Community Behavioral Health

Clinical Guidelines for the Pharmacologic Treatment of Schizophrenia

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1. INTRODUCTION AND BACKGROUND

Community Behavioral Health (CBH) is committed to working with our provider partners to continuously improve the quality of behavioral health care for our shared population. Whenever possible, this is best accomplished by the implementation of evidence-based practices, as well as those informed by nationally recognized treatment guidelines, while respecting the need for individualized treatment and recovery planning.

The following are medication prescribing standards, adapted for the CBH Network from national treatment guidelines. They are intended to guide providers in aligning their practices with the best available scientific evidence to help members with schizophrenia access state-of-the-art care.

To assess quality of care, CBH will be collecting several standardized metrics. These metrics come either from the Healthcare Effectiveness Data and Information Set (HEDIS) set of measures, used by most major healthcare organizations for quality improvement, or are measures of clear clinical priority in our network. While CBH will be collecting specific data related only to guidelines that have been issued to the network thus far, the use of empirical guidelines and practice parameters is encouraged in all prescribing.

CBH expects providers to follow these guidelines in addition to all other relevant CBH, state, and federal regulations and standards, including CBH prescribing Bulletins (e.g. DBHIDS/CBH Bulletin 07-07: Screening for and Treatment of the Components of Metabolic Syndrome[1]), the Network Inclusion Criteria (NIC) Standards of Excellence,[2] and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines for Resiliency and Recovery-Oriented Treatment.[3]

Note further that the following are guidelines for the pharmacologic treatment of schizophrenia. CBH and DBHIDS encourage a biopsychosocial and recovery-based approach to treatment; in each case these guidelines for medication treatment should be but one part of a robust, multidisciplinary treatment approach that involves high-quality psychosocial treatment, collaboration with physical health providers, and inclusion of families and other supports.

CBH has updated its guidelines for the treatment of schizophrenia to reflect the published evidence-based practice parameters of the American Psychiatric Association issued in 2010.[4] CBH encourages its network providers to remain current with the state of evidence-based practice parameters and to incorporate these into the clinical care offered. These guidelines reflect the best scientific evidence available to guide treatment delivery and should be

[1] Department of Behavioral Health and Mental Retardation Services (DBHIDS) Bulletin 07-07: Screening for and Treatment of the Components of Metabolic Syndrome, November 1, 2007.
[2] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Network Inclusion Criteria, 2019.
[3] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Philadelphia Behavioral Health Practice Guidelines.
[4] *Practice Guideline for the Treatment of Individuals with Schizophrenia*, Second Edition.

considered the standard of care in the CBH Network. Resources related to these guidelines for providers may be accessed at https://psychiatryonline.org/guidelines.

2. GUIDELINES (SUMMARIZED AND ADAPTED FROM THE APA GUIDELINES)

1. Every individual should have as thorough an initial evaluation as their clinical status allows, including complete psychiatric and general medical histories and physical and mental status examinations. Interviews with family members or other persons knowledgeable about the individual should be conducted routinely (unless the individual refuses to grant permission), especially since some members with psychosis are unable to provide a reliable history at the first interview. Family inclusion, to the extent possible, is a vital part of care adherent to DBHIDS recovery principles.

2. Measurement of body weight and vital signs (heart rate, blood pressure, temperature) is also required and will serve as a baseline measurement to ensure that medication prescribed is consistent with DBHIDS/CBH Bulletin 07-07 regarding the appropriate monitoring for adverse metabolic effects of antipsychotic medications.

3. Initial medical evaluation should also include a Complete Blood Count (CBC); measurements of blood electrolytes, glucose, cholesterol, and triglycerides; tests of liver, renal, and thyroid function; a syphilis test; and, when indicated and permissible, determination of HIV status and a test for Hepatitis C. Routine evaluation of substance use with a toxicology screen should also be part of the medical evaluation. A pregnancy test should be strongly considered for individuals with childbearing potential. In individuals for whom the clinical picture is unclear or where there are abnormal findings from a routine examination, more detailed studies (e.g. Magnetic Resonance Imaging (MRI) scan or Computed Tomography (CT) scan) should be considered. Members' files should include documentation of all components of evaluation completed; providers should obtain documentation of evaluation completed by outside providers as this applies.

4. Ongoing evaluation of substance use should be documented to ensure the negative effects of substance use are not limiting recovery. This evaluation should involve an assessment of tobacco use given the high rate of tobacco use in people with schizophrenia, the related adverse health outcomes, and, in some cases, the effect that tobacco smoking may have on antipsychotic blood levels.

5. Given the burden of physical health challenges faced by persons with schizophrenia and the physical health effects of many medication treatments, collaboration with physical health providers—and documentation of such collaboration—is imperative.

6. Upon diagnosis of schizophrenia, pharmacologic treatment (with an FDA-approved antipsychotic medication) should be initiated promptly, provided it will not interfere with diagnostic assessment, because acute psychotic exacerbations are associated with emotional distress, disruption to the person's life, and a substantial risk of dangerous behaviors to self, others, or property. Except in cases of emergency, a fully informed consent process must take place.

7. The selection of an antipsychotic medication should be guided by the member's previous experience with antipsychotics, including the degree of symptom response, past experience of side effects, and preferred route of medication administration. While most members prefer oral medication, the experience of recurrent relapses related to nonadherence should prompt a discussion of long-acting injectable antipsychotic medication.

