Today’s topic: Canadian Psychiatric Association Schizophrenia Guidelines
Speaker: Julia Stratton PGY6 Child and Adolescent Psychiatry Fellow
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Questions?
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Canadian Treatment Guidelines for Schizophrenia in Children and Youth.
• 17 F
• Grade 11 Honors Student
• 2 siblings
• Dad – Engineer
• Moved from Pakistan at 1 year old
• Not cuddly or affectionate as child
• Lost contact with friends in context of current situation.
• Enjoys social media and art
• Unremarkable development and past history, no Substance Use, Trauma or FHx
• UCC from Family MD started on Abilify
  • 3 week course of psychotic symptoms and change in personality at home
  • Delusion of sexual assault, persecution, though broadcasting
  • Admitted to 6E with Psychosis NOS
  • Stabilized on Risperidone
  • Discharge to ROH OPD
What is Psychosis?
What is Psychotic Disorder?
What is Psychosis?

• 9-25%

• Disordered Thoughts that affects one’s evaluation of reality

• Multiple Etiologies – occur after a trauma, acute fatigue, substance use

• Normal Variants
  • Monster under my bed 5yo vs 16yo with ID vs 16yo with OCD
  • Must be understood in the developmental context
What is a Psychotic Disorder?

• Psychosis that lasts

• Brief Psychotic Disorder, Schizophrenia etc

• 1/3 begin before age 20
  • 10-15% will have no further symptoms

• Key is to identify the developmental context and then if it truly is psychosis, if this falls within a phase of typical schizophrenia spectrum and other psychotic illnesses.
Section: Canadian Treatment Guidelines for Individuals at Clinical High Risk of Psychosis (Adults and Youth)
Recommendation 1:

Those at clinical high risk need to be referred without delay to specialist care or early intervention program.
Recommendation 2:

Assess clinical high-risk states using a structured interview:

- Comprehensive Assessment of At-Risk Mental States (CAARMS)
- Structured Interview for Prodromal Symptoms (SIPS)

Identify the comorbid problems that may need to be treated.

*Key – 73% of those identified as showing a clinical high risk state also had a comorbid axis 1 diagnosis. Depression was the most common.*
Who is at Risk?

- Attenuated Positive Symptom Syndrome (APSS)
  - Most common
  - Emergence or Worsening of non-psychotic-level disturbances in though content, processes or perceptual abnormalities in the past year

- Brief Intermittent Psychotic Symptom Syndrome (BIPSS)
  - 1+ positive symptom
  - Too short to meet diagnostic criteria

- Genetic Risk and Deterioration (GRD)
  - Function Decline + Genetic Risk (SZTP or 1st degree relative with SSD)

- Key - 25-35% increased risk of developing psychotic disorder over several years
What are the Phases?

• Premorbid = Baseline

• Prodrome
  • Retrospective term
  • Marked by changes from baseline up to the appearance of psychotic features.
  • Important because prevent worsening of symptoms
  • 80-90% with Schizophrenia
  • Unclear how many with prodrome develop Psychotic D/o
  • Think of a Spectrum

• Duration of untreated psychosis
AND THEN WHAT?
Recommendations 3-6:

3. CBT with or without family intervention.

4. Treat the identified comorbidity.
   
   *Key - The presence of a comorbidity does not appear to increase the risk of transition to psychosis but treatment can relieve distress and improve functioning.*

5. Offer interventions for functional deficits in social, academic or employment spheres.

   *Key - Functional deficits predict conversion to psychosis*

6. Treatment is able to prevent or at least postpone a first psychotic episode in adult Clinical High Risk patients.

   *Key – 6 month conversion reduced by 64%, 12 month by 56%*
Recommendations 7-9:

7. Monitored by Psychiatry, Psychology or equivalent mental health provider

8. ADULT – if CBT ineffective add medication to stabilize, do not continue the medication long term for primary prevention.

9. If there are residual symptoms after intervening, monitor for up to 3 years. If they request a discharge offer follow up
   Option to self refer
   Ask their primary care provider to follow

Key – Study 2.5 year follow up, 71% had not converted to psychosis but 43% had attenuated positive symptoms and social and role functioning were poorer than controls.
• No Prodrome
• Not CHR
• No Comorbidities
Section: Canadian Treatment Guidelines on \textbf{Psychosocial Treatment} of Schizophrenia in Children and Youth.
Recommendations 1-12:

Build trust with the patient and their family, instilling hope and a focus on recovery.

