clinical confidence; [II] recommended with moderate clinical confidence or [III] on the basis of clinical circumstances.

B. Treatment Plan:

A treatment plan must be formulated and implemented after the initial assessment [I].

- Periodic reevaluation of the diagnosis and the treatment plan is essential to good clinical practice and should be iterative and evolve over the course of the patient's association with the clinician [I].

C. Establishing a Therapeutic Alliance

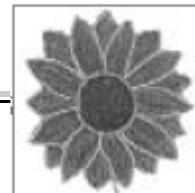
- A supportive therapeutic alliance must be established. Engagement of the family and other significant support persons, with the patient's permission, is recommended to further strengthen therapeutic effort [I].
- The social circumstances of the patient are areas that

may be explored by health care clinicians [III].

- The family's needs can be facilitated by referring family members to family organizations.
- Because an accurate history of past and current treatments and responses to them is key in treatment planning, excellent documentation is paramount [II].

D. Acute Phase Treatment

- Determine and address the factors that led to the occurrence of the acute episode. Connect the patient to appropriate aftercare.
- Efforts to engage and collaborate with family members and other natural caregivers are often successful during the crisis...and are strongly recommended.
- A thorough initial evaluation is recommended, including complete psychiatric and general medical histories and physical and mental status examinations.
- Pay special attention to the presence of suicidal potential and the presence of command hallucinations and take precautions whenever there is any question about the patient's suicidal intent...
- Pharmacological treatment should be initiated promptly. The physician should discuss the possible risks and benefits for the treatment if possible [I].
- Patients with recurrent relapses related to nonadherence are candidates for a long-acting injectable medication. The recommended dose is that which is both effective and not likely to cause side effects that are subjectively difficult to tolerate and may result in nonadherence. Careful attention must be paid to potential drug-drug interactions (with adjunctive medications) [I].
- Providing information to patient and family is recommended. Patients can be encouraged to collaborate with the psychiatrist about selecting and adjusting the medication and other treatments provided [II].
- The acute phase is the best time to initiate a relationship with family members who are particularly concerned about outcome at this time [I].



E. Stabilization Phase

- Goals are to reduce stress and provide support to minimize relapse; and to enhance adaptation to promote recovery, continuing the regimen of medication if the patient has improved for at least 6 months [I].
- It is critical to assess continuing side effects to minimize adverse side effects that may otherwise lead to medication nonadherence and relapse [I].
- Education about illness can begin at this stage [II].
- It is important that there be no gaps in service delivery [I].
- Adjustment to life in the community can be facilitated by realistic goal setting without undue pressure to perform at high levels vocationally and socially [I].
- Maintain a level of momentum aimed at improving community functioning to instill a sense of hope and progress [I].

F. Stable Phase

- Sustain symptom remission and ensure patient is maintaining or improving his level of functioning and quality of life. Regular monitoring for adverse effects is recommended [I].
- It is helpful to retain strong ties with persons who interact with the patient frequently, who would be most likely to notice any resurgence of symptoms and stresses [II].
- Antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness and are strongly recommended [I].
- Treatment can be complicated by the fact that there is no reliable strategy available to identify the minimum effective dose to prevent relapse.
- Whether first or second generation medications are used it is important to minimize side effects while maintaining a treatment that will prevent relapse (see sidebar for excerpted text).
- It is important to evaluate whether residual negative symptoms are in fact secondary to a parkinsonian syndrome or untreated major depression, since interventions are available to address these causes of negative symptoms [II].
- It is important to discuss with the patient the risks of relapse versus the long-term potential risks of maintenance treatment with the prescribed antipsychotic [I].
- If a patient decides to discontinue medication it is impor-

From Part A: Treatment Recommendations for Patients with Schizophrenia, Executive Summary:

F. Stable Phase.

American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia (Second Edition)

“For most patients treated with first-generation antipsychotics, a dose is recommended that is around the ‘extrapyramidal symptom (EPS) threshold’ (i.e. the dose that will induce extrapyramidal side effects with minimal rigidity detectable on physical examination), since studies indicate that higher doses are usually not more efficacious and increase the risk of subjectively intolerable side effects [II]. Lower doses of first generation antipsychotic medications may be associated with improved adherence and better subjective state and perhaps ultimately better functioning. Second-generation antipsychotics can generally be administered at doses that are therapeutic yet well below the “EPS threshold”. The advantages of decreasing antipsychotic doses to minimize side effects can be weighed against the disadvantage of a somewhat greater risk of relapse and more frequent exacerbations of schizophrenic symptoms. In general, it is more important to prevent relapse and maintain the stability of the patient [III].”

tant to educate the patient and family members about early signs of relapse, advising them to develop plans for action should these signs appear and encouraging the attendance at outpatient clinics regularly [I].

