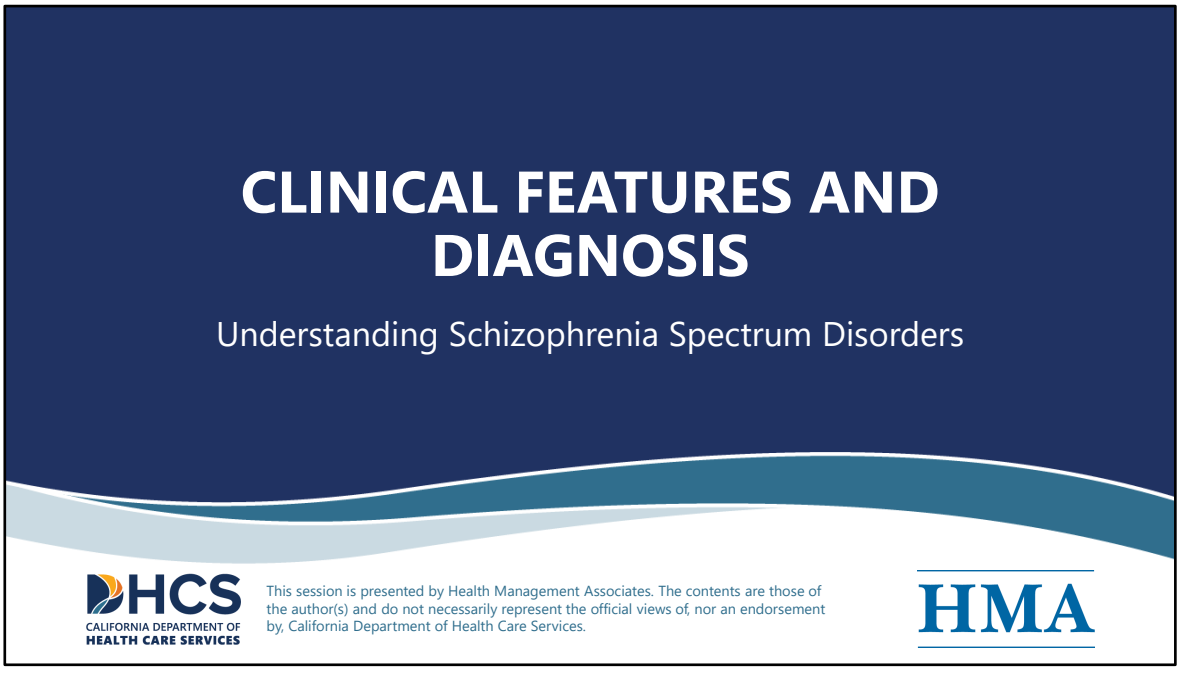
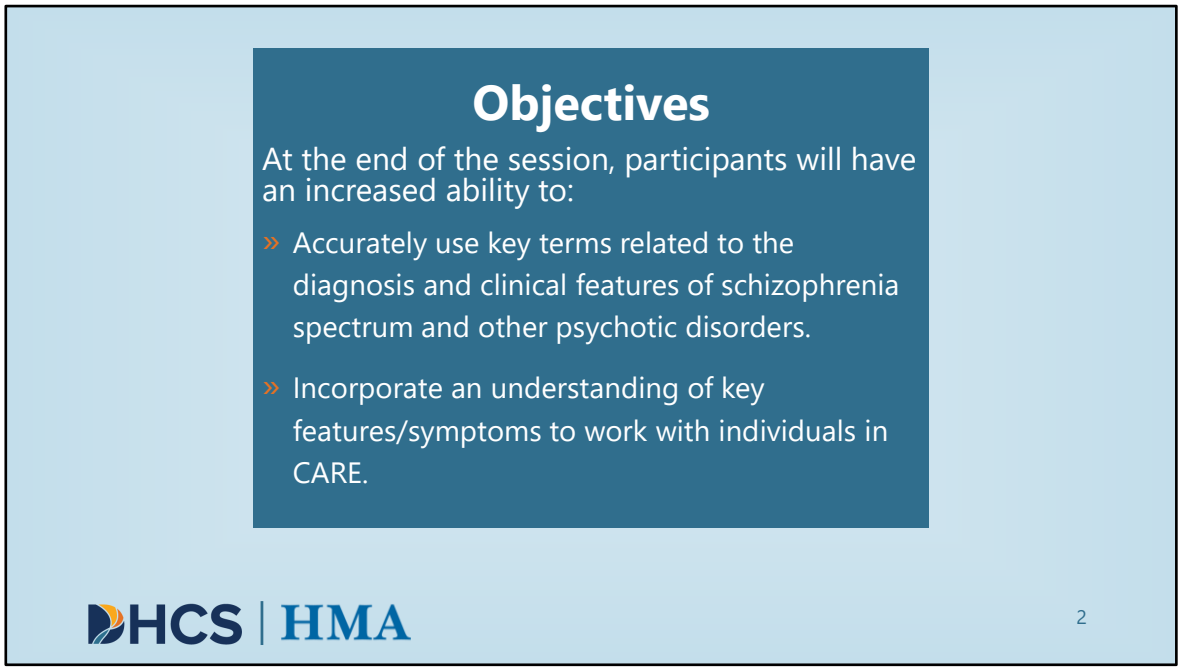


