

# VA/DOD Psychosis Guidelines

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## SCOPE

### **DISEASE/CONDITION(S)**

Psychoses/schizophrenia

### **GUIDELINE CATEGORY**

Diagnosis

Evaluation

Management

Screening

Treatment

### **CLINICAL SPECIALTY**

Emergency Medicine

Family Practice

Internal Medicine

Psychiatry

Psychology

### **INTENDED USERS**

Advanced Practice Nurses

Nurses

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

### **GUIDELINE OBJECTIVE(S)**

- To promote evidence-based management of patients with psychoses/schizophrenia
- To identify the critical decision points in the management of patients with psychoses

## **TARGET POPULATION**

Patients with psychoses or schizophrenia who are eligible for care in the Veterans Health Administration (VHA) or Department of Defense (DoD) health care delivery system

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Initial Screening**

1. Assessment of suicide risk including detailed history and direct questioning
2. Establishing level of risk: imminent, short-term, or long-term
3. Assessment of risk for violence by evaluating history of previous violence, targeted individual in community, serious psychiatric illness, psychosocial illness, psychosocial disruption, history of violent suicide attempt, substance abuse, verbal abuse and hostility, history of poor adaptation to stress, and male gender
4. Assessment of risk for medical instability via vital signs and other evidence of serious illness
5. Assessment of risk for inability to maintain self at home or in community
6. Following legal mandates for those who refuse help or must be hospitalized
7. Obtain history: psychiatric, marital, family, military, past physical or sexual abuse, medication or substance use (including over the counter), physical examination, and laboratory tests
8. If necessary, additional assessments including physical examination with neurological examination, neurobehavioral and/or neurocognitive examination, specialized laboratory tests, or lumbar puncture
9. Mental status examination
10. Assess functional and psychosocial support system
11. Identify emergent psychosocial needs requiring immediate intervention
12. Diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for schizophrenia; schizoaffective; atypical psychosis; rapid cyclus; current manic, hypomanic, or mixed episode; current bipolar depressive; cyclothymia; current non bipolar depressive; past history of bipolar disorder; or bipolar disorder
13. Establishing agreement to treatment plan
14. Treatment of patient for cyclothymia, past history of bipolar disorder, and psychotic disorder
15. Psychosocial rehabilitation, as needed
16. Determination of care setting: day hospital, inpatient hospitalization, and assertive case management (ACM)
17. Establishing contact with family members

### **Treatment**

1. Antipsychotic agents - conventional
  - Chlorpromazine
  - Thioridazine
  - Mesoridazine
  - Trifluoperazine
  - Fluphenazine
  - Perphenazine
  - Thiothixene

- Loxapine
  - Haloperidol
  - Molindone
2. Second generation antipsychotic agents
    - Clozapine
    - Risperidone
    - Olanzapine
    - Quetiapine
    - Ziprasidone
    - Aripiprazole
  3. Patient and family education
  4. Assessment of response in 6 to 8 weeks
  5. Changing medication based on treatment response or side effects and reassess at 6 to 8 weeks

### **Management**

1. Assessment of seven domains and initiate psychosocial rehabilitation as needed
2. Assessment of independent living skills (ILS)
3. Referral to ILS training including cognitive behavioral therapy (CBT)
4. Exit counseling and referral for continued training
5. Assessment of housing needs (unsupported housing, residential treatment support, and supported housing) and refer for placement as needed
6. Assessment of level of family support
7. Providing family education and referring to community-based advocacy/assistance programs, as needed
8. Assessment of social skills difficulties and refer for social skills training
9. Providing supported employment (SE) and transitional employment, as needed
10. Assess level of case management needs and implement as needed:
  - Standard case management
  - Assertive community treatment (ACT)
  - Intensive case management (ICM)
  - Mental health intensive case management (MHICM)

### **MAJOR OUTCOMES CONSIDERED**

- Efficiency and effectiveness of initial assessment process
- Control of symptoms
- Complications and morbidity rates
- Level of patient and family satisfaction regarding the management of psychosis
- Recovery rates and rates of relapse
- Clinical and social functioning of patient
- Quality of life
- Cost of care
- Need for hospitalization and length of hospital stay
- Compliance with medication

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Veterans Health Administration (VHA) Clinical Practice Guideline for the Management of Persons with Psychosis, Version 1 (1997) was the seed guideline. It served as the starting point for the development of questions and key terms.

Researchable questions were developed separately for the psychosocial rehabilitation section. The questions specified:

- Population - characteristics of the target population
- Intervention - diagnostic, screening, therapy, and assessment
- Control - the type of control used for comparison
- Outcome - the outcome measure for this intervention (morbidity, mortality, patient satisfaction, and cost)

A systematic search of the literature was conducted. It focused on the best available evidence to address each key question, and ensured maximum coverage of studies at the top of the hierarchy of study types: evidence-based guidelines, meta analyses, and systematic reviews (Cochrane, evidence-based medicine, evidence-based practice center reports). These sources may yield a definitive answer to some questions.

The search continued using well-known and widely available databases that were appropriate for the clinical subject. Limits on language (English), time (1997 through June 2000) and type of research (Randomized Controlled Trials [RCT]) were applied. The search included Medline and additional specialty databases, depending on the topic.

The search strategy did not cast a wide net. Once definitive clinical studies that provided valid relevant answers to the question were identified, the search stopped. It was extended to studies/reports of lower quality (observational studies) only if there were no high quality studies.

The results of the search were organized and reported using reference manager software. The reports included the key words, the source, study type, measures, and conclusions. At this point, additional exclusion criteria were applied. Typical exclusions were studies with physiological endpoints or studies of populations that were not comparable to the population of interest (e.g., studies dealing with children and adolescents were excluded).

For the psychosocial rehabilitation modules of the guideline, the results of the search were posted on the Web. The button on the first screen, "Psychosocial Rehabilitation Search Strategy" has the details for each search, including a tabulation of the exclusions. The library database can be searched by author, by category, and by keyword. In addition, Cochrane studies are a searchable category.

The assembled experts suggested numerous additional references. Copies of specific articles were provided to participants on an as-needed basis. This document includes references through July,

2001. During the final editing stages, important review documents were incorporated into the document and added to the reference list.

#### **NUMBER OF SOURCE DOCUMENTS**

Not stated

#### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

#### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

##### **Quality of Evidence Grading**

**I:** Evidence is obtained from at least one properly randomized controlled trial (RCT).

**II-1:** Evidence is obtained from well-designed controlled trials without randomization.

**II-2:** Evidence is obtained from well-designed cohort or case-controlled analytical studies, preferably from more than one center or research group.

**III-3:** Evidence is obtained from multiple time series, with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

**III:** Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

#### **METHODS USED TO ANALYZE THE EVIDENCE**

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

#### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

The clinical experts evaluated the studies according to criteria proposed for judging the internal validity of randomized controlled trials and developed evidence tables.

The literature was critically analyzed with evidence grading. The rating scale used for this document was based on the evidence rating used by U.S. Preventative Services Task Force (U.S. PSTF) Guide to Clinical Preventive Services, Second Edition (1996).

#### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

#### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

This guideline for the management of persons with psychosis is the product of many months of diligent effort and consensus building among knowledgeable individuals from the Veterans Health Administration (VHA), Department of Defense (DoD), and academia, and guideline facilitators from the private sector. An experienced moderator facilitated the multidisciplinary Working Group that included psychiatrists, psychologists, internists, social workers, nurses, and pharmacists as well as consultants in the field of guideline and algorithm development. A policy maker and civilian practitioners joined this group of experts from the Veterans Health Administration and Department of Defense.

The members of the Working Group participated in two workshops in Washington, DC to reach a consensus about the guideline recommendations. The draft was revised by the experts through numerous conference calls to incorporate the best evidence into the final guideline.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

### **Recommendation Grades**

- A. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated
- B. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered useful/effective
- C. A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds
- D. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered not useful/effective
- E. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration

## **COST ANALYSIS**

The guideline developers reviewed published cost analyses.

## **METHOD OF GUIDELINE VALIDATION**

Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Not stated

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# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

The recommendations for the management of psychoses are organized into 10 major algorithms. Each algorithm, the objectives and annotations that accompany it, and the evidence supporting the recommendations are presented below. The strength of recommendation grading (A-E) and quality of evidence grading (I-III) are defined at the end of the "Major Recommendations" field.

*Note: A list of abbreviations and acronyms is provided at the end of the "Major Recommendations" field.*

- [Initial Screening for Psychoses](#)
- [Psychoses and Schizophrenia Treatment](#)
- [Psychosocial Rehabilitation Core](#)
- [Health Education](#)
- [Self-Care/Independent Living Skills](#)
- [Housing](#)
- [Family Support](#)

- [Social Skills](#)
- [Work Restoration Services](#)
- [Case Management](#)

## **Module A - Initial Screening for Psychoses**

### **A. Ascertain Chief Complaint**

#### *Annotation*

The common feature is that the person has reported signs or symptoms of psychotic illness, or has been identified as demonstrating behavior consonant with such symptoms in an interview or living situation. Entry points include the following:

- Primary care, with diversion to outpatient specialty care
- Mental health walk-in clinic
- Mental health setting, with a new emergence of complaint of psychotic symptoms
- Emergency room (ER) setting
- Referral by family, mental health intensive case managers, community residential personnel, or representatives of community agencies
- Outreach after discharge from inpatient care

For definitions of the specific symptoms, please refer to the introduction for Diagnostic and Statistical Manual of Mental Disorders - fourth edition (DSM-IV), which contains a basic glossary and discussion of these behaviors.

### **B. Ascertain Chief Complaint: Assess Risk for Suicide**

#### *Objective*

Identify persons who pose an active risk for suicide.

#### *Annotation*

Ask whether the person is alone and is able to take care of himself/herself. Make sure the mental status exam includes specific screens for suicide, homicide, and grave disability. The history should be annotated to distinguish new onset or atypical behavior from recurrent presentation. The history should also include availability of medications, weapons for dangerous behavior, and nutritional status poor enough to pose a health risk.

Of special concern is the person who, because of significant cognitive impairment (either new or pre-existing), is oblivious to personal safety issues. An example is the person with delirium who may inadvertently harm himself or herself trying to escape from a frightening hallucination or the person with dementia who has poor judgment and may leave the hospital to go home even though unable to successfully cross the street.

The clinician should perform a screening to ascertain the likelihood of the person becoming suicidal or violent toward others. Suicidal behavior is best assessed with the following criteria: current suicidal ideas or plans, presence of active mental illness (severe depression or psychosis), hopelessness, impulsivity, presence of substance use disorder, past history of suicidal acts, formulation of plan, availability of means for suicide (firearms, pills, etc.), disruption of important personal relationship, or failure at important personal endeavors. If some

or all of these criteria are present, a referral or consultation with a mental health professional is indicated.

*Evidence*

	<b>Risk Factor</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Psychiatric illness	Mann et al., 1999; U.S. Preventive Services Task Force (USPSTF), 1996; Walsh et al., 1999	II-2; II; II-2	A; A; A
2	Long duration of treatment with antipsychotic drugs	Walsh et al., 1999	II-2	A
3	High frequency of auditory hallucinations	Walsh et al., 1999	II-2	A
4	Currently depressed	Walsh et al., 1999	II-2	A
5	Family history of suicide attempt	USPSTF, 1996	II	A
6	Family history of completed suicide	USPSTF, 1996	II	A
7	Family history of substance abuse	USPSTF, 1996	II	A
8	Personal history of childhood abuse	Mann et al., 1999	II-2	A
9	Personal history of suicide attempt	Mann et al., 1999; USPSTF, 1996	II-2; II	A; A
10	Serious medical illness	USPSTF, 1996	II	A

	<b>Risk Factor</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
11	Head injury	Mann et al., 1999	II-2	A
12	Substance abuse	Mann et al., 1999; USPSTF, 1996	II-2; II	A; A
13	Smoking	Mann et al., 1999	II-2	A
14	Social adjustment problems	USPSTF, 1996	II	A
15	Traits of aggression and impulsivity	Mann et al., 1999; USPSTF, 1996	II; II-2	A; A
16	Living alone	USPSTF, 1996	II	A
17	Divorce or separation	USPSTF, 1996	II	A
18	Unemployment	USPSTF, 1996	II	A
19	Recent bereavement	USPSTF, 1996	II	A
20	Caucasian race	USPSTF, 1996; Walsh et al., 1999	II; II-2	A; A
21	Male	USPSTF, 1996	II	A
22	Advanced age	USPSTF, 1996	II	A
23	Younger age (Psychosis)	Walsh et al., 1999	II-2	A

**C. Ascertain Chief Complaint: Assess Risk for Violence**

*Objective*

Identify persons who pose an active risk for violence.

