

Schizophrenia Care Guide

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

SUMMARY

GOALS

- ✓ Minimize frequency and severity of psychotic episodes
- ✓ Encourage medication adherence
- ✓ Manage medication side effects
- ✓ Monitor as clinically appropriate

ALERTS

- Suicidal ideation or gestures
- Abnormal movements
- Delusions
- Neuroleptic Malignant Syndrome
- Danger to self or others

DIAGNOSTIC CRITERIA/EVALUATION (PER DSM V)

1. Rule out delirium or other medical illnesses mimicking schizophrenia (see page 5), medications or drugs of abuse causing psychosis (see page 6), other mental illness causes of psychosis, e.g., Bipolar Mania or Depression, Major Depression, PTSD, borderline personality disorder (see page 4).
 - Ideas in patients (even odd ideas) that we disagree with can be learned and are therefore not necessarily signs of schizophrenia.
 - Schizophrenia is a world-wide phenomenon that can occur in cultures with widely differing ideas.
2. Diagnosis is made based on the following: (Criteria A and B must be met)
 - A. Two of the following symptoms/signs must be present over much of at least one month (unless treated), with a significant impact on social or occupational functioning, over at least a 6-month period of time: Delusions, Hallucinations, Disorganized Speech, Negative symptoms (social withdrawal, poverty of thought, etc.), severely disorganized or catatonic behavior.
 - B. At least one of the symptoms/signs should be Delusions, Hallucinations, or Disorganized Speech.

TREATMENT OPTIONS

MEDICATIONS

Antipsychotic medications are usually necessary and helpful

- Informed consent for psychotropic medication required (unless California Penal Code section 2602, order is in effect for involuntary psychotropic medication)
- Clinical situation directs medication selection
- Long-acting injectables and clozapine are quite effective but frequently underused

Oral Neuroleptic Medications in CDCR

- First Line: risperidone, olanzapine, ziprasidone, haloperidol, fluphenazine, loxapine, perphenazine, trifluoperazine, thiothixene, chlorpromazine
- Second Line: aripiprazole, iloperidone, lurasidone, quetiapine, paliperidone, pimozide, clozapine (often 3rd line but can be second line) should be considered in refractory cases. See the CCHCS/DHCS Clozapine Care Guide.

Injectable Neuroleptic Medications in CDCR

- First Line Short-Acting Emergency IM: haloperidol, ziprasidone, chlorpromazine, olanzapine
- First Line Long-Acting Maintenance: haloperidol decanoate, fluphenazine decanoate, risperidone
- Second Line Long-Acting Maintenance: aripiprazole, paliperidone palmitate

PSYCHOSOCIAL INTERVENTIONS

Group therapy and individual therapy (these are important but often underemphasized)

Brief and frequent supportive interventions and education are highly beneficial.

MONITORING

Every visit:

1. Assess symptom relief (it may be necessary to obtain information from multiple sources to adequately assess a patient's actual response and side-effects)
2. Adverse effects: based on objective assessment over time, not solely on patient self-report
 - Extrapyrarnidal symptoms (EPS), Akathisia (AK), Neuroleptic Malignant Syndrome (NMS), and Tardive Dyskinesia (TD)
 - Metabolic effects: weight gain, BP, thyroid dysfunction (esp. with phenothiazines)
 - Constipation
 - Cardiac effects
3. Reinforce pregnancy avoidance
4. Use the Mental Health Registry* to assist with monitoring

As indicated on page 6:

PE: height, weight, BP, Abnormal Involuntary Movement Scale (AIMS) at baseline, 3 months, and 12 months or annually.

Laboratory: CBC, CMP, glucose/HgbA1c, lipids, thyroid function, pregnancy test (page 6)

EKG: (see page 6)

*To access Mental Health Registry →QM LifeLine→QM Portal in external links→Patient Registries→Mental Health Registry (also named Psychotropic Medication Monitoring Registry)