1. Evidence-based, pharmacological treatment guideline for depression in Korea, revised edition.
Won E; Park SC; Han KM; Sung SH; Lee HY; Paik JW; Jeon HJ; Lee MS; Shim SH; Ko YH; Lee KJ; Han C; Ham BJ; Choi J; Hwang TY; Oh KS; Hahn SW; Park YC; Lee MS; Clinical Research Center for Depression.
[Journal Article. Practice Guideline]
UI: 24753693

This paper aims to introduce, summarize, and emphasize the importance of the 'Evidence-Based, Pharmacological Treatment Guideline for Depression in Korea, Revised Edition'. The guideline broadly covers most aspects of the pharmacological treatment of patients in Korea diagnosed with moderate to severe major depression according to the DSM-IV TR. The guideline establishment process involved determining and answering a number of key questions, searching and selecting publications, evaluating recommendations, preparing guideline drafts, undergoing external expert reviews, and obtaining approval. A guideline adaptation process was conducted for the revised edition. The guideline strongly recommends pharmacological treatment considered appropriate to the current clinical situation in Korea, and should be considered helpful when selecting the appropriate pharmacological treatment of patients diagnosed with major depressive disorder. Therefore, the wide distribution of this guideline is recommended.

Status
MEDLINE
Author NameID
Won, Eunsoo E;
Other ID
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20140422
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Kuipers E; Yesufu-Udechuku A; Taylor C; Kendall T. 
BMJ. 348:g1173, 2014. 
[Journal Article. Practice Guideline. Research Support, Non-U.S. Gov't] 
UI: 24523363
Status MEDLINE
Authors Full Name Yesufu-Udechuku, Amina; Taylor, Clare; Kendall, Tim.
Institution Kuipers, Elizabeth. Department of Psychology, Institute of Psychiatry, King's College London, London SE5 8AF, UK.
Date Created 20140213
Year of Publication 2014

3. Practitioner review: current best practice in the management of adverse events during treatment with ADHD medications in children and adolescents. [Review]
Cortese S; Holtmann M; Banaschewski T; Buitelaar J; Coghill D; Danckaerts M; Dittmann RW; Graham J; Taylor E; Sergeant J; European ADHD Guidelines Group. 
UI: 23294014
BACKGROUND: Medication is an important element of therapeutic strategies for ADHD. While medications for ADHD are generally well-tolerated, there are common, although less severe, as well as rare but severe adverse events AEs during treatment with ADHD drugs. The aim of this review is to provide evidence- and expert-based guidance concerning the management of (AEs) with medications for ADHD.
METHODS: For ease of use by practitioners and clinicians, the article is organized in a simple question and answer format regarding the prevalence and management of the most common AEs. Answers were based on empirical evidence from studies (preferably meta-analyses or systematic reviews) retrieved in PubMed, Ovid, EMBASE and Web of Knowledge through 30 June 2012. When no empirical evidence was available, expert consensus of the members of the European ADHD Guidelines Group is provided. The evidence-level of the management recommendations was based on the SIGN grading system.
RESULTS: The review covers monitoring and management strategies of loss of appetite and growth delay, cardiovascular risks, sleep disturbance, tics, substance misuse/abuse, seizures, suicidal thoughts/behaviours and psychotic symptoms.

CONCLUSION: Most AEs during treatment with drugs for ADHD are manageable and most of the times it is not necessary to stop medication, so that patients with ADHD may continue to benefit from the effectiveness of pharmacological treatment.

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4.
Early psychosis declaration for Asia by the Asian Network of Early Psychosis.
Asian Network of Early Psychosis Writing Group.
[Journal Article. Practice Guideline]
UI: 23019280
In line with the Early Psychosis Declaration issued by the World Health Organization and the International Early Psychosis Association, as well as the International Clinical Practice Guidelines for early psychosis by the latter in 2005, increasing interest in early intervention programmes is evident throughout Asia. Experience sharing and close collaboration that take into account the unique Asian context are needed to facilitate development of early psychosis services, education, and research in the region. The Asian Network of Early Psychosis has defined a set of Asian-specific principles to guide best practice in mental health care delivery for psychotic disorders in Asia. These principles are outlined in this paper.
5. International consensus clinical practice statements for the treatment of neuropsychiatric conditions associated with epilepsy.
Kerr MP; Mensah S; Besag F; de Toffol B; Ettinger A; Kanemoto K; Kanner A; Kemp S; Krishnamoorthy E; LaFrance WC Jr; Mula M; Schmitz B; van Elst LT; Trollor J; Wilson SJ; International League of Epilepsy (ILAE) Commission on the Neuropsychiatric Aspects of Epilepsy.
Epilepsia. 52(11):2133-8, 2011 Nov.
[Journal Article. Practice Guideline]
UI: 21955156
In order to address the major impact on quality of life and epilepsy management caused by associated neuropsychiatric conditions, an international consensus group of epileptologists met with the aim of developing clear evidence-based and practice-based statements to provide guidance on the management of these conditions. Using a Delphi process, this group prioritized a list of key management areas. These included: depression, anxiety, psychotic disorders, nonepileptic seizures, cognitive dysfunction, antiepileptic drug (AED)-related neurobehavioral disorders, suicidality, disorders in children and adolescents, disorders in children with intellectual disability, and epilepsy surgery. Clinical practice statements were developed for each area and consensus reached among members of the group. The assessment and management of these conditions needs to combine knowledge of psychiatric disorders, knowledge of the impact of epilepsy and its treatment on psychopathology, and an ability to deliver care within epilepsy services. The aim of these statements is to provide guidance on quality care for people with epilepsy that have a range of neuropsychiatric disorders. Copyright Wiley Periodicals, Inc. 2011 International League Against Epilepsy.
6. NSAID prescribing precautions.
Risser A; Donovan D; Heintzman J; Page T.
American Family Physician. 80(12):1371-8, 2009 Dec 15.
[Journal Article. Practice Guideline]
UI: 20000300
Nonsteroidal anti-inflammatory drugs (NSAIDs) are commonly used, but have risks associated with their use, including significant upper gastrointestinal tract bleeding. Older persons, persons taking anticoagulants, and persons with a history of upper gastrointestinal tract bleeding associated with NSAIDs are at especially high risk. Although aspirin is cardioprotective, other NSAIDs can worsen congestive heart failure, can increase blood pressure, and are related to adverse cardiovascular events, such as myocardial infarction and ischemia. Cyclooxygenase-2 inhibitors have been associated with increased risk of myocardial infarction; however, the only cyclooxygenase-2 inhibitor still available in the United States, celecoxib, seems to be safer in this regard. Hepatic damage from NSAIDs is rare, but these medications should not be used in persons with cirrhotic liver diseases because bleeding problems and renal failure are more likely. Care should be used when prescribing NSAIDs in persons taking anticoagulants and in those with platelet dysfunction, as well as immediately before surgery. Potential central nervous system effects include aseptic meningitis, psychosis, and tinnitus. Asthma may be induced or exacerbated by NSAIDs. Although most NSAIDs are likely safe in pregnancy, they should be avoided in the last six to eight weeks of pregnancy to prevent prolonged gestation from inhibition of prostaglandin synthesis, premature closure of the ductus arteriosus, and maternal and fetal complications from antiplatelet activity. Ibuprofen, indomethacin, and naproxen are safe in breastfeeding women. Care should be taken to prevent accidental NSAID overdose in children by educating parents about correct dosing and storage in childproof containers.

