Apa schizophrenia guidelines 2019

SCHIZOPHRENIA

Drugs

Summary

A GUIDE TO SELECTED PSYCHOACTIVE DRUGS

Drug	Type	Pleasurable Effects	Adverse Effects
Alcohol	Depressant	Initial high followed by relaxation and disinhibition	Depression, memory loss, organ damage, impaired reactions
Heroin	Depressant	Rush of euphoria, relief from pain	Depressed physiology, agonizing withdrawal
Caffeine	Stimulant	Increased alertness and wakefulness	Anxiety, restlessness, and insomnia in high doses; uncomfortable withdrawal
Methamphetamine ("speed," "ice")	Stimulant	Euphoria, alertness, energy	Irritability, insomnia, hypertension, seizures
Cocaine	Stimulant	Rush of euphoria, confidence, energy	Cardiovascular stress, suspiciousness, depressive crash
Nicotine	Stimulant	Arousal and relaxation, sense of well-being	Heart disease, cancer (from tars)
Ecstasy (MDMA)	Stimulant; mild hallucinogen	Emotional elevation, disinhibition	Dehydration, overheating, and depressed mood, cognitive, and immune functioning
Marijuana	Mild hallucinogen	Enhanced sensation, relief of pain, distortion of time, relaxation	Impaired learning and memory, increased risk of psychological disorders, lung damage from smoke

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	APA	CANADIAN	NICE	MAUDSLEY
ACUTE T/T OF 1ST EPISODE	SGAs/FGAs	Olanzapine Risperidone Quetiapine	SGAs/FGAs	SGAs/FGAs
PROPHYLAXIS	To continue same antipsychotic	To continue same antipsychotic	To continue same antipsychotic	To continue same antipsychotic
DURATION	ACUTE: 4 TO 8 wks. STABILIZATION: upto 6 months. STABLE :upto 1 to 1.5yrs in 1st episode; 5 to 10 yrs in case of 2 or more episode & indefinite for multiple prior episodes or more than 2 episodes in 5yrs.	ACUTE PHASE: 6 to 12 wks STABILIZATION PHASE: 1 Yr STABLE PHASE: upto 2 yrs in 1st episode and upto 5yrs in case of multiple episodes.	Acute treatment to last 2yrs . No duration of long term treatment indicated	Same as NICE

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Schizophrenia (Lifetime prevalence about 0.3% to 0.7% [APA, 2013])
• Two or more of the following for at least 1 month: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms. • Impairment in one or more areas of function (social, occupational, educational self-care) for a significant period of time since the onset of the illness. • Continuous signs of the illness for at least 6 months (this can include prodromal or residual symptoms, which are attenuated forms of the symptoms described above).
Schizophreniform Disorder (Lifetime prevalence similar to Schizophrenia [APA, 2013])
• The same symptoms of schizophrenia described above that are present for at least 1 month but less than 6 months.
Schizoaffective Disorder (Lifetime prevalence about 0.3% [APA, 2013])
• A period of illness where the person has both the psychotic symptoms necessary to meet criteria for schizophrenia and either a major depression or manic episode. •The person experiences either delusions or hallucinations for at least 2 weeks when they are not having a depressive or manic episode. • The symptoms that meet criteria for depressive or manic episodes are present for over half of the illness duration.
Delusional Disorder (Lifetime prevalence about 0.2% [APA, 2013])
• The presence of at least one delusion for at least a month. • The person has never met criteria for schizophrenia. • The person's function is not impaired outside the specific impact of the delusion. • The duration of any depressive or manic episodes have been brief relative to the duration of the delusion(s).
Brief Psychotic Disorder (Lifetime prevalence unclear [APA, 2013])
• One or more of the following symptoms present for at least 1 day but less than 1 month: delusions, hallucinations, disorganized speech, grossly disordered or catatonic behavior.
Attenuated Psychotic Disorder (In Section III of the [APA, 2013]-V, Lifetime presence unclear [APA, 2013])
• One or more of the following symptoms in an "attenuated" form: delusions, hallucinations, or disorganized speech. • The symptoms must have occurred at least once a week for the past month and must have started or gotten worse in the past year. • The symptoms must be severe enough to distress or disable the individual or to suggest to others that the person needs clinical help. • The person has never met the diagnostic criteria for a psychotic disorder, and the symptoms are not better attributed to another disorder, to substance use, or to a medical condition.

Apa schizophrenia treatment guidelines 2020.