- An adequate trial of medication should last at least 6 months. A clozapine trial should be considered for a patient who has had no response or partial and sub-optimal response to two trials of antipsychotic medication (including at least one second generation agent or for a patient with persistent suicidal ideation or behavior that has not responded to other treatments). [I]
- Effective psychosocial treatments: family intervention [I]; supported employment [I]; assertive community treatment [I]; skills training [II], and cognitive behaviorally oriented psychotherapy [II]. The selection of treatment should be

(Continued on page 8)



(Continued from page 7)

tailored to the individual.

- Interventions for families include education, problem solving and communication to reduce symptom relapse and contribute to improved patient functioning and family well-being [II].
- Training programs need to combine medications with a range of psychosocial services to reduce the need for crisis-oriented hospitalizations and emergency department visits and enable greater recovery [I].

G. Other Specific Treatment Issues

• 1. *First Episode*

Close observation and documentation of the signs and symptoms over time are important because first episodes of psychosis can be polymorphic and evolve into a variety of specific disorders [I].

- First episode patients are generally more sensitive to the therapeutic effects and side effects of medications and often require lower doses than patients with chronic schizophrenia. Minimizing the risk of relapse in a remitted patient is a high priority, given the potential clinical, social, and vocational costs of relapse [I]. Family members are especially in need of education and support at the time of the patient's first episode [I].

• 2. *Negative symptoms*

Assessing secondary negative symptoms and treating them is important. If negative symptoms persist, they are presumed to be primary negative symptoms of the deficit state. There are no treatments with proven efficacy for primary negative symptoms.

• 3. *Substance use disorders*

Nearly half of patients with schizophrenia have comorbid substance use disorders, excluding nicotine [I]. A comprehensive integrated treatment model is recommended in which the same clinicians or team of clinicians provide treatment for schizophrenia as well as treatment of substance use disorders [III].

• 4. *Depression*

Depression symptoms are common at all phases of schizophrenia. A careful differential diagnosis that considers the contributions of side effects of antipsychotic medications, demoralization, the negative symptoms of schizophrenia, and substance intoxication is recommended [I].

Trials on second generation antipsychotics have shown that they may have greater efficacy for depressive symptoms [II].

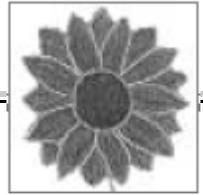
• 5. *Suicidal and aggressive behaviors*

Suicide is the leading cause of premature death among patients with schizophrenia. Specific demographic risk factors for suicide among persons with schizophrenia are young age, high socioeconomic status background, high IQ with a high level of premorbid scholastic achievement, high aspirations and expectations, early age at onset/ first hospitalization, a chronic and deteriorating course with many relapses, and greater insight into the illness. However it is still not possible to predict whether a person will attempt or die by suicide. Medications may reduce the risk of suicide but clozapine is the most extensively studied and has been shown to reduce the rates of suicide [II] and persistent suicidal behavior [I].

A minority of patients with schizophrenia have an increased risk for aggressive behavior. The risk for aggressive behavior increases with comorbid alcohol abuse, substance abuse, antisocial personality, or neurological impairment. Identifying risk factors for aggressive behavior and assessment of dangerousness are part of a standard psychiatric evaluation [I].

H. Treatment Settings and Housing Options

- In general patients should be cared for in the least restrictive setting that is likely to be safe and to allow for effective treatment [I]. Indications for hospitalization usually include the patient's being considered to pose a serious threat of harm to self or others or being unable to care for self and needing constant supervision or support [I].
- Treatment programs that emphasize highly structured behavioral techniques and skills training that can improve patients' functioning are recommended for patients with treatment resistant schizophrenia who require long-term hospitalization [I].
- Day treatment programs in the stabilization phase can add structure, support to increase social functioning [I].



Cognitive Therapy of Schizophrenia

by David G. Kingdon and Douglas Turkington. *The Guilford Press, New York, London 2005. First volume in a series: "Guided to Individual Evidence-Based Treatment" Jacqueline B. Persons, Series Editor.*

It is refreshing to pick up a publication on the treatment of schizophrenia that is devoted to working on cognition and thought disorder. For a long time families were told not to get involved with their loved ones' delusions. "You cannot reason with psychosis", people would tell families. But here in this informative and hopeful manual, therapists are doing just that, albeit through interventions conducted by trained professionals.