Status
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Comments
Comment in: Am Fam Physician. 2009 Dec 15;80(12):1366; PMID: 20000299
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20091216
Year of Publication
2009

7.
Implementation of a rational pharmacotherapy intervention for inpatients at a psychiatric department.
Sorensen L; Nielsen B; Stage KB; Brosen K; Damkier P.
[Clinical Trial. Journal Article. Practice Guideline]
UI: 18622885

The objective of the study was to develop, implement and evaluate two treatment algorithms for schizophrenia and depression at a psychiatric hospital department. The treatment algorithms were based on available literature and developed in collaboration between psychiatrists, clinical pharmacologists and a clinical pharmacist. The treatment algorithms were introduced at a meeting for all psychiatrists, reinforced by the project psychiatrists in the daily routine and used for educational purposes of young doctors and medical students. A quantitative pre-post evaluation was conducted using data from medical charts, and qualitative information was collected by interviews. In general, no significant differences were found when comparing outcomes from 104 charts from the baseline period with 96 charts from the post-intervention period. Most of the patients (65% in the post-intervention period) admitted during the data collection periods did not receive any medication changes. Of the patients undergoing medication changes in the post-intervention period, 56% followed the algorithms, and 70% of the patients admitted to the psychiatric hospital department for the first time had their medications changed according to the algorithms. All of the 10 interviewed doctors found the algorithms useful. The treatment algorithms were successfully implemented with a high degree of satisfaction among the interviewed doctors. The majority of patients admitted to the psychiatric hospital department for the first time had their medications changed according to the algorithms.

Status
MEDLINE
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Date Created
20080714
Year of Publication
2008

8.
ASHP therapeutic position statement on the use of second-generation antipsychotic medications in the treatment of adults with psychotic disorders.
Noel JM; American Society of Health-System Pharmacists.
[Journal Article. Practice Guideline]
UI: 17420192
Status
MEDLINE

There is currently a lack of evidence-based guidelines to guide the pharmacological treatment of neurobehavioral problems that commonly occur after traumatic brain injury (TBI). It was our objective to review the current literature on the pharmacological treatment of neurobehavioral problems after traumatic brain injury in three key areas: aggression, cognitive disorders, and affective disorders/anxiety/psychosis. Three panels of leading researchers in the field of brain injury were formed to review the current literature on pharmacological treatment for TBI sequelae in the topic areas of affective/anxiety/psychotic disorders, cognitive disorders, and aggression. A comprehensive Medline literature search was performed by each group to establish the groups of pertinent articles. Additional articles were obtained from bibliography searches of the primary articles. Group members then independently reviewed the articles and established a consensus rating. Despite reviewing a significant number of studies on drug treatment of neurobehavioral sequelae after TBI, the quality of evidence did not support any treatment standards and few guidelines due to a number of recurrent methodological problems. Guidelines were established for the use of methylphenidate in the treatment of deficits in attention and speed of information processing, as well as for the use of beta-blockers for the treatment of aggression following TBI. Options were recommended in the treatment of depression, bipolar disorder/mania, psychosis, aggression, general cognitive functions, and deficits in attention, speed of processing, and memory after TBI. The evidence-based guidelines and options established by this working group may help to guide the pharmacological treatment of the person experiencing neurobehavioral sequelae following TBI. There is a clear need for well-designed randomized controlled trials in the treatment of these common problems after TBI in order to establish definitive treatment standards for this patient population.

OBJECTIVE: To make evidence-based treatment recommendations for patients with Parkinson disease (PD) with dementia, depression, and psychosis based on these questions: 1) What tools are effective to screen for depression, psychosis, and dementia in PD? 2) What are effective treatments for depression and psychosis in PD? 3) What are effective treatments for PD dementia or dementia with Lewy bodies (DLB)?

METHODS: A nine-member multispecialty committee evaluated available evidence from a structured literature review using MEDLINE, and the Cochrane Database of Health and Psychosocial Instruments from 1966 to 2004. Additional articles were identified by panel members.

