Help is at hand

Schizophrenia

The Royal College of Psychiatrists

About this leaflet

This leaflet is for:

- anyone who has been given a diagnosis of schizophrenia
- anyone who thinks they might have schizophrenia
- friends and relatives of someone who has been given this diagnosis.

In it you will find:

- what it is like to have schizophrenia
- what may cause it
- the different treatments available
- how to help yourself
- some information for relatives.

Why do we use the "S" word?

"Schizophrenia" is a word that many people associate with violence and disturbance. The media regularly use it in this way, although it is unfair and inaccurate. Many people feel stigmatised by being described as having "schizophrenia".

We use the word "schizophrenia" because there does not seem, at the moment, to be a better one to describe this particular pattern of symptoms and behaviours. Even if you don't find the use of this term helpful, we hope that the information in this leaflet can still be useful.

What is schizophrenia?

Schizophrenia is a mental disorder that affects around 1 in every 100 people. It affects men and women equally and seems to be more common in city areas and in some minority

ethnic groups. It is rare before the age of 15, but can start at any time after this, most often between the ages of 15 and 35.

Symptoms of schizophrenia

These are often described in two groups – positive and negative.

"Positive" symptoms

These unusual experiences are most common in schizophrenia, but can occur in other mental disorders.

Hallucinations

A hallucination happens when you hear, smell, feel or see something – but there isn't anything (or anybody) actually there to account for it. In schizophrenia, the commonest hallucination is that of hearing voices.

What's it like to hear voices?

They sound utterly real. They seem to be coming from outside you, although other people can't hear them. You may hear them in different places or you may hear them coming from a particular object, such as a television. The voices may talk to you directly, or they may talk to each other about you. It can sound as if you are over-hearing a conversation. Voices can be pleasant but are often rude, critical, abusive or just plain irritating.

How do people react to them?

Sometimes you may feel that you have to do what they say, even if they are telling you to harm yourself or to do something you know is wrong. Much of the time to you can ignore them. Sometimes they will get you down.

Where do they come from?
Voices are not imaginary, but they are created by the mind. Brain scans have shown that the part of the brain that is active when someone hears voices is the part that is active when they are talking, or forming words in their mind. It is as though the brain mistakes your own thoughts for real voices coming from our surroundings.

Do other people hear voices?
People with other mental disorders, such as severe depression, may also hear voices that talk directly to them. In depression, these voices are critical and repeat the same word or phrase over and over again.
Some people hear voices which do not interfere with their daily life. They may be pleasant, or not very loud, or only happen from time to time. These do not usually need any kind of treatment.

Other kinds of hallucination
Visions and hallucinations of smell, taste or being touched can also happen, but these are less common.

Delusions

A delusion is a belief that you hold with complete conviction, although it seems to be based on a misinterpretation or misunderstanding of situations or events. While you have no doubts, other people see your belief as mistaken, strange or unrealistic. They find that they can't really discuss this belief with you. If they ask you why you believe it, your reasons don't make sense to them, or you can't explain it – you "just know".

How does it start?

- You may suddenly start to believe it. This may follow some weeks or months when you have felt that there has been something strange going on, but that you couldn't explain what it was.
- You may develop a delusional idea as a way of explaining hallucinations that you are having. For example, if you have heard voices commenting on your actions, you may decide that you are being monitored by some government agency.

Paranoid delusions

These are delusional ideas that make you feel persecuted or harassed. They may be:

- unusual – you may feel that MI5 or the government is spying on you. You may believe that you are being influenced by neighbours who are using special powers or technology.
- everyday – you may start to believe your partner is unfaithful. You do so because of odd details that seem to have nothing to do with sex or infidelity. Other people can see nothing to suggest that this is true.

Delusions of persecution are obviously distressing for you. They can also be upsetting for the people you see as your persecutors, especially if they are close to you, like your family.

Ideas of reference

You start to see special meanings in ordinary, day-to-day events and believe that they are specially connected to you. For example, that radio or TV programmes are about you, or that people are communicating with you in odd ways, such as through the colours of cars passing in the street.

Coping with delusions

- Delusions may, or may not, affect the way you behave.
- It can be difficult to discuss them with other people because you realise that they won't understand.
- If you feel that other people are trying to harm or harass you, you will probably just keep away from them. Occasionally, you may feel so threatened that you want to retaliate.
- You may try to escape from feelings of persecution by moving from place to place.

