Schizophrenia
Behavioral Healthcare, Inc. has adopted practice parameters consistent with the guidelines of the American Psychiatric Association, NICE, NHS/Maudsley and TMAP in the management of Schizophrenia. The following is a summary of some, but not all, of the major points in the practice parameters. The reader is referred back to the source documents for a more comprehensive understanding of the assessment and treatment of Schizophrenia.

Background Information
1. Core features:
   a. Uncommon: Schizophrenia affects 0.5% to 1% of the population (Center for Disease Control and Prevention)
   b. Costly: According to the Center for Disease Control and Prevention, Schizophrenia costs about $6 billion dollars annually.
   c. Debilitating: Patients with schizophrenia are less likely to be married, more likely to be unemployed and more likely to receive disability and Medicaid benefits than the general population.
   d. Symptoms fall into two groups
      a. Positive symptoms --- generally the more obvious and externally troubling symptoms of auditory hallucinations, visual hallucinations, paranoia and delusions.
      b. Negative symptoms --- symptoms generally defined by a prolonged and sometimes profound deficit in affect, motivation, ability to experience pleasure and ability to act spontaneously.
   e. Schizophrenia is a life-long chronic illness and while it can be managed, it does not resolve.
2. Comorbidity:
   a. Anxiety disorders are common among patients with Schizophrenia, particularly OCD.
   b. Substance abuse disorders are common. Patients often smoke and use stimulants to combat negative symptoms.
   c. Depression is common and more difficult to detect given negative symptoms.

Recommendations
1. Assessment: Assessments should be through direct clinical interview, with the support of appropriate clinical instruments such as the PANNS, BPRS, or other scales on an as-needed basis. The assessment should include:
   a. A comprehensive history of the patient’s psychosis and negative symptoms over time with particular focus time of onset, duration and severity
   b. Careful evaluation of risk factors including family history, precipitants, age of onset and substance use
   c. Thorough psychiatric evaluation should be offered to all patients to uncover likely comorbidities
2. Treatment: Treatment should include, but not be limited to:

   Therapy:
   a. Multiple therapies have good evidence for increasing quality of life in patients with schizophrenia. Patients should be encouraged to participate in these therapies.
   b. Therapists should focus on day-to-day living with particular focus on negative symptoms
   c. Providers should aggressively treat comorbid conditions, such as anxiety, as they frequently worsen the course of the disease.
   d. Therapists should aggressively treat substance abuse as it is very likely to worsen course.
   e. Therapy organizations should coordinate support services, when possible, as people with schizophrenia often require help with housing, social supports, employment etc.

Medication:
   a. Essentially all patients will require pharmacotherapy to achieve remission of psychosis. Prescribers should use second generation antipsychotics (SGAs) appropriately with particular focus on side effects as many of these agents can cause metabolic derangements.
   b. If patients do not respond to SGA’s typical antipsychotics such as perphenazine and haloperidol should be considered

3. Contraindicated / Cautioned treatment: For schizophrenia, there is currently no good evidence that mood stabilizers alone, are effective treatment. Some of these agents, particularly lithium may be helpful for augmentation.

Sources