*Annotation*

A person at high risk for violence is someone who has expressed thoughts of potential harm to self or others, has demonstrated violent acts or feelings, is paranoid, has thought control override symptoms, or has expressed great hostility toward political or prominent figures. Impulsivity and a previous history of violence increase the risk of current violence. Persons with definite intent (suicidal/homicidal ideation, intent, and/or plan) to harm self or others require voluntary or involuntary emergency psychiatric treatment.

*Evidence*

	<b>Risk Factor</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	History of violence	Harris & Rice, 1997; Thienhaus & Piasecki, 1998; USPSTF, 1996	II-1	B
2	Homicidal ideation	Thienhaus & Piasecki, 1998	II-1	B
3	Any ideation of committing harm	Thienhaus & Piasecki, 1998	II-1	B
4	Antisocial personality disorder	Harris & Rice, 1997; Thienhaus & Piasecki, 1998	II-1	B
5	Poor impulse control, inability to delay gratification	Thienhaus & Piasecki, 1998; Kay, Wolkenfeld, & Murrill, 1988; Harris & Rice, 1997; USPSTF, 1996	II-1	B
6	Loss of reality testing, with delusional beliefs or command hallucinations	Thienhaus & Piasecki, 1998	II-1	B
7	Feeling controlled by an outside force	Link, Stueve, & Phelan, 1998; Thienhaus & Piasecki, 1998	I; II-1	A; B
8	Believing that others wish him or her harm	Link, Stueve & Phelan, 1998; Thienhaus & Piasecki, 1998	I; II-1	A; B
9	Perception of rejection or humiliation at the hands of	Thienhaus & Piasecki, 1998	II-1	B

	<b>Risk Factor</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
	others			
10	Frontal lobe dysfunction, head injury	Hastings & Hamberger, 1997; Krakowski, Czobor, & Chou, 1999	I	A
11	Being under the influence of substances	Harris & Rice, 1997; Thienhaus & Piasecki, 1998; USPSTF, 1996	II-1	B
12	Availability of drugs, alcohol, or weapons upon release from care	Thienhaus & Piasecki, 1998	II-1	B

**D. Ascertain Chief Complaint: Assess Risk for Medical Instability**

*Objective*

Identify persons who are at risk for medical instability and identify an appropriate setting for care.

*Annotation*

At this stage the clinician should be concerned with immediate safety and should review the person's vital signs. Vital signs can signal the presence of a medical or surgical illness presenting with mental status changes. If needed, the person should be stabilized by means normally used in an intensive care or emergency medicine setting.

**E. Ascertain Chief Complaint: Assess Risk for Inability to Maintain Self at Home or in Community**

*Objective*

Identify persons who are at risk for inability to maintain himself or herself in the home or community, and to identify an appropriate setting for care.

*Annotation*

The person may not be able to provide for the basic needs of food, shelter, or medical care as the result of mental illness. This could lead to significant risk (e.g., a person who is an insulin-dependant diabetic who is unable to care for the diabetes because of psychiatric symptomatology). Non-adherence, in itself, is generally not a reason for hospitalization, unless it places a person in one of the imminent risk categories.

**F. Follow Legal Mandates if the Person Refuses Help or Disengages**

*Objective*

Build a treatment alliance to allow the person to obtain needed care.

### *Annotation*

If the clinician has encountered resistance from the person in accepting his or her recommended treatment plan, the following actions may be helpful:

- Attempt to understand the person's view of his or her problem.
- Attempt to discover why the person is refusing treatment.
- Try to explain the treatment and its expected outcomes to the person in clear, simple language.
- If possible, bring in the person's significant others in a cooperative role.
- Wherever necessary, obtain the person's consent to procedures.
- Apply legal mandates as appropriate.
- Display compassion, empathy, and patience.

### **G. Does the Person Require Immediate Hospitalization?**

#### *Objective*

Identify persons in immediate need of hospitalization.

#### *Annotation*

Persons with acute or chronic psychotic conditions can be managed in a number of settings including an inpatient psychiatric unit, a partial hospital setting, or in their current residence. For the most part, decisions regarding the setting of care are based on safety considerations. Individuals at risk for suicide or violence or those with command hallucinations or who are unable to care for themselves in the community often require stabilization in an inpatient setting. Hospitalization may also be appropriate for persons with medical problems that require monitoring. See Appendix D in the original guideline document, Criteria for Acute Inpatient Hospital Admission, for more details.

### **H. Admit to Hospital; Follow Legal Mandates**

#### *Objective*

Ensure that legal rights are respected during the admission.

#### *Annotation*

Apply legal mandates as appropriate. Local policies and procedures with regard to threats to self or others should be in place, reflecting local and state laws and the opinion of the Veterans Administration (VA) Regional Counsel. Primary care, mental health, and administrative staff must be familiar with these policies and derived procedures. Implementation should also reflect local resources.

### **I. Obtain History (Psychiatric, Marital, Family, Military, Past Physical or Sexual Abuse, Medication or Substance Use Including Over the Counter [OTC]), Physical Examination, and Laboratory Tests**

#### *Objective*

Obtain the information on which to base a diagnosis.

#### *Annotation*

At this stage the clinician begins the process of reaching a diagnosis by ruling out non-relevant psychiatric, social, and medical conditions. The first step in this process is to obtain a thorough history, including psychiatric, psychosocial, and medical problems that the person has experienced in the past. Identifying physiological abnormalities is especially important, as an underlying physiological abnormality or disease process may be the cause of psychiatric symptoms. If standard medical tests fail to reveal the cause of the difficulties, the diagnostic evaluation should be continued. More advanced studies, such as assessment, functional neuroimaging, electrophysiological studies, and specialized laboratory tests, may also be included.

Refer to "Table 3: Laboratory Tests for Change in Mental Status" in the original guideline document for more information.

#### **J. Perform Mental Status Examination**

##### *Objective*

Obtain information on which to base a diagnosis.

##### *Annotation*

A mental status examination consists of:

- A description of the person and the person's manner of dress, alertness in the interview situation, remarkable or characteristic behaviors, and cooperation with the interview
- Speech-rate, rhythm, fluency, presence of stutters, stammers, dysarthria, aphasia
- Perceptual disorder-Illusions or hallucinations (commenting, critical, command auditory hallucinations, visual hallucinations, olfactory, tactile or gustatory, hypnopompic or hypnagogic)
- Thought process - The goal directedness of the person's discourse as opposed to varieties of derailment: circumstantiality, tangentiality, flight of ideas, loosening of associations, formal thought disorder, word salad, clang associations, neologisms, etc.
- Thought content - Overvalued ideas; delusions; obsessions; ruminations; paranoid ideas; suicidal or homicidal ideation, intent, and/or plan; depersonalization; or derealization
- Neurocognitive exam (as above)
- Insight
- Judgment

#### **K. Functionality and Psychosocial Support System**

##### *Objective*

Obtain information on which to base an assessment of the need for functional or psychosocial support.

##### *Annotation*

The clinician should refer to Module L below, the "Psychosocial Rehabilitation Core Module," to identify, with the person's active participation, the domains of functionality and support that need

to be assessed. The psychosocial rehabilitation process is designed, however, to function over a period of time. This assessment has to do with immediate needs for housing, transportation and access, life skills, work and/or employment, education, financial, social skills, health awareness, family, legal, cultural, and/or spiritual help. Essentially this is a full evaluation of the issues relevant to Axes IV and V of DSM-IV.

**L. Does the Person Have Emergent Psychosocial Needs (Axis IV) that Require Immediate Attention?**

*Objective*

Identify emergent psychosocial needs.

*Annotation*

The issues that most frequently require immediate attention are housing, family crisis, and/or economic.

Making choices is essential to the successful treatment of persons with severe mental disorders. As a consequence, clinicians are encouraged to collaborate in the process of identifying the domains, as well as in selecting services.

**M. Does the Person Have Emergent Psychosocial Needs (Axis IV) that Require Immediate Attention?**

*Objective*

Determine if the person's symptoms are due to a medical condition.

*Annotation*

Secondary mental disorders are a group of behavioral mental disorders whose distinctive symptoms are largely the result of brain dysfunction due to an underlying medical condition (e.g., lupus, Huntington's disease, subdural hematoma, encephalopathy) and are detectable by current methods of clinical and laboratory evaluation. Management of the medical disorder plays an important-if not essential-part.

Wise identified some of the important and urgent conditions, including withdrawal, to be considered as possible causes of secondary mental disorders.

- Wernicke's; withdrawal from alcohol/drugs
- Hypoxemia
- Hypoglycemia
- Hypoperfusion
- Hypertensive encephalopathy
- Intracranial bleed; infection
- Meningitis/encephalitis
- Poisons (medications, street drugs)

Refer to "Table 4: Common Causes of Secondary Neurological Psychoses" in the original guideline document for more information.

**NOTE: For all annotations N through S, the objective is to describe the criteria for each of the DSM-IV Disorders with psychosis as a feature of the symptom picture.**

**N. Does the Person Have Emergent Psychosocial Needs (Axis IV) that Require Immediate Attention?**

*Objective*

Determine whether person uses alcohol or substances in a way that should be a focus of treatment.

*Annotation*

Any substance can be misused, but the following should be of most concern:

- Alcohol
- Cigarettes
- Illegal drugs
- Legal prescription drugs
- Legal over-the-counter drugs

Although alcohol is just one of many substances that may present a problem for the person, because of the prevalence of alcohol use in the general population, special screening and treatment techniques have been developed for alcoholism.

A screen is considered positive for alcohol abuse/dependence, if a person:

- Scores eight or more on the Alcohol Use Disorders Identification Test (AUDIT) (see Appendix E of the original guideline document, "Assessment Instruments")
- Endorses two or more of the four items in the CAGE instrument (see Appendix E in the original guideline document, "Assessment Instruments")

Screening for Level of Use

The clinician should determine not only which substances the person is using, but how much of each. The commonly defined stages of substance use are:

- Use
- Hazardous use
- Abuse
- Dependence
- Risk of relapse

Some clinicians consider abuse/dependence to represent a single level of substance abuse. DSM-IV, however, presents separate sets of criteria for substance abuse and substance dependence.

If the person needs treatment for alcohol or substance use, the clinician should refer to the VA/Department of Defense (DoD) Clinical Practice Guideline for Management of Substance Use Disorders.

Note: For definitions of the specific symptoms of each disorder below, please refer to the introduction for DSM-IV, which contains a basic glossary and discussion of these behaviors.

*Evidence*

	<b>Risk Factor</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Use of labs	Anton, Moak, & Latham, 1995	II-2	A
2	Screening of asymptomatic persons	USPSTF, 1996	II-2	D
3	Annual screening of hazardous use	USPSTF, 1996; Substance Abuse and Mental Health Services Administration (SAMHSA), 1995	III	B
4	Consider volume and use	Hawks, 1994; Room, Bondy, & Ferris, 1995; Hasin et al., 1996; Midanik et al., 1996	II-2	A
5	Use of AUDIT score	Saunders et al., 1993	II-1	A
6	Use of CAGE score	Mayfield, McLeod, & Hall, 1974	II-2	A
7	Routine screening for other drug abuse or dependence	USPSTF, 1996	III	D
8	Use of Drug Abuse/Dependence Screener	Schorling & Buchsbaum, 1997	III	C

**O. Person Meets DSM-IV Criteria for Schizophrenia Disorder**

DSM-IV diagnostic criteria for schizophrenia:

1. Characteristic symptoms – Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated):
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (i.e., affective flattening, alogia, or avolition)

Note: Only one criterion/a symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or they consist of two or more voices conversing with each other.

