» If the patient is a parent/guardian – refer to social worker to assess home functioning and childcare.

MEDICINE TREATMENT

» See Sections 16.1.2: Aggressive disruptive behaviour in adults and 16.1.3 Aggressive disruptive behaviour in children and adolescents.

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REFERRAL

» All patients with active psychosis.

16.5.2 SCHIZOPHRENIA SPECTRUM DISORDERS (SCHIZOPHRENIA)

F20-F20.9/F21/F22.0-22.9; F25.0-25.9 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8)

DESCRIPTION

Schizophrenia is the most common, chronic psychotic disorder and is characterised by recurrent, severe, psychotic episodes which are accompanied by a marked deterioration in personal, social, and occupational functioning.

Onset is usually in adolescence or young adulthood. Prognosis is worsened with delay in initial treatment, repeated episodes, and comorbid substance use. Comorbid substance use and medical conditions (e.g., metabolic syndrome) are common.

The diagnosis of schizophrenia should be confirmed by a specialist. In stable patients with good insight and support, primary care facilities may continue treatment and social support.

GENERAL MEASURES

» See Section 16.6: Psychiatric patients - general monitoring and care.
» Supportive intervention includes:
  - Psychoeducation of the patient and their family regarding the nature of schizophrenia, the importance of treatment adherence, and early signs of recurrent episodes.
  - Supportive group therapy for patients with schizophrenia.
» Rehabilitation may be enhanced by:
  - Assertive community programs.
  - Occupational therapy.
  - Work assessment, and bridging programmes.
  - Appropriate placement and supported employment.
» Assessment of risk to self and others, and early signs of relapse should be performed at every review.

MEDICINE TREATMENT

Adults

- Haloperidol, oral. (Doctor prescribed)
  - Initial dose: 1.5 mg daily, increasing to 5 mg daily, if initial treatment tolerated and according to clinical response
  - Once stabilised, administer as a single dose at bedtime.

Elderly

- Haloperidol, oral. (Doctor prescribed) *LoE:IVb*
  - Initial dose: 0.75 mg twice daily.
  - Increase dose more gradually until symptoms are controlled or until a maximum of 5 mg daily, if tolerated, is reached.
  - Once stabilised, administer as a single dose at bedtime.

See Section 16.8.2: Special considerations: Older patients (≥ 45 years).

If there is a good response / tolerability to haloperidol, or patient's preference:

- Flupenthixol decanoate, IM, 10–40 mg every 4 weeks. (Doctor prescribed)
  - Initial dose: 10 mg.

OR

- Zuclopenthixol decanoate, IM, 100–400 mg every 4 weeks. (Doctor prescribed)
  - Initial dose: 100 mg.

Note:

» Patients should initially be stabilised on an oral antipsychotic agent before changing to a depot preparation.
» Administer an initial test dose of the depot antipsychotic and observe the patient for 1 week before administering higher doses.
» Reduce the oral antipsychotic formulation, stopping once patient is stabilised on the long-term depot therapy.
» Long-acting injectable antipsychotics are particularly useful in patients unable to adhere to their oral medication regimens, but need to be accompanied by a track and trace programme to be effective for adherence
» Long-term therapy should always be in consultation with a doctor or, if available, with a psychiatrist. Patients should be re-assessed every 6 months.

For breakthrough episodes on an injectable antipsychotic, consider additional short-term therapy of:

- Risperidone, oral 2 mg daily (Doctor prescribed).

If good response to IM antipsychotic but patient has extrapyramidal side effects (EPSEs), add:

- Anticholinergic, e.g.:
- Orphenadrine, oral, 50 mg 8 hourly, and refer for review of medication. *LoE:IVb*[23]

Note:

» Anticholinergic medicines (e.g. orphenadrine) should not be used routinely as prophylaxis to prevent EPSEs to antipsychotic medication.

» For management of extra-pyramidal adverse drug reactions and acute dystonic reactions: See Section 16.2.1: Extra-pyramidal side effects.

If poor response, to IM antipsychotic or poor EPSE response to anticholinergic switch to risperidone:

- Risperidone, oral, 2 mg daily (Doctor prescribed).
  - Increase to 4 mg daily if there is a poor response after 4 weeks.

If patient is already stabilised on chlorpromazine:

- Chlorpromazine, oral (Doctor prescribed).
  - Maintenance dose: 75–300 mg at night, but may be as high as 800 mg.

REFERRAL

» Poor social support.
» High suicidal risk or risk of harm to others.
» Children and adolescents.
» The elderly.
» Pregnant and lactating women.
» No response or intolerance to medicine treatment.
» Concurrent medical or other psychiatric illness.
» Epilepsy with psychosis.
» Early sign of relapse.

16.6 PSYCHIATRIC PATIENTS - GENERAL MONITORING AND CARE

DESCRIPTION

Nursing staff are required to monitor users with serious mental illness between medical or psychiatric doctor visits.
Regular monitoring with documented nursing notes in the file should occur monthly to 6-monthly depending on the severity of the illness and the risk of relapse, aggression, absconding or poor adherence, with referral as required.
Monitoring includes:

» A mental state enquiry and examination.
» A brief psychosocial assessment.
» A risk assessment for harm to self or others with referral if deemed high risk.
» Adherence support.
» Women: family planning, pregnancy counselling, supportive home visits in childcare.
» General health: screen at baseline and annually - weight and body mass index, blood pressure (See Section 4.7: Hypertension), finger-prick blood glucose test for diabetes (See Section: 9.2.2: Type 2 Diabetes mellitus, adults), HIV (See chapter 11: HIV and AIDS), and tuberculosis (See Section 17.4: Pulmonary tuberculosis (TB)).
» Lifestyle advice for obesity, smoking, alcohol, other substances, and high-risk sexual behaviour or victim of abuse. *LoE:IVb*[24]