RESULTS: The Beck Depression Inventory-I, Hamilton Depression Rating Scale, and Montgomery Asberg Depression Rating Scale should be considered to screen for depression in PD (Level B). The Mini-Mental State Examination and the Cambridge Cognitive Examination should be considered to screen for dementia in PD (Level B). Amitriptyline may be considered to treat depression in PD without dementia (Level C). For psychosis in PD, clozapine should be considered (Level B), quetiapine may be considered (Level C), but olanzapine should not be considered (Level B). Donepezil or rivastigmine should be considered for dementia in PD (Level B) and rivastigmine should be considered for DLB (Level B).
CONCLUSIONS: Screening tools are available for depression and dementia in patients with PD, but more specific validated tools are needed. There are no widely used, validated tools for psychosis screening in Parkinson disease (PD). Clozapine successfully treats psychosis in PD. Cholinesterase inhibitors are effective treatments for dementia in PD, but improvement is modest and motor side effects may occur.

Status
MEDLINE
Authors Full Name
Shannon, K; Voon, V; Ravina, B; Kleiner-Fisman, G; Anderson, K; Shulman, L M; Gronseth, G; Weiner, W J; Quality Standards Subcommittee of the American Academy of Neurology.
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Comments
Comment in: Neurology. 2007 Jan 2;68(1):80; author reply 81; PMID: 17200503  Comment in: Neurology. 2007 Jan 2;68(1):81; author reply 81; PMID: 16585044
Date Created
20060411
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2006

11.
Basic standards for management of patients with serious mental illness in the community.
Agius M; Biocina SM; Alptekin K; Rotstein V; Morselli P; Persaud A.
[Comparative Study. Journal Article. Practice Guideline]
UI: 16395843
Status
MEDLINE
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Biocina, Sanja Martic; Alptekin, Koksal; Rotstein, Vladimir; Morselli, Paolo; Persaud, Albert.
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Date Created
20060106
Year of Publication
2005

12.
OBJECTIVES: Due to inherent dangers and barriers to research in emergency settings, few data are available to guide clinicians about how best to manage behavioral emergencies. Key constructs such as agitation are poorly defined. This lack of empirical data led us to undertake a survey of expert opinion, results of which were published in the 2001 Expert Consensus Guidelines on the Treatment of Behavioral Emergencies. Several second-generation (atypical) antipsychotics (SGAs) are now available in new formulations for treating behavioral emergencies (e.g., intramuscular [i.m.] olanzapine and ziprasidone; rapidly dissolving tablets of olanzapine and risperidone). Critical questions face the field. The SGAs are significantly different from the FGAs and from each other and have not been studied in unselected patients as were the FGAs. Can the SGAs be thought of as a class, do all antipsychotics have similar anti-agitation effects in different conditions, and, if equally effective, what limits might their safety profiles impose? Should antipsychotics be used more specifically to treat psychotic conditions, while benzodiazepines (BNZs) alone are used nonspecifically? Few data are available concerning combinations of SGAs and BNZs, and findings concerning the traditional combination of haloperidol plus a BNZ may not be relevant to combinations with SGAs. The culture is also evolving with more emphasis on patient involvement in treatment decisions. An international consensus has been developing that calming rather than sedation is the appropriate endpoint of behavioral emergency interventions. We undertook a new survey of expert opinion to update recommendations from the earlier survey.

METHOD: A written survey of 61 questions (1,020 options) was mailed to 50 experts in the field, 48 (96%) of whom completed it. The survey sought to define level of agitation at which emergency interventions are appropriate, scope of assessment depending on urgency and patients’ ability to cooperate, guiding principles for selecting interventions, and appropriate physical and medication strategies at different levels of diagnostic confidence for a variety of provisional diagnoses and complicating conditions. A modified version of the RAND Corporation’s 9-point scale for rating appropriateness of medical decisions was used to score most options. Consensus was defined as a non-random distribution of scores by chi-square "goodness-of-fit" test. We assigned a categorical rank (first line/preferred, second line/alternate, third line/usually inappropriate) to each option based on the 95% confidence interval around the mean. Ratings were used to develop guidelines for preferred strategies in key clinical situations. This study received financial support from multiple sponsors, with the panel kept blind to sponsorship to reduce possible bias. Medication ratings were based on responses of only those respondents with direct experience with each drug. In reporting practice patterns, the panel was asked to respond based on actual data rather than estimates.

RESULTS: The expert panel reached consensus on 78% of the options rated on the 9-point scale. The responses suggest that physicians can make provisional diagnoses with some confidence and that pharmacological and nonpharmacological interventions are selected differentially based on diagnosis and other salient demographic and medical features. BNZs are recommended when no data are available, when there is no specific treatment (e.g., personality disorder), or when they may have specific benefits (e.g., intoxication). No single SGA emerges as a nonspecific replacement for haloperidol; instead, different SGAs are preferred in various circumstances consistent with current evidence. To the degree that haloperidol is recommended,
it is almost always in combination with a BNZ; haloperidol alone is preferred only in the medically compromised. In contrast, the SGAs are more often recommended for use alone, and the panel would avoid combining BNZs with some SGAs. Oral risperidone alone or combined with a BNZ receives strong support in a variety of situations. Oral olanzapine was rated very similarly to risperidone, with slightly higher ratings than risperidone in situations where it has been studied (e.g., schizophrenia, mania) and slightly lower ratings where it has not been studied or safety may be a concern; there was less support for combining oral olanzapine with a BNZ. For oral treatment of agitation related to schizophrenia or mania, olanzapine alone, risperidone alone or combined with a BNZ, and haloperidol plus a BNZ are first line, with strong support also for combining divalproex with the antipsychotic for presumed mania. Oral ziprasidone and quetiapine generally received similar second-line ratings in most situations. If a parenteral agent is needed, i.m. olanzapine alone received somewhat more support than i.m. ziprasidone alone; however, there was more support for i.m. ziprasidone alone or combined with a BNZ than for i.m. olanzapine plus a BNZ, probably reflecting safety concerns. For example, for a provisional diagnosis of schizophrenia, first-line parenteral options are i.m. olanzapine or ziprasidone alone or i.m. haloperidol or ziprasidone combined with a BNZ. Neither of the new parenteral formulations received as much support as traditional agents (i.m. BNZs, i.m. haloperidol) when no data are available or the diagnosis involves medical comorbidity or intoxication. When initial intervention with risperidone, ziprasidone, or haloperidol is unsuccessful, the panel recommended adding a BZD to the antipsychotic. However, when initial treatment with olanzapine or quetiapine is unsuccessful, increasing the dosage is recommended. Perphenazine was consistently rated second line and droperidol and chlorpromazine received third-line ratings throughout.