Advise parents and care givers about their right to an assessment of their own physical and mental health needs and explain how they would access this.

Balance confidentiality and information sharing with Youth autonomy.

Understand culture specific beliefs about psychosis by ensuring proper communication and cultural competence.
Recommendations 13-14:
Family Intervention

Offer Family Intervention ASAP to all families for preventing and reducing relapses.

At least 10 sessions over 3 months - 1 year in either single-family or multi-family group intervention

*Key – family plays a crucial role. Include support and education, problem solving and communication skills as well as crisis management and barriers to recovery.*

Focus on the family working to recovery as a family, not only the patient.
Recommendations 15-16: Cognitive Behavioral Therapy

15. Offer CBT to assist in promoting recovery, for positive and negative symptoms and for those in recovery.

16. Need to have a trained professional* in an individual or group format with a minimum number of 16 sessions covering:
   - Basic principals
   - Thought monitoring
   - Coping
   - Protecting or Improving Self-Esteem
   - Stress Reduction
   - Functional Improvement

*Key – Group > Individual for youth
Recommendations 17-25:

- Offer supported educational and employment programs in regular training settings without time limits or delays

- Offer social skills training and Cognitive Remediation

- Provide psychoeducation and resources in oral and written forms
2 Month Impression:
Continued delusions and suspicion around male student though trending towards an over-valued idea.

Made a friend at school.

Difficulty with cognitive load at school so had to drop her advanced math course.

Medication causing sedation and impairing her ability to get to and perform at school.

Elevated Ceruloplasmin normalized

Psychosocial Plan:
Continued Psychoeducation and support

Provided Schizophrenia Resources

Referred for CBT
Section: Canadian Treatment Guidelines on Pharmacological Treatment of Schizophrenia in Children and Youth.
Recommendations 1-3:

Urgently refer after 4 weeks of sustained psychotic symptoms

Psychiatry should be the antipsychotic prescriber.

Offer antipsychotics as a combination of care.

Key – Adolescents experience longer treatment delays than adults, antipsychotic medication is as effective (as adults) & the risk of suicide is higher with early onset
Recommendations 4 & 5:

4. Medication and mode of administration should be a joint decision, with discussion of side effects and must be followed with monitoring.

   Key – Lack of evidence for clinical superiority between antipsychotics with the exception of clozapine.

5. When starting or changing an antipsychotic, consider an ECG if:
   a. risk is specified in the Health Canada data base
   b. physical exam identifies specific cardiovascular risk (BP)
   c. Personal or Familial Hx of CVD
Recommendations 6-9:

6. Dose below the lower end of the licenced range for adults to start, then titrate to an optimal dose for 4-6 weeks.

9. Discuss interactions between the antipsychotic medication and substances, alternative medications and nicotine.

Key – 40% greater risk of a psychotic disorder with ever using cannabis, and age of onset is 2.7 years earlier.
Recommendations 10-13:

10. Monotherapy except during cross-titration.

13. Inform that there is a high risk of relapse if medication is stopped in the first 1-2 years after an acute episode.

Key – 80% have a relapse in the first 5 years, medication non-adherence is the number one predictor.
Recommendations 21-23:

21. When clinically appropriate, offer the opportunity to discuss their experience of urgent sedation. Provide them with a clear explanation of the decision to use urgent sedation/restraint and record this in their notes.

*Key – There is insufficient evidence to support the use of antihistamines in cases of agitation. Typical antipsychotics should be limited due to the risk of EPS.*

22. Aripiprazole is the only Health Canada approved medication for Schizophrenia in youth under 18 years of age

23. Offer Clozapine to non-responders (2 antipsychotics for 6-8 weeks)
6 Month Impression:
Medication causing sedation and impairing her ability to get to and perform at school. Risperidone 2mg po qhs decreased by 0.25mg each month and maintained at 1.5mg

Continued to have overvalued ideas at the 6 month mark

On MSE continued to be concrete and interpersonally odd with intense eye contact. Though she began to make jokes.

Dx Schizophreniform Disorder

Pharmacotherapy Plan:
Continue Risperidone 1.5mg

Referred to First Episode
Dx: Brief Psychotic Disorder

Risperidone to Aripiprazole
4mg

Symptom Free

College, Dating, Friends

Continuing to follow closely
• PUFA’s

• Neuropsych Testing

• IM’s

• Parent and Patient Guideline
Questions or Comments?

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