



BEHAVIORAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED TREATMENT GUIDELINES FOR PSYCHOTIC DISORDERS

EXECUTIVE SUMMARY	2
INTRODUCTION AND STATEMENT OF INTENT	2
DEFINITION OF DISORDER	2
GENERAL GOALS OF TREATMENT	2
SUMMARY OF 1 ST , 2 ND AND 3 RD LINE TREATMENT.....	2
APPROACHES FOR PATIENTS WHO DO NOT RESPOND TO INITIAL TREATMENT	3
CLINICAL AND DEMOGRAPHIC ISSUES THAT INFLUENCE TREATMENT PLANNING	3
FLOW DIAGRAM.....	4
ASSESSMENT	5
PSYCHIATRIC ASSESSMENT	5
PSYCHOLOGICAL TESTING	5
SCREENING/SCALES.....	5
MODALITIES & TREATMENT MODELS.....	6
GROUP THERAPY	6
INDIVIDUAL THERAPY.....	7
FAMILY THERAPY / COUPLES THERAPY.....	8
INDIVIDUAL MEDICATION MANAGEMENT	9
GROUP MEDICATION MANAGEMENT.....	10
PSYCHO EDUCATIONAL GROUPS.....	11
CASE MANAGEMENT	12
REFERRAL	12
PRIMARY CARE	12
APPENDIX A: GLOSSARY	14
APPENDIX B: LITERATURE SUMMARY.....	16
APPENDIX C: SAMPLE TREATMENT PLANS.....	19
TREATMENT PLAN FOR PSYCHOTIC DISORDERS - ADULT	19
TREATMENT PLAN FOR PSYCHOTIC DISORDERS - CHILD AGE 6-12.....	20

Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with primary psychotic disorders. It may also assist clinicians treating patients who have some psychotic symptoms or functional impairment similar to patients with primary psychotic disorders, but where etiology is uncertain. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models, modalities, and/or referrals that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this group of disorders. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is:

- Effective
- Efficient
- Age Appropriate
- Culturally Relevant
- Acceptable to clinicians, program managers, and patients and family

Definition of disorder

Although there are many conditions in which psychotic symptoms may occur, this guideline was developed to address treatment of patients with disorders in which psychosis is a primary and persistent problem including schizophrenia, schizoaffective disorder, delusional disorder and persisting psychosis secondary to brain damage. See the DSM for criteria for these disorders.

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore function. For psychotic disorders, recovery may not mean the complete absence of symptoms, but usually means that the person will be able to work, to participate in family and community life, and to be less troubled by their illness.

Summary of 1st, 2nd and 3rd line treatment

The first line therapy for all psychotic disorders with the possible exception of delusional disorder is medication management. However, it's become increasingly clear that pharmacotherapy is most effective when combined with psychoeducation, intensive case management, family interventions, and possibly some forms of intensive or long term psychotherapy to increase adherence to medication, to decrease high expressed emotion in the patient's environment, and to work around the deficits in cognition and executive functioning experienced by many of these patients.

Currently, our Behavioral Health Clinics have the capacity for:

- Routine, outpatient medication management
- Crisis Intervention
- Some case management
- Limited individual psychotherapy

To adequately address the mental health needs of most patients with these disorders, we would need:

- Intensive case management (patient to case manager ratios of <30:1)
- Psychoeducational groups for patients and families
- In-home services
- A long term, therapeutic relationship with psychiatrists and other providers
- Rehabilitative services (occupational therapy, recreational therapy, etc.)

This guideline is designed for general use for most patients but may need to be adapted to meet the special needs of a specific patient as determined by the patient's provider.



Given the large unmet mental health needs of the native population, we will need to strengthen our coordination of care with other agencies as well as our internal resources. With limited case management at this time, we can only adequately meet the needs of patients with relatively good insight and community supports intact. Individuals with lower functional levels will need to be referred to appropriate community resources.