CONCLUSIONS: Within the limits of expert opinion and with the expectation that future research data will take precedence, these guidelines suggest that the SGAs are now preferred for agitation in the setting of primary psychiatric illnesses but that BNZs are preferred in other situations.

Status
MEDLINE
Authors Full Name
Currier, Glenn W; Carpenter, Daniel; Ross, Ruth W; Docherty, John P; Expert Consensus Panel for Behavioral Emergencies 2005.
Institution
Allen,Michael H. University of Colorado School of Medicine, USA.
Date Created
20051201
Year of Publication
2005

13. Guide to anaesthetic selection for electroconvulsive therapy. [Review] [84 refs]
Wagner KJ; Mollenberg O; Rentrop M; Werner C; Kochs EF.
UI: 16142990
Electroconvulsive therapy (ECT) is used in the treatment of severe psychiatric disorders. It involves the induction of a seizure for therapeutic purposes by the administration of a variable-frequency electrical stimulus via electrodes applied to the scalp. The original application of ECT in non-anaesthetised patients resulted in many traumatic effects and was replaced, in the early 1960s, with a modified ECT regimen that used anaesthesia with neuromuscular blockade. This remains the worldwide standard today. The development of modern ECT devices, with improved impulse modes, has also reduced the incidence of post-interventional cognitive adverse effects. The variety of centrally-acting co-medications administered and the cardiovascular effects occurring during the procedure make patients receiving ECT a challenge for the anaesthetist. The efficacy of ECT depends on the production of adequate seizures; however, the anaesthetic agents commonly used during ECT suppress the generation of convulsions. Therefore, the efficacy of ECT requires knowledge of anaesthetic precepts, understanding of the interaction between anaesthetic drugs and seizure activity, and awareness of the physiological effects of ECT as well as the treatment of those effects. Successful and safe ECT depends on the correct choice of anaesthetic drugs for the individual patient, which have to be chosen with respect to the individual concomitant medication and pre-existing diseases. This review provides information for the optimal selection, set-up and practice of anaesthetic drug treatment in ECT. [References: 84]
encouraging further discussion as well as providing practical guidance to clinicians and researchers. A second edition is planned for publication in 2008.

