

Schizophrenia Clinical Guidelines

Developed in collaboration with Northeast Behavioral Health Partnership, Centennial Mental Health, North Range Behavioral Health and Larimer Center for Mental Health
DSM-IV-TR Diagnostic Code: 295.xx; 295.40; 295.70

Diagnostic Considerations:

1. **Review diagnostic criteria** in DSM-IV-TR. Use the diagnostic decision tree for differential diagnosis, particularly to rule out other disorders that can include psychotic features, (e.g. schizoaffective disorder, bipolar disorder or depression with psychotic features, or substance-related disorders and substance withdrawal). Also consider referral to PCP to rule out Psychotic Disorder Due to a General Medical Condition, delirium, or dementia.

2. **Review medical history and current health status.** Request medical records from the client's PCP, and ensure ongoing communication between physical and behavioral health providers. Individuals with schizophrenia are often on multiple medications and have an increased risk for chronic and severe medical conditions, e.g. heart disease, diabetes, and emphysema (see Appendix A). Assess medication side effects and lifestyle risk factors, such as smoking, substance abuse/dependence, physical activity level and nutrition, as these can negatively impact health status, complicate treatment, and decrease medication effectiveness.

3. **Complete assessment using a variety of sources** such as objective scales and measures, client's self-report, and reports from the client's support network. Commonly used assessments for schizophrenia include: Brief Psychiatric Rating Scale, Positive and Negative Syndrome Scale, and the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Assess family history, symptom type, duration and onset, and gather information from friends and family to make an accurate diagnosis and inform treatment planning.

4. **Assess for strengths, resources, and environmental stressors.** Difficulty maintaining adequate housing/homelessness, limited social support or unhealthy family dynamics, problems obtaining benefits/employment and financial issues, or legal entanglements often contribute to greater instability. Assess the individual's acceptance/understanding of their illness, what personal strengths and coping strategies they utilize, and what natural supports are available.

5. **The average age of onset** is 18 in men and 25 in women. Late life onset (after 60 years) is inconsistent with the typical course of this disorder. If the client presents with late onset symptoms, consider referral to PCP to assess for medical etiology.

6. **Symptoms of early onset schizophrenia (EOS)**, in children and adolescents, are the same as onset in adulthood, except that delusions and hallucinations are less elaborate and hallucinations, when present, may be more visual than later onset. It is difficult to establish the diagnosis in children due to developmental issues, and the condition is relatively rare. Hallucinations are surprisingly common in children with diagnoses other than schizophrenia. Consider referral to a mental health professional with a specialty in EOS to assist in differential diagnosis, particularly for communication disorders, when disorganized speech is present, and pervasive developmental disorders, when disturbance of behavior, language, affect and social relatedness are present.

7. **Assess for cultural factors** that may contribute to the presentation of symptoms, understanding of the disorder, and identifying appropriate treatment. For example, certain

cultural norms and values include communication with, or visions of, spirits or ghosts, and are sometimes mistaken for psychotic symptoms.

Treatment Guidelines:

1. **The development of a therapeutic alliance** and identifying the client's treatment and life goals greatly improves engagement in treatment and overall outcomes. Attend to all aspects of the client's life to ensure a holistic approach to treatment planning.

2. **Attend to the client's physical health** by coordinating with the primary care physician (PCP) or psychiatrist to identify medical risk factors and coordinate efforts to reduce those risks. Encourage and support regular medical check-ups. Set health goals with the client around lifestyle factors that influence health such as smoking cessation, nutrition and physical activity. Consider referral to wellness groups for additional support (See Appendix A, See also "Promoting Wellness Clinical Guidelines").

3. **Integration of multiple treatment approaches** is most effective in promoting long term recovery; medication management, psychotherapy, psychosocial approaches, family and client psychoeducation, case management, and peer services. If substance abuse is co-occurring, consider referral to Integrated Dual Diagnosis Program (IDDT). Recovery is positively correlated with family support and attitude, employment, social activity and social skills training.

4. **Medication is one of the treatment foundations.** The treatment team should have regular contact to discuss medication effectiveness, monitor side effects, improve medication adherence, and provide psychoeducation. Consider using med boxes or long-acting medications to improve adherence. A focus on client's attitudes and behaviors related to medications is more effective in treatment adherence than psychoeducation alone. Medication side effects and complications can be serious, in terms of short term toxicity, and long term medical conditions. Exercise special caution in medication management for youth (See attached medication algorithms).

