

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.

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.

SIGNIFICANT CONCERNS FOR INDIVIDUALS WITH SCHIZOPHRENIA

SUBSTANCE ABUSE

Nearly one-half of patients with schizophrenia have co-morbid substance use disorders, excluding nicotine abuse/dependence, which itself exceeds 50% prevalence in this group. The goals of treatment for patients with schizophrenia, who also have a substance use disorder, should include harm reduction, abstinence, relapse prevention, and rehabilitation. A model of integrated treatment is the preferred method of treatment; the same clinicians or teams of clinicians provide treatment for schizophrenia as well as treatment of substance use disorders.

SUICIDE

Suicide is the leading cause of premature death among patients with schizophrenia. Some risk factors for suicide among patients with schizophrenia are the same as those for the general population: male gender, white race, single marital status, social isolation, unemployment, a family history of suicide, previous suicide attempts, substance use disorders, depression or hopelessness, and a significant recent adverse life event. Specific demographic risk factors for suicide among persons with schizophrenia are young age, high socioeconomic status background, high IQ with a high level of pre-morbid scholastic achievement, high aspirations and expectations, early age at onset/first hospitalization, a chronic and deteriorating course with many relapses, and greater insight into the illness.

GENERAL MEDICAL CONDITIONS

With recent research indicating individuals with schizophrenia are more likely to die 25 years earlier than their peers without schizophrenia, all medical conditions must be evaluated, treated, and monitored. Coordination of care is essential between the psychiatric provider and the primary care physician. Patients with schizophrenia and related severe and persistent mental illness suffer disproportionately from a variety of co-morbidities, including cardiovascular disease, respiratory disease, diabetes, infectious diseases (e.g., HIV), and substance use disorders (including nicotine, alcohol, and other substances). The increased frequencies of the various co-morbid conditions are determined by multiple factors, including associations with schizophrenia itself (e.g., diabetes, smoking), life style (e.g., smoking, substance use, obesity, lack of exercise), environment (e.g., poverty, institutionalization), and medications (e.g., extrapyramidal syndromes, tardive dyskinesia, hyperprolactinemia, weight gain, hyperglycemia, hyperlipidemia, and cardiac arrhythmias). Thus, treatment selection and clinical management of patients with schizophrenia must consider the patient's past medical history and general medical status of the patient in determining the treatment plan.

CULTURAL FACTORS

Cultural factors are known to affect the course, diagnosis, and treatment of schizophrenia. There is a robust pattern of evidence that race has a substantial effect on whether persons with substantively similar symptoms receive a diagnosis of an affective disorder or a schizophrenia spectrum psychotic disorder. Compared with Caucasians, African Americans, especially men, are less likely to receive a diagnosis of a mood disorder and more likely to receive a diagnosis of schizophrenia. African Americans with schizophrenia are also less likely to receive a diagnosis of a co-morbid affective or anxiety disorder. While it is possible that such differences may reflect actual illness variation among racial/ethnic groups, there is growing evidence that cultural differences in symptom and personal presentation, help seeking, interpretation of symptoms and clinical judgments by (usually Caucasian) clinicians, and treatment referral are likely causing race-linked biases in diagnosis and therefore in treatment. Additional possible causes or contributors to this pattern of disparity include low levels of cultural competence among clinicians, unbalanced research samples, inaccurate or biased pathology assessment tools, and the failure of researchers to control for socioeconomic status, education, and urbanicity. These remarkably consistent findings suggest that clinicians should be mindful of the extent to which cultural factors influence their diagnostic approach.

RACE

Once individuals receive a diagnosis, substantial data suggest that race affects the type of pharmacological treatment they receive. For example, the Schizophrenia Patient Outcomes Research Team (PORT) showed that among patients for whom psychotropic medications at doses outside the recommended range were prescribed, patients from racial/ethnic minority groups (especially African Americans) were much more likely than Caucasian patients to receive doses above

recommended levels. The same patients were also more likely to receive prophylactic anti-Parkinsonian agents, suggesting increased rates of adverse side effects related to higher doses.

Among patients with schizophrenia who were also experiencing significant depression, Caucasian patients were significantly more likely to receive adjunctive medications. In addition, there is growing evidence that racial/ethnic minority patients with psychotic disorders are less likely than Caucasian patients to receive second-generation antipsychotics and more likely to receive long-acting injectable agents.

There is clearly a need for more research to describe and understand the differences in patterns of treatment by race and ethnicity. Most of the published research focuses on African Americans; the needs and treatments of other cultural groups also require attention. The observed phenomena provide little guidance about whether the care delivered is appropriate. In the meantime, the strength and consistency of these findings suggest that clinicians should consider the extent to which a patient's race and/or ethnicity are playing a role in the treatment and should ensure that care is being individualized and optimized.

To some extent, differences in drug dosing or side effect risk may be related to genetically based differences in drug metabolism. For example, the activity of the enzyme encoded by the CYP2D6 gene is very low or absent in 5%–8% of Caucasians but only 2%–5% of African Americans and Asians. Low activity of the enzyme encoded by the CYP2D6 gene may dramatically affect the metabolism of many drugs, increasing serum levels. There is also suggestive evidence that up to one-third of African Americans possess genetic polymorphisms of other enzymes that metabolize psychotropic agents, resulting in altered metabolism and potential for enhanced medication side effects. Ethnic factors may also confer a susceptibility to medication side effects in certain persons. For example, patients of Jewish descent have been noted to be at greater risk for clozapine-induced agranulocytosis than other patients with schizophrenia and therefore may require close monitoring during clozapine treatment. (APA, 2004)

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