15.
Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. [Review] [197 refs]
Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders.
Ui: 15660702
BACKGROUND: The Royal Australian and New Zealand College of Psychiatrists is co-ordinating the development of clinical practice guidelines (CPGs) in psychiatry, funded under the National Mental Health Strategy (Australia) and the New Zealand Health Funding Authority. This paper presents CPGs for schizophrenia and related disorders. Over the past decade schizophrenia has become more treatable than ever before. A new generation of drug therapies, a renaissance of psychological and psychosocial interventions and a first generation of reform within the specialist mental health system have combined to create an evidence-based climate of realistic optimism. Progressive neuroscientific advances hold out the strong possibility of more definitive biological treatments in the near future. However, this improved potential for better outcomes and quality of life for people with schizophrenia has not been translated into reality in Australia. The efficacy-effectiveness gap is wider for schizophrenia than any other serious medical disorder. Therapeutic nihilism, under-resourcing of services and a stalling of the service reform process, poor morale within specialist mental health services, a lack of broad-based recovery and life support programs, and a climate of tenacious stigma and consequent lack of concern for people with schizophrenia are the contributory causes for this failure to effectively treat. These guidelines therefore tackle only one element in the endeavour to reduce the impact of schizophrenia. They distil the current evidence-base and make recommendations based on the best available knowledge.
METHOD: A comprehensive literature review (1990-2003) was conducted, including all Cochrane schizophrenia reviews and all relevant meta-analyses, and a number of recent international clinical practice guidelines were consulted. A series of drafts were refined by the expert committee and enhanced through a bi-national consultation process.
TREATMENT RECOMMENDATIONS: This guideline provides evidence-based recommendations for the management of schizophrenia by treatment type and by phase of illness. The essential
features of the guidelines are: (i) Early detection and comprehensive treatment of first episode cases is a priority since the psychosocial and possibly the biological impact of illness can be minimized and outcome improved. An optimistic attitude on the part of health professionals is an essential ingredient from the outset and across all phases of illness. (ii) Comprehensive and sustained intervention should be assured during the initial 3-5 years following diagnosis since course of illness is strongly influenced by what occurs in this 'critical period'. Patients should not have to 'prove chronicity' before they gain consistent access and tenure to specialist mental health services. (iii) Antipsychotic medication is the cornerstone of treatment. These medicines have improved in quality and tolerability, yet should be used cautiously and in a more targeted manner than in the past. The treatment of choice for most patients is now the novel antipsychotic medications because of their superior tolerability and, in particular, the reduced risk of tardive dyskinesia. This is particularly so for the first episode patient where, due to superior tolerability, novel agents are the first, second and third line choice. These novel agents are nevertheless associated with potentially serious medium to long-term side-effects of their own for which patients must be carefully monitored. Conventional antipsychotic medications in low dosage may still have a role in a small proportion of patients, where there has been full remission and good tolerability; however, the indications are shrinking progressively. These principles are now accepted in most developed countries. (vi) Clozapine should be used early in the course, as soon as treatment resistance to at least two antipsychotics has been demonstrated. This usually means incomplete remission of positive symptomatology, but clozapine may also be considered where there are pervasive negative symptoms or significant or persistent suicidal risk is present. (v) Comprehensive psychosocial interventions should be routinely available to all patients and their families, and provided by appropriately trained mental health professionals with time to devote to the task. This includes family interventions, cognitive-behaviour therapy, vocational rehabilitation and other forms of therapy, especially for comorbid conditions, such as substance abuse, depression and anxiety. (vi) The social and cultural environment of people with schizophrenia is an essential arena for intervention. Adequate shelter, financial security, access to meaningful social roles and availability of social support are essential components of recovery and quality of life. (vii) Interventions should be carefully tailored to phase and stage of illness, and to gender and cultural background. (viii) Genuine involvement of consumers and relatives in service development and provision should be standard. (ix) Maintenance of good physical health and prevention and early treatment of serious medical illness has been seriously neglected in the management of schizophrenia, and results in premature death and widespread morbidity. Quality of medical care for people with schizophrenia should be equivalent to the general community standard. (x) General practitioners (GPs)s should always be closely involved in the care of people with schizophrenia. However, this should be truly shared care, and sole care by a GP with minimal or no specialist involvement, while very common, is not regarded as an acceptable standard of care. Optimal treatment of schizophrenia requires a multidisciplinary team approach with a consultant psychiatrist centrally involved. [References: 197]
16. Australian and New Zealand clinical practice guidelines for the treatment of depression. [Review] [247 refs]
Ellis P; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression.
BACKGROUND: The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is co-ordinating the development of clinical practice guidelines (CPGs) in psychiatry, funded under the National Mental Health Strategy (Australia) and the New Zealand Ministry of Health.
METHOD: The CPG team reviewed the treatment outcome literature, consulted with practitioners and patients and conducted meta-analyses of outcome research.
TREATMENT RECOMMENDATIONS: Establish an effective therapeutic relationship; provide the patient with information about the condition, the rationale for treatment, the likelihood of a positive response and the expected timeframe; consider the patient's strengths, life stresses and supports. Treatment choice depends on the clinician's skills and the patient's circumstances and preferences, and should be guided but not determined by these guidelines. In moderately severe depression, all recognized antidepressants, cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT) are equally effective; clinicians should consider treatment burdens as well as benefits, including side-effects and toxicity. In severe depression, antidepressant treatment should precede psychological therapy. For depression with psychosis, electroconvulsive therapy (ECT) or a tricyclic combined with an antipsychotic are equally helpful. Treatments for other subtypes are discussed. Caution is necessary in people on other medication or with medical conditions. If response to an adequate trial of a first-line treatment is poor, another evidence-based treatment should be used. Second opinions are useful. Depression has a high rate of recurrence and efforts to reduce this are crucial. [References: 247]
Status MEDLINE
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Date Created
20040622
Year of Publication
2004
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Expert Consensus Panel for Optimizing Pharmacologic Treatment of Psychotic Disorders.
[Guideline. Practice Guideline]
UI: 14640143
Status MEDLINE
Authors Full Name
Expert Consensus Panel for Optimizing Pharmacologic Treatment of Psychotic Disorders.
Date Created 20031125
Year of Publication 2003

Kane JM; Leucht S; Carpenter D; Docherty JP; Expert Consensus Panel for Optimizing Pharmacologic Treatment of Psychotic Disorders.
[Journal Article. Practice Guideline]
UI: 14640142
OBJECTIVES: A growing number of atypical antipsychotics are available for clinicians to choose from in the treatment of psychotic disorders. However, a number of important questions concerning medication selection, dosing and dose equivalence, and the management of inadequate response, compliance problems, and relapse have not been adequately addressed by clinical trials. To aid clinical decision-making, a consensus survey of expert opinion on the pharmacologic treatment of psychotic disorders was undertaken to address questions not definitively answered in the research literature.
METHOD: Based on a literature review, a written survey was developed with 60 questions and 994 options. Approximately half of the options were scored using a modified version of the RAND 9-point scale for rating the appropriateness of medical decisions. For the other options, the experts were asked to write in answers (e.g., average doses) or check a box to indicate their preferred answer. The survey was sent to 50 national experts on the pharmacologic treatment of psychotic disorders, 47 (94%) of whom completed it. In analyzing the responses to items rated on the 9-point scale, consensus on each option was defined as a non random distribution of scores by chi-square "goodness-of-fit"test. We assigned a categorical rank (first line/preferred choice, second line/alternate choice, third line/usually inappropriate) to each option based on the
95% confidence interval around the mean rating. Guideline tables indicating preferred treatment strategies were then developed for key clinical situations.