Muddled thinking (or "Thought Disorder")

It becomes harder to concentrate – you probably can't:

- finish an article in the newspaper or watch a TV programme to the end
- keep up with your studies at college
- keep your mind on the job at work.

Your thoughts seem to wander. You drift from idea to idea without any obvious connection between them. After a minute or two, you can't

remember what you were originally trying to think about. Some people describe their thoughts as being "misty" or "hazy" when this is happening.

When your ideas are disconnected in this way, it can be hard for other people to understand you.

Feelings of being controlled

You may feel that:

- your thoughts are vanishing – as though someone is taking them out of your mind
- that the thoughts you are thinking are not yours, but that someone else has put them in your mind
- your body is being taken over, or that you are being controlled like a puppet or a robot.

People explain these experiences in different ways. Some people have technological explanations, such as the radio, television or laser beams, or believe that a device has been implanted in them. Other people may blame witchcraft, angry spirits, God or the Devil.

"Negative" symptoms

These are less obvious than positive symptoms.

- Your interest in life, energy, emotions and 'get-up-and-go' just drain away. It's hard to feel excited or enthusiastic about anything.
- You can't concentrate. You may not bother to get up or go out of the house.
- It can be difficult to wash or tidy up, or to keep your clothes clean.
- You may feel uncomfortable with people – that you have nothing to say.

Other people can find it hard to understand that negative symptoms are actually symptoms, and that you aren't just being lazy. This can be upsetting, both for you and your family. Your family feel that you just need to pull yourself together. You can't explain that … you just can't.

Negative symptoms are much less dramatic than positive symptoms, but they can be just as troublesome.

Does everyone with schizophrenia have all these symptoms?

No. Someone can hear voices without negative symptoms, but may not have thought disorder. Some people with delusional ideas seem to have very few negative symptoms. If someone only has thought disorder and negative symptoms, the problem may not be recognised for years.

Loss of insight

After a while, the symptoms can be so intense that they take over your life. It can feel as though everyone else is wrong, that they just can't understand what you can.

Depression

- Before help or treatment, around half of those having schizophrenia for the first time will feel depressed.
- Around 1 in 7 people with continuing symptoms will have depression. This may not be recognised because the signs can be mistaken for negative symptoms.
- Although antipsychotic medication has been blamed for this in the past, it seems that treatment with medication actually reduces depression in schizophrenia.
- If you have schizophrenia and feel depressed, make sure that you tell someone and that they take you seriously. See our leaflet on 'Depression' for further information on signs, symptoms and treatment.

What causes schizophrenia?

We don't yet know for sure. It is likely to be a combination of several different factors which will be different for different people.

Genes

1 in 10 people with schizophrenia has a parent with the illness. Studies of twins can help to show how much is due to genes and how much to upbringing.

Identical twins have exactly the same genetic make-up as each other, down to the last molecule of DNA. If one identical twin has schizophrenia, their twin has about a 50:50 chance of having it too. Non-identical twins don't have the same genetic make-up as each other. If one of them has schizophrenia, the risk to the other twin is just slightly more than for any other brother or sister.

These findings hold true even if twins are adopted and brought up in different families. This suggests that the difference is truly due to genes rather than upbringing.

Relatives with schizophrenia	Chance of developing schizophrenia
None	1 in 100
1 parent	1 in 10
1 identical twin (same genetic make up)	1 in 2
1 non-identical twin (different genetic make up)	1 in 80

Research suggests that genes account for about half of the risk of developing schizophrenia. We don't yet know the combination of genes responsible for this.

Brain damage

Modern brain scans show that, compared with people who don't suffer from the illness, there are differences in the brains of some people with schizophrenia. For some people with schizophrenia, parts of their brain may not have developed normally, because of:

- problems during birth that affect the supply of oxygen to the baby's brain
- viral infections during the early months of pregnancy.

Street drugs and alcohol

Sometimes, the use of street drugs seems to bring on schizophrenia. These include ecstasy (E), LSD (acid), amphetamines (speed) and crack. We know that amphetamines can give you psychotic symptoms, but these actually stop when you cease taking the amphetamines. We don't yet know whether these drugs on their own can trigger off a long-term illness, but they may do if you are vulnerable. Using street drugs and alcohol can make matters worse for people who already have schizophrenia. Some people use street drugs and alcohol to cope with their symptoms.