2. Social/occupational dysfunction – For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
3. Duration - Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
4. Schizoaffective and mood disorder exclusion - Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
5. Substance/general medical condition exclusion - The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.
6. Relationship to a pervasive development disorder - If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

**P. Person Meets DSM-IV Criteria for Schizophrenia Disorder**

DSM-IV diagnostic criteria for schizophreniform disorder:

1. Criteria A and E of schizophrenia disorder are met and the condition is not due to a general medical condition.
2. The episode (prodrome, active, and residual phases) lasts at least one, but less than six, months.

**Q. Person Meets DSM-IV Criteria for Schizophrenia Disorder**

DSM-IV diagnostic criteria for delusional disorder:

1. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least one month's duration.
2. Criterion A for schizophrenia has never been met.

Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme.

3. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.
4. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
5. The disturbance is not due to the direct physiological effects of a substance (e.g., drug abuse, a medication) or a general medical condition.

**R. Person Meets DSM-IV Criteria for Schizophrenia Disorder**

DSM-IV diagnostic criteria for a brief psychotic episode:

1. Presence of psychotic symptoms
2. Duration of at least one day but less than a month, with eventual full return to premorbid level of functioning
3. Not accounted for by a mood disorder with psychosis, a schizoaffective or schizophrenic disorder, or physiological effects due to substance use for medical conditions

**S. Person Meets DSM-IV Criteria for Schizoaffective Disorder**

DSM-IV diagnostic criteria for schizoaffective disorder:

Schizoaffective disorder is a complex and poorly understood clinical entity. Operationalized diagnostic criteria for schizoaffective disorder were not formalized and adopted until 1987 (DSM-III-R).

Consider the diagnosis of schizoaffective disorder if:

1. Mood episode is concurrent with the active phase symptoms of schizophrenia. These consists of two or more of the following:
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior
  - Negative symptoms

AND

2. During the same period of illness, there have been delusions or hallucinations in the absence of prominent mood symptoms for at least 2 weeks.

AND

3. Mood symptoms are present for a substantial portion of the total duration of illness.

AND

4. The symptoms are not due to substance abuse or a general medical condition.

**Note for Annotations T through Z - Codified for American Psychiatry, beginning with DSM-III and continuing through DSM-IV, the schizophrenic disorders are considered diagnoses of exclusion. Only after other Axis I disorders, and in particular the mood disorders, have been ruled out is the diagnosis of schizophrenia ruled in.**

**T. Person Meets DSM-IV Criteria for Psychotic Disorder, Not Otherwise Specified (Atypical Psychosis)**

DSM-IV diagnostic criteria for psychotic disorder, not otherwise specified (atypical psychosis):

This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior), about which there is inadequate information to make a specific diagnosis or about which there is contradictory information and disorders with psychiatric symptoms that do not meet the criteria for any specific psychotic disorder.

**U. Person Meets DSM-IV Criteria for Rapid Cyclers**

DSM-IV diagnostic criteria for rapid cyclers:

In DSM-IV, rapid cycling is defined as a course specifier for bipolar disorder as four or more affective episodes in 12 months. Episodes must meet full criteria for major depression, hypomania, mania, or mixed episode, and must be demarcated by 8 weeks of remission or by a switch to an episode of the opposite pole (e.g., depression to hypomania).

**V. Person Meets DSM-IV Criteria for Current Manic, Hypomanic, or Mixed Episode**

DSM-IV criteria for current or past manic/hypomanic episode are:

1. A distinct period of persistently elevated, expansive, or irritable mood, lasting at least 4 days, that is clearly different from the usual nondepressed mood and is observable by others.
2. During this period of abnormal mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility
  - Increase in goal-directed activity or psychomotor agitation
  - Excessive involvement in pleasurable activities that have a high potential for painful consequences

These symptoms are not severe enough to cause marked impairment in social or occupational functioning or require hospitalization and have no psychotic features. Symptoms are not secondary to a substance or general medical condition.

A history of mania or hypomania will exclude a person from a diagnosis of major depressive episode, but persons presenting with depressive symptoms and such a history should be referred to a mental health professional because of the need for treatment and the risk that routine antidepressant medication might precipitate an unnecessary and potentially dangerous manic episode.

**W. Person Meets DSM-IV Criteria for Current Bipolar Depressive Disorder**

DSM-IV criteria for a major depressive episode, and meets the additional criterion of a history of at least one manic or hypomanic episode.

DSM-IV criteria for a major depressive episode:

1. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.

Note: Symptoms that are clearly due to a general medical condition or mood-incongruent delusions or hallucinations are not included.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
  - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - Fatigue or loss of energy nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
2. The symptoms do not meet criteria for a Mixed Episode (see p. 335 in DSM-IV).
  3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  4. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or general medical condition (e.g., hypothyroidism).
  5. The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one); the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

#### **X. Person Meets DSM IV Criteria for Cyclothymia Disorder**

DSM-IV criteria for current cyclothymia:

1. For at least two years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
2. During the above two-year period, the person has not been without the symptoms in Criterion A for more than two months at a time.
3. No major depressive episode, manic episode, or mixed episode has been present during the first two years of the disturbance.

Note: After the initial 2 years (1 year in children and adolescents) of cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar II disorder and cyclothymic disorder may be diagnosed).

4. The symptoms in Criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
5. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
6. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

#### **Y. Person Meets DSM IV Criteria for Current Non Bi-Polar Depressive Episode**

DSM-IV criteria for current or past major depressive episode:

1. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.

Note: Symptoms that are clearly due to a general medical condition or mood-incongruent delusions or hallucinations are not included.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., appears tearful). Note: In children and adolescents, can be irritable mood
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
2. The symptoms do not meet criteria for a Mixed Episode.
  3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  4. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or general medical condition (e.g., hypothyroidism).
  5. The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one); the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

**Z. Person Meets DSM-IV Criteria for Past History of Bipolar Disorder-No Current Symptoms**

Meets criteria for a bipolar episode in the past but has no current symptoms.

**AA. Person Meets DSM-IV Criteria for Bipolar Disorder, Not Otherwise Specified**

*Annotation*

This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior), about which there is inadequate information to make a specific diagnosis or about which there is contradictory information and disorders with psychiatric symptoms that do not meet the criteria for any specific psychotic disorder.

**BB. Identify Psychosocial Needs**

*Objective*

Determine the person's needs in major domains of psychosocial recovery-such areas as housing, life skills, employment, education, social skills, health awareness, and family.

*Annotation*

After determining that the person accepts psychosocial rehabilitation, the next step is to determine which domains of rehabilitation are appropriate. Seven domains for psychosocial rehabilitation services are highly recommended, having demonstrated effectiveness based on controlled studies and expert consensus. This list is not restrictive, nor is it prescriptive. Clinicians should not restrict themselves to these seven domains, nor should they assume that each domain is equally appropriate for all persons. Rather, these seven domains of rehabilitation are commonly offered and available as services essential for recovery among persons with psychoses. See Module L, the "Psychosocial Rehabilitation Core Module," for a further overview of the seven modules.

**CC. Discuss Treatment Options with Person/Family; Select Modalities to Meet Needs; Obtain Person/Legal Guardian Agreement to Treatment Plan**

*Objective*

Establish agreement to the treatment plan.

### *Annotation*

#### Collaboration

Treatment options should be presented and discussed with the person/legal guardian. See Module W below, "Family Support," for a discussion of the involvement of family members.

#### Consent

Unless the person is unresponsive, confused, or otherwise unable to make a rational decision due to a clinical condition, assume that the person has the decisional capacity to consent to or refuse assessment or treatment. Proceed with treatment if the person has a legal guardian who authorizes treatment; or if the person is under commitment, or temporary commitment has been obtained; or if there is other legal authority to proceed (e.g., applicable state laws or advance directives).

### **DD. Treat for Cyclothymia Disorder**

#### *Objective*

Assist person in the control of mood swings.

#### *Annotation*

Cyclothymia is a mild form of bipolar disorder, which can represent the prodromal phase of bipolar illness. The hallmark of cyclothymia is its biphasic nature characterized by marked changes in mood and behavior, for example, from lethargy and low self-esteem to high physical activity and overconfidence. Often, persons with cyclothymia are incorrectly diagnosed with an Axis II condition, such as borderline personality disorder. Family history is often helpful as an external validator for the diagnosis of cyclothymia, and any person with significant "mood swings" who has a clear family history of bipolar disorder should be considered part of the "bipolar spectrum" with respect to diagnosis and treatment.

Treatment of cyclothymia should emphasize close clinical follow-up in order to determine possible patterns of the mood swings, such as seasonal worsening. Persons should be encouraged to keep a diary or calendar to assist in diagnosis and in documenting results of treatment. In cases in which a person is distressed by the symptoms and/or where functional impairment occurs, cyclothymia should be treated as a bipolar disorder, with mood stabilizers as the first line of treatment. Tricyclic antidepressants have the potential to worsen the status of persons with cyclothymia and should be avoided. For depressive episodes that persist more than two weeks, a serotonin reuptake inhibitor antidepressant or bupropion may be beneficial.

Care must be taken to not provoke mania, hypomania, mixed states, or rapid cycling by prescribing antidepressants without mood stabilizer coverage. Low doses of mood stabilizers may be effective in cyclothymia, and help to minimize adverse effects.

### **EE. Past History of Bipolar Disorder, No Current Symptoms**

#### *Objective*

Institute prophylaxis and consider psychosocial rehabilitation to prevent recurrence of bipolar disorder and to assist the person in psychosocial adjustment.

#### *Annotation*

Initiate prophylaxis and consider psychosocial rehabilitation for past history of bipolar disorder-no current symptoms.

#### **FF. Treat for Psychotic Disorder, Not Otherwise Specified (Atypical Psychosis)**

##### *Objective*

Assist the person in the control of his/her condition.

##### *Annotation*

This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior), about which there is inadequate information to make a specific diagnosis or about which there is contradictory information and disorders with psychiatric symptoms that do not meet the criteria for any specific psychotic disorder. This is also a poorly understood and poorly described category in the literature. There is very low stability of these disorders over time, higher than expected rates of recovery, and associations with personality disorders.

If possible these persons should be closely observed and reassessed to ascertain the underlying pathology. If symptoms are of high severity, or create a dangerous situation, or person strongly insists, then active treatment based on predominant symptom picture is appropriate.

#### **GG. Does Not Meet DSM-IV Criteria for Any of the Above**

##### *Objective*

Assist with control of symptoms and make appropriate referral.

##### *Annotation*

Reassess the symptom picture, reevaluate the etiology of the problem, the medical and psychosocial stressors, and reformulate the treatment plan. Make appropriate referral as indicated.

#### **HH. Provide Psychosocial Rehabilitation Based on Identified Needs**

##### *Objective*

Activate treatment to meet the person's psychosocial rehabilitation needs.

##### *Annotation*

##### *Identify Domains for Action*

Clinicians are encouraged to collaborate in the process of identifying the domains, as well as selecting services. The psychosocial rehabilitation modules (Modules L through Z) are designed to function as an interactive document, assisting the clinician and the person in making choices and selecting needed rehabilitative services.

##### Resources for Information about Rehabilitation Services

- The International Association of Psychosocial Rehabilitation Services (IAPRS) is an important resource, as is the National (or State) Alliance for the Mentally Ill (NAMI)
- The Commission on Accreditation of Rehabilitation Facilities (CARF) ensures that clinicians offering rehabilitation services meet standards of community-based and residential care. CARF standards for Behavioral Health (Alcohol and other Drugs, Mental Health, and

Psychosocial Program), Employment and Community Support Services, and Early Childhood and Family Support Services, will provide valuable guidelines and program descriptions for rehabilitation services. For additional information, contact CARF, 4891 East Grant Road, Tucson, Arizona 85712, or (520) 325-1044.