RESULTS: The expert panel reached consensus on 88% of the options rated on the 9-point scale. The experts overwhelmingly endorsed the atypical antipsychotics for the treatment of psychotic disorders. Risperidone was the top choice for first-episode and multi-episode patients, with the other newer atypicals rated first line or high second line depending on the clinical situation. Clozapine and a long-acting injectable atypical (when available) were other high second line options for multi-episode patients. The expert's dosing recommendations agreed closely with the package inserts for the drugs, and their estimates of dose equivalence among the antipsychotics followed a linear pattern. The experts considered 3-6 weeks an adequate antipsychotic trial, but would wait a little longer (4-10 weeks) before making a major change in treatment regimen if there is a partial response. The experts recommended trying to improve response by increasing the dose of atypical and depot antipsychotics before switching to a different agent; there was less agreement about increasing the dose of conventional antipsychotics before switching, probably because of concern about side effects at higher doses. If it is decided to switch because of inadequate response, risperidone was the expert's first choice to switch to, no matter what drug was initially tried. Although there was some disparity in the expert's recommendations concerning how many agents to try before switching to clozapine, the expert's responses suggest that switching to clozapine should be the antipsychotic of choice for patients with suicidal behavior. When switching oral antipsychotics, the experts considered cross-titration the preferred strategy. When switching to an injectable antipsychotic, the experts stressed the importance of continuing the oral antipsychotic until therapeutic levels of the injectable agent are achieved. The experts considered psychosocial interventions the first choice strategy for partially compliant patients, with pharmacologic interventions the first choice for patients with clear evidence of noncompliance. However, because it can be difficult to distinguish partially compliant from noncompliant patients, the experts recommended combining psychosocial and pharmacologic interventions to improve compliance whenever possible. When patients relapse because of compliance problems or if there is any doubt about compliance, the experts recommended the use of a long-acting injectable antipsychotic and would select an injectable atypical when this option becomes available. The experts would also consider using an injectable atypical antipsychotic (when available) in many clinical situations that do not involve compliance problems. The experts stressed the importance of monitoring for health problems—especially obesity, diabetes, cardiovascular problems, HIV risk behaviors, medical complications of substance abuse, heavy smoking and its effects, hypertension, and amenorrhea—in patients being treated with antipsychotics. Although many patients are prescribed adjunctive treatments, multiple antipsychotics, and combinations of different classes of drugs (e.g., antipsychotics plus mood stabilizers or antidepressants) in an effort to enhance response, the experts gave little support to any of these strategies, with the exception of antidepressants for patients with dysphoria/depression, antidepressants or ECT for patients with suicidal behavior, and mood stabilizers for patients with aggression/violence. When asked about indicators of remission and recovery, the experts considered acute improvement in psychotic symptoms the most important indicator of remission, whereas they considered more sustained improvement in multiple outcome domains (e.g., occupational/educational functioning, peer relationships, independent living) important in assessing recovery.

CONCLUSIONS: The experts reached a high level of consensus on many of the key treatment questions in the survey. Within the limits of expert opinion and with the expectation that future research data will take precedence, these guidelines provide direction for addressing common clinical dilemmas that arise in the pharmacologic treatment of psychotic disorders. They can be
used to inform clinicians and educate patients regarding the relative merits of a variety of interventions. Clinicians should keep in mind that no guidelines can address the complexities involved in the care of each individual patient and that sound clinical judgment based on clinical experience should be used in applying these recommendations.

Status
MEDLINE

Authors Full Name
Kane, John M; Leucht, Stefan; Carpenter, Daniel; Docherty, John P; Expert Consensus Panel for Optimizing Pharmacologic Treatment of Psychotic Disorders.

Date Created
20031125

Year of Publication
2003

UI: 12099305

The insanity defense is a legal construct that excuses certain mentally ill defendants from legal responsibility for criminal behavior. This practice guideline has delineated the forensic psychiatric evaluation of defendants raising the insanity defense. The document describes acceptable forensic psychiatric practices. Where possible, standards of practice and ethical guidelines have been specified. And where appropriate, the practice guideline has emphasized the importance of analyzing the individual case, the jurisdictional case law and the state (or federal) statute. This practice guideline is limited by the evolving case law, statutory language and legal literature. The authors have emphasized the statutory language of current legal standards, as well as the state or federal courts' interpretation of those standards because the same statutory language has been interpreted differently in different jurisdictions. Similarly, this practice guideline has reviewed the state and federal trends that determine which diagnoses meet the criteria for mental disease or defect. These trends yield to jurisdictional court interpretations. Finally, the authors hope this practice guideline has begun the dialogue about formulating a forensic psychiatric opinion by surveying the various approaches used to analyze case data. The forensic psychiatrist's opinion in each case requires an understanding of the current jurisdictional legal standard and its application, as well as a thorough analysis of the individual case. The psychiatrist's analysis and opinion should be clearly stated in the forensic psychiatric report. It should be noted that the role of a psychiatric expert witness in the criminal justice system is predicated on the law's interest in individualizing the criteria of mitigation and exculpation. Forensic psychiatric analyses and formulations of opinions are, therefore, subject to change as the legal guidance changes.

Status

OBJECTIVES: Behavioral emergencies are a common and serious problem for consumers, their communities, and the healthcare settings on which they rely to contain, assess, and ultimately help the individual in a behavioral crisis. Partly because of the inherent dangers of this situation, there is little research to guide provider responses to this challenge. Key constructs such as agitation have not been adequately operationalized so that the criteria defining a behavioral emergency are vague. The significant progress that has been made for some disease states with better treatments and higher consumer acceptance has not penetrated this area of practice. A significant number of deaths of patients in restraint has focused government and regulators on these issues, but a consensus about key elements in the management of behavioral emergencies has not yet been articulated by the provider community. The authors assembled a panel of 50 experts to define the following elements: the threshold for emergency interventions, the scope of assessment for varying levels of urgency and cooperation, guiding principles in selecting interventions, and appropriate physical and medication strategies at different levels of diagnostic confidence and for a variety of etiologies and complicating conditions.

METHOD: In order to identify issues in this area on which there is consensus, a written survey with 808 decision points was developed. The survey was mailed to a panel of 52 experts, 50 of whom completed it. A modified version of the RAND Corporation 9-point scale for rating appropriateness of medical decisions was used to score options. Consensus on each option was defined as a non-random distribution of scores by chi-square "goodness-of-fit" test. We assigned a categorical rank (first line/preferred choice, second line/alternate choice, third line/usually inappropriate) to each option based on the 95% confidence interval around the mean rating. Guideline tables were constructed describing the preferred strategies in key clinical situations.