[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

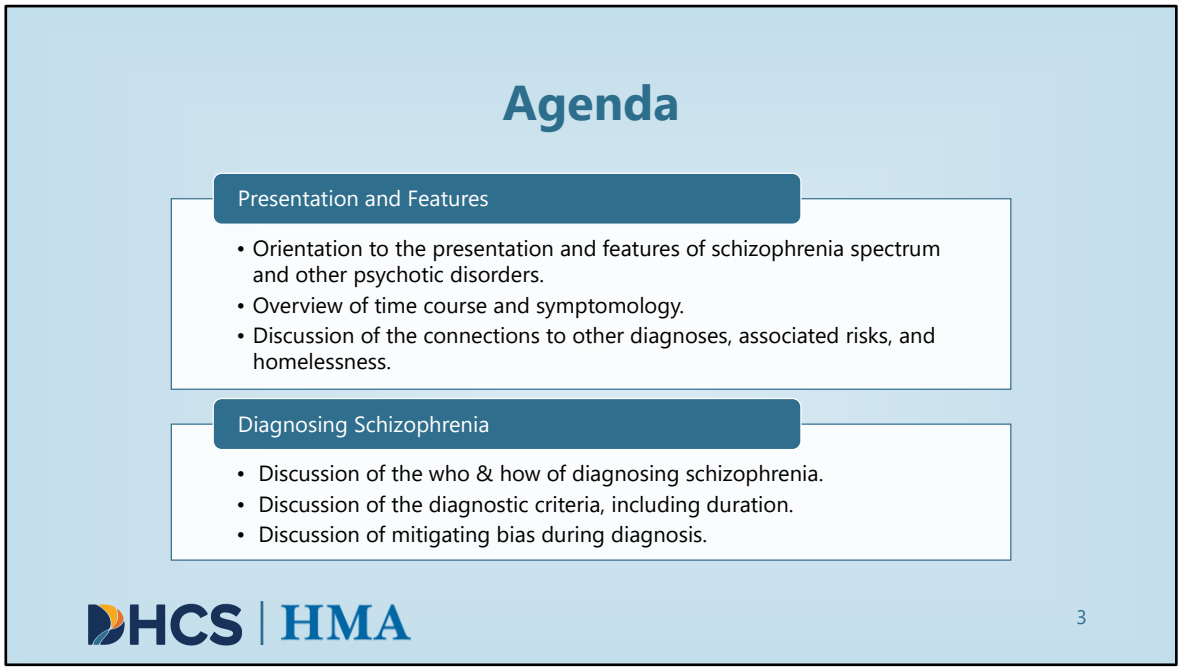
Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Accurately use key terms related to the diagnosis and clinical features of schizophrenia spectrum and other psychotic disorders.
- Incorporate an understanding of key features/symptoms to work with individuals in CARE.



[Slide Image Description: This slide shows the major sections of this training on a light blue background.]

In this training, we will discuss the following:

- Presentation and Features
    - Orientation to the presentation and features of schizophrenia spectrum and other psychotic disorders.
    - Overview of time course and symptomology.
    - Discussion of the connections to other diagnoses, associated risks, and homelessness.
- Diagnosing Schizophrenia
    - Discussion of the who & how of diagnosing schizophrenia.
    - Discussion of the diagnostic criteria, including duration.
    - Discussion of mitigating bias during diagnosis.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

HMA

Presenter

MARC AVERY, MD

Principal
Health Management Associates

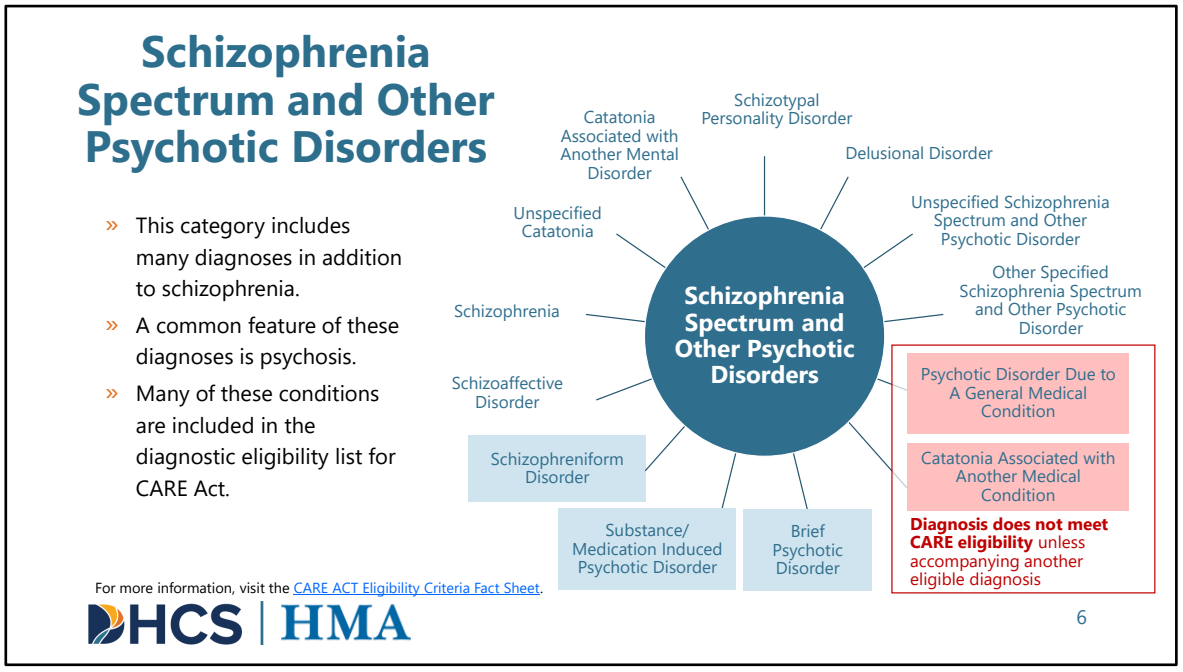
DHCS | HMA

4

[Slide Image Description: This slide includes images of the presenter of this training on a light blue background.]