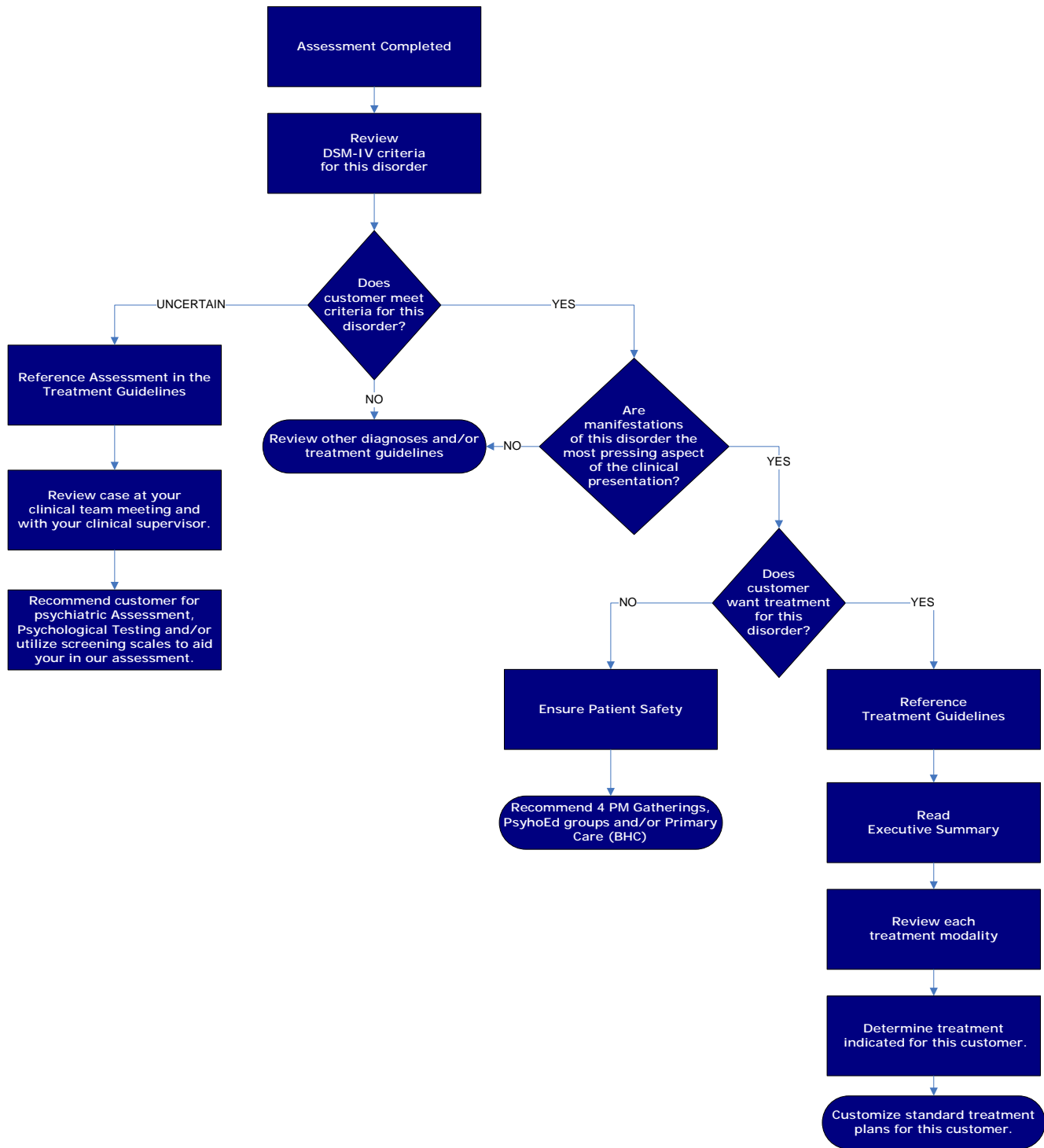
Approaches for patients who do not respond to initial treatment

The first step in addressing patients who do not respond to treatment is to assess the accuracy of the diagnosis or problem and the adherence, tolerability or accessibility of the treatment. Adherence is particularly problematic when the patient's illness impairs insight and motivation to the point that the patient may not be aware of their illness or impairments, or have the capacity to follow through on recommendations. Building alliance with the patient and helping them elucidate their goals is one approach for patients not responding to treatment. For patients with serious functional impairment related to their psychotic disorder, the addition of supportive and rehabilitative interventions is often more critical than the choice of medication. Clinicians are cautioned against an over reliance on a medication change to address ongoing problems in the absence of psychosocial interventions. There are several well reasoned antipsychotic treatment pathways available to clinicians which are referenced, but not recreated later in this guideline.