The book is a manual of cognitive therapy that describes a variety of ways of developing and implementing treatment programs to work with people with a wide range of symptoms. In a step by step manner it discusses the background for cognitive therapy; explains schizophrenia and then proceeds to the process of therapy. The development of a therapeutic relationship and engagement with the client are discussed first. The authors do not minimize the difficulty here, but suggest a number of methods. [I felt a considerable amount of empathy with the hypothetical therapist and client. My experience as a family member, trying to engage with my own relative, has demanded a number of psychological approaches.] Once the client is engaged, the next step is assessment followed by case formulation and treatment planning. The authors describe the need for a full assessment in order to understand "the personal, social, medical and mental health history as well as the presenting problem or symptoms", and provide the names of useful scales for measuring outcomes, while warning that they should not be a substitute for comprehensive assessment. Developing the formulation with the client is described with reference to case histories. Examples are given of how to approach the client in order to be understood, to be persuasive and to be appropriately empathic. One such example is in preparing the client for treatment:

"You've been referred to me because I am trained in using a specific approach to help people with the type of problems that you have, called cognitive therapy. It's a way of understanding how thoughts, feelings and behavior link together and that can be very helpful in disentangling and dealing with distressing experiences, like the voices you're hearing [or concerns you have]."

Later the authors describe how to develop a strategy to explore and manage delusional beliefs: "Whatever the be-

lief, eliciting it and understanding it is central to assisting the person in dealing with it and its possible consequences effectively". In their discussion of different types of delusions, the authors point out that reasoning rarely displaces grandiose beliefs but that underlying issues may still be dealt with. The aim of the treatment, other than to try to displace the delusions, is to reduce the stress and disability that they cause.

I found these two chapters on dealing with delusions and voices of most interest, since these ideas had not before been suggested to families, although I am aware that families have involved themselves with their relatives in a similar way to good effect.

In a table of examples of coping strategies for auditory hallucinations, sample suggestions for behavioral control include taking a warm bath; going for a walk or other exercise; listening to music, and retreating to a quiet place. I quote these because they are useful to *anyone* seeking to reduce stress. Other coping strategies in the table are related strictly to work with the therapist (p.123).

Succeeding chapters addresses thought interference (having thoughts that seem to be your own but uncharacteristic of you); passivity phenomena (external force controlling your thoughts, feelings and actions) and thought disorder. Work with negative symptoms, working with families and medication regimens are covered. Dealing with comorbid conditions (conditions that are present at the same time) such as substance misuse and personality disorders is mentioned only briefly. Relapse prevention is referred to as a "key aspect of all the work done with symptoms so far. It is based on a formulation that enables the person to understand and come to an acceptance of what has happened to him or her." Some triggers are identified: anniversaries and family gatherings; meetings with specific people; changes in medication; use of alcohol or drugs, but the authors point out that "sometimes the relationship to life events may not be clear".

The last chapter discusses areas of difficulty, from engaging with a very actively psychotic person lacking insight to working with risk of aggressive behaviour and suicidal ideation. Appendices provide rating scales; informational handouts and sheets for use by patients during therapy.

My final impression is that this manual describes a courageous therapeutic intervention that has been attempted only rarely up to the present, but is likely to be worth the enormous effort required by both therapist and client. It requires a high degree of skill and training by the therapist as well as commitment by the patient, of which the book can give only a small indication.