8. In cases of treatment resistance (defined as symptoms that fail to respond to two adequate trials of traditional antipsychotic medications[5]), serious consideration to an appropriately monitored trial of clozapine should be given. Providers should be familiar with clozapine prescribing guidelines and regulations (see the clozapine Risk Evaluation and Mitigation Strategy (REMS) program) or be able to collaborate with a clozapine-prescribing provider.

9. Whether prescribed in oral or long-acting injectable form, the member's ability to obtain the medication through their pharmacy benefit provider must be considered: many members may begin a medication in the hospital, only to find that the medication is not routinely covered upon discharge. Efforts must be made to eliminate the occurrence of such predictable interruptions in treatment.

10. The most common contributors to symptom relapse are antipsychotic medication nonadherence, substance use, and stressful life events, although relapses are not uncommon because of the natural course of the illness, despite continuing treatment. If nonadherence is suspected, reasons for it should be evaluated and considered in the treatment plan.

11. Providers should consider adherence scales such as the Drug Attitude Inventory (DAI-10 and DAI30), the Personal Evaluations of Transitions in Treatment (PETiT), Medication Adherence Rating Scale (MARS), or Clinician Rating Scale (CRS).[6]

[5] Kane JM, Honigfeld G, Singer J. Clozapine for the treatment resistant schizophrenic: a double-blind comparison versus chlorpromazine/benztropine. Arch Gen Psychiatry. 1988;45:789–96.

[6] Questionnaires and supporting information available at http://www.easacommunity.org/files/Medication%20Adherence%20Scale.pdf.

Strategies to improve adherence that are deemed most rigorously backed by research from the Expert Consensus Guidelines on Adherence include:[7]

- Symptom and side effect monitoring
- Social work targeting logistical problems (for example, assistance with community resource navigation)
- Medication monitoring/environmental supports

Additional strategies include but are not limited to:

- Cognitive Behavioral Therapy (CBT)
- Consideration of long-acting antipsychotics
- Devoting more time in the therapeutic encounter to specifically address adherence
- Shared decision-making approaches

12. A comprehensive treatment/recovery plan that emphasizes avoiding hospitalization, treatment interruptions, medical illness, substance use, and other barriers to recovery must be developed and individualized to reflect individual recovery goals, consistent with both APA guidelines and the DBHIDS NIC Standards for Excellence.

13. Ongoing collateral contact with important people in the member's life, when the member consents, should occur.

14. Adjunctive medications are also commonly prescribed for comorbid conditions. Benzodiazepines may be used to treat catatonia as well as to manage both anxiety and agitation acutely until the antipsychotic has had time to be therapeutically effective (primarily in individual settings). Antidepressants can be considered for treating comorbid major depression or obsessive-compulsive disorder. Mood stabilizers and beta-blockers may be considered for reducing the severity of recurrent hostility and aggression. However, these medications are not recommended as primary treatments for schizophrenia, or even as routinely prescribed "adjuncts" absent clear indications. Careful attention must be paid to potential drug interactions, especially those related to metabolism by cytochrome P450 enzymes. Anticholinergic medications should be considered for treatment-emergent movement side effects (e.g. dystonia) if dose modification or medication change is not advisable.

15. Once stabilized on medication, ongoing evaluations should occur to ensure the member is maintaining progress toward recovery goals, that increases in symptoms or relapses are effectively treated, and that monitoring for adverse treatment effects continues.

[7] Velligan, D. I., Weiden, P. J., Sajatovic, M., Scott, J., Carpenter, D., Ross, R., & Docherty, J. P. (2010). Strategies for addressing adherence problems in individuals with serious and persistent mental illness: recommendations from the expert consensus guidelines. Journal of Psychiatric Practice®, 16(5), 306-324.

Relapses are often precipitated by psychosocial stressors, so such ongoing evaluations must be comprehensive in this regard (i.e. not limited to "medication management").

Monitoring for the adverse metabolic effects of antipsychotic medications should occur according to DBHIDS/CBH Bulletin 07-07. Ongoing evaluations for Extrapyramidal Side Effects (EPSE) should be documented regularly (the use of a standardized instrument, such as the Abnormal Involuntary Movement Scale (AIMS),[8] is preferred). The risk of tardive dyskinesia should, of course, form part of any informed consent discussion related to antipsychotic medications, even those considered "atypical." Monitoring for other adverse effects, such as hyperprolactinemia should be done according to the prescribing information for each individual agent.

3. CBH IMPLEMENTATION REVIEW

CBH encourages providers to maintain robust internal quality management programs to ensure treatment of CBH members adheres to these and other applicable guidelines. In addition to "as needed" reviews of records when quality issues arise, CBH will be tracking and sharing three main performance metrics with providers, all of which are standard National Committee for Quality Assurance (NCQA) HEDIS measures:

1. SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
2. SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
3. SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia: Assesses adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

In addition, providers must maintain documentation of all evaluations and interventions described in these guidelines, whether delivered by the provider or an outside practitioner. CBH and the DBHIDS Network Improvement and Accountability Collaborative (NIAC) will continue to monitor treatment provided to ensure that care is consistent with the DBHIDS NIC Standards of Excellence.

[8] Guy W. ECDEU Assessment Manual for Psychopharmacology: Revised (DHEW publication number ADM 76-338). Rockville, MD, US Department of Health, Education and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, NIMH Psychopharmacology Research Branch, Division of Extramural Research Programs, 1976: 534–7.