Clinical and demographic issues that influence treatment planning

Functional status and availability of community supports are probably the most critical factors influencing treatment planning. Comorbid substance abuse problems and homelessness are common complications in adults. Comorbid behavioral problems and family problems are common complications in children.

Flow Diagram



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Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	<ul style="list-style-type: none"> ▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms 	<ul style="list-style-type: none"> ▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed 	<ul style="list-style-type: none"> • Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	<ul style="list-style-type: none"> ▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.) 	<ul style="list-style-type: none"> ▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed 	<ul style="list-style-type: none"> ▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	<p>In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.</p>	<ul style="list-style-type: none"> ▪ Depends on the referral question 	<ul style="list-style-type: none"> ▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

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Modalities & Treatment Models

Group Therapy

For children 0 to 5 years old, primary psychotic disorders are very rarely diagnosed and would not be treated in a group setting. Older children and adults can benefit from social skills groups.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> ▪ Customer is 6 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers of any age with a psychotic disorder, family education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Adjunct treatment following psychiatric assessment and medication management ▪ Concurrent with case management and support services ▪ Patient’s family already enrolled in a family support intervention (may be group) 	<ul style="list-style-type: none"> ▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances 	<ul style="list-style-type: none"> • Diagnosed social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) ▪ Meets CMI or SED criteria without receiving rehab services ▪ Untreated Psychosis

STRUCTURE

- Groups will be facilitated by a Master’s Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services
- Four week co-occurring parent support group

Duration	60 to 90 minutes for 8 to 10 weeks
Frequency	Once a week
Size	Medicaid guidelines for co-facilitation should be followed
Open vs. Closed	Closed

TREATMENT MODEL

If a group were to be developed, it could be based on the following empirically supported models: psycho educational, supportive, Multimodal Integrative Cognitive Stimulating Group Therapy (MICST), and CBT.

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Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> • Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers of any age with a psychotic disorder, family education and involvement is predictive of good outcome and should be integrated whenever possible. (i.e. may have greater impact than individual psychotherapy) • Adjunct treatment following psychiatric assessment and medication management • Concurrent with case management and support services 	<ul style="list-style-type: none"> ▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances 	<ul style="list-style-type: none"> ▪ Meets SED criteria without receiving rehab services (i.e. rehabilitative services such as community oriented skills training may be more critical than individual psychotherapy) ▪ Requires more intensive care than weekly individual services

STRUCTURE

Duration	45 to 60 minutes
Frequency	<ul style="list-style-type: none"> ▪ Weekly or Bi-weekly ▪ 16 to 20 sessions for treatment ▪ Up to 8 sessions to prepare client for group

TREATMENT MODEL

Depending on the developmental age to the client, behavioral, play, parenting skills training, social skills training and independent living skills training could be appropriate interventions

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Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> ▪ First line of psychosocial treatment for 0 to 5 year old (medication is first line) ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers with psychotic disorders of any age, family education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness ▪ Adjunct treatment following psychiatric assessment and medication management 	<ul style="list-style-type: none"> ▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances 	<ul style="list-style-type: none"> ▪ Custody dispute ▪ Requires more intensive care than weekly individual services

STRUCTURE

Duration	60 minutes
Frequency	<ul style="list-style-type: none"> ▪ Weekly or Twice a Month ▪ 12 to 24 sessions for treatment

TREATMENT MODEL

Empirically validated treatments include psychoeducation to improve understanding of illness, adherence to medication, and to lower expressed emotion in the patient’s environment

Other family interventions that may be helpful include Family Systems, Strategic, Structural, Filial family, and Play therapies.