Cannabis

(hash, marijuana, pot, ganja, skunk, dope, spliffs, joints)

- There is now good evidence to suggest that the use of cannabis doubles the risk of developing schizophrenia.

- It is more likely if you start using cannabis in your early teens.
- If you have smoked it frequently (more than 50 times) during your teens, the effect is even stronger – you are 6 times more likely to develop schizophrenia.

Stress

Difficulties often seem to happen shortly before symptoms get worse. This may be a sudden event like a car accident, bereavement or moving home. It can be an everyday problem, such as difficulty with work or studies. Long-term stress, such as family tensions, can also make it worse.

Family problems

At one time, it was thought that schizophrenia was caused by communication problems within the family. There is no evidence to support this idea. However, family tensions worsen schizophrenia.

Childhood deprivation

There is some evidence that, as with other mental disorders, early experiences of deprivation and abuse can make it more likely that you will develop schizophrenia.

Outlook

Many people with schizophrenia now never have to go into hospital and are able to settle down, work and have lasting relationships.

In the long term:

For every 5 people who develop schizophrenia:

- 1 in 5 will get better within five years of their first episode of schizophrenia.

- 3 in 5 will get better, but will still have some symptoms. They will be times when the symptoms get worse.
- 1 in 5 will continue to have troublesome symptoms.

What will happen without treatment?

Some people have one symptom of schizophrenia, such as hearing voices, but none of the other symptoms. They may not need any treatment or special help. However, if the voices become too loud or unpleasant (or if other problems develop), then treatment will probably be needed.

Suicide is more common in people with schizophrenia. This is more likely if someone has active symptoms, has become depressed, is not receiving treatment or has had their level of care reduced.

Research suggests that the longer schizophrenia is left untreated, the greater its impact on your life. The sooner it is identified and treated, the better the outlook.

If the symptoms are identified early, and treatment is started:

- you are less likely to have to go into hospital
- you are less likely to need intensive support at home
- if you do go into hospital, you will spend less time there
- you are more likely to be able to work and live independently.

Treatment

If you have the symptoms of schizophrenia for the first time, medication should be started as soon as possible, usually by a general practitioner.

You may well not need to go into hospital, although you will need to see a psychiatrist and a community mental health team. Assessment and treatment can now be done at home by community teams. Even if you do have to go into hospital, it will usually be for only a few weeks. Afterwards, any help or treatment can continue at home.

Medication can help the most disturbing symptoms of the illness. However, it does not provide a complete answer. It is usually an important first step which makes it possible for other kinds of help to work.

Support from families and friends, psychological treatment and services such as supported housing, day care and employment schemes are vitally important.

Medication

Why take medication?

The aim is to reduce the effects of the symptoms on your life. Medication should:

- weaken delusions and hallucinations gradually, over a period of a few weeks
- Help you think more clearly
- increase your motivation and ability to look after yourself.

How is it taken?

- Medication for schizophrenia comes as tablets, capsules, or syrup. It's hard for anybody to remember to take tablets several times a day, so there are now some that you only need to take once a day.
- If you find it hard to take tablets every day, you may find it easier to take antipsychotic medication as an injection. This is called a 'depot injection' and is given at weekly or every 2,3 or 4 weeks. Most of the depot injections are older, "typical" antipsychotics, but one of the atypicals, Risperidone, is now available in this form.

"Typical" antipsychotics

In the mid-1950s, several medications appeared that could reduce the symptoms of schizophrenia. They became known as "antipsychotic" medications. These older drugs are called "typical"or "first-generation" antipsychotics. They work by reducing the action of a particular chemical messenger in the brain called dopamine.

Side-effects

- Stiffness and shakiness, like Parkinson's disease, along with feeling sluggish and slow in your thinking. In most cases, this will mean that you are taking too much of the medication. It should be reduced to a level at which these symptoms disappear. If you need higher doses, these side-effects can be controlled with anti-Parkinsonian medication.
- Uncomfortable restlessness (akathisia).
- Problems with your sex life.

- A long-term side-effect is tardive dyskinesia (TD for short) – persistent movements, usually of the mouth and tongue. This affects about 1 in 20 people every year who are taking these medications.