Marc Avery, from Health Management Associates, is a board-certified psychiatrist and a recognized national leader in the subject of person-centered, integrated psychiatric care for high-needs and safety net patients. He has had the privilege and responsibility of providing (and overseeing) behavioral health care services to many hundreds of individuals with schizophrenia spectrum disorders and psychotic conditions including working with families, supporters, peer service providers, and other persons who assist in the care and treatment of persons with schizophrenia and related conditions.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]



[Slide Image Description: This slide shows a circle with arrows listing schizophrenia spectrum and other psychotic disorders.]

This slide depicts all of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) conditions that are listed in the schizophrenia spectrum and other psychotic disorders chapter. All of the CARE Act eligible diagnoses are contained in this chapter.

The content of this presentation applies specifically to schizophrenia itself. This is because schizophrenia is among the most common of the conditions in the DSM-5 chapter. However, much of this material also applies to the closely related conditions of schizophreniform and schizoaffective disorders. The other conditions shown on this slide are all related in terms of having prominent psychotic symptoms but may otherwise be experienced and appear quite differently than schizophrenia.

The DSM-5 chapter of schizophrenia spectrum disorders includes many different diagnoses with similar sounding names, in addition to schizophrenia itself. These diagnoses are clumped into one grouping because psychosis is a feature of all of them. Each of these has somewhat different diagnostic criteria. Note that this list

includes conditions that present similarly to schizophrenia but may not meet the six-month criteria for a formal schizophrenia diagnosis: brief psychotic disorder is for psychosis of up to one month duration, and schizophreniform is used for illness in the two-to-six-month time window.

As noted, all CARE Act eligible diagnoses are contained in this DSM-5 chapter. However, not all of the diagnoses in the chapter are eligible for CARE. The two that aren't eligible are psychotic disorder or catatonia that is associated with a general medical condition. These diagnoses must be accompanying another eligible diagnosis to meet criteria for the CARE process.

There are other conditions where someone might experience psychosis that are not contained in this chapter (e.g., severe bipolar disorder or depression with psychosis). Even though these conditions may feature psychotic symptoms, they are neither contained in this chapter nor are they eligible for CARE.

Keep in mind that having an eligible diagnosis is just one of the eligibility criteria for CARE. For example, someone diagnosed with Brief Psychotic Disorder, Schizophreniform Disorder (often associated with early diagnosis), or Substance/Medication Induced Psychotic Disorder would have to meet eligibility criteria related to the severity and duration of their symptoms, even though their diagnosis does not require a six-month time frame.

For more information, visit the CARE ACT Eligibility Criteria Fact Sheet.

Serious Mental Illness (SMI), Race & Ethnicity

- Providers are more likely to over diagnose people from racial and ethnic minority groups.
- Those in racial and ethnic minority groups are more likely to experience negative treatment outcomes, such as reduced symptom improvement, and fewer follow-ups after diagnosis.

For more information, see A Closer Look at Equitable Mental Healthcare: Racial Disparities in Serious Mental Illness and Mental Health Disparities, Treatment Engagement, and Attrition Among Racial/Ethnic Minorities with Severe Mental Illness: A Review.

DHCS | HMA

7

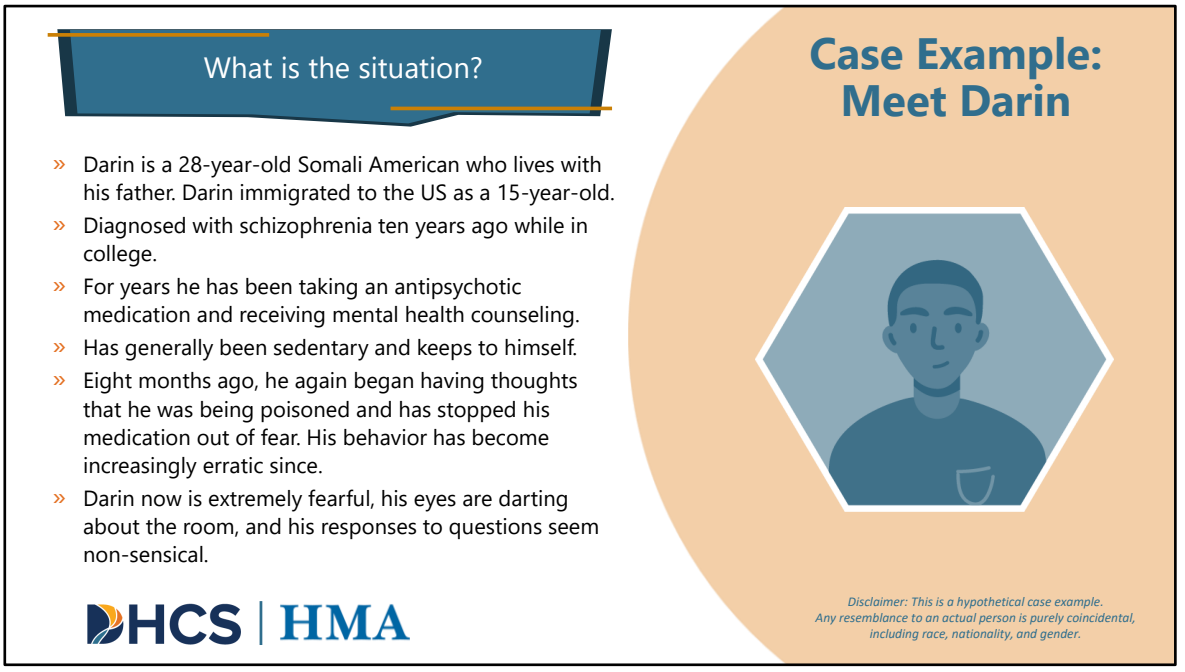
[Slide Image Description: This slide shows a picture of two individuals holding hands and statistics about serious mental illness (SMI), race & ethnicity.]