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Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> ▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psycho therapy and/or psycho education ▪ First line treatment with any primary psychotic disorder ▪ Should be considered for any psychotic symptom 	<ul style="list-style-type: none"> ▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances ▪ Adverse reaction to same drug in the past 	<ul style="list-style-type: none"> ▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

Duration	30 minute follow up appointments with parent or guardian present following a longer diagnostic evaluation
Frequency	Consider hospitalization in patients requiring follow up in less than 1 week. Weekly assessment may be necessary during acute phases of illness or the early phases of a medication trial. This can typically be reduced to monthly or even once every three months in a stable patient. Three month intervals for follow up can be considered the minimum frequency.

TREATMENT MODEL

There is inadequate evidence to recommend one antipsychotic agent over another based on efficacy or effectiveness trials, however, second generation antipsychotics (SGA's) are standard of care, first line agents based on decreased risk of EPS and TD.

Refer to APA and ANMC formulary for guidelines on choosing specific antipsychotic agent.

Contact the ANMC pharmacy for a list of antipsychotic medications currently on the formulary. At the drafting of this document, all FDA approved and US marketed second generation antipsychotics were on the formulary, but not necessarily in all tablet sizes or formulations. Prescription of these medications is not restricted to behavioral health providers, but initiation of them by a non-behavioral health clinician requires behavioral health approval.

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Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> ▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments 	<ul style="list-style-type: none"> ▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity ▪ Adverse reaction to same drug in the past 	<ul style="list-style-type: none"> • Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Groups require co-facilitation between and psychiatrist or ANP and a Case manager or RN

Duration	<ul style="list-style-type: none"> ▪ 60-90 minutes ▪ Indefinite
Frequency	Group could be available once a week, however, goal for individual patient attendance would be once a month
Size	
Open vs. Closed	Open

TREATMENT MODEL

Some matching by diagnosis, medication, or functional level is highly advised.

At the drafting of this document, there are no medication management groups for customers with psychotic disorders, but there was a Clozaril group in the past in which all patients prescribed this medication through the behavioral health clinic saw the psychiatrist and nurse together to review laboratory values, response to the medication, and overall functional status. The group appeared to normalize symptoms, treatment and monitoring. It provided a supportive peer group to otherwise very low functioning and socially isolated customers. It also provided a forum for ongoing education to clients and their care givers on their illness, prognosis, risks and benefits of treatment, etc. beyond what would otherwise be available in less frequent and shorter individual appointments.

Psycho Educational Groups

This modality can be extremely helpful for families of customers with substance abuse and/or a mental health disorders. Psycho education should be considered for the family even if the customer cannot participate.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
<ul style="list-style-type: none"> ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development 	<ul style="list-style-type: none"> ▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity 	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

TREATMENT MODEL

Suggested topics for groups:

- Typical medications
- Communication
- Parenting skills
- Normal developmental milestones
- Education about disorders
- Community resource linkage
- Symptom management
- Relaxation and stress management
- Independent living skills
- Diet and nutrition

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Case Management

All Ages	
Assessment	<ul style="list-style-type: none"> ▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	<ul style="list-style-type: none"> ▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	<ul style="list-style-type: none"> ▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral outside BH Fireweed or PCC

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

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CONSIDERATIONS OF TREATING PSYCHOTIC DISORDERS IN A PRIMARY CARE SETTING

Many primary care clinicians are not familiar with the medications commonly used to treat these disorders or with strategies for assessment of target symptoms or problems. Nevertheless, many patients with these problems present in primary care and refuse referral. Others are stable, can observe warning signs of their illness, and truly do not require ongoing specialist follow up while stable. Comanagement, consultation, or referral of these patients will continue to require case by case consideration and coordination of care between behavioral health and primary care departments.

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Expressed Emotion	In patients with schizophrenia, "High Expressed Emotion" vs. "Low Expressed Emotion" in the patient's immediate family has been found to influence rates of rehospitalization independent of other risk factors. Family based interventions have been created based on this finding with some evidence of success.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
MICA	Mentally Ill Chemical Abusing – an acronym for the population of, and treatments for people with significant functional impairment caused by a chronic psychotic disorder and on going substance abuse
MICST	Multimodal Integrative Cognitive Stimulating Group Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.