Some Typical antipsychotics:

Tablets	Trade Name	Normal Daily Dose (mg)	Max . Daily Dose (mg)
Chlorpromazine	Largactil	75-300	1000
Haloperidol	Haldol	3-15	30
Pimozide	Orap	4-20	20
Trifluoperazine	Stelazine	5-20	
Sulpiride	Dolmatil	200-800	2400
Aripiprazole	Abilify	10-30	

Depot Injections (may be given 2-4 weekly)	Trade Name	Normal 2 weekly Dose	Max. 2 weekly Dose
Haloperidol	Haldol	50	
Flupenthixol decanoate	Depixol	40	
Fluphenazine decanoate	Modecate	12.5-100	
Pipothiazine palmitate	Piportil	50	
Zuclopenthixol decanoate	Clopixol	200	

"Atypical" antipsychotics

Over the last 10 years, several newer medications have appeared. They work on a different range of chemical messengers in the brain (such as serotonin) and are called "atypical" or "second-generation" antipsychotics.

They are less likely to cause Parkinsonian side-effects, although they may cause weight gain and problems with sexual function. They may also help the negative symptoms, on which the older drugs have very little effect. They also seem much less likely to produce tardive dyskinesia. Many people who use these newer medications have found the side-effects less troublesome than those of the older medications.

Side-effects

- Sleepiness and slowness
- Weight increase
- Interference with your sex life
- Increased chance of developing diabetes
- In high doses, some may produce the same Parkinsonian side-effects as the typicals.

Some Atypical antipsychotics:

Tablets	Trade Name	Normal Daily Dose (mg)	Max. Daily Dose (mg)
Amisulpiride	Solian	50 – 800	1200
Clozapine	Clozaril	200-450	900
Olanzapine	Zyprexa	10-20	20
Quetiapine	Seroquel	300-450	750
Risperidone	Risperdal	4-6	16
Sertindole	Serdolect	12-20	24
Zotepine	Zoleptil	75-200	300

Depot Injections	Trade Name	Normal 2 weekly Dose	Max. 2 weekly Dose
Risperidone	Risperdal Consta	25	50

Clozapine

- This is an atypical antipsychotic medication, and the only one that has been shown to be more effective for people who do not respond to other sorts of antipsychotic. It also seems to reduce suicide in people with schizophrenia.
- It has many of the same side-effects as other atypical antipsychotics, but may also make you produce more saliva.
- The main drawback is that it can affect your bone marrow. This leads to a shortage of white cells which makes you vulnerable to infection. If this happens, the medication needs to be stopped as quickly as possible to allow the bone marrow to recover. Weekly blood tests need to be done for the first 6 months of taking Clozapine, then 2 weekly and eventually 4 weekly.

How well does medication work?

- These medications work well for many people – about 4 in 5 people get help from them. They control the disorder, but do not cure it. You have to go on taking the medication to prevent the symptoms returning.
- Even if the medication helps, the symptoms may come back. This is much less likely to happen if you carry on taking medication, even when you feel well.

How long will I have to take medication for?

- Most psychiatrists will suggest that you take medication for a long time.
- If you want to reduce or stop your medication, discuss this with your doctor.
- You should usually reduce your medication

gradually so, you can notice any symptoms returning, before you become really unwell again.

What happens if you stop your medication?

If you stop taking the tablets, the symptoms of schizophrenia will usually come back – not immediately, but often within 6 months.

Getting back to normal

What happens after your positive symptoms have been controlled? Schizophrenia can make it difficult to deal with the demands of everyday life. Sometimes, this is because of the symptoms. Sometimes, the illness may have gone on for so long that you may just have got out of the habit of doing things for yourself. It can be difficult to get back to doing ordinary things, like washing, answering the door, shopping, making a phone call or chatting with a friend.

Is medication enough?

Medication is very useful. However, even if you are taking medication, you will usually need to use other types of help to give yourself the best chance of a good recovery.

Psychological (or talking) treatments

Cognitive Behavioural Therapy (CBT)

This may be done by clinical psychologists, psychiatrists or nurse therapists. The therapist helps you to:

- identify problems that are most troublesome for you. These could be thoughts, experiences or ways of behaving.
- look at how you tend to think about them – your "thinking habits".
- look at how you react to them – your "behaving habits".
- look at the effect your thinking or behaving habits have on the way you feel or the way you behave.
- work out if any of these thinking or behaving habits are unrealistic or unhelpful.
- work out if there are other ways of thinking about these things, or reacting to them, that would be more helpful.
- try out new ways of thinking and behaving.
- see if these work. If they do help you, use them regularly. If they don't, find better ones that do work for you.