RESULTS: The expert panel reached consensus on 83% of the options. The relative appropriateness of emergency interventions was ascertained for a continuum of behaviors. When asked about the frequency with which emergency interventions (parenteral medication, restraints, seclusion) were required in their services, 47% of the experts reported that such interventions
were necessary for 1%-5% of patients seen in their services and 32% for 6%-20%. In general, the consensus of this panel lends support to many elements of recent Health Care Financing Administration regulations, including the timing of clinician assessment and reassessment and the intensity of nursing care. However, the panel did not endorse the concept of "chemical restraint," instead favoring the idea that medications are treatments for target behaviors in behavioral emergencies even when the causes of these behaviors are not well understood. Control of aggressive behavior emerged as the highest priority during the emergency; however, preserving the physician-patient relationship was rated a close second and became the top priority in the long term. Oral medications, particularly concentrates, were clearly preferred if it is possible to use them. Benzodiazepines alone were top rated in 6 of 12 situations. High-potency conventional antipsychotics used alone never received higher ratings than benzodiazepines used alone. A combination of a benzodiazepine and an antipsychotic was preferred for patients with suspected schizophrenia, mania, or psychotic depression. There was equal support for high-potency conventional or atypical antipsychotics (particularly liquids) in oral combinations with benzodiazepines. Droperidol emerged in fourth place in some situations requiring an injection.

CONCLUSIONS: To evaluate many of the treatment options in this survey, the experts had to extrapolate beyond controlled data in comparing modalities with each other or in combination. Within the limits of expert opinion and with the expectation that future research data will take precedence, these guidelines provide some direction for addressing common clinical dilemmas in the management of psychiatric emergencies and can be used to inform clinicians in acute care settings regarding the relative merits of various strategies. [References: 80]


OBJECTIVE: To define and investigate key issues in the management of dementia and to make literature-based treatment recommendations.
METHODS: The authors searched the literature for four clinical questions: 1) Does pharmacotherapy for cognitive symptoms improve outcomes in patients with dementia? 2) Does pharmacotherapy for noncognitive symptoms improve outcomes in patients with dementia? 3) Do educational interventions improve outcomes in patients and/or caregivers? 4) Do other nonpharmacologic interventions improve outcomes in patients and/or caregivers?

RESULTS: Cholinesterase inhibitors benefit patients with AD (Standard), although the average benefit appears small; vitamin E likely delays the time to clinical worsening (Guideline); selegiline, other antioxidants, anti-inflammatories, and estrogen require further study. Antipsychotics are effective for agitation or psychosis in patients with dementia where environmental manipulation fails (Standard), and antidepressants are effective in depressed patients with dementia (Guideline). Educational programs should be offered to family caregivers to improve caregiver satisfaction and to delay the time to nursing home placement (Guideline). Staff of long-term care facilities should also be educated about AD to minimize the unnecessary use of antipsychotic medications (Guideline). Behavior modification, scheduled toileting, and prompted voiding reduce urinary incontinence (Standard). Functional independence can be increased by graded assistance, skills practice, and positive reinforcement (Guideline).
sequence them. We therefore undertook a new survey of expert opinion in order to bridge gaps between the research evidence and key clinical decisions.

METHOD: Based on a literature review, a written survey was prepared which asked about 1,276 options for psychopharmacologic interventions in 48 specific clinical situations. Most options were scored using a modified version of the RAND Corporation 9-point scale for rating appropriateness of medical decisions. We contacted 65 national experts, 58 of whom (89%) completed the survey. Consensus on each option was defined as a non-random distribution of scores by chi-square test. We assigned a categorical rank (first-line/preferred choice, second-line/alternate choice, third-line/usually inappropriate) to each option based on the confidence interval of its mean rating. Guideline tables indicating preferred treatment strategies were then developed for key clinical situations.

RESULTS: The expert panel reached consensus on many key strategies, including acute and preventive treatment for mania (euphoric, mixed, and dysphoric subtypes), depression, and rapid cycling, and approaches to managing the complications of treatment resistance and comorbidity. Use of a mood stabilizer is recommended in all phases of treatment. Divalproex (especially for mixed or dysphoric subtypes) and lithium are the cornerstone choices among this class for both acute and preventive treatment of mania. Regardless of which is selected first, if monotherapy fails, the next recommended intervention is to use these agents in combination. The combination can then serve as the foundation on which other medications are added, if needed. Carbamazepine is the leading alternative mood stabilizer for mania. Expert opinion regards other new anticonvulsants as second-line options (e.g., if the previously mentioned mood stabilizers fail or are contraindicated). For milder depression, a mood stabilizer, especially lithium, may be used as monotherapy. Divalproex and lamotrigine are other first-line choices. For more severe depression, a standard antidepressant should be combined with lithium or divalproex. Bupropion, selective serotonin reuptake inhibitors (SSRIs), and venlafaxine are preferred antidepressants, and should be tapered 2 to 6 months after remission. Divalproex monotherapy is recommended for initial treatment of either depression or mania with rapid cycling. Antipsychotics are recommended for use with the above regimens for mania or depression with psychosis, and as potential adjuncts in non-psychotic episodes. Atypical antipsychotics, especially olanzapine and risperidone, were generally preferred over conventional antipsychotics. Recommendations are also given concerning the use of electroconvulsive therapy (ECT), clozapine, thyroid hormone, stimulants, and various novel agents for patients with treatment-refractory illness.

CONCLUSIONS: The experts reached high levels of consensus on key steps in treating bipolar disorder despite obvious gaps in high-quality data. To evaluate many of the treatment options in this survey, the experts had to extrapolate beyond controlled data; however, their recommendations are generally conservative. Experts reserve strongest support for initial strategies and individual medications for which there are high-quality research data, or for which there are longstanding patterns of clinical usage. Within the limits of expert opinion and with the understanding that new research data may take precedence, these guidelines provide clear pathways for addressing common clinical questions in a manner that can be used to inform clinicians and educate patients regarding the relative merits of a variety of interventions.

[References: 0]
Clinical practice guidelines for bipolar disorder from the Department of Veterans Affairs. [Erratum appears in J Clin Psychiatry 1999 May;60(5):341]

Bauer MS; Callahan AM; Jampala C; Petty F; Sajatovic M; Schaefer V; Wittlin B; Powell BJ. Journal of Clinical Psychiatry. 60(1):9-21, 1999 Jan.