PORT Updated Treatment Recommendations 2004

Recommended antipsychotic dosage ranges for the treatment of schizophrenia

Medication	Chlorpromazine equivalence ¹	Acute therapy	Maintenance Therapy
First generation antipsychotic medications			
Fluphenazine HCl	2	6-20 MG/DAY	6-12 mg/Day
Fluphenazine decanoate ²	NA	NA	6.25-25 mg/2Wks
Trifluoperazine	5	15-50 mg/day	15-30 mg/day
Perphenazine	10	30-100 MG/DAY	30-60 mg/day
Mesoridazine	50	150-400 mg/day	150-300 mg/day
Chlorpromazine	100	300-1,000 mg/day	300-600 mg/day
Thioridazine	100	300-800 mg/day	300-600 mg/day
Butyrophenone			
Haloperidol	2	6-20 mg/day	6-12 mg/day
Haloperidol decanoate ³	NA	NA	50-200 mg/4wks
Others			
Thiothixene	5	15-50 mg/day	15-30 mg/day
Molindone	10	30-100 Mg/day	30-60 mg/day
Loxapine	10	30-100mg/day	30-60 mg/day
Second generation antipsychotic medications			
Clozapine	NA	150-600 mg/day	150-600 mg/day
Risperidone	NA	2-8 mg/day	2-8 mg/day
Olanzapine	NA	10-20 mg/day	10-20 mg/day
Quetiapine	NA	300-750 mg/day	300-750 mg/day
Ziprasidone	NA	120-160 mg/day	120-160 mg/day
Aripiprazole	NA	10-30 mg/day	10-30 mg/day

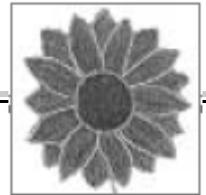
Note – NA = not applicable
 1: Approximate dose equivalent to 100 mg of chlorpromazine (relative potency); it may not be the same at lower vs. higher doses. Chlorpromazine equivalent doses are not relevant to the second generation antipsychotics and therefore are not provided for these agents.
 2: Fluphenazine decanoate dosage recommendations are based on an empirical rule suggested by Kane (1996) (25 mg every 3 wks of decanoate is equivalent to 665 chlorpromazine equivalents per day). These are theoretically determined values and should be interpreted as approximations only (Baldessarini et al. 1988).
 3: Haloperidol decanoate dosage recommendations are based on the following rules: 5 mg oral haloperidol (250 chlorpromazine equivalents) per day is equivalent to 50 mg haloperidol decanoate every month. These are theoretically determined values and should be interpreted as approximations only (Zito 1994).

About the Cochrane Collaboration

The Cochrane Collaboration is an international non-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It was founded in 1993 and named for the British epidemiologist, Archie Cochrane. Visit the website at: www.cochrane.org

The Collaboration produces and disseminates systematic review of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. It publishes its Database of Systematic Reviews quarterly as The Cochrane Library. These reviews are mostly prepared by health care professionals who volunteer to work in one of the many Collaborative Review Groups.

These professionals add up to more than 11,500 people working in over 90 countries, half of whom are authors of Cochrane Reviews. Increasingly these contributors are from low, lower-middle and upper middle income countries There are 50 Review Groups covering the whole spectrum of disease entities. The Schizophrenia Group has published an impressive number of Reviews (over 60), mostly covering medications used for schizophrenia with a few reviews covering psychosocial or cognitive therapies. The Depression, Anxiety and Neurosis Group has published a large number of Reviews (~50) covering pharmacological, psychological and psychosocial treatments.



MDRI Film-Maker Protects People in Paraguay Psychiatric Hospital

Alison A. Hillman, Director of Mental Disability Rights International's (MDRI) Americas Advocacy Initiative, recently won an award in the documentary category at "Picture This" - Canada's international disability film festival. The film, an expose of egregious human rights violations against patients in a psychiatric hospital in Paraguay, was instrumental to the success of a petition to the Inter-American Commission on Human Rights submitted by MDRI and the Center for Justice in International Law. They obtained an historic ruling to protect 460 people in Paraguay's psychiatric facility. In addition to immediate life-saving medical treatment and protection from sexual abuse, the Commission ordered



As a result of MDRI's work, Jorge Bernal (above) now lives and receives services in the community. Jorge had been diagnosed with autism and kept in an isolation cell for 4 years in Paraguay's State Neuro-Psychiatric Institution

Paraguay to end the barbaric practice of long-term isolation.

For more information on human rights, go to

www.mdri.org

Poor Adherence

A study on adherence to antipsychotic medication done in the United States and published in the *Schizophrenia Bulletin*, Vol. 30, No.2, 2004 by Valenstein, Blow et al. reports that poor adherence to medication by people being treated for schizophrenia is common. The study used national Department of Veterans Affairs pharmacy data to examine whether patients receiving atypical agents are more adherent with their medication and explored patient factors associated with adherence. The summary concludes: "our data indicate that any improvements that occur in adherence with the use of the atypical antipsychotics are not likely to be dramatic. Although atypical agents may have fewer extrapyramidal side effects and improve patients' quality of life, many patients remain poorly adherent and do not enjoy the full benefit of these expensive medications. More intensive multi-component interventions may be needed to improve adherence and reduce morbidity among these vulnerable patients.