This kind of therapy can help you to feel better about yourself, and to learn new ways of solving problems. We now know that cognitive therapy can also help you to cope with troublesome hallucinations or delusional ideas. Most people have between 8 and 20 sessions lasting about 1 hour. For CBT to be effective, you should have at least ten meetings over a period of about 6 months.

Counselling and supportive psychotherapy

These don't directly affect the symptoms of schizophrenia, but may be helpful if:

- you need to get things off your chest
- you need to talk things over in greater depth
- you need some support with the daily problems of life.

Family work

This is **not** to do with trying to find reasons for the schizophrenia. Family meetings are designed to help you and your family cope better with the situation. They can be used to discuss information about schizophrenia, ways to support someone with schizophrenia, and how to solve practical problems that may be caused by the symptoms of the illness. Around ten meetings are needed over a period of about 6 months.

Cognitive remediation

This is being researched and is not yet widely available. It is a kind of "mental gym" that has shown some promise in helping to improve memory, and concentration in people with schizophrenia.

Support from the Community Mental Health Team (CMHT)

- A mental health worker from your local community mental health team should see you regularly. Community psychiatric nurses can give you time to talk, and can help sort out problems with medication.

- Occupational therapists can:
  - help you to be clear what your skills are and what you can do
  - show you how to improve things you aren't doing so well
  - work out ways of helping you to do more for yourself and can help you to improve your social skills (how you get on with other people)
  - help you to get back to work.

- There may be help for families. This usually involves giving information about the illness and treatment, and helping to sort out some of the practical problems of day-to-day living. This may involve regular meetings for a while with a member of the CMHT.
- The psychiatrist will usually organise your medication and take responsibility for your overall care.
- The care co-ordinator will be responsible for making sure that your package of care actually happens.

How treatments compare

- Apart from Clozapine (see page 18), there is little evidence at the moment to suggest that there are large differences in effectiveness of any of the typical or atypical antipsychotics.
- It is also not possible to say in advance whether one antipsychotic will work better for you than another.
- In practice, you may need to try one antipsychotic and see how you get on with it. If it isn't working, or you have troublesome side-effects, discuss trying another with your psychiatrist.

- On the whole, people seem to find the side-effects of the atypical antipsychotics are easier to put up with than the side-effects of the typicals. So, treatment should usually start with an atypical.
- Clozapine does seem to work better than other antipsychotics for some people. However, its potentially serious side-effects mean that it would usually only be used after other treatments have failed. If you have had two antipsychotics (including one atypical) each for 6-8 weeks, without real benefit from either, Clozapine can be considered.
- We know that CBT is helpful for people who are taking medication. We do not know how well it works if someone is not taking medication.
- Research is being carried out to find out if early schizophrenia can be treated just with CBT.
- If you want further information about treatments, read the NICE guidelines (listed at end of the leaflet)
- If you are unhappy with the treatment you are receiving, you can ask for a second opinion from another psychiatrist.

Social Life

Day Centres

You may not have a job, or may be unable to go back to work. Even so ,it's good to get out and do something every day. Many people go regularly to a day hospital, day centre, or community mental health centre. These can offer a range of activities – 'keep fit', creative pursuits like painting and pottery, education or help with getting back to work. You can get active again and spend some time with other people.

Work projects

These provide training to help you develop your skills. They will often have contacts with local employers and can support you when you go back to work.

If your illness goes on for a long time, you may need a specialist rehabilitation service.

Supported accommodation

This could be a bedsit or flat where there is someone around to help you with day-to-day problems.

CPA – Care Programme Approach (England & Wales only)

This is a way of making sure that people with schizophrenia get appropriate care and support. It involves:

- A care co-ordinator who is responsible for organising all the different parts of your care and treatment.
- Regular review meetings every 3-6 months. These involve you, your care co-ordinator, your psychiatrist and any other people who are giving you care or support. This can include your family or carers.
- A care plan that is reviewed at the regular CPA meetings. It is re-written each time and you will have a copy to approve or change.
- Plans are made with you at these meetings about what to do if you find yourself becoming unwell again, or run into difficulties.
- Carers are entitled to have an assessment of their needs every year.

Self-help

Learn to recognise your early warning signs such as:

- Going off your food, feeling anxious or not sleeping.
- Other people comment that you've stopped bothering to change your clothes, clean your home or cook for yourself.
- Mild symptoms – feeling a bit suspicious or fearful, worrying about people's motives, starting to hear voices quietly or occasionally, finding it difficult to concentrate
- Not looking after yourself.