UI: 10074872

BACKGROUND: For the last several years, the Department of Veterans Affairs (VA) has been involved in the development of practice guidelines for major medical, surgical, and mental disorders. This article describes the development and content of the VA-Clinical Practice Guidelines for Bipolar Disorder, which are available in their entirety on the Journal Web site (http://www.psychiatrist.com).

METHOD: A multidisciplinary work group composed of content experts in the field of bipolar disorder and practitioners in general clinical practice was convened by the VA's Office of Performance and Quality and the Mental Health Strategic Health Group. The work group was instructed in algorithm development and methods of evidence evaluation. Draft guidelines were developed over the course of 6 months of meetings and conference calls, and that draft was then sent to nationally prominent content experts for final critique.

RESULTS: The Bipolar Guidelines are part of the family of the VA Clinical Guidelines for Management of Persons with Psychosis and consist of explicit algorithms supplemented by annotations that explain the specific decision points and their basis in the scientific literature. The guidelines are organized into 5 modules: a Core Module for diagnosis and assignment to mood state plus 4 treatment modules (Manic/Hypomanic/Mixed Episode, Bipolar Depressive Episode, Rapid Cycling, and Bipolar Disorder With Psychotic Features). The modules specify particular diagnostic and treatment tasks at each step, including both somatotherapeutic and psychotherapeutic interventions.

CONCLUSION: The VA Bipolar Guidelines are designed for easy clinical reference in decision making with individual patients, as well as for use as a scholarly reference tool. They also have utility in training activities and quality improvement programs.

Status
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Comments
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This summary provides an overview of the assessment and treatment recommendations contained in the Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders. Depressive disorders in children and adolescents are marked by core symptoms similar to those seen in adults, although symptom expression varies greatly with developmental stage. These disorders are common, chronic, and recurrent, and they are associated with comorbid psychiatric conditions and poor outcome that can be alleviated by early identification and treatment. Opinions differ regarding treatment planning and duration of treatment required. Development of a treatment relationship with the patient and family is crucial for a successful outcome. Psychotherapy is an appropriate treatment for all children and adolescents with depressive disorders. Antidepressants may prove useful in some cases and are especially recommended for patients with psychosis, bipolar depression, and severe depression. Continuation treatment is necessary in all patients after the acute phase; long-term maintenance is required in some. Early detection and intervention is effective in ameliorating the poor psychosocial outcome.

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Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. AACAP. [Review] [230 refs]
UI: 9785729
Child and adolescent major depressive disorder and dysthymic disorder are common, chronic, familial, and recurrent conditions that usually persist into adulthood. These disorders appear to be manifesting at an earlier age in successive cohorts and are usually accompanied by comorbid psychiatric disorders, increased risk for suicide, substance abuse, and behavior problems. In addition, depressed youth frequently have poor psychosocial, academic, and family functioning, which highlights the importance of early identification and prompt treatment. Both psychotherapy and pharmacotherapy have been found to be beneficial for the acute treatment of youth with depressive disorders. Opinions vary regarding which of these treatments should be offered first and whether they should be offered in combination. In general, the choice of initial therapy depends on clinical and psychosocial factors and therapist's expertise. Based on the current literature and clinical experience, psychotherapy may be the first treatment for most depressed youth. However, antidepressants must be considered for those patients with psychosis, bipolar depression, severe depressions, and those who do not respond to an adequate trial of psychotherapy. All patients need continuation therapy and some patients may require maintenance treatment. Further research is needed on the etiology of depression; the efficacy of different types of psychotherapy; the differential effects of psychotherapy, pharmacotherapy, and integrated therapies; the continuation and maintenance treatment phases; treatment for dysthymia, treatment-resistant depression, and other subtypes of major depressive disorder; and preventive strategies for high-risk children and adolescents. [References: 230]

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When treating patients with psychoses, clinicians must often consider changing their treatment from one antipsychotic agent to another. The transition may be necessary because the patient experiences serious side effects or because the existing therapy no longer controls the patient's
A principal problem in changing antipsychotic agents is the potential for withdrawal symptoms resulting from discontinuation of the existing therapy. These syndromes can manifest as reemergence or worsening of psychosis, rebound or unmasked dyskinesia, and cholinergic-rebound symptoms. Withdrawal signs and symptoms may include insomnia, nausea, vomiting, anxiety, and agitation. When switching a patient to the new antipsychotic agent risperidone, the clinician can keep withdrawal symptoms to a minimum by considering the patient's clinical history and current status. For some patients, abrupt withdrawal of the current antipsychotic may be possible. For others, the dose of the previous medication must be gradually reduced before risperidone is initiated. In many cases, the transition is best made by overlapping the existing therapy and risperidone. [References: 42]

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28.
Combining individual and family treatment: guidelines for the therapist.
Successfully combining individual and family treatment for psychosis-prone outpatients who live with their families is a process of keeping the needs of the patient and the family in balance. The therapist has to respond to each in an even-handed way that preserves an alliance with both. Through guidelines and case reports, this chapter describes how to maintain that balance. The therapist-patient relationship is the core of treatment and keeps the clinician's focus squarely on the individual needs of the patient. In keeping with that focus, the therapist encourages self-determination on the patient's part and sets up opportunities for the family to communicate directly with the therapist in front of the patient, rather than surreptitiously behind the patient's back. In keeping with a collateral emphasis on the family, the therapist involves the family regularly and early in the course of treatment, respects the family's knowledge of the patient, puts that knowledge to use, and works with the family to deal promptly and effectively with incipient emergencies. The therapist knows that it is not only the therapist but also the family who stimulate a patient to change. The therapist, building on whatever strengths the patient and family possess, enlists the family as an ally in promoting and bringing about therapeutic progress.

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