Preferred Practice Guidelines

Schizophrenia

This guideline is based in part on the following:

American Psychiatric Association "Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition" Retrieved on 6/28/13 from:

http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243185&PDFSource=6

The practice guidelines included in this document are not intended to be required treatment protocols. Physicians and other health professionals must rely on their own expertise in evaluating and treating patients. Practice guidelines are not a substitute for the best professional judgment of physicians and other health professionals. Behavioral health guidelines may include commentary developed by the Company's behavioral health committees. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited. With respect to the issue of coverage, each patient should review his/her Policy or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The practice guidelines do not supersede the Policy or Certificate and Schedule of Benefits.

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Introduction:

Schizophrenia is a disorder, or group of disorders, that influences nearly all aspects of a person's life. Schizophrenia is unrelated to what some people call a "split personality." Treatment planning has three main goals:

- To reduce or eliminate symptoms,
- Maximize quality of life and adaptive functioning, and
- To promote and maintain recovery from the effects of the illness to the greatest degree possible.

Identification:

Main Symptoms (two or more present)

- Delusions
- Hallucinations
- Disorganized speech
- Grossly disorganized or catatonic behavior
- Negative symptoms (e.g., flattened affect, avolition)

Impairment

Social and/or occupational dysfunction

Suicide

Suicidal thoughts, plans or attempts may be present

Duration

Main symptoms present for at least one month with continuous signs of disturbance for at least six months

Course

Varies widely based on severity and medication adherence but for most, adverse impact will typically range from months to years.

Treatment:

Psychiatric Management
Consists of an array of interventions and activities that research has shown to be important in managing the illness, including:

- Diagnostic evaluation, including medication and substance abuse evaluation and assessment for comorbid medical conditions

Assessment of risk, especially suicidality, at every treatment contact

- Development of a treatment plan
- Establishing and maintaining a therapeutic alliance
- Providing education to patients and families, emphasizing a recovery model
- Maximizing treatment adherence by managing medication side effects
- Focusing on attitudes and behaviors regarding medications
- Treatment of comorbid and co-occurring conditions
- Coordination of holistic care
- Attention to psychosocial issues
- Use rating tools such as the Positive and Negative Symptoms Scale (PANSS)

Acute Phase – Treatment should include:

- Antipsychotic medication
- Psychosocial interventions – reducing stressful relationships, environments or life events; providing a structured environment;
- Family involvement in treatment; risk reduction; discharge planning

Stabilization Phase –

- Maintenance of antipsychotic medications to facilitate further symptom reduction and consolidate remission;
- Psychosocial interventions, including supportive psychotherapy, peer support, and/or other evidence-based recovery programs (e.g. WRAP)
- Transition to community support resources;
- Psycho-education for the patient and family aimed at reducing the risk of relapse;
- Formally funded community resources such as Targeted Case Management (where available).

Stable Phase –

- Maintenance of antipsychotic medications to reduce relapse and recurrence;
- Continued psychosocial interventions;
- Housing assistance;
- Self-help peer support programs, supported employment, social skills training, etc.

Atypical Antipsychotics – The Food and Drug Administration (FDA) recommends that any patient treated with atypical antipsychotics be monitored for symptoms of hyperglycemia and/or emerging symptoms of diabetes mellitus and for excessive weight gain. The American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists and the North American Association for the Study of Obesity, among others, specifically recommend the minimum monitoring schedule outlined in Table 1.

The prescribing psychiatrist is responsible for ensuring that his or her patients are being monitored at least as frequently as recommended. It is well known that people on antipsychotic medication develop dyskinesias and EPS which must be monitored and documented as indicated.

Table 1**

* HgbA1c is an alternative for some individuals, especially if obtaining a fasting glucose is difficult due to poor adherence.

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually
Personal/family history	X					X
Weight (BMI)	X	X	X	X	X	
Waist circumference	X					X
Blood pressure	X			X		X
Fasting plasma glucose	X			X		X
Fasting lipid profile	X			X		X

** More frequent assessments may be warranted based on clinical status

- Since schizophrenia is known to interact with co-morbid medical conditions, it is important to assess for such conditions and to coordinate treatment with other providers.
- Since patients are particularly vulnerable to relapse following an acute episode, especially when medications are discontinued, it is important that there are no gaps in service delivery
- Long-acting injectable antipsychotics can assist in promoting adherence to antipsychotic medications. While they can be used in all patients, long-acting injectable antipsychotics are especially important for patients with a history of nonadherence to oral medications. Nearly half of patients with schizophrenia have co-occurring substance abuse disorders. In such cases, an integrated multidisciplinary treatment approach is recommended to address both disorders simultaneously
- All antipsychotic drug use and particularly second generation antipsychotic use should be monitored closely.

Referral criteria:

Referral to a behavioral health specialist may be necessary when:

- Active symptoms require a medication evaluation or adjustment
- There are side effects from the current medications
- There are chronic comorbid medical conditions
- There is suicidal ideation or a history of suicide attempts
- There is homicidal ideation or a history of violence
- There is evidence of a substance use disorder
- There is a need for a single point of contact to coordinate interventions.

A follow-up visit with a behavioral health provider should occur within seven calendar days of discharge from a hospital for treatment of schizophrenia.

A psychiatric evaluation should occur within 14 days of a new episode of care of schizophrenia.

Education:
The following themes should ideally be communicated to the member and closest caregivers:

- Schizophrenia is a biological and no-fault illness.
- Schizophrenia is responsive to daily medication treatment.
- Let the member know he or she should continue medications even if he or she is feeling better.
- Severity and risk of relapse often depend on whether medications are taken as prescribed.
- Encourage the member to talk to his or her doctor about side effects before stopping medications or if he or she has any questions.
- It is important to seek out available support in the community (e.g., ACT teams, psychosocial rehabilitation and recovery.
- services, peer support and self-help, supervised housing, vocational rehabilitation, respite care)
- It is important to reduce stress and use family support.
- Emphasize recovery model and the availability of both formal and informal support networks.

References:

1. American Diabetes Association (2004) Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 27:596-601. Retrieved on 6/28/13 from: http://care.diabetesjournals.org/content/27/2/596.full.pdf+html

2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, APA 2015.

3. American Psychiatric Association. Practice guideline for the treatment of patients with schizophrenia. 2nd ed. Arlington (VA): American Psychiatric Association; 2004 Feb. Retrieved on 6/28/13 from: http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1665359

4. Nasrallah H.A., Duchesne I., Mehnert A., et al. Health-related quality of life in patients with schizophrenia during treatment with long-acting injectable risperidone. J Clin Psychiatry 2004, 65:531-536.

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6. Singh, A.C., Massey, A.J., Thompson, M.D., Rappa, L.R., Honeywell, M.S., Addressing Nonadherence in the Schizophrenic Population, Journal of Pharmacy Practice, December 1, 2006; 19(6): 361 - 368.