## **II. Reevaluate Level of Recovery and Degree to Which the Treatment Plan Has Met the Person's Needs**

### *Objective*

Prevent relapse and promote recovery and rehabilitation of persons who have been stabilized following treatment for psychoses.

### *Annotation*

#### Bipolar Disorder

The goal of treatment for bipolar disorder is complete remission of symptoms and a return to premorbid function. Bipolar disorder is an episodic, long-term illness with a variable course. Once the acute symptoms of a manic or depressive episode have been in remission for three to six months, a decision regarding further treatment will need to be made.

#### Psychosis

For persons with psychosis or schizophrenia, the following recommendations should be considered:

- Antipsychotic agents are effective in preventing psychotic relapse in stabilized persons.
- Newer antipsychotic agents may interact with psychosocial treatments to promote recovery and rehabilitation.
- Persons with a history of poor adherence to medication regimens should be considered candidates for long-acting depot medications.
- Persons with comorbid depression will benefit from adjunctive antidepressant medication.
- Persons who demonstrate aggressive or assaultive behavior will benefit from clozapine

See Module J for a detailed discussion of maintenance/prophylactic treatment for persons in recovery from psychosis or schizophrenia.

## **Module J - Psychoses and Schizophrenia Treatment**

### **A. Determine Appropriate Setting for Care**

#### *Objective*

Determine the treatment setting that is most appropriate for a patient with schizophrenia, schizophreniform disorder, delusional disorder, or brief psychotic disorder.

#### *Annotation*

Patients with acute or chronic psychotic conditions can be managed in a number of settings including an inpatient psychiatric unit, a partial hospital setting, or in their current residence. For the most part, decisions regarding the setting of care are based on safety considerations. Individuals with histories of violent or self-destructive behaviors or those with command hallucinations may be at risk for dangerous behaviors. If patients are at risk for these behaviors, an inpatient setting is usually preferred. Hospitalization may also be appropriate for patients with

medical problems that require monitoring. See Appendix D in the original guideline document, "Criteria for Admission," for more details.

Alternatives to hospitalization such as day hospitalization and assertive community treatment should be considered for patients who do not require the intensive monitoring of a psychiatric inpatient unit.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Day hospitals are a less costly alternative for many patients	Creed et al., 1997; Herz et al., 1971; Knapp et al., 1994; Langsley, Machotka, & Flomenhaft, 1971; Marshall et al., 2001; Wilder, Levin, & Zwerling, 1966	I	A

**B. Initiate Contact with Patient's Family and/or Significant Other**

*Objective*

With the patient's informed consent, establish a working relationship, whenever feasible, with important individuals in the patient's support network. This relationship can improve treatment adherence, lead to the early detection of relapse, and decrease stress in the patient's environment.

*Annotation*

Family members and significant others can provide valuable information about the patient's recent history including signs and symptoms of illness, adherence to treatment, substance use, etc. Furthermore, contact with family members may facilitate family education programs, which are discussed in Annotation D.

Family members are often the first individuals to detect prodromal signs of psychotic relapse. Detection of prodromal symptoms may result in reducing the overall risk of psychotic relapse.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Family members are able to detect signs of impending relapse weeks or months before the psychosis emerges	Herz, 1985	II	B

**C. Prepare to Select Treatment with an Antipsychotic Medication**

*Objective*

Confirm the essential role of pharmacotherapy for the effective treatment of psychosis.

*Annotation*

Nearly all psychotic episodes should be treated with an antipsychotic medication.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Antipsychotic medications are effective for acute schizophrenia.	Casey & Laskey, 1960; Laskey & Klett, 1962; Lehman & Steinwachs, 1998; May et al., 1976	I	A
2	Antipsychotic medications are most effective at moderate doses.	Baldessarini, Cohen, & Teicher, 1988; Dixon, Lehman, & Levine, 1995; Lehman & Steinwachs, 1998; Owen et al., 2000	I	A
3	Antipsychotic medications are effective for treating schizoaffective disorder.	Levinson, Umapathy, & Musthaq, 1999	I	A

*Areas for Assessment*

Patients on an antipsychotic should be assessed on a regular basis for their response to an antipsychotic and the presence of side effects. Knowledge of the most common side effects of the agent(s) they are receiving should guide this evaluation. The most common side effects of conventional and second generation antipsychotics are described in Annotation I, Table 2.

**D. Initiate Patient and Family Education**

*Objective*

Educate patient and family members/significant others about the nature of schizophrenia and its treatments.

*Annotation*

Prior to initiating treatment with medication or psychosocial treatments, the potential risks and benefits of the treatment should be discussed.

Patient and family psychoeducation has the potential for reducing vulnerability to psychotic relapse.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Family education can improve outcomes in	Dyck et al., 2000; Hogarty et al., 1991; Lehman & Steinwachs, 1998;	I	A

	Interventions	Sources of Evidence	QE	R
	schizophrenia	Mari & Streiner, 1996		

**E. Initiate Second Generation Antipsychotic Medication Other than Clozapine in Patients Experiencing a First Episode; Assess Every 1 to 2 Weeks for 6 Weeks**

*Pharmacologic Management of First Episodes*

*Objective*

Select an antipsychotic drug for a first episode of schizophrenia and initiate treatment at the appropriate dose.

*Annotation*

Nearly all episodes of schizophrenia should be managed with antipsychotic medications. Motor vs. metabolic side effect profiles of first vs. second generation antipsychotics are an important consideration. Second generation antipsychotics are typically regarded as the drugs of choice for first episode patients. Patients experiencing a first episode are more sensitive to neurological side effects of antipsychotics than multi-episode patients.

*Evidence*

	Interventions	Sources of Evidence	QE	R
1	Antipsychotic medications are effective for first episode schizophrenia.	Lehman & Steinwachs, 1998; Loebel et al., 1992; Remington, Kapur, & Zipursky, 1998; Robinson et al., 1999	I	A
2	Second generation antipsychotics are preferred for patients experiencing a first episode.	Emsley, 1999; Sanger et al., 1999; Williams, 2001	I	A

**F. Adequate Response in 6-8 Weeks?**

*Objective*

Evaluate symptoms and side effects in patients who are receiving an antipsychotic.

*Annotation*

Clinicians should evaluate positive, negative, neurocognitive, and mood symptoms in assessing response to an antipsychotic medication.

Clinicians should consider a range of antipsychotic drug side effects in assessing clinical response.

**G. Continue Follow-Up to Prevent Relapse and Promote Recovery and Rehabilitation**

*Objective*

Prevent psychotic relapse and promote recovery and rehabilitation of patients who have been stabilized following one or more psychotic episodes.

*Annotation*

Antipsychotic agents are effective in preventing psychotic relapse in stabilized patients.

Second generation antipsychotic agents may interact with psychosocial treatments to promote recovery and rehabilitation.

Patients with a history of poor adherence to medication regimens should be considered candidates for long-acting depot medications.

Patients with comorbid depression may benefit from adjunctive antidepressant medication.

Patients who demonstrate suicidal behavior, aggressive or assaultive behavior, or who have problems with substance abuse may benefit from clozapine.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Antipsychotic agents are effective in preventing psychotic relapse in stabilized patients.	Davis et al., 1993; Lehman & Steinwachs, 1998	I	A
2	Patients who have recovered from a first episode should continue on an antipsychotic for one to two years.	Crow et al., 1986; Dixon, Lehman, & Levine, 1995; Kane et al., 1982	I	C
3	Patients who receive depot antipsychotics have lower relapse rates than patients who receive conventional oral medications.	Davis et al., 1993; Hogarty et al., 1979	I	A
4	Patients who develop depressive symptoms during maintenance treatment can benefit from adjunctive antidepressants.	Siris et al., 1994; Goff et al., 1995	I	A
5	Clozapine is more effective than other agents for aggressive behaviors in schizophrenia.	Glazer & Dickson, 1998; Rabinowitz, Avnon, & Rosenberg, 1996	II-2	C

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
6	Clozapine is more effective than other agents for management of suicidality in schizophrenia.	Meltzer et al., 2003; Reid, Mason, & Hogan, 1998; Sernyak et al., 2001; Walker et al., 1997	I; II-2	A

**H. Change to a Second Generation Drug Not Already Tried; If Adherence is Poor, Consider a Long-acting Injectable Antipsychotic; Initiate Clozapine if Patient Has An Inadequate Response to Trials of 2 Agents, One of Which Was a Second Generation Antipsychotic**

See Annotation J.

**I. Indication to Change Based on Treatment Response or Side Effects?**

*Objective*

Assess treatment response and identify patients who are having a poor clinical response or unacceptable side effects.

*Annotation*

An adequate trial of antipsychotic medication should consist of six to eight weeks at a dose that is well-tolerated and sufficient for an antipsychotic response.

When patients show inadequate response to a medication regimen after an adequate trial it may be helpful to assure they are receiving adequate amounts of the drug.

Patients who demonstrate some improvement during the first six to eight weeks should, under certain circumstances, continue on that medication for an additional three to six months before concluding that the trial is unsuccessful. Evaluation of antipsychotic response should include an assessment of side effects.

Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids. Baseline and periodic monitoring of blood glucose, serum lipids, blood pressure, and body mass index (BMI) would be prudent particularly in those patients identified as having diabetes, or who are at increased risk for developing diabetes, or those with other known risk factors for cardiovascular disease. In accordance with Veterans Health Administration (VHA) policy, clinical assessment of weight, lipids and glycemic control are recommended every 6 to 12 months during long-term therapy. More frequent monitoring is recommended during the first 6 months of treatment. These measures may help guide initial selection of antipsychotic medications, improve early detection of the need for medical intervention, and enhance ongoing reevaluation of the appropriateness of psychiatric medications.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
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	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Patients should receive a 6 to 8 week trial of an antipsychotic before concluding they have an inadequate response.	Janicak et al., 1993; Kahn & Davis, 1995	II-1	B
2	Low plasma concentrations of an antipsychotic are associated with an inadequate response.	Bell et al., 1998; Janicak et al., 1989; Levinson et al., 1995; Van Putten et al., 1991	I	A
3	Initial and periodic monitoring of metabolic parameters should occur.		III	A

**J. Change Antipsychotic Medication; Assess in 6-8 Weeks**

*Objective*

Patients who have an inadequate response due to lack of efficacy or poorly tolerated adverse effects should have a trial on another antipsychotic.

*Annotation*

The selection of an antipsychotic medication should be based on medication history, sensitivity to side effects, route of administration, patiental preferences, and other factors. Patients who have an inadequate response to respond to a conventional antipsychotic after an adequate trial may improve if changed to a second generation antipsychotic.

Therapy with a single antipsychotic agent is preferred. The evidence for combination therapy is very limited. While other pharmacological augmentation strategies targeted at psychotic symptoms (e.g., addition of lithium or divalproex to an antipsychotic) can be helpful in some cases, the evidence suggests consideration of a clozapine trial for patients who have inadequate responses to more than one antipsychotic medication. Therefore, patients who have an inadequate response to two separate trials of antipsychotics--at least one of which is a second generation antipsychotic--should have a trial with clozapine.

Patients who experience extrapyramidal syndrome (EPS) on effective doses of a conventional antipsychotic should be changed to a second generation antipsychotic.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Clozapine is more effective than other agents for treatment of	Azorin et al., 2001; Breier et al., 1994; Kane et al., 1988; Lehman & Steinwachs, 1998; Pickar et al.,	I	A

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
	refractory schizophrenia.	1992; Rosenheck et al., 1997; Wahlbeck, Cheine, & Essali, 2000		
2	Patients who fail to respond to a conventional agent may respond to a second generation antipsychotic.	Bouchard et al., 2000; Breier & Hamilton, 1999; Conley et al., 1998; Copolov, Link, & Kowalczyk, 2000; Emsley et al., 2000; Wirshing et al., 1999	I	A
3	Patients who have EPS at an effective dose of a conventional agent should be changed to a second generation agent.	Arvanitis & Miller, 1997; Claghorn et al., 1987; Marder & Meibach, 1994; Keck et al., 1998	I	A
4	Second generation antipsychotics are associated with a lower risk of Tardive Dyskinesia (TD).	Jeste et al., 1999; Kane et al., 1993	II-3	C
5	Monitor for diabetes in patients who are receiving second generation antipsychotics, particularly when there is a family history of diabetes.	Koro et al., 2002; Newcomer et al., 2002; Sernyak et al., 2002	II	B

**K. Was Patient Previously Treated with Antipsychotics with Optimal Response and Minimal Side Effects?**

*Objective*

Assure that patients who have a poor response to an antipsychotic due to lack of efficacy or poorly tolerated side effects have their medication histories reviewed.