As we discuss schizophrenia spectrum and other psychotic disorders, pay attention to the ways that our biases may impact the way we perceive those with a serious mental illness and especially the intersection of serious mental illness and race.

- People from racial and ethnic minority groups are especially vulnerable to misdiagnosis and overdiagnosis (especially Black Americans).
- Those in racial and ethnic minority groups are more likely to experience negative treatment outcomes, such as reduced symptom improvement and fewer follow-ups after diagnosis.

As we talk about how these disorders present and are diagnosed, consider the ways in which biases might influence how we perceive individuals and how that might get in the way of an accurate diagnosis (which can then impact how that individual is connected to the right treatment and support).

For more information, see A Closer Look at Equitable Mental Healthcare: Racial Disparities in Serious Mental Illness and Mental Health Disparities, Treatment Engagement, and Attrition Among Racial/Ethnic Minorities with Severe Mental Illness: A Review.



[Slide Image Description: This slide shows an image of an individual depicting Darin and a description of Darin's situation.]

- Darin is a 28-year-old who lives with his father. He immigrated from Somalia to California when he was 15 years old.
- Darin was diagnosed with schizophrenia at age 18 after having an emotional breakdown in college. His first symptoms were persecutory thoughts and hearing voices around the school administration at his school.
- Prior to symptom onset, he was quite successful academically but has since dropped out of college. He has been a client at a local mental health center where he received regular counseling and an antipsychotic medication, Lurasidone.
- Darin has generally been stable at home, however, his father reports that despite care he receives, he is sedentary and generally keeps to himself.
- Six months ago, Darin started having thoughts that someone might be trying to poison him and stopped taking his medication out of fear. Since then, his behavior has become increasingly erratic, and he has been spending many nights on the streets. Yesterday he was brought into an ER after being found walking down the

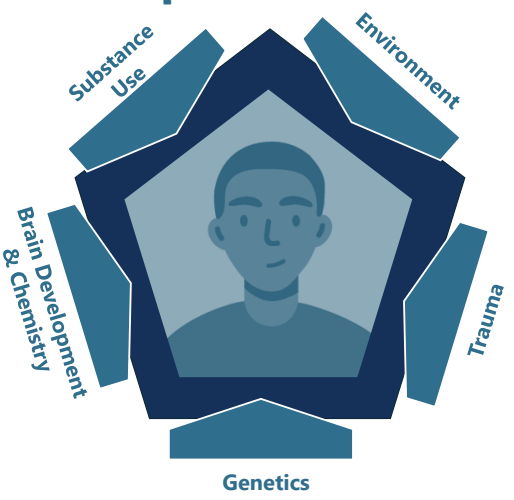
street and appearing to yell out at (imaginary) persons.

- Darin's Mental Health Case Manager visits him in the ER—he appears restless and afraid. His eyes appear to dart about the room, as if he was seeing or hearing things. When asked how he's doing, he says "The CEOs, they know my name, the name is the game, the game is the answer, but they won't answer." When asked if he understands what's happening to him, he replies "Yes! I'm being poisoned!" And when asked why he was yelling in the street, he responds "I need to let everyone know the poisoners are here!" The MH Case Manager is considering making a referral to CARE to help Darin receive better care.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

Factors of Schizophrenia

- Causes of schizophrenia are not well understood.
- Multiple factors play a role in how schizophrenia may present.



DHCS | HMA

9

[Slide Image Description: This slide shows an image of Darin with colored arrows listing factors of schizophrenia.]