About the Personal Story

The personal story overleaf demonstrates the continuing unconditional love offered by two parents to a son whose experience of schizophrenia is severe and unremitting owing, in great part, to his strong desire to be normal and well. Whether you could call his poor adherence to taking medicine a lack of insight is debatable. This is a universal story showing the deep concern, trepidation, tolerance, compassion and perseverance of one family as told by a woman, mother to a son sick with schizophrenia. Many of you will see yourselves in this story, and many will recognize the inadequacies of mental health services and of treatment which is all too common in both developing and developed countries.



My Story

By Judy Sinyard

In the beginning my husband and I had the most beautiful baby boy. It was not until 2 ½ years later that I had come to know that there really was a difference between boys and girls. My son nursed every 2 hrs 24 hrs a day and my daughter nursed every 4 and slept through the night within a few months. This difference in my son continued to show as hyperactivity. This hyperactivity was not severe and he did not have aggression.

He was diagnosed in grade 7 with ADHD (Attention Deficit Hyperactivity Disorder). Now, all along I realized I was seeing that his dad had some differences too. These differences were becoming more prominent as time went on. Apparently the pediatrician had a private chat with him about the hereditary nature of ADHD in fathers. One year and a number of assessments later he was also diagnosed with ADHD. Three years later we were divorced and my son at 15 went to live with his father.

My previous career working with adults, adolescents and children with developmental challenges, did not prepare me in the slightest for my son's first psychotic episode. It happened two weeks before his eighteenth birthday. This is the day that our culture marks as the beginning of adulthood. From the little knowledge I had, my suspicion of the possibility of my son having schizophrenia or a brain tumour led me to take him to an emergency department of a large city hospital, three hours from our rural home.

Getting to this point took a full month of confusion and misdirection. With advice from our family doctor to take him to either of two hospitals if he worsened over the weekend, and with much effort, I finally convinced him to go to the hospital with me. The first hospital I called stated that they did not have a psychiatrist on duty on the weekend and the staff member gave me no other direction. The second hospital staff person listened and then advised me to bring him in. My son's agreement to go with me that Saturday morning in 1997, led us to get immediately in the car without any forethought or preparation for what might possibly take place. I did not bring any clothes or other belongings with us. I was concerned he would change his mind before we arrived and I had no idea how to deal with that possibility.

During our eight hour wait in the emergency room, no more than thirty minutes would pass without him saying, "Let's go now mom." I would reply with the same gentle, flat response,

"We need to see the doctor first." I had tried to conceive of how I would deal with him just getting up and leaving. I quickly put this out of my thoughts as no remote answer had come to mind. We saw three different doctors that Saturday in 1997. He was admitted to the psychiatric ward of the General Hospital and I was given a room for family members who resided outside of the city.

I was awakened from my dream at 3:30 in the morning to the soft voice of a nurse on the phone asking me to come down to the ward. My son was dressed, asking for me, and determined to go home. But he was easily convinced to return to bed knowing that I was in the hospital on another floor. I asked if he could have something to help him sleep and waited silently by his bed until he fell asleep. I returned to my room but lay awake for a few hours. I had a sense of peace, knowing that he was finally going to get the help he needed. I also felt a hollow sense of fear that the unknown tends to bring.

On Tuesday morning he was finally seen by a psychiatrist who began treatment of a low dose of chlorpromazine. After consultation with his father who was convinced that my son had been hypnotized and was doing vast amounts of hallucinogenic drugs, the course of action was along the lines of drug induced psychosis. The psychiatrist had told me that the treatment would be the same if it *was* drug induced or other psychotic illness. After our meeting I returned to my son's room. We were trying to organize some of the belongings his father had brought for him. He was glad to get his Walkman. Suddenly, a woman entered the room and asked for my son by name. He was too ill to answer and I said this is my son Aaron. She then stood directly in front of him and proceeded to tell him that the doctor had put him on a form three (involuntary admission) and that if he did not agree with that then she would hire a lawyer for him. She left the room as quickly as she had appeared. I was stunned and very confused by what had happened. So was my son. I never knew what that was all about until over a year later.

I was so hoping it was drug induced psychosis. This would mean that the symptoms would go away. I was looking forward to the possibility of seeing a smile on my son's face again. Most of all, I ached for the joy of a conversation with him. I was putting my faith in the possibility of medication bringing him back. My son, it was learned in the future, had

taken LSD maybe twice and no other drugs other than smoking marijuana. Little did I know at the time, that this day was only the *beginning* of our family's worst nightmare.