6. **Evidence-based therapeutic approaches for schizophrenia** include CBT (with special considerations for schizophrenia), behavioral interventions, social skills training and family therapy for children. Focus on instilling hope, reducing stressful environmental factors, increasing structure, promoting relaxation and decreasing stress through active coping. Symptom self-management can encourage the client to be aware of early warning signs for relapse, and developing a relapse prevention plan (See Appendix B for additional practical tips).

7. **Regularly assess** suicidal risk factors, including suicidal ideation, depression, anxiety, hopelessness, presence of command hallucinations, and substance use.

8. **Family psychoeducation** is key at all phases of this disorder, improving recovery from acute episodes, as well as assisting in relapse prevention and maintenance of recovery. Educate the client and family about schizophrenia and its treatment, how to identify early warning signs of relapse and the importance of providing as well as obtaining support. Involve the family to a degree that balances the client's need for independence and privacy with the need for support.

9. **Involve case management** to address basic needs such as housing, benefits, and community resources such as social or recreational groups to promote socialization. Refer to Supported Employment, Clubhouse, Assertive Community Treatment, and Wellness Management and Recovery to increase opportunities for a sense of community and accomplishment.

10. The use of **peer support or consumer-run services** should be emphasized. Evidence suggests such services are associated with reduced hospitalizations, improved functioning, reduced substance use, and improved quality of life.

Appendix A

Physical Health Risk and Severe Mental Illness (SMI)

Individuals with severe mental illness, more specifically those with a diagnosis of schizophrenia or bipolar disorder, have a significantly shorter life span than the general population, by as much as 25 years, and this differential mortality gap appears to be increasing over time. This higher mortality rate, for individuals with schizophrenia and bipolar disorders, is secondary to the fact that these individuals are more likely to develop chronic medical conditions, including cardiovascular disease and diabetes, than the general population, and are more likely than the general population to have lifestyle issues, including smoking, lack of exercise, and poor dietary habits that lead to "at risk" factors for cardiovascular disease (CVD) and diabetes, including obesity and metabolic problems. In addition, antipsychotic medication, in particular some of the atypical antipsychotics, used to treat individuals with schizophrenia, have been shown to cause an increase in obesity rates as well as development of type 2 diabetes.

These studies suggest that interventions aimed at monitoring and modifying risk factors are needed to improve health outcomes. This information supports the following for behavioral health staff treating an individual with schizophrenia:

- Ensure regular visits with prescriber to monitor risk factors and consider changes to medication if risk continues or increases.
- Coordination of care with PCP to monitor physical health risk factors and conditions.
- Development of a health plan for clients with risk factors to improve health related behaviors; nutrition, exercise, smoking cessation, and substance use prevention/treatment.
- Referral to appropriate resources to support health goals, such as wellness groups or classes, providing vouchers to fitness centers, and/ or peer services.

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Appendix B

Practical Strategies for Working with Clients with Schizophrenia

- CBT for psychosis (CBTp) has been found to be effective in reducing positive symptoms (hallucinations, delusions, paranoia, disorganized thinking and speech) in chronic, partially remitted patients with schizophrenia. However, when a person is acutely ill, it is equivocal whether CBTp speeds recovery.
- Part of CBTp involves teaching the client to challenge the veracity of their delusions. Occasionally, clients are convinced and unshakable in the belief that their delusions are true, and they are unwilling to examine the veracity of this subjective experience. In these cases, the clinician must negotiate treatment goals aimed at reducing distress rather than the symptoms themselves, otherwise the client will likely drop out of treatment.
- Writing down simple points in a workbook for the client as a memory aid is more effective than providing handouts, which are rarely read and frequently lost.
- It's important to balance the nature and duration of sessions against the client's level of tolerance. Keep initial sessions brief or allow client to leave when they have had enough. The one to one nature of therapy is highly stressful so initial sessions may serve merely to provide habituation to the social stress of being with the clinician. Teaching the client simple strategies to deal with tension and anxiety (e.g., brief relaxation) may be helpful in habituating to the therapy situation and also provides a concrete task on which to focus attention.
- Simple attention focusing tasks, such as focusing on some item in the room for a short period, may be helpful in reducing the effect of irrelevant stimuli on the client's conscious awareness.
- The verbal and nonverbal cues that the therapist might expect to indicate severe distress, depression, or suicidality may not be expressed by someone with schizophrenia. Affect may be flat or inappropriate, which may result in the therapist missing important signs of risk. Don't make assumptions about mental state and have the client agree from the outset that he or she will inform the therapist of important changes in his or her life or mood.

References

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