

SCHIZOPHRENIA SPECTRUM DISORDERS

DSM-IV TR Diagnostic Code: Schizophreniform Disorder 295.40

Schizophrenia 295.10 (disorganized type),
295.20 (catatonic type),
295.30 (paranoid type),
295.60 (residual type),
295.90 (undifferentiated type)

Schizoaffective Disorder 295.70

Diagnostic Guidelines

1. Establish diagnostic accuracy as defined in DSM-IV-TR. A thorough initial workup is recommended that includes a complete psychiatric and general medical history, a mental status examination, and a physical examination that includes a neurological evaluation. Basic laboratory tests should be conducted to rule out conditions that can mimic schizophrenia, to determine the presence of co morbid conditions, and to guide routine medical care when necessary.
2. Consider the diagnosis if signs of psychosis are present: delusions, hallucinations, loose associations, strange affect, bizarre behavior (e.g., catatonia).

A psychosocial rehabilitation assessment should be completed identifying strengths and skills as well as current obstacles to recovery. ***Please refer to Colorado Health Networks Clinical Guidelines for Case Management and Psychosocial Rehabilitation for further information.***

- ensure the presence of support systems, including community services and case management.
3. Other considerations during initial diagnostic period:
 - substance abuse - the presence of substance abuse may increase suicide risk; and may mimic the signs and symptoms of the disorder
 - other psychiatric disorders;
 - medical problems - rule out medical causes of psychotic symptoms;
 - assessment of dangerousness to self or others - assure safety.

Treatment Guidelines

1. Stabilization of psychotic symptoms is necessary, frequently in a structured setting, prior to other forms of treatment. Acute psychotic symptoms usually improve within days but may take 5 to 6 weeks even with effective antipsychotic medication. Specific treatment goals are to prevent harm; control disturbed behavior; suppress symptoms; effect a rapid return to the best level of functioning; develop an alliance with the individual, the family, and other support systems; formulate short- and long-term goals for living; and connect the individual with follow-up care in the community. (American Journal of Psychiatry 154:4, April 1997 Supplement, p. 2) A structured and predictable environment will assist in reducing stress and over stimulation.
2. The treatment approach should generally be practical, supportive, and reality-oriented. Focus of treatment should be on restoring or maintaining baseline skills and developing new skills based on the comprehensive psychosocial rehabilitation assessment. Because of the need for multiple system involvement, a case manager should always be designated. Peer support resources should always be included where available.

Recommended clinical interventions:

- from first contact, the focus of intervention should be on instilling hope for recovery and encouraging rehabilitation efforts;
 - treatment should be practical and supportive. Avoid regressive and emotionally intense therapies;
 - involve the family and other social supports. Provide resources for rehabilitation and support groups;
 - social skills training is an important treatment component;
 - education should be conducted with the individual and family regarding the illness and treatments, including medication, possible side effects,
 - treatment plan should be comprehensive, addressing strengths and identifying opportunities for skill acquisition and enhancement.
 - concurrent substance abuse treatment should be provided for the individual with a co-occurring disorder;
 - psychosocial rehabilitation, education and assistance in developing a Wellness Recovery Action Plan W.R.A.P. (Copeland), and pre-vocational skills training should be included in the overall treatment plan;
 - provide assertive community treatment to the consumer who continues to struggle with stabilization and recovery after discharge from the hospital.
3. The treatment plan should be comprehensive in orientation and include personal, social and vocational needs. Goals and objectives should be identified by the individual and should be realistic, measurable and achievable. Family involvement, psychoeducation, case management, community resources and supports and a W.R.A.P. should be part of the treatment plan.

Antipsychotic medications: Assessment for anti-psychotic medications should be considered mandatory.

Assessment for antipsychotic medication should include:

- positive signs of psychosis, e.g., delusions and hallucinations;
- active danger to self and/or others;
- presence of concomitant substance abuse, medical symptoms or problems
- history of previous responsiveness to medication;
- history of previous in-patient treatment;

In choosing a medication category, consider:

- family history of medical responsiveness;
- presenting symptoms meeting the DSM-IV diagnosis criteria;
- treatment history with other medications.
- a thorough medical evaluation, including neurological workup, to rule out organic factors as the cause of the psychosis
- looking for other medications which may adversely interact with antipsychotic medication;
- injectable antipsychotic medications for individuals who have difficulty complying with self-administered medication.
- any history of neuroleptic malignant syndrome.

Choosing medications:

- Atypical antipsychotics are the first line of treatment for schizophrenia. (McEvoy, Scheifler and Frances, 1999, p. 12)
- A depot medication should only be considered when the patient will not take oral medications or continues to be unable to accept his or her mental illness and need for medication. (McEvoy, Scheifler and Frances, 1999, p. 12)
- the individual is more likely to respond to a medication to which she/he or a family member has responded in past;
- the individual's confidence in a medication will affect the efficacy;
- suicide potential should be considered in selecting psychotropic drugs;
- mood stabilizers and antidepressants should be considered for schizoaffective disorder;
- side effect profile of medications should be considered;
- obtain the individual's history of drug allergies or adverse reactions to medications.

Obtain informed consent:

- review benefits and risks associated with medications;
- when utilizing conventional antipsychotics, include a review of the risk of tardive dyskinesia with the individual. Family should be involved (if individual consents);
- review the risk of recurrent symptoms and illness without treatment. Document informed consent in the individual's record (both provider and case manager);

- medication education and compliance training should routinely be provided to individuals.

Initiating treatment:

- identify target symptoms;
- aim to use the lowest effective dose when utilizing conventional antipsychotics--a previously effective dose may be started in a given individual;
- Initiating treatment in divided doses with conventional antipsychotics may enhance stabilization. Compliance is enhanced by changing to a single daily dose generally given at night to avoid daytime sedation;
- mood-stabilizing medications should be considered if affective symptoms are associated with the psychosis;
- monitor blood level with mood-stabilizing medications.

Monitoring antipsychotics:

- establish baseline AIMS and monitor every 3 months;
- monitor target symptoms to assess adequacy of dose;
- observe for side effects, particularly EPS such as dystonic reactions, akathisia (can't sit still), or akinesia. Consider anticholinergic medications (e.g., cogentin, artane) for such problems; tapering and discontinuing medication:

- ***Weigh benefits/risks with individual:***

- formulate follow-up plan including appointments and review of recurrent symptoms, which may include relapse. Resume previously effective dose if relapse;
- individual should be stabilized on medication for 6-12 months before tapering;
- maintenance medication is necessary in chronic cases.

- ***Considerations with tardive dyskinesia:***

- Atypical antipsychotics are the drugs of first choice;
- ensure diagnosis is accurate. Rule out organic causes;
- review benefits/risks with individual and family;
- notify QI department regarding any cases of tardive dyskinesia;
- for cases with extended use of neuroleptics, the treatment plan should provide for periodic assessment of side effects;
- AIMS monitoring for tardive dyskinesia should be conducted every 3 months.

- ***Other considerations:***

- ongoing monitoring for concurrent substance abuse should be provided;

- extended use of mood stabilizers requires continued blood level monitoring and periodic blood testing for medication-specific adverse reactions;
- ECT may be indicated in selected cases of treatment-resistant, fulminant psychosis, with or without treatment-resistant mood symptoms.
- Assistance of a nurse and utilization of a weekly medication planner box may help with compliance in the initial stages of treatment when some disorganization may still be present.

Bibliography

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