Two hours had passed since he had taken the medication. I sat in his room reading a magazine, waiting to see some change in his behaviour. He laid on his bed with eyes closed, listening to his Walkman with headphones. He began to take deep short breaths. I walked over to his bed, and touching his arm I asked him if he was OK. He opened his eyes and clearly responded with appropriate intonation, "Yea, I'm OK mom." He was listening to static at full volume and I tried to convince him to switch to a music station but he refused. I sat back down and continued reading. Again, he began to take deep short breaths.

I walked to the nurses' station to question this odd behaviour and was assured that as long as he was not hurting himself to just ignore it. This made perfect sense to me. I was so hyper-vigilant to his behaviour because my experiences to this point were nothing like I'd experienced before. It was all new to me. I found myself at ease again and continued reading in his room. Within a short time his breathing became more rapid and deep. He did not respond to my asking if he was OK this time and the breathing did not cease. I returned to the nurses' station with my concern over his breathing. Two nurses accompanied me to his room and I stood in the hallway taking a much needed mental break, thinking about things other than being in the hospital. I was thinking about my daughter at home and I was thinking about work.

When one of the nurses ran out of the room the other nurse was telling my son to breathe; it jolted me back to the reality of where I was. I entered the room to see my son's entire body rigid. His head was tilted so far back that I easily slipped my arm under his neck. I gently told him to breathe. He was gasping so hard for air that I knew he was dying. Alarms were ringing and the room began to fill with people and equipment. I left and stood in the hallway. I had no idea what had happened until much later that day. My son had a severe dystonic reaction and went into respiratory arrest as a result of the medication. A nurse had told me that it was a good thing I was there. In the 25 years that she worked in the field she had never seen such a reaction before. As far as I knew the 15mg of chlorpromazine was the first medication he had been given. It was a year later at a Consent & Capacity Board hearing, in the forensic hospital, that it was explained that the reaction was probably a result of the combination of other meds he was on which included 5mg of stelazine and 10mg of nozinan. He recovered from this incident in the Neurology Critical Care Unit and was transferred two days later to a psychiatric hospital. As a result of this incident and the outcome of my son's schizophrenia I have a strong belief in Early Intervention Programs.

He was hospitalized for three months in the Kingston Psychiatric Hospital. He was given extensive testing and placed on risperidone. During this time he also walked away from the hospital in freezing rain during a winter day. He walked around, lost in this city for three hours, without a coat. He phoned me at home and I convinced him to call the hospital so they could pick him up. He had frost bite on his feet and lost a nail from one big toe. Upon returning home, he was well enough to take his own medication. He was almost the person that I knew him to be.

He stopped taking his medication twice in that first year. The second time he decompensated to a state of acute psychosis. I called mental health crisis lines trying to find a way to help him. The continued response was, "I'm sorry there is nothing you can do. You'll have to wait for a crisis". I was too distraught to ask what kind of crisis. This *was* a crisis to me. I could not even begin to imagine what else could be more of a crisis than to see my son so ill.

The crisis came within weeks. He attempted suicide by hanging and overdosing on his medication. The rope broke and saved his life. He had an abrasion on his neck but nothing more. He was sent from our local rural hospital to yet another city hospital. He was hospitalized for four days and sent on a bus home to his dad. He was not only not stable on medication at this point, he stopped taking his medication within three days of being home. Again there were many attempts to help him but all health facility personnel responded with the same advice, "I'm sorry there is nothing you can do but wait for a crisis." I began to wonder if this was really happening. Maybe it was a very realistic dream and I would awaken at some point. What crisis has to occur before getting someone who is very ill into treatment? The answer came within two weeks.

In his acute psychotic state, my son broke into a neighbor's empty home because he believed it had appeared out of the blue. He laid rocks around her home in a ritualistic manner believing he was saving the planet. I can only imagine the fear this single woman felt after seeing my son and his strange behaviours on the street and then experiencing this intrusion in her home. He was arrested and taken to yet a different city hospital and quickly sent to jail in our small town. He was then transferred to the Kingston Psychiatric forensic unit for assessment and given a diagnosis of paranoid schizophrenia in November 1997.