*Annotation*

Patients who responded well to an antipsychotic in the past are likely to have a similar response when the agent is administered again. See Annotation J.

**L. Initiate Antipsychotic Medication with an Agent Not Already Tried**

See Annotation J.

**Module L - Psychosocial Rehabilitation Core Algorithm**

## A. Ascertain Chief Complaint

### *Annotation*

The first step is to determine whether the patient is medically and psychiatrically stable. This is a check on whether action steps recommended earlier have indeed achieved their desired objectives and whether the patient and clinician are ready to identify a domain for rehabilitation.

## B. Assessment of Seven Domains

### *Objective*

The next step is to determine which domain(s) of rehabilitation are appropriate. The checklist that follows identifies seven domains for which psychosocial rehabilitation services are highly recommended, having demonstrated effectiveness based on controlled studies and/or expert consensus. This list is not restrictive, nor is it prescriptive. Clinicians should not restrict themselves to these domains, nor should they assume that each domain is equally appropriate for all patients.

Clinicians are encouraged to use the checklist for at least the following purposes:

1. Assess whether or not a patient in recovery from a serious mental illness needs services for each of the domains listed.
2. Identify which rehabilitation services are available.
3. Consider possibility of needs for other rehabilitation services.

Domain	Is Statement True?	If Statement is False?
1	Patient is fully informed about all aspects of health needs and avoids high-risk behavior.	Activate Health Education Module (M)
2	Patient has self-care and independent living skills consistent with living arrangement goals.	Activate Self-Care/Independent Living Skills Module (U)
3	Patient has safe, decent, affordable, stable housing that is consistent with treatment goals.	Activate Housing Module (V)
4	Family actively supports patient and is very well-informed.	Activate Family Support Module (W)
5	Patient is sufficiently socially active.	Activate Social Skills Module (X)

Domain	Is Statement True?	If Statement is False?
6	Patient has a job that provides adequate income and fully utilizes skills.	Activate Work Restoration Module (Y)
7	Patient is able to locate and coordinate access to needed services.	Activate Case Management Module(Z)

**C. Identify Domains for Action**

The clinician and the patient should identify which domains apply. Making choices is essential in rehabilitation of patients with severe mental disorders. As a consequence, clinicians and patients are encouraged to collaborate in the process of identifying the domains, as well as selecting programs in which required services are available. The psychosocial rehabilitation section is designed as an interactive document with which the clinician assists the patient in making choices and in selecting the essential services for rehabilitation.

When reviewing the patient's need to participate in any module, the clinician should also keep in mind that the patient might need services in closely related areas. For example, many patients who experience difficulties in employment also need assistance in obtaining transportation to and from work. Although the Work Restoration Module cannot at present offer recommendations for solutions to patients' transportation problems, the clinician should attempt to identify resources to meet these additional needs.

**D. Select Modality or Modalities to Meet Needs (Also See Grid in Appendix B in the original guideline document)**

In addition to the interventions that are suggested in each of the modules, the Psychosocial Rehabilitation Grid in Appendix B in the original guideline document outlines specific services, programs, and modalities considered effective for each of the seven domains.

**Module M - Health Education**

**A. Patient Who Is Not Fully Informed About Health Needs or Who Does Not Avoid High Risk Behavior**

Patients treated in this module have a diagnosis of psychosis and have health education issues (indicated by a "False" response to the checklist question "Patient is fully informed about all aspects of health needs, and avoids high-risk behavior").

*Annotation*

Physical health is closely tied to a patient's overall way of life. When considering a patient's health information needs, the clinician must consider not only the patient's existing level of knowledge about health issues, but also willingness to pursue good health practices and opportunities to put such practices into use. Module M should be seen as a guide to other modules in which physical health issues are treated.

**B. Can Patient Usefully Participate in Education Process?**

*Objective*

Identify those patients who will be able to understand and use the information they receive during health education interventions.

*Annotation*

As discussed above, physical health is the outcome of not only knowledge, but also interest in and opportunity to pursue good health practices. The clinician should evaluate the patient to assess:

- Ability to understand and remember the information
- Interest in changing health behavior in this area, and
- Ability to pursue better health practices.

If the answer to any of these questions is "no," it may be advisable to reassess the patient at a future time and refer to physical health education when better prepared or living in different circumstances.

**C. Does Patient Need Assistance with Understanding Illness and Treatment?**

*Objective*

Identify the patient who could benefit from learning more about illness and its treatment.

*Annotation*

The clinician should talk with the patient and try to determine whether the patient has a good understanding of the illness. If the patient has good conceptual skills but lacks specific information about this illness, refer to Module U for information about self-care skills training.

**D. Does Patient Need Assistance with Alcohol/Drug Abuse and/or Dependence?**

*Objective*

Identify the patient who should receive assistance as described in the VA/Department of Defense Substance Use Disorder Guideline.

*Annotation*

The clinician should screen for alcohol and drug abuse or dependence, using an accepted screening instrument (see Module A, Annotation N). The clinician should also look for other signs of alcohol or drug use, such as arrests for alcohol or drug-related activities, or records of alcohol/drug-related hospitalizations or outpatient visits. The clinician should also try to determine the patient's level of interest in lessening or stopping dependence on alcohol or drugs. Even a minimal level of interest on the patient's part should be supported by referral to the proper treatment program.

**E. Does Patient Need Assistance with Prevention of Sexually Transmitted Disease?**

*Objective*

Identify the patient who could benefit from information about the prevention of sexually transmitted diseases (STDs).

*Annotation*

The clinician should ask the patient about sexual activity and safe sexual practices. The clinician should look for other evidence of the patient's need for STD information in clinical history. A history of STDs would indicate a need for counseling in this area.

**F. Counsel/Refer to Sexual Health Education**

*Objective*

Provide the patient with an understanding of healthy sexual practices and support the patient in being assertive in preventing STDs.

*Annotation*

The sexuality of men and women with schizophrenia and other psychotic disorders should be acknowledged and addressed. The identified vulnerability of the chronic mentally ill to high-risk sexual behavior and their concomitant lack of knowledge about the consequences of such behavior constitute appropriate indication to address sexual issues with patients with psychoses.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Present patient with information on choice of protective methods.	Collins et al., 2001	I	A
2	Provide individual (rather than group) teaching on safer sex practices.	Hajagos et al., 1998	III	B
3	Provide patient with training to act as a risk reduction advocate to friends.	Kelly et al., 1997	I	B
4	Provide patient with assertiveness training as well as human immunodeficiency virus (HIV) prevention information.	Weinhardt et al., 1998	I	A

**G. Does Patient Need Assistance with Smoking Cessation?**

*Objective*

Identify the patient who could benefit from assistance with smoking cessation.

*Annotation*

The clinician should screen for tobacco use, using an accepted screening instrument. The clinician should also try to determine the patient's level of interest in lessening or stopping

tobacco use. Even a minimal level of interest on the patient's part should be supported by referral to the proper treatment program (refer to Tobacco Use Cessation Guideline).

## **Module U - Self-Care/Independent Living Skills (ILS)**

### **A. Patient Who Does Not Have Self-Care or Independent Living Skills Consistent With Goals**

Patients treated in this module have a diagnosis of psychosis and have self-care or ILS issues (indicated by a "False" answer to the checklist question "Patient has self-care and ILS consistent with living arrangement goals").

#### *Annotation*

Housing loss and rehospitalization are potential negative outcomes that may result from self-care or ILS deficits. Improvements in the patient's self-care or ILS skills may not only lessen the threat to housing stability, but may also create a feedback effect of improvements to the patient's social skills, employment prospects, and overall quality of life.

### **B. Assess Patient's Self-Care and Independent Living Skills Training Needs**

#### *Objective*

Identify the specific skill deficits for which the patient needs training.

#### *Annotation*

Self-Care and ILS skills cover multiple areas. The clinician should assess each of these areas:

1. Medication and symptom self-management
2. Communication and social interaction
3. Problem-solving
4. Personal care and hygiene
5. Shopping
6. Cooking
7. Using transportation
8. Money management
9. Maintaining a schedule
10. Leisure skills

### **C. Refer Patient to Self-Care and Independent Living Skills Training**

#### *Objective*

Obtain the best mix of skills training modalities to meet the patient's needs and improve self-care skills.

#### *Annotation*

Self-care and ILS training programs vary in focus, and they may teach combinations of skills. The clinician should try to identify a program that focuses on the patient's particular skill deficits. If this is not possible, more general programs may also be helpful to the patient. Some studies have found improvements in skills not specifically taught in their programs.

Skills training studies fall into two groups: studies of Cognitive Behavioral Therapy (CBT), and studies of other types of training. CBT appears to be useful for a number of outcomes. CBT was significantly more effective than other therapies for symptom reduction, improvement in self-esteem, and reduction of cognitive deficit.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider CBT if available.	Jones et al., 1999; Kuipers et al., 1998; Leclerc et al., 2000; Medalia et al., 1998; Sensky et al., 2000; Sovani & Thatte, 1998; TARRIER, 1999; TARRIER et al., 1998, 1999; Wykes et al., 1999	I; I; I; I; I; III; I; I; I	A
2	Consider training modules to increase a patient's self-esteem.	Lecomte et al., 1999	I	B
3	Consider programs to encourage medication compliance.	Azrin & Teichner, 1998; Chaplin & Kent, 1998; Delaney, 1998	I; I; I	A
4	Consider ILS training.	Lieberman et al., 1998; Kopelowicz, Wallace, & Zarate, 1998	I; I	A
5	Consider special attention for patients aged 60 years and above.	Roberts et al., 2000	III	B

**D. Has Patient Met Skills Goals?**

*Objective*

Determine to what extent the patient has met the goals established for the self-care/ILS training program.

*Annotation*

Before assigning the patient to any self-care/ILS training program, establish measurable goals with the patient and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the patient's progress: feedback from program staff, the patient's report of status, and other relevant feedback from family members or community contacts.

**E. Consider Exit Counseling**

### *Objective*

Identify the patient who is ready to exercise self-care/ILS skills without clinician supervision.

### *Annotation*

Some patients may eventually attain a level of self-care/ILS skills in which they no longer require assistance with activities of daily living. The decision to release the patient from self-care/ILS training should be reached together by the clinician and the patient. When this occurs, the clinician should remind the patient of the availability of refresher sessions or further training whenever needed.

## **F. Would Patient Benefit from More Time in Training?**

### *Objective*

Determine whether the patient who has not met training goals might benefit from more time in the current training program.

### *Annotation*

Before assigning the patient to any self-care/ILS training program, establish measurable goals with the patient and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the patient's progress: feedback from program staff, the patient's report of status, and other relevant feedback from family member or community contacts.

## **G. Refer Patient for Continuing Training**

### *Objective*

Give the patient more time to benefit from training.

### *Annotation*

If the patient expresses an interest in remaining in the current training program, and program staff agree, it may be advisable for the patient to remain in the current program. If the patient feels frustrated by the current training program, it may be advisable to refer to a different level of training.

## **Module V - Housing**

### **A. Patient Who Does Not Have Safe, Decent, Affordable Housing**

Patients treated in this module have a diagnosis of psychosis and have a housing problem (indicated by a "False" answer to the checklist question "Patient has safe, decent, affordable, stable housing that is consistent with treatment goals").

### *Annotation*

Homelessness is a major public health problem among patients with severe mental illness. Multiple studies have demonstrated that housing stability reduces the need for resource-intensive treatment, including inpatient services. Two safety issues require particular attention.