- Try to avoid things that make you worse, such as:
  - stressful situations such as spending too much time with people
  - using street drugs or alcohol
  - getting anxious about bills
  - disagreements with family, friends or neighbours.
- Learn relaxation techniques.
- Make sure you regularly do something you enjoy.
- Find ways of controlling your voices:
  - spend time with other people
  - keep busy
  - listen to a personal stereo (TV and radio also work, but may annoy your family or neighbours)
  - remind yourself that your voices can't harm you
  - remind yourself that your voices don't have any power over you and can't force

you to do anything you don't want to
  - join a self-help group for people with similar experiences to yours (see page 31)
- Identify someone you trust to tell you if you are becoming unwell again
- Learn about schizophrenia and your medication:
  - talk it over with your nurse, mental health worker or psychiatrist
  - ask for written information about your diagnosis and treatment
  - if your medication is not working well, ask about alternative medications.
- Look after your body:
  - try to eat a balanced diet, with lots of fresh vegetables and fruit
  - try not to smoke – cigarettes harm your lungs, your heart, your circulation and your stomach
  - take some regular exercise, even if it's only 20 minutes out walking every day. Regular vigorous exercise (double your pulse rate for 20 minutes 3 times a week) can help improve your mood.
- If there is an inaccurate or abusive item about schizophrenia in the press, a radio talk show or on TV, don't get depressed, get active. Write a letter, e-mail them, phone them up and tell them where they are wrong. It works!

For families...

It may be hard to understand what is happening if your son or daughter, husband or wife, brother or sister, or partner develops schizophrenia. Sometimes, no-one realises what is happening.

What do you see?

Your relative may become odd, distant or just different from how they used to be. They may avoid contact with people and become less active. If they have delusional ideas, they may talk about them, but may also keep quiet about them. If they are hearing voices, they may suddenly look away from you as if they are listening to something else. When you speak to them, they may say little, or be difficult to understand. Their sleep pattern may change so that they stay up all night and sleep during the day.

You may wonder if this behaviour is just rebellious. It can happen so slowly that, only when you look back, can you see when it started. It can be particularly difficult to recognise these changes during the teenage years, when young people are changing anyway.

Was it my fault?

You may start to blame yourself and wonder 'Was it my fault?' You may wonder if anyone else in the family is going to be affected, what the future holds, or how they can get the best help.

Can I talk to the mental health team?

Families have often been left out of discussions about their relative because of worries about confidentiality. This should not be the case now. If someone with schizophrenia is living with or being supported by their family, their family should be able to have the information that will allow them to care most effectively for them. Even if there are difficulties in this area, they cannot stop the family from informing the mental health team about what is going on with their relative.

Families need as much help and information as possible and the mental health team needs to listen to their worries and concerns. It can advise on drugs and their side-effects, as well as suggesting small, manageable tasks that may help recovery.

The Princess Royal Trust for Carers and the Royal College of Psychiatrists have published a checklist of questions for families to help them to find out what they need to know. Several voluntary organisations concerned with schizophrenia (see page 31) provide useful information and support.

What can we do?

Families also need advice. Someone with schizophrenia will be more sensitive to stress, so it is helpful to avoid arguments and keep calm – perhaps easier said than done!

Compulsory admission to hospital

Someone with schizophrenia may not always realise they are ill. They may refuse treatment when they badly need it. The Mental Health Act (in England and Wales), and similar legal arrangements in other countries, allows a person to be admitted to hospital against their will. This is only used if someone needs assessment or treatment, they cannot or will not accept it, and:

- their health is at risk or
- they are a danger to themselves or
- they are a danger to other people.

If this is to happen, three professionals must agree that it is necessary. They are:

- a doctor, usually a general practitioner who knows the person
- a doctor with special training in mental health, usually a psychiatrist
- an "Approved Social Worker", also with special training in mental health.

If you are kept in hospital under this law, you can appeal against the decision. You should be told how to do this when you go into hospital.

You can find out more about this in the "further reading" section of this leaflet.

Some myths...

Isn't schizophrenia a split personality?