It took a few months before he was fit to stand trial and he had already served his time for the crime. He could have walked out the doors of the courtroom that day. He was *not* very stable on medication! He pleaded Not Criminally Responsible (NCR) and was returned to the Forensic Unit to

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MEMBER UPDATES

Schizophrenia Days in Morocco: Oumnia Sets the Pace

By *Amina Bencherki*

Members of the AI OUMNIA Association of Families and Friends in Casablanca, Morocco, recently organized an event called Franco-phone Schizophrenia Days 2005. The purpose of the event was:

-To improve understanding of

schizophrenia;

-To inform, to support and to bring families out of their isolation;

-To improve the quality of life for those who are sick;

-To create a Day Centre designed for those who are sick.

This event, sponsored by the Pfizer Laboratories, was an amazing occasion to make the public aware of the difficulties of this disease and to launch an appeal to all our present and future partners, mental health professionals, social service organizations and the private sector, that they learn about those who are sick and their families: .

To publicize these two days, the AI OUMNIA Association, in partnership with Pfizer, developed advertisements which they placed in almost all the pharmacies of Casablanca; in psychiatrists' offices, as well as in all the most frequented public places like supermarkets, sports clubs, etc. Along with this action we had also sensitized the press and mobilized their support. They wrote several articles before and after and publicized the event.

The program began on Friday 11 March 2005 with a presentation/discussion attended by 120 people. The speakers were Professor Nadia Kadiri and Dr. Mohamed Jamai. A reception followed. On Saturday we convened an open house in the course of which there were various activities demonstrating the work of AI OUMNIA and its objectives, notably the creation of a Day Centre for people with mental illness, as well as information about schizophrenia. There was a film presentation of a television program on the disorder which was followed by a discussion. A poet read her poems and a psychologist said a few words.

The response to these two days has been very positive in the sense that it has allowed the association, those who are sick and their families to make people aware of what their



Members of Oumnia gather for a photograph during Schizophrenia Days.

lives are like, and that they are a real part of society; that from now on they will never be ignored, hidden or rejected. The two days motivated us more and convinced us of the rightness of our fight so that we have decided to increase our efforts. We will take all necessary action to gather funds for our project, firstly establishing a Day Care Centre in Casablanca and then taking the second step of founding centres in other cities in Morocco.

Sadly, we have verified the disarray of families, their isolation, their need for help and knowledge as well as a total lack of support/ care infrastructure for the mentally ill and the complete void that surrounds patients and their families, dragging them down into their illness despite all the medications they take.

But medication is insufficient to help our sick loved ones to recover.

This is the message that we tried to get across in the course of the two days, to prick the conscience of society to feel the importance and the urgency of taking concrete actions to better the quality of life for these thousands of persons who are suffering terribly; to permit them to regain their dignity as human beings.

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or email: ambencherki@diac.co.ma

(Translated from the French)

FUCOPEZ Costa Rica



Members of the recently established family association in Costa Rica, FUCOPEZ—Costa Rican Foundation for people with Schizophrenia—made their presence felt at the XIX Central American Congress of Psychiatry, the IV National Psychiatry Congress, by holding a workshop for families organized by Maritza Meza, Founding President of FUCOPEZ.

Anil Vartak Gets Award

Anil Vartak of SAA's Ekalavya self help support group recently won one of Pune's prestigious awards: Sangharsha Sanman Puraskar, given in memory of Dr. Anita Awachat, a well-known anti-addiction activist. Anil was chosen for being a valiant survivor and a crusader for the cause of mental health over two decades. In his response to this recognition he attributed the change in the course of his life to the Recovery Philosophy.

Bangladesh Schizophrenia Association

The first newsletter (in Bengali) of the Society for the Welfare of Persons with Schizophrenia was distributed at the 2004 Disability Fair held in Dhaka. The publication was the work of Badrul Mannan, a committed advocate, who heads the association. To obtain a copy contact Badrul at rajan@bangla.net

Uganda Schizophrenia Fellowship

WFSAD board member and chairman of the Uganda Schizophrenia Fellowship, Thomas Walunguba, has announced the opening of a new branch of the Fellowship in Masaka. Forty people attended the opening and it was obvious from the stories they told at the first meeting that there was great joy and also relief in finding others with whom they could share their experiences. Leaders were elected at the meeting. Grateful thanks are offered to the Uganda Society for Disabled Children of Masaka for sponsoring a lunch for the new branch.

Hungarian Family Alliance: The Situation in Hungary

*Report from Istvan Molnar
Translated by Tamas Barnabas*

In Hungary psychiatric patients' rights are governed by law. Every patient has the right to treatment in the least restricted setting close to his home. However, guaranteed rights and access to appropriate medications in themselves do not always do the job. There is great need for good community support as well. Psychiatric patients will obtain their rights and freedoms only if they can demonstrate their own personal freedom.