- Housing for patients with psychosis should not be above a second floor level unless precautions are taken so that they cannot jump from the windows. This step should be taken because over 10% of patients with serious mental illness commit suicide.

- Patients with mental illness should not be housed in areas of high drug traffic. This is particularly important if the patient has a substance dependence or abuse problem.

**B. Does Patient Currently Have Housing?**

*Objective*

Determine urgency of the housing problem.

*Annotation*

If the patient has no idea where to sleep tonight, plans to sleep on the street, or plans to sleep in a dangerous environment, the answer should be "no." Otherwise, the answer is "yes."

**C. Will Patient Accept Assistance?**

*Objective*

Identify and engage patient's willingness to participate in a housing intervention.

*Annotation*

The provider should distinguish the patient's refusal of all ongoing care from unwillingness to engage in a collaborative effort to resolve a housing issue. Some patients refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction).

*Evidence*

	<b>Interventions</b>	<b>Source of Evidence</b>	<b>QE</b>	<b>R</b>
1	Identify willingness to engage in ongoing care.	Willenbring, Olson, & Bielinski, 1995	III	B

**D. Refer for Placement in Unsupported Housing**

*Objective*

Identify and engage patients who require assistance with obtaining unsupported housing.

*Annotation*

Unsupported housing is an environment where there is no provider to furnish ongoing support. This is an appropriate choice for the patient who will not accept an assisted living situation or who has the resources to maintain housing once it has been obtained.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Days homeless was greater for individuals assigned to independent apartments than for those placed in staffed group homes, but only for	Goldfinger et al., 1999	I	C

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
	members of minority groups.			
2	Housing interventions, such as Section 8 housing certificates, can be successful tools for stabilizing homeless mentally ill patients.	Hurlburt, Hough, & Wood, 1996	I	A
3	Providing support that increases housing stability reduces need for treatment. Independent living arrangements may be cost-effective policy choice.	Dickey et al., 1997	I	B

**E. Reassess Periodically**

*Objective*

Provide opportunity to improve treatment effectiveness.

*Annotation*

Reassessment of initial plans should occur periodically. The patient's progress and goals should be reassessed and the treatment plan updated at least annually. Plans should also be reviewed after significant clinical change (e.g., hospital admission, relapse, and accomplishment of care goals).

**F. Clinically Stable Candidates for Residential Treatment**

Patients have a diagnosis of psychosis, have a housing problem (indicated by a "No" answer to the checklist question "Patient has safe, decent, affordable, stable housing that is consistent with treatment goals"), and do not meet the criteria for involuntary treatment. In addition, such patients do not have the resources to maintain housing without assistance, will accept an assisted living situation, and require and will accept 24-hour supervision.

**G. Assess Type and Intensity of Residential Treatment Support Required**

*Objective*

Match patient's need with the most appropriate services.

*Annotation*

Residential treatment (RT) includes a variety of modalities in which a provider supplies, arranges for or confirms, and monitors the provision of ongoing, periodic support, which assists the patient in maintaining housing in the community. This includes professional services provided by paid caregivers, but also "natural supports" in which those providing direct support are not paid caregivers. This may also include mutually supportive client networks.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	When homeless mentally ill adults are provided permanent housing, they are likely to avoid unstable housing patterns (McKinney demonstration project).	Dickey et al., 1996	I	A
2	Although consumers more frequently prefer independent living, placement in staffed group housing resulted in somewhat fewer days homeless for minority groups.	Goldfinger et al., 1999	I	B
3	Client support networks, combined with skills training and client run group work experience, can enhance community tenure.	Fairweather, 1969	I	A

**H. Select Residential Treatment or Supported Housing Modality Which Best Matches Needs**

*Objective*

Match patient's need with the most appropriate services.

*Annotation*

A wide range of services may be available. A listing of possibilities, with associated evidence, is listed in Appendix B in the original guideline document, "Psychosocial Rehabilitation Grid."

**I. Clinically Stable Candidates for Supported Housing (SH)**

Patients have a diagnosis of psychosis, have a housing problem (indicated by a "No" answer to the checklist question "Patient has safe, decent, affordable, stable housing that is consistent with treatment goals"), and do not meet the criteria for involuntary treatment. In addition, such patients do not have the resources to maintain housing without assistance, will accept an assisted living situation, but do not require, or will not accept, 24-hour supervision.

**J. Assess the Type and Intensity of SH Support Required**

*Objective*

Match patient's need with the most appropriate services.

*Annotation*

SH includes a variety of modalities in which a provider supplies, arranges for or confirms, and monitors the provision of ongoing, periodic support, which assists the patient in maintaining housing in the community. This includes professional services provided by paid caregivers, and also "natural supports" in which the patients providing direct support are not paid caregivers.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Homeless people placed in supportive housing experience marked reductions in shelter use, hospitalization, length of stay per hospitalization, and time incarcerated.	Culhane, Metraux, & Hadley, 2001	II	A
2	Days homeless was greater for individuals assigned to independent apartments than for those placed in staffed group homes, but only for members of minority groups.	Goldfinger et al., 1999	I	B
3	Long-term residential stability can be enhanced by providing access to safe and affordable supportive housing.	Lipton et al., 2000	II	A

**Module W - Family Support**

**A. Patient Whose Family Does Not Actively Provide Support**

Patients treated in this module have a diagnosis of psychosis and have a family support issue (indicated by a "False" answer to the checklist question "Family actively supports patient, and is very well-informed").

*Annotation*

When a patient is struggling to live with schizophrenia, family support can be of vital importance. Not all families will provide the understanding and support the patient needs. Family support programs should be considered for any patient whose family:

- Does not understand schizophrenia
- Does not accept that the patient is legitimately ill
- Has unrealistic expectations for the patient's treatment outcome
- Actively or passively undermines the patient's treatment program
- Does not assist the patient in activities of everyday life

Family education and family support programs can help families of patients with schizophrenia to build better communication skills, to develop empathy for the ill patient, and to learn techniques to aid the patient in movement toward recovery.

**B. Does Patient Agree to Family Involvement?**

*Objective*

Ensure compliance with all confidentiality requirements.

*Annotation*

The patient's family, relatives, and/or attorney reside "outside" the circle of confidentiality and as such are not entitled to obtain clinical information regarding the patient without the express consent of the patient. The patient's right to consent is embedded in the legal precedents inherent in the right to privacy as well as other ethical constraints.

**C. Will Patient Allow Family Contact to Gather Information Only?**

*Objective*

Open a channel of communication with the ill patient's family, whenever possible.

*Annotation*

Refusal of family involvement may reflect the patient's response to family pressures and the intrusive nature of their demands. Families, on the other hand, may feel frustrated at being excluded from participation in the treatment of a significant other, particularly if they have been the primary caregivers. The clinician must balance the potential benefits to be gained from family inclusion with maintaining the viability of the therapeutic alliance and trust established with the patient, which is the cornerstone to successful treatment. The clinician may be able to build on the therapeutic alliance to demonstrate the advantages of family participation at a level comfortable for the patient through limited family intervention in information gathering.

**D. Can Legal Mandates Be Applied?**

*Objective*

Determine when it is necessary to override the patient's wish to exclude family from the treatment program.

*Annotation*

The decision to breach confidentiality must be taken seriously with caution and substantial justification. Advice of both legal counsel and the Ethics Committee is recommended.

**E. Provide Family Education**

*Objective*

Help families of patients with schizophrenia build better communication skills, develop empathy for the ill patient, and learn techniques to aid the patient in movement toward recovery.

*Annotation*

As noted in a recent literature review, numerous studies "confirm the potential advantages and benefits of services to families and family education." The potential benefits of family education include:

- Decrease in frequency of relapse
- Decrease in hospitalization
- Encouragement of compliance with medication
- Increased sense of self-efficacy in managing the relative's illness
- Improvement in negative symptoms

- Increase in families' knowledge about schizophrenia
- Increase in satisfaction with care

Family education and family support programs, however, should not be seen as "quick-fixes." Pharoah et al. note that "Patients and their families must be willing to spend a significant amount of time in contact with health services" to gain these benefits. Likewise, Solomon et al. recommend "Family education should be available as needed rather than compressed into a narrow time period." The timing of family interventions should also be considered. As noted by Dixon et al., the merits of a program may depend on whether it is provided at an early or later phase of an illness.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Studies confirm the potential advantages and benefits of services to families.	Dixon, Adams, & Lucksted, 2000	I	B
2	Family intervention may decrease the frequency of relapse.	Barrowclough et al., 1999; Pharoah, Mari, & Streiner, 1999	I	A
3	Family intervention may decrease hospitalization and encourage compliance with medication.	Pharoah, Mari, & Streiner, 1999	I	A
4	Family intervention may increase a sense of self-efficacy in managing the relative's illness.	Soloman et al., 1997	I	A
5	Participants experienced significantly reduced negative symptoms compared with standard care. Negative symptoms were significantly correlated with relapse.	Dyck et al., 2000	I	B
6	Family intervention may increase families' knowledge about schizophrenia.	Merinder et al., 1999	I	A
7	Family intervention may increase satisfaction with care.	Merinder et al., 1999	I	A

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
8	There is no data to suggest that family intervention either prevents or promotes suicide.	Pharoah, Mari, & Streiner, 1999	I	A
9	More sophisticated evaluations of family interventions are needed to better discern what works for whom.	Dixon, Adams, & Lucksted, 2000	I	B

**F. Is Family Comfortable and Willing to Participate in Care?**

*Objective*

Determine readiness of the patient's family to participate in care.

*Annotation*

In Dixon et al. overview of family education studies, they note the first element that should be assessed before recommending family education: "the interest of the family and patient." They also recommend assessing "whether the patient and family would choose family psychoeducation instead of alternatives available in the agency to achieve outcomes identified."

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Appropriateness of family psychoeducation for a particular patient and family should consider the interest of the family and patient and the extent and quality of family and individual involvement.	Dixon, Adams, & Lucksted, 2000	I	B
2	As time passes, people learn how to help relatives. Family education can accelerate the learning process.	Solomon et al., 1997	I	A

**G. Refer Family to Community-Based Advocacy/Assistance Programs**

*Objective*

Anchor the family in community-based programs that enhance the family's sense of empowerment and ability to manage the stressors of caregiving and management.

**Module X - Social Skills**

**A. Patient Who is Not Sufficiently Socially Active**

Patients treated in this module have a diagnosis of psychosis and have social skills issues (indicated by a "False" answer to the checklist question "Patient is sufficiently socially active").

*Annotation*

The importance of social skills to patients with severe mental illness is twofold: first, social skills enable the patient to engage in social activities that improve quality of life; and second, the increased self-esteem from mastery of social skills may lead to improvements in other areas of the patient's life. Social skills training may take place in formal settings (social skills classes) or informal settings (discussion groups, recreation groups, etc.). Such training may take place in an inpatient setting, at an outpatient facility, or in community locations.

**B. Determine Cause of the Patient's Social Difficulties**

*Objective*

Identify the skills deficits or other factors causing the patient to experience social difficulties.

*Annotation*

Patients may experience social difficulties for many reasons. The clinician should try to determine which of these factors is relevant:

- Does the patient have difficulty with emotional control?
- Does the patient lack knowledge of basic social rules?
- Does the patient have social skills but lack interest in socializing?
- Does the patient have social skills but is out of practice in using them?
- Does the patient have an interest in socializing but does not have opportunities to socialize?

An understanding of the origin of the patient's social difficulties will help the clinician select appropriate training programs.

**C. Refer to Social Skills Training**

*Objective*

Assist the patient in developing adequate social skills.

*Annotation*

One of the first decisions the clinician and patient should make is the location of social skills training. Many clinicians favor a combination of inpatient and outpatient services that can provide a controlled transition from the hospital to the community. Some clinicians favor enrolling patients in outpatient socialization program while they are still in inpatient status, to forestall the difficulties of dependency associated with institutionalization.