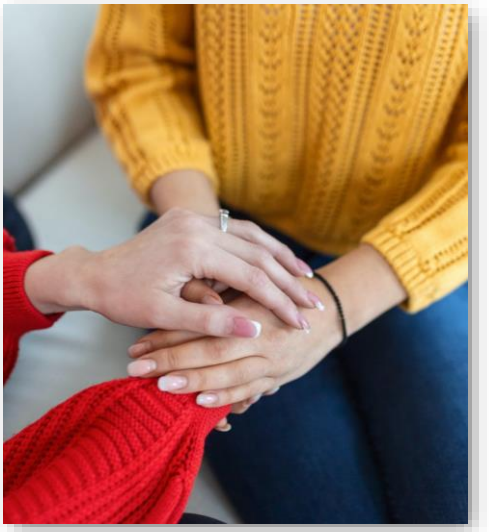
With Darin in mind, let's start by talking about schizophrenia in general. Many of us may have an associate, client, or loved one with this condition. But what causes schizophrenia in the first place? The fact is, the causes of schizophrenia are not well understood. This may be because there is probably not one single pathway that leads to developing schizophrenia. Most researchers believe that multiple factors may play a role, including brain development, brain chemistry, genetics, along with risk factors such as substance use, trauma, and environmental factors (including stress).

It is thought that these risk factors result in alterations in transmission of certain neurotransmitters—the chemicals that our brain cells naturally release when communicating with one another.

Schizophrenia Presentation

When

- 50% of all lifetime mental illness begins by age 14, and 75% by age 24.
- Often a diagnosis is made following one or more episodes of psychosis.
- This may follow a prolonged period of functional impairment (known as the prodromal period).
- May appear suddenly or following an acute crisis without previous symptoms or signs of illness.



Read more about mental illness statistics at Facts & Statistics - NAMI California.

DHCS | HMA

10

[Slide Image Description: This slide shows an image of two individuals holding hands with a description of how schizophrenia presents itself.]

Let's first talk about how schizophrenia begins in a person.

- Schizophrenia most typically presents in teenage years or early adulthood.
- Often a diagnosis is made following one or more episodes of psychosis (we'll define the word 'psychosis' a bit later in this presentation).
- The psychosis (and eventual diagnosis of schizophrenia) may appear suddenly without warning or following a prolonged period of functional impairment (known as a prodromal period).
- In other persons, someone may eventually be diagnosed with schizophrenia following what was thought to be another condition (e.g., bipolar disorder).

Consider our case example, Darin. Remember that he was first diagnosed with schizophrenia at age 18 after having an emotional breakdown in college. This came on rather suddenly (that is, he had no prodromal period). His first symptoms back then were persecutory thoughts and hearing voices. He recently began having thoughts that he was being poisoned and has stopped his medication out of fear.

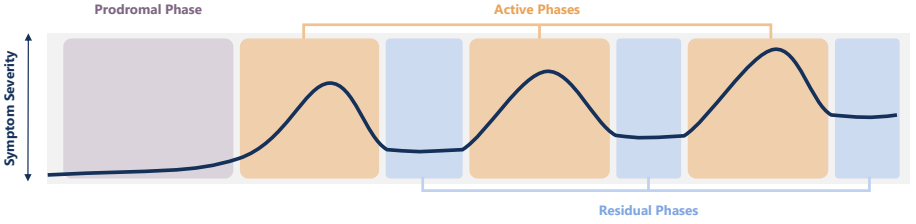
Keep in mind that although schizophrenia often presents during late teens or early 20s, referrals to CARE Act are likely to occur long after initial symptoms occur and after attempts at less restrictive measures are tried.

Read more about mental illness statistics at Facts & Statistics - NAMI California.

Time Course of Schizophrenia

The experience of schizophrenia is highly variable between persons, but it can be thought of as a chronic condition characterized by active phases with periods of residual, long-term symptoms.

- Generally, three phases of symptomatology: prodromal, active, and residual.
- Diagnosis usually occurs during an active phase, in which symptoms are dramatic.
- Symptoms are likely to progress in severity over time, especially if untreated.



Depiction of phases is illustrative. See Long-Term Course and Outcome of Schizophrenia, Phases of Schizophrenia, and the Course and Outcomes: Understanding Schizophrenia Spectrum Disorders Series training materials for more information on the course of illness over time.

DHCS | HMA

11

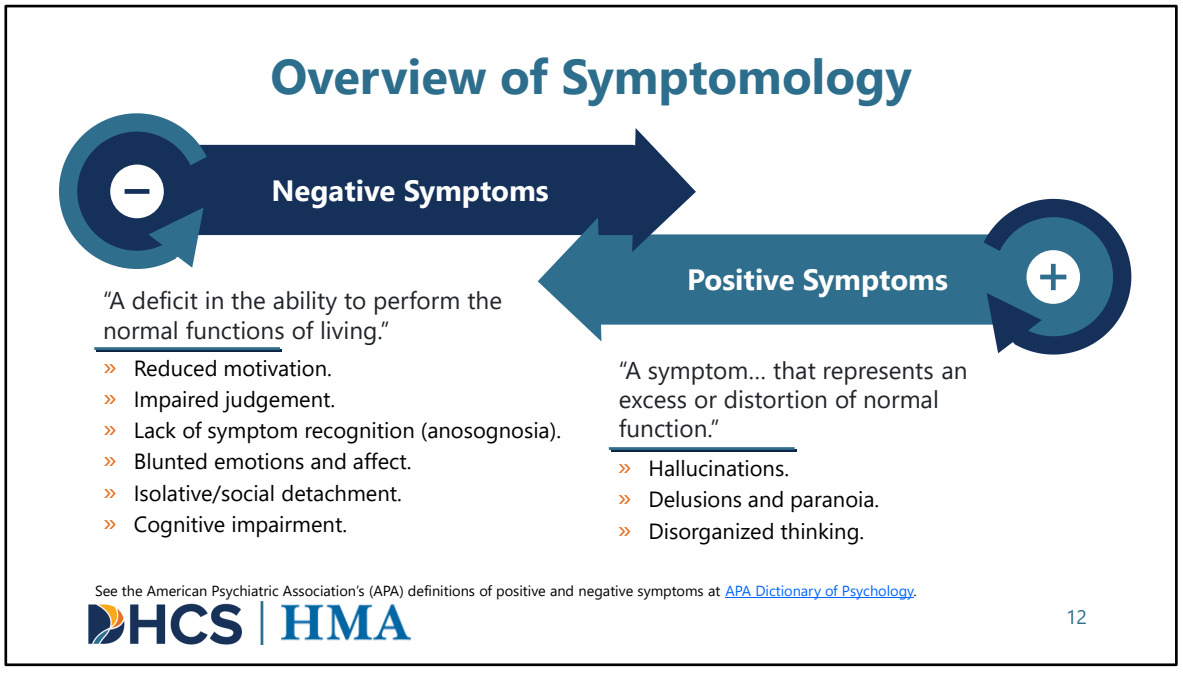
[Slide Image Description: This slide shows an illustrative chart depicting the three phases of schizophrenia: the prodromal phase, the active phase, and the residual phase.]

