Schizophrenia Clinical Guidelines
Developed in collaboration with Foothills Behavioral Health Partner’ Providers, Mental Health Partners, Jefferson Center for Mental Health and Arapahoe House
DSM 5 Diagnosis code: 295.90

Diagnostic Considerations:
1. **Diagnostic Criteria in DSM 5:**

   Schizophrenia is listed in the Schizophrenia Spectrum and Other Psychotic Disorders section of the DSM 5, which also includes the following: delusional disorder, brief psychotic disorder, schizophréniform disorder, schizoaffective disorder, substance/medication induced psychotic disorder, psychotic disorder due to medical condition, catatonia, and other specified or unspecified spectrum and other psychotic disorder. All disorders in this category are defined by abnormalities in at least one of the following domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Some disorders in other sections may present with similar symptoms to schizophrenia, for example, post-traumatic stress disorder, substance use disorders, and borderline personality disorder; it is important to rule these out when diagnosing schizophrenia. This guideline is specific to the research and literature pertaining to Schizophrenia, however some aspects may apply to other disorders on this spectrum.

<table>
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<th>Schizophrenia Diagnostic Criteria</th>
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<td><strong>Two</strong> (or more) of the following occurring for a significant portion of a one month period, with continuous signs of disturbance that persists at least 6 months, along with clinically significant distress or impairment in functioning. At least one symptom must be either 1, 2, or 3:</td>
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<td>1. Delusions</td>
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<td>2. Hallucinations</td>
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<td>3. Disorganized speech (e.g. frequent derailing or incoherence)</td>
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<td>4. Grossly disorganized or catatonic behavior</td>
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<td>5. Negative symptoms (i.e. diminished emotional expression or avolition)</td>
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Specify: - First episode (acute, in partial remission, in full remission)  
- Multiple episodes (acute, in partial remission, in full remission)  
  - Continuous  
  - Unspecified  
  - Catatonia (use additional code 293.89)

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 conditions, e.g. heart disease, diabetes, substance use disorders, and emphysema (see Appendix A). Assess medication side effects and lifestyle risk factors, such as alcohol, drug, and tobacco use; decreased physical activity level; and poor 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 (Overall & Gorham, 1962); Positive and Negative Syndrome Scale (Kay et al., 1967); and the Structured Clinical Interview for DSM-5 Disorders (SCID-5) (First et al., 2015). Assess family history of mental or psychotic disorders and obtain collateral information about symptom type, duration and onset from friends and family perceptions, 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, legal entanglements, or lack of access to food and basic needs 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. **Assess risk factors for suicide,** including suicidal ideation, depression, anxiety, hopelessness, presence of command hallucinations, and substance use. Because 20% of individuals diagnosed with schizophrenia attempt suicide, assessment and reassessment of suicide risk is required.

6. **The average age of onset** is early to mid-20s in men and late 20s in women. Onset in adolescence is rare. Males have an earlier onset, longer duration and emphasis on negative symptoms and females have later onset, brief presentations and more mood symptoms. Late life onset (after 40 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. The lifetime prevalence of schizophrenia appears to be approximately 0.3%-0.7%, although there is reported variation by race/ethnicity, across countries and by geographic origin for immigrants and children of immigrants.

7. **It is difficult to diagnose schizophrenia in children** because of developmental issues and the rarity of early onset schizophrenia (EOS). Symptoms of 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. 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. This is particularly relevant for communication disorders, when disorganized speech is present, and pervasive developmental disorders, when disturbance of behavior, language, affect and social relatedness are present.

8. **Assess for cultural factors** that may contribute to the presentation of symptoms, understanding of the disorder, and identification of appropriate treatment. Consider that certain commonly held practices or beliefs (e.g. communication with deceased loved ones) in one culture may be labeled as delusions or hallucinations, and mislabeling could lead to inaccurate diagnosis.

**Treatment Guidelines:**

1. **Developing a therapeutic alliance** and identifying the client’s treatment and life goals greatly improves engagement in treatment and overall outcomes. It is important to attend to all aspects of the client’s life to ensure a holistic approach to treatment planning, including spiritual, wellness, and cultural aspects. Peer services and the sharing of lived experience by peer specialists and motivational interviewing approaches can be helpful.