There are numerous practice guidelines available for schizophrenia and early course psychosis. While no practice guidelines are a substitute for your clinical judgement and decision making, they can offer useful information and serve as a good reference. For example, these guidelines can offer useful information about managing patients with schizophrenia prodrome, early course schizophrenia, and longer standing illness. Many offer treatment pathways around medication usage, such as when to use clozapine, as well as psychosocial interventions and the role of peer support. Most guidelines take up to a year to draft, and many are not updated for many years after release, so are not able to reflect the most current evidence. SMI Adviser has assembled a collection of current guidelines you can access. We do not endorse any but offer a variety each with a slightly different focus. They include ones from a commercial insure, a review of those from the American Psychiatric Association (APA), two from the Schizophrenia Patient Outcomes Research Team (PORT) and two from Canada. U.S. Guidelines International Guidelines In December 2019, the American Psychiatric Association (APA) Board of Trustees approved updated practice guidelines for the treatment of schizophrenia. The last full APA practice guideline was published in 2004, with an update in 2009. The 2019 guidelines aim to improve care quality and treatment outcomes for patients with schizophrenia. The lifetime prevalence of schizophrenia is approximately 0.7%, though estimates vary across study populations. Schizophrenia is associated with significant morbidity and early mortality. Between 4 and 10% of patients with schizophrenia are estimated to die by suicide, with rates highest among young men in the early stages of disease. Clinical practice guidelines were developed to reduce the significant disease burden among patients with schizophrenia. Clinical practice guidelines were developed using systematic review data of the current scientific literature. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) system was used to describe the quality of evidence supporting each proposed guideline. Guidelines were also graded based on investigator certainty that the benefits of the statement outweighed the harms. Recommendations with high evidence quality and investigator certainty are described herein. Guideline statements are classified into 3 categories: (1) initial assessment and treatment plan; (2) pharmacotherapy; (3) and psychosocial treatment. Initial Assessment and Treatment Plan The initial assessment of a patient with a possible schizophrenia-spectrum disorder should include an assessment of patient symptoms; patient preferences and goals for treatment; patient symptom and trauma history; patient tobacco and substance use; psychosocial and cultural circumstances; and risk for suicide attempt. A physical and cognitive assessment should also be performed.The initial assessment should use a quantitative measure to determine symptom severity and impairment level. Patient treatment plans should be comprehensive, well-documented, and incorporate evidence-based nonpharmacological and pharmacological treatments. Pharmacotherapy Patients with schizophrenia should receive an antipsychotic medication. During treatment, patients should be closely monitored for drug efficacy and adverse events.Patients who improve with antipsychotic treatment should continue to receive an antipsychotic medication.Patients with treatment-resistant schizophrenia may best benefit from clozapine.Patients with high risk for suicide attempts may best benefit from clozapine treatment over other antipsychotic medications.Patients with acute dystonia associated with antipsychotic treatment should receive an anticholinergic medication.Patients with moderate to severe tardive dyskinesia associated with antipsychotic treatment should receive treatment with a reversible inhibitor of the vesicular monoamine transporter 2 (VMAT2). Psychosocial Treatment Patients presenting with first episode psychosis should be treated in a coordinated specialty care program.Patients with schizophrenia should be treated with cognitive behavioral therapy for psychosis (CBTp).Patients with schizophrenia should receive psychoeducation.Patients with schizophrenia should receive employment support services.Patients with a history of difficulty engaging in treatment should receive community-based services that enhance compliance. These practice guidelines provide an overview of appropriate care standards for patients with schizophrenia. Guidelines are based on strong quantitative and qualitative evidence put forth in the literature. While care recommendations will continue evolve with the literature, the present APA guidelines represent best efforts to guide schizophrenia care. Disclosure: Several study authors declared affiliations with the pharmaceutical industry. Please see the original reference for a full list of authors' disclosures. Reference Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020;177(9):868-872. Schizophrenia Schizophrenia And Psychoses At its December 2019 meeting, the American Psychiatric Association (APA) Board of Trustees approved "The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia." The full guideline is available at APA's Practice Guidelines website.The goal of this guideline is to improve the quality of care and treatment outcomes for patients with schizophrenia, as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association 2013). Since publication of the last full practice guideline (American Psychiatric Association 2004) and guideline watch (American Psychiatric Association 2009) on schizophrenia, there have been many studies on new pharmacological and nonpharmacological treatments for schizophrenia. Additional research has expanded our knowledge of previously available treatments. The guideline focuses specifically on evidence-based pharmacological and nonpharmacological treatments for schizophrenia but also includes statements related to assessment and treatment planning that are an integral part of patient-centered care (Box 1).Since the publication of the Institute of Medicine (now known as National Academy of Medicine) report, Clinical Practice Guidelines We Can Trust (Institute of Medicine 2011), there has been an increasing focus on using clearly defined, transparent processes for rating the quality of evidence and the strength of the overall body of evidence in systematic reviews of the scientific literature. This guideline was developed using a process intended to be consistent with the recommendations of the Institute of Medicine (2011) and the