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BHS Treatment Guidelines for **Psychotic Disorders**

Term or Acronym	Term Definition
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined “modality” as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the “model” of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because “dual diagnosis” is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

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Appendix B: Literature Summary

Evidence Based Clinical Guidelines Southcentral Foundation Research Project Summary Sheet Psychotic Disorders

Diagnosis: Psychotic Disorders is a category that includes Schizophrenia and subtypes, Delusional Disorder and Schizoaffective Disorder.

295. __ Schizophrenia (Type and Course) consists of two symptoms from 1) delusions, 2) hallucinations, 3) disorganized speech, 4) grossly disorganized, 5) negative symptoms (affective flattening, avolition). The course must be six months with one month of the above symptoms.

297.1 Delusional Disorder is the existence of nonbizarre delusions (false beliefs) that involve situations that occur in real life. The course is that these must be present for one month

295.70 Schizoaffective Disorder is the presence of major depressive or mania symptoms accompanied by meeting the above criteria for schizophrenia.

General Information: This review searched the following data bases: Cochrane Reviews, American Psychological Association, American Psychiatric Association, The Journal of Empirical Mental Health, The National Guideline Clearinghouse, The Texas Algorithm Project, The Harvard Algorithm Project and SAMHSA, NIMH and Mental Health Today. The keywords for this search were: schizophrenia, psychotic disorders, group therapy, group psychotherapy, evidence-based, empirically supported treatments/therapies/interventions, reviews, and Boolean combinations of such terms.

This search produced significant hits from which a few are taken. The literature seems to be quite consistent and based on the severity, location and theoretical perspective surrounding the disorder. There is also considerable research and investigation into the underlying etiology of schizophrenia and the multi-courses of its development, treatment and recovery. It is fair to suggest that a pure biological accounting of the disorder is only partially accurate and that much of the neurological findings are as confusing as clarifying. What did appear clear is that the courses for most persons afflicted by this challenge need interventions from multiple sources and perspectives. Likewise, for most individuals, brief interventions are not empirically supported.

Group Therapy and Psychotic Disorders: Group therapy has and is an essential component of both the guidelines from the Am. Psychiatric Assoc and British "National Health Services" Centre for Review on Schizophrenia. Pekkala & Merinder (2002) noted in the Cochrane Review, that group psychoeducation including the family helped to improve medications compliance and was helpful in generating support in the family. This is a brief, education based group. Family education (that can be accomplished in group) has been noted as essential. Likewise, music group therapy was shown to improve medication compliance and therefore symptom relief (Tucker, 2003). Art therapy, that has been applied successfully to schizophrenic-like illnesses, could be conducted in group settings (Ruddy & Milnes, 2004; Cochrane Review). Lastly, Ahmed & Boisvert (2003) propose a Multimodal Integrative Cognitive Stimulating Group Therapy (MICST) model for working with schizophrenia. This is a longer term model that combines cognitive interventions, psychoeducation, relaxation and stress management and rehabilitative skills trainings into a comprehensive ongoing relationship with a small group of clients. It is not necessarily attempting to have global changes rather improve both client and staff interactions in a long-term care model.

In Delusional disorders, there were no citations about group therapy in the evidence based category. Mueser (2004, in press) noted that psychological interventions have not been reviewed for efficacy other than the use of individual cognitive therapy in a limited way.

Individual Therapy and Psychotic Disorders: Cognitive-Behavioral and Supportive therapies have been successfully employed in dealing with these disorders. Cormac et al (2004, Cochrane Review) and Tarrier (1999) both noted that while medication management is the mainstay treatment, CBT demonstrated

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BHS Treatment Guidelines for **Psychotic Disorders**

significant diminishment in hospitalizations. There was also significant improvement in “mental state” and symptom severity following CBT. Lastly, CBT seems to help in medication compliance.

Tarrier et al (2000) completed a follow-up and found that CBT and Supportive care were equally helpful in symptom relief, hospitalization and medication maintenance over routine care alone. This suggests and some formal interventions with purposeful goals with this population produce decreased human discomfort and cost savings.