- The experience of schizophrenia over time is highly variable between persons, but it can be thought of as a chronic condition characterized by active phases with periods of residual, long-term symptoms.
    - Generally, the three phases of symptomatology are prodromal, active, and residual.
        - "Prodromal" refers to the period of time before the first recognition of a disease. During this period, people may observe subtle differences in behavior that feel out of place, such as odd beliefs, unusual perceptual experiences, decrease in motivation, sleep disturbances, or changes in emotional expressions. This phase can last weeks or years.
        - The "active" phase—sometimes called the "acute" phase—are when symptoms are most noticeable. This phase, especially the first time it happens, can feel alarming to friends and family.
            - The diagnosis of schizophrenia is typically made during one of

these acute episodes, though there is often a delay, sometimes for years, between onset of symptoms and diagnosis.
    - During the active phase, episodes are often dramatic and may include an exacerbation of positive and negative symptoms.
- The “residual” period is similar to the prodromal stage, in that individuals may still experience symptoms, but these symptoms may be less pronounced. The person may still have some beliefs that are odd to others, and they may still have trouble concentrating or having organized thought. However, some
persons have few symptoms during the residual phase.

- Keeping in mind that each person’s experience varies, schizophrenia generally follows a typical pattern of episodes of acute episodes, often characterized by prominent "positive" symptoms alongside "negative" symptoms.
    - These symptoms—in both the active phases and the residual phases in between—may exhibit progression over time, if untreated. A major strategy of treating schizophrenia is to, on one hand, reduce the number, severity, and impact of the acute episodes as well as during residual phases.
- A referral to CARE Act is more likely to occur after the person has experienced schizophrenia for some time and may already have experienced one or more cycles of illness.

Depiction of phases is illustrative. See Long-Term Course and Outcome of Schizophrenia, Phases of Schizophrenia, and the Course and Outcomes: Understanding Schizophrenia Spectrum Disorders Series training materials for more information on the course of illness over time.



[Slide Image Description: This slide shows two arrows depicting positive and negative symptoms.]

Schizophrenia is a complex condition that may present with one or more of many symptoms. To help understand these symptoms, they have been divided into two groups: "positive" and "negative" symptoms.

The terms positive and negative do not refer to "good" versus "bad" symptoms, and the "negative symptoms" certainly are not meant to suggest that the person is doing anything wrong**.**

Rather, note that the American Psychiatric Association (APA) defines negative symptoms as "A deficit in the ability to perform the normal functions of living."

Some of the negative symptoms you might see in someone living with schizophrenia are things like:

- Reduced motivation.
- Impaired judgement.
- Lack of symptom recognition (anosognosia).

- Blunted emotions and affect.
- Isolative/social detachment.
- Cognitive impairment.

Positive symptoms are defined by the APA as "A symptom… that represents an excess or distortion of normal function."

Positive symptoms include:
- Hallucinations.
- Delusions and paranoia.
- Disorganized thinking.

The positive symptoms of schizophrenia tend to stand out, especially when someone is in an especially acute phase of their disease. For example, someone that is responding to external stimuli by shouting in the street and by expressing delusional and paranoid thoughts. The negative symptoms may be less dramatic in appearance and can even be missed by clinicians and caregivers. However, the negative symptoms of schizophrenia often are just as difficult for an individual experiencing them. Though the negative symptoms are often less dramatic, they are actually more strongly correlated with longer-term functional challenge, impairment, and disability. Consider how difficult it can be to maintain quality of life and to adhere to a treatment plan if you have reduced motivation, your cognitive abilities are impaired and you are not thinking clearly, and—in many cases—you do not even recognize that you are actually having any symptoms at all.

These two symptom groupings are not necessary separated in time. For instance, an acute episode may present with prominent exacerbation of negative symptoms, whereas positive symptoms may be present during the "residual" phases. One of the goals of treatment of schizophrenia is preventing and treating the occurrence of acute episodes while reducing the experience or impact of the residual symptoms.