Acceptance by other people enables people to return to the mainstream of everyday life. Without support and friendship from family and friends recovery will be very slow.

In 1996 a small group of people founded the Hungarian Family Alliance for Patients with Schizophrenia. Membership now exceeds 250 people and its meetings are attended by participants from all over the country. KESZ has joined the European Federation of Family Associations for the Mentally Ill (EUFAMI), and prepared a strategic plan called the Program of Organic Growth. Support for this endeavour is being sought from the Hungarian Government.

Suicide is very high in Hungary. 90% of these are psychiatric patients. The third highest death rate is related to psychiatric conditions. Untreated psychosis leads to many fatalities. Although reasons for this can be lack of awareness that treatments are available, there are social factors as well. From the inception of our organization we have had these two factors in mind. ***The patients psychiatrist knows more about the illness, and the patient's family knows more about the patient.***

Half a century ago the prominent Hungarian psychiatrist and writer Teven Benedek wrote about people with schizophrenia in his book *The Golden Cage*. We must sadly admit that in spite of the radical social changes in Hungary, most psychiatric patients are still the captives of the so-called Golden Cage. This is shown by the statistics.

Istvan Molnar is President of KESZ, the Hungarian Family Alliance. Contact him at Kesz50@axelero.hu



PERSONAL STORY (Conclusion)

(Continued from page 13)

stabilize. During this next month in the forensic unit he stopped taking his medication. He was deteriorating rapidly and the Consent & Capacity Board deemed him incompetent to make his own decision to stop taking medication. His lawyer advised him to appeal and during this appeal process he was unmedicated once again and became acutely psychotic. After some time he agreed to treatment and began a slow recovery on olanzapine.

After being transferred to the STEP unit of the Whitby Mental Health Centre (a psychoeducation and psychosocial program), in September 1998, and still under NCR status, he recovered to the point of attending a regular high school and obtaining his grade twelve. It was during this time that his father was appropriately diagnosed with bipolar disorder. My son moved into a group home in July 1999. He stopped taking his medication and while deteriorating he was given an absolute discharge from his NCR status in August 1999. In Jan 2000, while acutely psychotic in the group home, he took a bus across Canada without any belongings and thus began his continuing pattern of homelessness, medication non-adherence, hospitalization and involvement in the criminal justice system.

Our journey has been seven years long. He has been hospitalized nine times in six different hospitals. Approximately 20 doctors have treated him. He has currently spent 18 months recovering to a stable level in Whitby Hospital. He has been in an approved group home of the hospital for the past 6 months and doing well. He is on bail and probation orders and in the process of court diversion. He also has an ACT

team (intensive treatment) working with him. His diagnosis is treatment resistant, chronic paranoid schizophrenia. He is on 400mg/day of clozapine along with epival and amitriptylene.

His father has since had a thorough assessment through the Centre for Addiction and Mental Health's mood disorder clinic and his diagnosis is Rapid Cycling Bipolar and Attention Deficit Disorder. He takes wellbutrin and epival. My son's father and I have a very good working relationship in order to assist our son. While stable and well and never having been hospitalized, his father was placed on disability. The difficult journey of getting his son treatment has taken its toll on him.

As a family who has been severely affected by mental illness we are surviving and doing well, now that support systems are in place for our son. There are times when visits to my son's grandparents find us visiting all together. It is those times that I have to remember to not sit in between them as they both talk at me simultaneously, oblivious to my dilemma of trying to listen to two separate conversations at once.

So, I close this chapter of my life never knowing what strengths and treasures will come from the people who cross my path and the experiences that the future still holds for my family. It is true that no matter what we have to endure as families with mental illness involved, we will always have some gains along with the losses.

Judy Sinyard is a facilitator for both the "Family to Family" and "Strengthening Families Together" family education programs in Toronto, Canada.



EVENTS

XII World Congress of Psychiatry: 5000 Years of Science and Care

September 10-15, 2005

Cairo International Convention & Exhibition Center, Egypt

Further information can be found at:

www.wpa-cairo2005.com

NAMI Annual Convention: On the Frontier of Recovery

June 18-21, 2005

Austin, Texas, USA

Further information can be found at:

www.nami.org

WPA Regional Meeting

October 30-November 2, 2005

Los Cabos, Mexico. Further information from:

Dr. Luis E. Revero Almanzor

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