Brief Therapy Models and Psychotic Disorders: The consensus of the literature reviewed does not espouse a brief, less than 20 session, therapy modality. Due to the nature of these disorders, especially schizophrenia, longer term affiliation and intervention are necessary. One citation selected noted that trained nurses providing as little as six hours of CBT interventions over two to three months reported overall symptom improvement. One caveat is that these clients were in secondary care, the practitioners were nurses and no mention in the review of the status of the clients as far as medications. Further, the timeframe is over 8 to 12 weeks. Above, the psychoeducational components can have significant impact and could be structured within the definition of brief therapy.

Professional Status in Brief Therapy: No specific data other than the nurse study noted above were researched. There is ample literature noting that in structured psychoeducational programming, a variety of trained practitioners can deliver the information. Likewise, the growth of family support and peer supports self-help within the general mental health system, while not having been thoroughly investigated as to efficacy, have, in clinical settings, demonstrated helpfulness. These are routinely run by non professionals.

Structure of most (Brief) Therapy: The uses of individual CBT or supportive therapy in combination with medications are most cited. The community outreach model and many structures like Assertive Community Treatment have the interventions taking place in the client’s environment. Structured treatment planning with specific purposes are standards of care. SEE THE DUAL DIAGNOSIS summary.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: “there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations” (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more “pluralistic” methodology in developing evidence based and culturally sensitive treatments.

Caution must be used to understand the cultural context, meaning and recovery for individuals being diagnosed from within the western paradigm. See Tseng and Streltzer (1997) and Castillo (1997). These books provide insight into interpreting symptoms outside the western professional categories.

Pharmacological Interventions: Am. Psychiatric Assoc treatment guide for Schizophrenia, the National Health Services Review, the National Guideline Clearinghouse guides all note that psychotropic medications are the first line of interventions with these disorders. The combination of newer anti-psychotics and antidepressants are general practice. Symptom relief for delusional disorders is questionable (Mueser, 2004 in press). Caution must be used to minimize side effects and quality of life measures as demonstrated in the Evidence Based practice guidelines for dual diagnosis. Both the Texas Algorithm and Harvard Algorithm have a medication protocol that balances symptom relief, side effects and partial responses.

Manuals: None.

References:

Ahmed, M., Boisvert, CM., Multimodal Integrative Cognitive Stimulating Group Therapy: Moving beyond the reduction of psychopathology in schizophrenia. *Professional Psychology: Research and Practice* 2003, Vol. 34. No. 6. 644-651

American Psychiatric Association, Treating Schizophrenia: A quick Reference Guide 2004

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BHS Treatment Guidelines for **Psychotic Disorders**

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Appendix C: Sample Treatment Plans

Treatment Plan for Psychotic Disorders - Adult

List of **Problem** Areas:

1. Bizarre content of thought (delusions of grandeur, persecution, reference, influence, control, somatic sensations, or infidelity, overvalued ideas or preoccupation)
2. Illogical form of thought/speech (loose associations, incoherence, illogical thinking, vague, abstract, neologisms, preservations)
3. Perception disturbance (hallucinations, illusions)
4. Disturbed affect (blunted, none, flattened, inappropriate)
5. Lost sense of self
6. Volition diminished (inadequate interest, drive, or ability to follow a course of action to its logical conclusion, pronounced ambivalence or cessation of goal-directed activity)
7. Relationship withdrawal (withdrawal from involvement with external world and preoccupation with egocentric ideas and fantasies, alienation feelings)
8. Psychomotor abnormalities (decrease in reactivity to environment, catatonic patterns, unusual mannerisms)
9. behavioral or functional problems secondary to these primary problems, (for example, difficulty keeping appointments, or maintaining housing or employment because of amotivational state and difficulty with executive function.)

Long Term **Goals**:

1. Significantly reduce or eliminate positive and negative psychotic symptoms
2. Restore normal functioning in affect, thinking, and relating
3. Workaround residual deficits and problems with appropriate rehabilitation and supports
4. Improve quality of life and relationships

Possible **Objectives**:

1. Pt. will adhere to medications and miss dose less than once a week.
2. Attend scheduled appointments
3. Contact clinic well in advance of running out of medication
4. Participate in psychoeducation group addressing medication adherence (with family involvement is most beneficial)
5. Participate in psychoeducation group for stress management skills and coping skills.
6. Referral to a Community Mental Health Clinic for intensive case management, in home care, and for longer term community support needs. (Possible referrals include: Anchorage Community Mental Health Clinic {formerly Southcentral Counseling Center}, Denali Family Services {under 21}, Quyana Clubhouse, The Arc of Anchorage {developmental needs}, Assests, NAMI, Alaska Children's Services {under 21}.)
7. Participation in Multimodal Integrative Cognitive Stimulating Group Therapy (MICSGT) ****Note : need specialized training in model, most often offered in a group home or other residential setting. Not service we provide in this clinic. This is a long term model.
8. Family education and support via individual and group meetings to improve familial understanding of illness including symptoms, prognosis, capacity, management strategies.

*******Note: Brief interventions alone are not empirically supported.**

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Treatment Plan for Psychotic Disorders - Child age 6-12

List of potential symptoms/problems:

1. Difficulty sustaining attention
2. Does not seem to listen when spoken to directly
3. Often does not follow through with directions and fails to finish HW, chores, or other duties
4. Difficulty organizing tasks and activities
5. Often avoids or dislikes, or is reluctant to engage in tasks that require sustained mental effort
6. Often loses things
7. Is easily distracted
8. Forgetful
9. Irritable
10. Hyperactivity
11. Difficulty sitting still, fidgety
12. Impulsivity
13. Is often "on the go" or acts if "Driven by a motor"
14. Danger to self or others (SI/HI)
15. Sleep difficulties
16. Flat or inappropriate affect
17. Delusions (infrequent in this age group)
18. Hallucinations (infrequent in this age group)
19. Grossly disorganized or catatonic behavior (rare in this age group)
20. Paranoia (rare in this age group)
21. Manic and/or mixed episodes (infrequent in this age group)
22. Loss of interest in once enjoyable activities
23. Loss of motivation to do normal daily activities and engage in personal interactions
24. Panic attacks (infrequent in this age group)
25. Phobias (rare in this age group)
26. Intrusive distressing thoughts possibly related to trauma- repetitive play may occur in which themes or aspects of a trauma are expressed
27. Intense fear, helplessness
28. Frightening dreams, night terrors
29. Trauma -specific reenactment
30. Dissociation (infrequent in this age group)
31. Fatigue
32. Aggression toward people and/or animals
33. Destruction of property
34. Deceitfulness or theft
35. Serious violation of rules

Long term goals:

1. Control or eliminate psychotic symptoms by complying with prescribed medications
2. Significantly reduce or eliminate any symptoms which are impeding ability to function at appropriate level.
3. Eliminate any self injurious behaviors and thoughts of harm to self or others
4. Return to satisfactory level of functioning without the necessity of intensive services.

BHS Treatment Guidelines for **Psychotic Disorders**

Possible objectives:

1. Customer will comply with medications 100% of the time
2. Customer to receive psychological assessment
3. Customer to participate in CBT and or MICST psycho education group weekly
4. Customer's family will be integral part of treatment.
5. Customer will learn 5 relaxation/stress mgnt. Skills and use regularly
6. Customer will learn and implement 5 coping tools to combat specific symptoms
7. Referral to Community Mental Health wrap-around services program (consider referral to: ARCA, ASSETS, SCC, NAMI, DFS)
8. Referral to Multimodal Integrative Cognitive Stimulating Group therapy (MICSTGT)****Note- specialized training required (not currently available).
9. Family participation in home based services model (HBT) (Not currently available)
10. Family will participate in education support groups
11. Customer and family will identify and utilize regular supports in home, school, or community
12. Customer will complete safety plan to involve home, school, and community involvement

Possible Interventions:

- | | |
|--|----------------------------------|
| 1. Referral | 10. Traditional Healing Practice |
| 2. Discussion | 11. Anger management |
| 3. Medication | 12. Skill building |
| 4. Insight based | 13. Psycho education |
| 5. Role play | 14. Linkage to services |
| 6. Role model | 15. Community support |
| 7. Behavioral | 16. Interpersonal |
| 8. Cognitive restructuring | 17. Psychological testing |
| 9. Talking Circle | 18. Play therapy |
| 19. Other expressive arts interventions (music, art, movement, Wilderness tx etc...) | |

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