See the American Psychiatric Association's (APA) definitions of positive and negative symptoms at APA Dictionary of Psychology.

Hallucinations

Hallucinations refer to experiencing something that is not there.

- Can be highly distressing, distracting, and confusing to experience.
- Are unique for each individual experiencing schizophrenia.
- Commonly auditory – that is, hearing voices that others do not. However, hallucinations may also be visual (seeing things), olfactory (smelling things), or even somatic (physical sensations).

DHCS | HMA

13

[Slide Image Description: This slide shows an image of an individual hugging their knees with a description of hallucination features.]

Hallucinations in schizophrenia refer to experiencing things that are not actually there. Hallucinations can be highly distressing, distracting, and confusing, or even dangerous. Hallucination are generally distinguished from illusions. Whereas hallucination refer to seeing or hearing things that aren't really there, illusions refer to a misinterpretation of real sounds, sights, etc. Both can be distressing, but hallucinations are specific to psychosis.

Types of hallucinations:

- Hearing: The most common form of hallucination is hearing things—such as hearing a voice, or multiple voices.
    - Each person's experience of hearing sounds or voices are unique—they can be fleeting or constant, loud or soft, singular or multiple voices, some benign comments while other voices may be perceived as commands.
- Seeing: Not all hallucinations are in the form of sounds—visual hallucinations, or seeing things, can also occur in schizophrenia.
    - These also can vary a lot from person to person—some people just see

fleeting shadows, while other visual hallucinations can be more fully formed.

- Other senses: Other types of hallucinations are also possible with the other senses of touch, taste, and smell; however, these are less common.

Looking to our example Darin, he hears voices that he doesn't like to acknowledge or talk about, and he does sometimes see things that make him very uncomfortable and nervous. He's very uncomfortable talking about these things with other people but they are a part of his ongoing experience.

Delusions

- Delusions are constant and false beliefs that often sound strange to an outside observer.
- There are many types of delusions:
  - Paranoid or persecutory
  - Ideas of Reference
  - Grandiose
  - Erotomania

DHCS | HMA

14

[Slide Image Description: This slide shows an image of an individual sitting on a bench and looking down with a description of the features of delusions.]

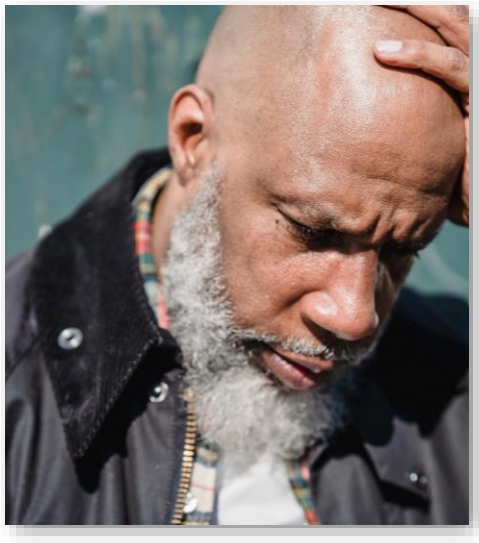
Delusions are another common feature in schizophrenia. Delusions refer to constant, false beliefs that are often bizarre sounding to an outside observer.

- For instance, someone might feel the body of a person they know well has been taken over by someone else entirely.
- There are many types of delusions
    - Paranoid or persecutory delusions are the false beliefs that some is out to "get them" or hurt them in some way.
    - Ideas of reference are delusions that environmental signs or media messages are communicating some sort of message to the person—such as the idea that the television is talking specifically about them.
    - Grandiose delusions are when someone has an expanded sense of self, their power, their wealth, or importance.
    - Erotomania is a false belief that someone, usually of importance, is in love with them.
        - Both grandiose delusions and erotomania can often occur during a manic episode of bipolar disorder. This might be considered

in persons with prominent grandiose delusions or erotomania.

- Like hallucinations, delusions can be highly distressing and preoccupying or may result in the person engaging in harmful behaviors as an attempt to address the false belief.

Looking to the case study, Darin experiences delusions and believes that someone is trying to poison him. He recognizes people see this as a delusion. Darin's anxiety can amplify the delusion and make him more suspicious.



Disorganized Thinking

- Persons with schizophrenia often experience disorganized thoughts and behavior, especially when in an acute episode of the illness.
- Disorganized thinking can present in a variety of forms, including:
  - Tangential thinking
  - Loose associations
  - Thought blocking
  - Word salad

For more information on disorganized thinking, visit The Care Transitions Network slide deck.

DHCS | HMA

15

[Slide Image Description: This slide shows an image of an individual looking down with their hand on their head with a description of the features of disorganized thinking.]

Persons with schizophrenia often experience disorganized thoughts and behavior, especially when in an acute episode of the illness. Persons may have difficulty organizing their speech into logical sentences, or in staying on topic in order to get basic needs accomplished (such as dressing appropriately for the weather or preparing food).

Persons who experience disorganized thinking of schizophrenia oftentimes have difficulty with communication with others in order to obtain basic care and services. This disorganization can lead to some ongoing difficulty in getting basic needs met around food, shelter, personal hygiene, and maintaining personal safety.

- Disorganized thinking can present in a variety of forms, these include:
  - Tangential thinking: losing the thread of a conversation and 'veer-off' topic
  - Loose associations: creation of disjoined statements with phrases or

statements that are often unrelated and non-sensical or difficult to track.