No. Too many people have the idea that someone with schizophrenia can appear perfectly normal at one moment, and change into a different person the next. This is nonsense. We misuse the word schizophrenia in two different ways. By it, we may mean 'having mixed or contradictory feelings about something'. This is just part of human nature – a much better word is "ambivalent". Just as commonly, we may mean that someone behaves in very different ways at different times. Again, this is part of human nature.

Doesn't schizophrenia make people dangerous?

People who have schizophrenia are rarely dangerous. Any violent behaviour is usually sparked off by street drugs or alcohol, which is similar to people who don't suffer from schizophrenia.

Although there is a higher risk of violent behaviour if you have schizophrenia, it is almost insignificant compared to the effects of drugs and alcohol in our society. If we stopped all the violence caused by schizophrenia, we would only succeed in preventing 1% of all the violence in society. People with schizophrenia are far more likely to be harmed by other people, than other people are to be harmed by them.

Schizophrenia never gets better

1 in 5 people with schizophrenia recover completely (see 'Outlook' on page 12).

Further Help

Rethink, Head Office, 30 Tabernacle Street, London, EC2A 4DD; tel: 020 7330 9100. National voluntary organisation that helps people with any severe mental illness, their families and carers. www.rethink.org; Young People's site: www.rethink.org/at-ease

National Schizophrenia Fellowship (Scotland), Claremont House, 130 Claremont Street, Edinburgh, EH7 4LB;
tel: 0131 557 8969.
email: info@nsfscot.org.uk; www.nsfscot.org.uk

Schizophrenia Ireland: 38 Blessington Street Dublin 7;
Information Helpline: 1890 621 631;
e-mail: info@sirl.ie; www.sirl.ie

Mind, Granta House, 15-19 Broadway, London E15 4BQ;
tel: 020 8519 2122;
e-mail: info@mind.org.uk;
Mindinfoline: 0845 766 0163;
www.mind.org.uk
Publishes a wide range of literature on all aspects of mental health.

Mind Cymru, 3rd Floor, Quebec House, Castlebridge, Cowbridge Road East, Cardiff CF11 9AB;
tel: 0292039 5123;
fax: 029 2034 6585.

Saneline: Helpline: 0845 767 8000 midday to 2 am every day of the year. A national mental health helpline offering emotional support and practical information for people with mental illness, families, carers and professionals. www.sane.org.uk

Schizophrenia home page
www.schizophrenia.com

Further Reading

Understanding NICE guidance – information for people with schizophrenia, their advocates and carers, and the public. National Institute for Clinical Excellence 2002: London http://www.nice.org.uk/pdf/CG1publicinfo.pdf

The following publucation are available from Rethink; www.rethink.org/publications
1. Does Severe Mental Illness Run In Families? Genetic counselling for schizophrenia and allied disorders Dr Adrianne Reveley, Rethink 1998 (3rd edition). Available free of charge.
2. Surviving Schizophrenia – A Family Manual, Consumers and Providers E. Fuller Torrey, Quills (Harper) 2001 (4th edition). £12.99 (including p&p).

Getting into the System – Living with Serious Mental Illness Gwen Howe, Jessica Kingsley 1997 ISBN 1 85302 457 0.

Mental Health Assessments Gwen Howe, Jessica Kingsley 1998 ISBN 1 85302 458 9.

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Core interventions in the treatment and management of schizophrenia in primary and secondary care. (2002) National Institute for Clinical Excellence: London. http://www.nice.org.uk/pdf/CG1NICE guideline.pdf

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Bebbington P. (2001) Choosing antipsychotic drugs in schizophrenia: A personal view. Psychiatric Bulletin, 25: 284 – 286.

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Fanous A. et al. (2001) Relationship Between Positive and Negative Symptoms of Schizophrenia and Schizotypal Symptoms in Nonpsychotic Relatives. Archives of General Psychiatry, 58(7): 669 – 673.

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Tarrier N. et al. (2004) Cognitive-behavioural therapy in first-episode and early schizophrenia: 18-month follow-up of a randomised controlled trial. British Journal of Psychiatry, 184: 231 – 239.

Walsh E, Buchanan A. & Fahy T (2002). Violence and schizophrenia: examining the evidence. British Journal of Psychiatry, 180: 490 – 495.

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'Partners in care', a joint campaign between the Royal College of Psychiatrists and The Princess Royal Trust for Carers, has produced materials for carers including a checklist of questions to ask mental health professionals, a checklist of questions for people with mental health problems and a checklist for carers. Further information about the campaign can be found on www.partnersincare.co.uk

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