Principles for the Development of Specialty Society Clinical Guidelines of the Council of Medical Specialty Societies (2012). Parameters used for the guideline's systematic review are included with the full text of the guideline. The APA website features a full description of the guideline development process.Development of guideline statements entails weighing the potential benefits and harms of each statement and then identifying the level of confidence in that determination. This concept of balancing benefits and harms to determine guideline recommendations and strength of recommendations is a hallmark of Grading of Recommendations Assessment, Development and Evaluation (GRADE), which is used by multiple professional organizations around the world to develop practice guideline recommendations (Guyatt et al. 2013). With the GRADE approach, recommendations are rated by assessing the confidence that the benefits of the statement outweigh the harms and burdens of the statement, determining the confidence in estimates of effect as reflected by the quality of evidence, estimating patient values and preferences (including whether they are similar across the patient population), and identifying whether resource expenditures are worth the expected net benefit of following the recommendation (Andrews et al. 2013).In weighing the balance of benefits and harms for each statement in this guideline, our level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. Evidence for the benefit of a particular intervention within a specific clinical context is identified through systematic review and is then balanced against the evidence for harms. In this regard, harms are broadly defined and might include direct and indirect costs of the intervention (including opportunity costs) as well as potential for adverse events from the intervention.Many topics covered in this guideline have relied on forms of evidence such as consensus opinions of experienced clinicians or indirect findings from observational studies rather than research from randomized trials. It is well recognized that there are guideline topics and clinical circumstances for which high-quality evidence from clinical trials is not possible or is unethical to obtain (Council of Medical Specialty Societies 2012). The GRADE working group and guidelines developed by other professional organizations have noted that a strong recommendation or "good practice statement" may be appropriate even in the absence of research evidence when sensible alternatives do not exist (Andrews et al. 2013; Brito et al. 2013; Djulbegovic et al. 2009; Hazlehurst et al. 2013). For each guideline statement, we have described the type and strength of the available evidence that was available as well as the factors, including patient preferences, that were used in determining the balance of benefits and harms.The authors of the guideline determined each final rating following parameters set forth in the "Guideline Development Process" endorsed by the APA Board of Trustees. A recommendation (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A suggestion (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty: although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or the benefits or the harms may be less clear. With a suggestion, patient values and preferences may be more variable, and this can influence the clinical decision that is ultimately made. Each guideline statement also has an associated rating for the strength of supporting research evidence. Three ratings are used: high, moderate, or low (denoted by the letters A, B, and C, respectively). These ratings reflect the level of confidence that the evidence for a guideline statement reflects a true effect based on consistency of findings across studies, directness of the effect on a specific health outcome, precision of the estimate of effect, and risk of bias in available studies (Agency for Healthcare Research and Quality 2014; Balshem et al. 2011; Guyatt et al. 2006).The scope of this practice guideline is shaped by the Treatments for Schizophrenia in Adults (McDonagh et al. 2017), a systematic review that was commissioned by the Agency for Healthcare Research and Quality (AHRQ) and that serves as a principal source of information for the guideline. The AHRQ review uses the DSM-5 definition of schizophrenia; however, many of the systematic reviews included studies that used earlier DSM or International Classification of Disease criteria for schizophrenia. Several studies, particularly those assessing harms and psychosocial interventions, also included patients with a schizophrenia spectrum disorder diagnosis. Consequently, discussion of treatment, particularly treatment of first-episode psychosis, may also be relevant to individuals with schizophreniform disorder.Although many of the studies included in the systematic review also included individuals with a diagnosis of schizoaffective disorder, these data were rarely analyzed separately in a way that would permit unique recommendations to be crafted for this group of patients. In addition, this guideline does not address issues related to identification or treatment of attenuated psychosis syndrome or related syndromes of high psychosis risk, which were not part of the AHRQ systematic review. Data are also limited on individuals with schizophrenia and significant physical health conditions or co-occurring psychiatric conditions, including substance use disorders. Nevertheless, in the absence of more robust evidence, the statements in this guideline should generally be applicable to individuals with co-occurring conditions, including individuals who receive treatment using integrated collaborative care or inpatient or outpatient medical settings. Although treatment-related costs are often barriers to receiving treatment and cost-effectiveness considerations are relevant to health care policy, cost-effectiveness considerations are outside the scope of this guideline and its recommendations.The full text of the practice guideline includes a detailed description of research evidence related to the effects of pharmacological and nonpharmacological treatments in individuals with schizophrenia. It also describes aspects of guideline implementation that are relevant to individual patients' circumstances and preferences.ReferencesAgency for Healthcare Research and Quality: Methods guide for effectiveness and comparative effectiveness reviews. AHRQ Publ No 10(14)-EHC063-EF. Rockville, MD, Agency for Healthcare Research and Quality, Jan 2014. Available at: www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=318. 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