Increasingly absent are those socialization services embedded in high-intensity, long-term care facilities (for example, as lengths of inpatient stays decline, the notably effective token economies are less available). On the other hand, lower-intensity inpatient services such as Psychiatric Residential Rehabilitation Treatment Programs (PRRTPs) are increasingly available.

*Evidence I*

	<b>Interventions (Inpatient)</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Refer to supportive discussion group.	Bellack & Mueser, 1993	I	A
2	Refer to physical exercise.	Bellack & Mueser, 1993	I	A
3	Refer to social activities.	Bellack et al., 1984	I	A
4	Refer to social milieu group.	Bentall, Higson, & Lowe, 1987	I	A
5	Refer to token economy program.		I	A
6	Refer to medication management program.		I	A
7	Refer to symptom management program.		I	A
8	Refer to leisure and recreation groups.		I	A

*Evidence II*

	<b>Interventions (Outpatient)</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	If possible, use individually-tailored interventions rather than, or supplementing, curriculum-based modules.	Chandler & Quinlivan, 2000	I	A
2	Refer to Fairweather Lodge program.	Fairweather, 1969	I	A
3	Refer to family counseling.		I	A
4	Refer to community resource management group.	Hayes & Halford, 1996	I	A

	<b>Interventions (Outpatient)</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
5	Refer to "community survival" group.	Lieberman et al., 1984	I	A
6	Refer to relapse prevention program.	Marder et al., 1996	I	A
7	Refer to problem-solving group.	Mueser, Kosmidis, & Sayers, 1992	I	A
8	Refer to role-playing group.	Mueser et al., 1990	I	A

**D. Has Patient Met Skills Goals?**

*Objective*

Determine to what extent the patient has met social skills goals.

*Annotation*

Before prescribing social skills training or introducing the patient to socialization venues, establish measurable goals with the patient and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the patient's progress: social skills trainer feedback, the patient's report of status, and other relevant feedback from family members or community contacts.

**E. Consider Exit Counseling**

*Objective*

Assist the patient in becoming fully independent in exercising social skills.

*Annotation*

Some patients will eventually attain competency in social skills. The patient who has reached this stage is ready to practice those social skills and to gain benefits from social interactions. The clinician can be helpful by assisting the patient in identifying social venues in which the patient can participate. Ideally, these should allow the patient to form relationships with patients in the wider community. The clinician should also support the patient in efforts to join such venues, whether by sponsorship, provision of information about the venue (for example public transportation routes that serve the location), or simply by providing encouragement and suggestions for success.

*Evidence*

	<b>Interventions</b>	<b>Source of Evidence</b>	<b>QE</b>	<b>R</b>
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	<b>Interventions</b>	<b>Source of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider patient for supported education.	Mowbray, 2000; Mowbray, Collins, & Bybee, 1999	III; II-2	B; B

**F. Would Patient Benefit from More Training?**

*Objective*

Determine whether the patient would benefit from more time in the current form of treatment.

*Annotation*

Before prescribing social skills training or introducing the patient to socialization venues, establish measurable goals with the patient and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the patient's progress: social skills trainer feedback, the patient's report of status, and other relevant feedback from family members or community contacts.

**G. Refer for Continuing Training**

*Objective*

Give the patient more time to benefit from training.

*Annotation*

If the patient expresses an interest in remaining in the current training program, and program staff agrees, it may be advisable for the patient to continue the current program. If the patient feels frustrated by the current training program, it may be advisable to refer to a different level of training program.

**Module Y - Work Restoration Services**

**A. Patient Who is Not Successful and Fulfilled in a Job**

Patients treated in this module have a diagnosis of psychosis, have an employment issue (indicated by a "False" answer to the checklist question "Patient has a job which provides adequate income and fully utilizes skills"), and agrees to participate in work restoration services.

*Annotation*

The Expert Consensus Guideline Series for the Treatment of Schizophrenia provided significant support for provision of "a transitional or supported employment program specialized for clients with severe mental illness." Vocational treatment in the work restoration model was very highly rated by the panel of clinicians surveyed, and was considered the treatment of choice for stable outpatients.

Recent studies and overviews also support the idea that work, especially paid work, contributes to the patient's quality of life beyond the immediate benefits of a paycheck. Bell et al. examined the effect of Neurocognitive Enhancement Therapy (NET), work therapy, and a combination of the two on cognitive outcomes: attention, memory, Executive Function, and affect recognition. They found "there may be a true synergy between Neurocognitive Enhancement Therapy

exercises that encourage mental activity, and work therapy that allows a natural context for increased mental activity to be exercised, generalized, and reinforced." Bryson et al. looked at the effect of work on quality of life (Quality of Life Score-QLS) and found "although work itself had some beneficial effects on Quality of Life Score Total ... the synergy of paid work had the most benefits."

**B. Provide Work Restoration Services**

*Objective*

Identify and engage patients with employment issues who can benefit from implementation of an SE (Supported Employment) intervention.

*Annotation*

All patients who wish to participate in paid employment should be given the opportunity to receive supportive employment services. Symptom severity, poor vocational histories, or questionable readiness for or interest in competitive employment should not be reasons for exclusion.

**C. Does Patient Wish to Participate in Competitive Work?**

*Objective*

Identify candidates for participation in some form of competitive work.

*Annotation*

The vocational specialist should engage in finding a work site for the patient that matches the patient's interests, skills, and limitations. Prior opinion held that lack of improvement or benefit from participation in employment is usually related to cognitive deficits rather than symptomatology. While evidence continues to be found to support this opinion, other recent studies present a complex picture of multiple causation. These studies suggest that all patients may benefit from participation in employment, regardless of cognitive status. Others have found a wide variety of factors influencing success in employment. These include self-motivation, severity of negative symptoms, work history and job difficulties, and self-perceived physical health. The range of results presented here suggests that each patient should be assessed not only for cognitive defects, but also for level of motivation, work history, physical health, and symptom severity.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider patient for SE regardless of symptom severity.	Anthony et al., 1995; Green, 1996	I; I	A
2	Attempt to place patient in supported paid	Bell, Lysaker, & Milstein, 1996; Bell & Lysaker, 1997	I; I	A

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
	employment.			
3	Find a work site for the patient that matches the patient's interests, skills, and limitations.	Becker et al., 1998; Bell, Lysaker, & Milstein, 1996; Blankertz & Robinson, 1996; Dixon et al., 2001; Drake et al., 1994; Goldberg et al., 2001; Gowdy & Carlson, 2001	III; I; I; III; II-3; III; III	B; A
4	Help patient make the transition from unemployment to employment in graduated steps.	Anthony et al., 1995; Drake et al., 1996	I; I	A
5	Provide continued support through follow-up to maintain the therapeutic alliance with program staff.	Solomon, Draine & Delaney, 1995	III	B

**D. Refer to Work Restoration Services: SE**

*Objective*

Foster success in a competitive work environment.

*Annotation*

The Expert Consensus Guideline Series for the Treatment of Schizophrenia provided significant support for provision of "a transitional or supported employment program specialized for clients with severe mental illness." Further studies continue to uphold this model. Drake et al. found that for achieving competitive employment, the ongoing support of an SE program is superior to an Enhanced Vocational Rehabilitation (EVR) model in which services are delivered by a group of rehabilitation agencies. Similarly, Drake et al. found that eliminating day treatment and replacing it with an SE program can improve integration into competitive jobs in the community.

Newer studies also continue to demonstrate the superiority of SE over prevocational training for obtaining competitive employment. Clark et al. showed that Individual Placement and Support (IPS) participants were significantly more likely to find work, to work more hours, and to have higher earnings than were Group Skills Training (GST) participants. In a meta-analysis of 11 randomized clinical trials (RCTs), Crowther et al. concluded, "Supported employment is more effective than prevocational training at helping people with severe mental illness obtain competitive employment."

For those patients referred to an SE program, a study published by Becker et al. points to an area for caution. In their survey of a series of unsatisfactory job terminations, Becker et al. found that "unsatisfactory terminations were associated retrospectively with multiple problems on the job that were related to interpersonal functioning, mental illness, dissatisfaction with jobs, quality of work, medical illnesses, dependability, and substance abuse." Their results suggest, "Supported employment programs need to address job maintenance with interventions that identify and address different types of difficulties as they arise on the job."

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Refer patient to SE program	Clark et al., 1998; Crowther et al., 2001; Drake et al., 1994, 1999	I; I; II-3, I	A
2	Address job maintenance with suitable interventions	Becker et al., 1998	III	B

**E. Refer to Work Restoration Services: Transitional Employment**

*Objective*

Foster success in a transitional employment situation.

*Annotation*

Transitional employment, in which the patient experiences work in normal places of business on a temporary basis, is not a major focus of the contemporary literature on SE. One study did, however, find a positive outcome of such employment. Blankertz and Robinson report that when clients in an employment specialist program were taught work skills and attitudes in group and individual sessions and through a trial work experience, all participants experienced "skill gains and positive changes in work attitudes."

*Evidence*

	<b>Intervention</b>	<b>Source of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider patient for transitional employment.	Blankertz & Robinson, 1996	I	A

**F. Refer to Work Restoration Services: Workshop**

*Objective*

Foster success, on multiple dimensions, in a workshop setting.

*Annotation*

The value of a workshop or sheltered employment experience seems to be as therapy rather than simply as an economic activity. For example, in the Drake et al. study, although IPS participants were more likely to obtain competitive employment, those participants in sheltered employment improved in terms of "total earnings, job satisfaction, and nonvocational outcomes." In the Bell et al. study, "participation in work activity was closely associated with symptom improvement." Participants particularly improved on "positive, hostility, and emotional discomfort symptoms." This effect was still seen at 1-year follow-up. In the Drake et al. study, IPS participants were more successful in obtaining competitive employment, but there were no significant differences between the IPS and day treatment groups in terms of suicide attempts, rehospitalization, incarcerations, homelessness, or dropout rate.

*Evidence*

	<b>Intervention</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Consider patient of incentive therapy or workshop/sheltered employment.	Bell, Lysaker, & Milstein, 1996; Bell & Lysaker, 1997; Drake et al., 1994, 1999	I III-3; I	A

**Module Z - Case Management**

**A. Patient Who Is Unable to Locate and Coordinate Access to Needed Services**

Patients treated in this module have a diagnosis of psychosis and have case management issues (indicated by a "False" answer to the checklist question "Patient is able to locate and coordinate access to needed services").

*Annotation*

Case management is a form of treatment that assists the patient diagnosed with psychosis in surviving and optimizing adjustment in the community. Most patients enter the case management mode of treatment because they are high users of expensive modalities such as inpatient care. In case management, one person, or a team of providers, assumes overall management of the patient's care. In standard case management the case manager (CM) usually makes contact with the patient in the clinic. In more intensive models of case management such as Assertive Community Treatment (ACT), Intensive Case Management (ICM), or the VA's Mental Health Intensive Case Management (MHICM), the CM normally conducts outreach to the patient in the community. The frequency of contact between the CM and the patient is typically higher than the frequency of contact in a customary outpatient setting. CMs provide continuity of care for the patient in the mental health system. The CM addresses not only the manifest symptoms of the illness but also psychosocial problems affecting the patient's housing, transportation, application and attainment of entitlements, attainment of food, Activities of Daily Living (ADLs), attendance at psychiatrist and therapist appointments, and employment.

**B. Does Patient Meet Criteria for Mental Health Intensive Case Management?**

*Objective*

Determine the level of case management services required by the patient.

*Annotation*

A patient meets the criteria for MHICM after 30 days of inpatient care, 3 admissions in one year, or failure of standard case management.

**C. Evaluate Needs; Implement Standard Case Management**

*Objective*

Ensure that the patient receives needed services when incapable of independently obtaining these services.

*Annotation*

In the standard type of case management (also known as brokered case management), the CM performs the function of a service broker. The CM's role is to connect the patient with needed services and to coordinate care among various service providers. In standard case management, the CM is usually responsible for between 15 and 80 patients. Most standard case management programs do not offer 24-hour coverage for clients. The point of contact between patients and CMs in this model is usually the clinic.