2. **Attend to the client’s physical health and wellness** by coordinating with the primary care physician (PCP) and psychiatrist to identify and reduce medical risk factors. Research indicates increased mortality rates, due to both side effects of antipsychotic medications and lifestyle...
factors. Encourage and support regular check-ups for whole-health (e.g., annual medical appointments, substance abuse treatment, and developmental disability treatment) and treatment of co-occurring conditions. Screen for associated risk factors (e.g. BMI, blood pressure, lipid and glucose levels, along with personal and family medical history) and set wellness goals with the client around lifestyle factors that influence health such as smoking cessation, alcohol and drug use, nutrition and physical activity. Consider referral to wellness groups or wellness coaching 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 a substance use disorder is co-occurring, consider referral to specialty treatment such as Integrated Dual Diagnosis Program (IDDT). Recovery is positively correlated with family support, 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 beliefs and behaviors related to medications is more effective in treatment adherence than psychoeducation alone, particularly motivational interviewing techniques to address ambivalence. Medication side effects and complications can be serious, in terms of short term toxicity, and long term medical conditions and should be communicated to the prescriber if noticed or reported during therapy. Use of alcohol, illicit drugs or non-prescribed medications should be discouraged. Exercise special caution in medication management for youth (See attached medication algorithms).

5. **Evidence-based therapeutic approaches for schizophrenia** include Cognitive Behavioral Therapy (CBT); with special considerations for schizophrenia, behavioral interventions (including Acceptance and Commitment Therapy, which emphasizes acceptance and mindfulness strategies), 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 (See Appendix B for additional practical tips.)

6. **Continuously reassess** risk factors, including: trauma (history or recent traumatic event); suicide risk factors; warning signs of relapse; changes in substance use; and key health indicators, including possible medication side effects. Adjust treatment plan and strategies as appropriate, which may include development or reassessment of a crisis plan.

7. **Family and support system psychoeducation,** unless clinically contraindicated or client does not give consent, is key at all phases of this disorder. This has been demonstrated to improve recovery from acute episodes, as well as assist in relapse prevention, and maintain 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.

8. **Involving comprehensive supports** is integral to effective treatment, and includes addressing basic needs such as housing, benefits, wellness and community resources, such as social or recreational groups. Programs may be available that integrate or address many key components, such as Psychosocial Rehabilitation (PSR), Supported Employment, Clubhouse, Assertive Community Treatment, IDDT, to increase opportunities for a sense of community and accomplishment. The use of peer support should be emphasized. Evidence suggests such services are associated with reduced hospitalizations, improved functioning, reduced substance use, and improved quality of life.
9. **Support for recovery** involves encouragement of symptom self-management; awareness of early warning signs for relapse; developing a relapse prevention, crisis, or self-care plan; and use of the support network. Ongoing involvement with peer supported activities, or other community or online supports can be helpful in maintaining recovery and enhancing quality of life.

*The Clinical Guidelines are meant to assist providers in making the best decisions about appropriate treatment in specific clinical circumstances. You are not required to follow them nor are you expected to be proficient in all of the therapeutic models described below. However, following the guidelines is one way to help ensure that your care is consistent with the most current research and best practices and that it is medically necessary.*

**References and Resources**


Canadian Agency for Drugs and Technologies in Health (CADTH). Optimal use recommendations for atypical antipsychotics: combination and high-dose treatment strategies in adolescents and adults with schizophrenia. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health (CADTH); 2011 Dec. 30 p.


**Web Resources for Clinicians, Clients and Family members**

Assertive Community Treatment Toolkit available at: [http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345](http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345)

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 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. These individuals are also more likely to have lifestyle issues, including smoking, lack of exercise, substance use, 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.

References


American Diabetes Associations et al. (2004). Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care Volume 27(2) 596-601


Osby et al. (2001). Excess Mortality in Bipolar and Unipolar Disorder in Sweden. Arch Gen Psychiatry;58:844-850


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 clinician 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 clinician 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 clinician of important changes in his or her life or mood.

- Employ motivational interviewing strategies to assess and promote readiness to change maladaptive behaviors, including those related to co-occurring substance use disorders. Strategies include scaling questions, exploring goals and decisional balancing.

References