*Evidence*

	<b>Intervention</b>	<b>Source of Evidence</b>	<b>QE</b>	<b>R</b>
1	Standard case management is significantly superior to no case management for substance abuse, income, and housing outcomes.	Cox et al., 1998	I	B

**D. Measure and Reevaluate Goals**

*Objective*

Determine to what extent the patient has met the goals established for the case management program.

*Annotation*

Before assigning the patient to a form of case management, establish measurable goals with the patient and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the patient's progress: CM feedback, the patient's report of status, and other relevant feedback from family members or community contacts.

**E. Consider Release from Case Management**

*Objective*

Determine whether the patient can function successfully without the support of a CM.

*Annotation*

The exit case management strategy is an area in need of further study. Although a few of the studies consulted for this module presented one- to three-year follow-up data for program participants, none systematically examined the effects of discontinuing case management for these patients. When case management services are withdrawn, some patients appear to relapse and lose many of the gains they had attained. However, the clinician should never assume the patient will need case management services indefinitely. Each patient should be seen as possessing the potential for independence as a key tenet of the "recovery" philosophy.

**F. Implement Assertive Community Treatment/Intensive Case Management/Mental Health Intensive Case Management**

*Objective*

Ensure that the patient receives needed services when incapable of obtaining these services independently.

*Annotation*

The rate of CM contact with patients is much higher than in other forms of case management.

*Evidence*

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
1	Refer patient with dual-diagnosis to ACT/ICM program with high fidelity to ACT model.	Drake et al., 1998; Phillips et al., 2001	I	A
2	Refer patient to ACT/ICM for superior outcomes in quality of life, housing, symptoms, and satisfaction with care.	Chinman, Rosenheck, & Lam, 2000; Dixon et al., 1997; Drake et al., 1998; Lehman et al., 1997; McHugo et al., 1999; Rosenheck & Neale, 1998	III; III; I; I; III; I	B
3	Refer to ACT/ICM if prevention of rehospitalization is determining factor.	Blow et al., 2000; Chandler et al., "Client outcomes in a three year," 1996; Chandler et al, "Client outcomes in a two model," 1996; Chandler et al., 1998; Essock, Frisman, & Kontos, 1998; Havassy, Shopshire, & Quigley, 2000; Issakidis et al., 1999; Joy, Adams, & Rice, 1999; McHugo et al., 1999; Rosenheck & Neale, 1998; Tyrer et al., 1998	II-2; I; I; I; I; I; I; I; III; I; I	A

	<b>Interventions</b>	<b>Sources of Evidence</b>	<b>QE</b>	<b>R</b>
4	Refer to ACT/ICM if length of stay reduction is determining factor.	Blow et al., 2000; Chandler et al., 1998; Gater et al., 1997; Lehman et al., 1997; Mares & McGuire, 2000; Tyrer et al., 1999	II-2; I; I; I; II-2I	A

**G. Consider Continuation of Standard Case Management or Release from Case Management**

*Objective*

Identify patients who may be able to move from ACT/ICM/MHICM to less intensive case management services.

*Annotation*

Some studies have shown that decreasing the intensity of case management, for example moving a patient from ICM to standard case management, is detrimental. This is especially true if the patient is a high user of services.

**H. Continue Assertive Community Treatment/Intensive Case Management/Mental Health Intensive Case Management**

*Objective*

Ensure that legal rights are respected during the admission.

*Annotation*

Apply legal mandates as appropriate. Local policies and procedures with regard to threats to self or others should be in place, reflecting local and state laws and the opinion of the VA Regional Counsel. Primary care, mental health, and administrative staff must be familiar with these policies and derived procedures. Implementation should also reflect local resources.

**I. Obtain History (Psychiatric, Marital, Family, Military, Past Physical or Sexual Abuse, Medication or Substance Use Including Over the Counter, Physical Examination, and Laboratory Tests)**

*Objective*

Identify the patient who is best served by remaining in the current form of case management.

*Annotation*

No evidence currently exists for a positive outcome when patients are reassigned to less intensive case management or are released from all case management. Because of this, caregivers should carefully consider each patient's individual progress before considering a change to standard case management or exit case management.

**Definitions**

**Quality of Evidence Grading**

**I:** Evidence is obtained from at least one properly randomized controlled trial (RCT).

**II-1:** Evidence is obtained from well-designed controlled trials without randomization.

**II-2:** Evidence is obtained from well-designed cohort or case-controlled analytical studies, preferably from more than one center or research group.

**III-3:** Evidence is obtained from multiple time series, with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.

**III:** Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

### **Recommendation Grades**

- A. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated
- B. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered useful/effective
- C. A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds
- D. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered not useful/effective
- E. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration

### **Abbreviations and Acronyms List**

**ACT** Assertive Community Treatment  
**ADL** Activities of Daily Living  
**AUDIT** Alcohol Use Disorders Identification Test  
**CARF** Commission on Accreditation of Rehabilitation Facilities  
**CBT** Cognitive Behavioral Therapy  
**CM** Case Manager  
**DoD** Department of Defense  
**EPS** Extrapyrarnidal Syndrome  
**ER** Emergency Room  
**GST** Group Skills Training  
**HIV** Human Immunodeficiency Virus  
**IAPRS** International Association of Psychosocial Rehabilitation Services  
**ICM** Intensive Case Management  
**ILS** Independent Living Skills  
**IPS** Individual Placement and Support  
**MHICM** Mental Health Intensive Case Management  
**NAMI** National Alliance for the Mentally Ill  
**NET** Neurocognitive Enhancement Therapy  
**OTC** Over-the-Counter  
**PRRTP** Psychiatric Residential Rehab Treatment  
**QE** Quality of Evidence

**QLS** Quality of Life Score  
**R** Recommendation  
**RCT** Randomized Controlled Trials  
**RT** Residential Treatment  
**SH** Supported Housing  
**SE** Supported Employment  
**STD** Sexually Transmitted Diseases  
**TD** Tardive Dyskinesia  
**VA** Veterans Affairs  
**VAMC** Veteran Administration Medical Centers  
**VASH** Veterans Affairs Supported Housing  
**VBA** Veterans Benefits Administration  
**VHA** Veterans Health Administration

### **CLINICAL ALGORITHM(S)**

Algorithms are provided in the original guideline document for:

- [Initial Screening for Psychoses](#)
- [Psychoses and Schizophrenia Treatment](#)
- [Psychosocial Rehabilitation Core](#)
- [Health Education](#)
- [Self-Care/Independent Living Skills](#)
- [Housing](#)
- [Family Support](#)
- [Social Skills](#)
- [Work Restoration Services](#)
- [Case Management](#)

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## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **REFERENCES SUPPORTING THE RECOMMENDATIONS**

[References open in a new window](#)

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence is identified and graded for selected recommendations (see "Major Recommendations" field).

Where evidence was ambiguous or conflicting, or scientific data were lacking, the clinical experience within the multidisciplinary group guided the development of consensus-based recommendations.

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## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Successful implementation of the guideline may help to:

- Formulate an efficient and effective assessment of the patient's complaints
- Optimize the use of therapy to control symptoms
- Minimize preventable complications and morbidity
- Achieve satisfaction and positive attitudes regarding the management of psychosis
- Promote recovery to the fullest extent possible

Implementation may lead to better care, earlier recognition of psychoses, better patient education, and effective multi-modal management. If this is accomplished, persons with psychoses can lead rewarding lives.

#### **POTENTIAL HARMS**

- Tricyclic antidepressants have the potential to worsen the status of persons with cyclothymia and should be avoided.
- Patients experiencing a first episode are more sensitive to neurological side effects of antipsychotics than multiple-episode patients.
- Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids. Baseline and periodic monitoring of blood glucose, serum lipids, blood pressure and body mass index (BMI) would be prudent particularly in those patients identified as having diabetes, or who are at increased risk for developing diabetes, or those with other known risk factors for cardiovascular disease.
- Extrapyramidal syndromes, tardive dyskinesia, anticholinergic side effects, orthostatic hypotension, elevations in prolactin level, sedation, and weight gain are the most common side effects of conventional and second-generation antipsychotics. Please refer to the original guideline document for a more complete discussion of drug side effects.

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## QUALIFYING STATEMENTS

#### **QUALIFYING STATEMENTS**

- Clinical practice guidelines, which are increasingly used in health care, are seen by many as a potential solution to inefficiency and inappropriate variations in care. Guidelines should be evidenced-based as well as based upon explicit criteria to ensure consensus regarding their internal validity. However, it must be remembered that the use of guidelines must always be in the context of a health care provider's clinical judgment in the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format.
- The guideline is not intended to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. The guideline is based on information available at the date of publication, and is intended to provide a general guide to best practice. It should be emphasized that evidence-based clinical practice involves using the best available research evidence, as well as exercising clinical judgment. Each individual person has different treatment needs. The clinician and patient must make choices that take individual preferences into account. The guideline can assist care providers, but the use of a guideline must always be considered a recommendation, within the context of a provider's clinical judgment, in the care of an individual patient.

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## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

### IMPLEMENTATION TOOLS

Clinical Algorithm

Pocket Guide/Reference Cards

Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

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## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness

Patient-centeredness

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## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

- Veterans Administration, Department of Defense. Management of persons with psychoses. Washington (DC): Department of Veteran Affairs; 2004 May. Various p.

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2004 May

### GUIDELINE DEVELOPER(S)

Department of Defense - Federal Government Agency [U.S.]

Department of Veterans Affairs - Federal Government Agency [U.S.]

Veterans Health Administration - Federal Government Agency [U.S.]

### SOURCE(S) OF FUNDING

United States Government

### GUIDELINE COMMITTEE

VA/DoD Clinical Practice Guideline Working Group

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

The list of contributors to this guideline includes physicians, psychologists, social workers, nurses and clinical pharmacists as well as experts in the field of guideline and algorithm development.

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the [Department of Veterans Affairs Web site](#).

Print copies: Available from the Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

## AVAILABILITY OF COMPANION DOCUMENTS

Various companion documents are available from the [Veterans Health Administration \(VHA\) Web site](#).

In addition, the [VHA Web site](#) provides references to related guidelines, performance measures, and other resources.

The following is also available:

- Guideline for Guidelines. Draft. Washington (DC): Veterans Health Administration, Department of Veterans Affairs. Available at: [VHA Web site](#).
- Putting clinical practice guidelines to work [online tutorial]. Available from the [Department of Veterans Affairs Web site](#).

See the following related QualityTool summaries on the Health Care Innovations Exchange Web site:

- [Department of Veterans Affairs/Department of Defense \(VA/DoD\) clinical practice guideline for the management of psychoses: modules A and J summary: initial screening for psychoses](#)
- [Department of Veterans Affairs/Department of Defense \(VA/DoD\) clinical practice guideline for the management of psychoses: modules A and J key point card: initial screening for psychoses](#)
- [Department of Veterans Affairs/Department of Defense \(VA/DoD\) clinical practice guideline for the management of psychoses: modules L-Z summary: psychosocial rehabilitation](#)
- [Department of Veterans Affairs/Department of Defense \(VA/DoD\) clinical practice guideline for the management of psychoses: modules L-Z key points card: psychosocial rehabilitation](#)
- [Management of persons with psychoses: health education algorithm](#)
- [Management of persons with psychoses: initial screening for psychoses](#)
- [Management of persons with psychoses: psychoses and schizophrenia treatment](#)

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on November 30, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on January 18, 2006, following the U.S. Food and Drug Administration advisory on Clozaril (clozapine). This summary was updated by ECRI Institute on October 2, 2007, following the U.S. Food and Drug Administration (FDA) advisory on Haloperidol. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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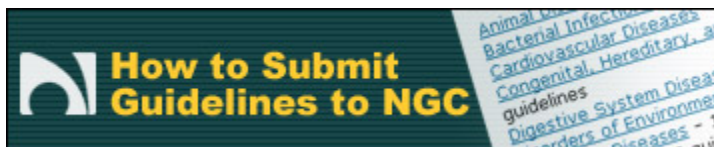
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