- Thought blocking: statements that are incomplete and suddenly drop mid-way into completion.
- Word salad: a more severe form of disorganized thoughts where words are mixed in a disorganized and non-sensical way.

Looking to our example, Darin is usually generally coherent but demonstrates some loose associations in his speech.

For more information on disorganized thinking, visit The Care Transitions Network slide deck.

Psychosis

- The term psychosis is used when an individual experiences hallucinations, delusions, and/or disorganized thoughts and behavior.
- Psychosis can occur in individuals with conditions other than schizophrenia, including conditions such as an acute phase of depression or bipolar disorder, using substances, during delirium, etc.

DHCS | HMA

16

[Slide Image Description: This slide shows an image of a sad individual leaning on a table with a description of the features of psychosis.]

So, what does the term “psychosis” mean?

Psychosis itself is not a diagnosis but refers to a cluster of symptoms including those we just covered—hallucinations, delusions, and disorganized thinking. Psychosis can occur in many different diagnoses, not just the schizophrenia spectrum disorders.

Persons who have psychosis are often in crisis. They may have suicidal thoughts, may be highly paranoid, may be behaving in a disorganized or erratic way, and may engage in risky, agitated, or aggressive behaviors. Persons who are having a psychotic episode are often highly vulnerable, and often lead to a psychiatric hospitalization.

The risk of acute psychosis is higher in persons with schizophrenia who are not receiving treatment with an antipsychotic medication.

Not all persons with an episode of psychosis have schizophrenia. Psychosis sometimes occurs with other types of psychiatric conditions, such as in severe bipolar disorder or

even in severe depression. A mental health professional typically is needed to evaluate a person with psychosis to determine whether the symptoms are due to schizophrenia or another condition. This is very important because a misdiagnosis can lead to confusion and providing the wrong treatments. Worse, a mistaken diagnosis that is recorded in a person's clinical record can linger for years, continually clouding the person's treatment options. Thus, an accurate diagnosis from the outset is the optimal situation for someone with psychosis. Also, even though psychosis can occur with other diagnoses, only those living with schizophrenia spectrum or other psychotic disorders in that class may be eligible for CARE.

Anosognosia

- A lack of symptom awareness (aka, anosognosia) is an impaired ability to recognize or understand their symptoms or illness.
- Anosognosia is often observed by clinicians as having poor insight into their condition, and/or demonstrating poor judgement as a result of symptoms they are experiencing.

For more information, visit the Strategies for Outreach & Engagement in CARE and the Capacity & Informed Consent in the CARE Process training materials.

DHCS | HMA

17

[Slide Image Description: This slide shows an image of an individual holding their hands on their knees with a description of the features of lack of symptom awareness.]

Persons with schizophrenia may not seem to recognize or understand their own symptoms or illness. This is a phenomenon that's known as "anosognosia." Anosognosia is often identified by clinicians in the mental status examination as lack of insight or poor judgement when completing the mental status examination. Whatever it is called, this lack of awareness makes it more difficult to provide informed consent. It can also make it more difficult to provide services and support and to engage them in care and treatment.

For more information, visit the Strategies for Outreach & Engagement in CARE and the Capacity & Informed Consent in the CARE Process training materials.

Cognitive Impairment

- Reduced attention
- Working memory
- General problem solving
- Recognizing social cues
- Learning and memory speed

DHCS | HMA

18

[Slide Image Description: This slide shows an image of an individual comforting another individual with a description of the features of cognitive impairment.]

One important clinical aspect of working with persons with schizophrenia is to recognize the potential cognitive impairments that a person might experience. The cognitive factors such as reduced attention, working memory, and problem solving may require adjusting how treatments are provided. For instance, in an educational meeting, instead of covering all the potential side effects of a proposed medication option, the clinician may choose to more carefully only review one, and to check for the person's understanding of basic concepts before moving on to more information.

One particular cognitive factor is worth discussing separately, and that is the potential for persons with schizophrenia to have impairment in recognizing key social cues in others. For instance, a person may not recognize anger or sadness in someone else. Clinicians may help by providing special forms of cognitive-behavioral interventions to help persons with this limitation to adjust and compensate for this difficulty.

Multiple or Additional Diagnoses (Comorbidity)

- Persons with schizophrenia are likely to have other disorders:
  - Mood disorder (such as depression or bipolar disorder)
  - Post-traumatic stress disorder (PTSD)
  - Substance use disorder, including tobacco
  - Anxiety disorder

For more on the association between schizophrenia and other disease states, see articles on comorbidities and schizophrenia, misdiagnosis, and the links to substance use disorders, depression, and bipolar disorders.

DHCS | HMA

19

[Slide Image Description: This slide shows an image of Darin and lists diagnoses that can be associated with schizophrenia.]

It is helpful to understand that persons living with schizophrenia are, unfortunately, also likely to have additional psychiatric diagnoses, a concept known as comorbidity.

Like the causes of schizophrenia itself, the reason why it is associated with other diagnoses is often not well known.

For example:

- It is common for a person with schizophrenia to experience significant depression, which may lead to a formal diagnosis of depression.
- Other persons may experience mania along with their condition leading to an additional diagnosis of bipolar disorder. The depression or mania may overlap temporally with the symptoms of schizophrenia itself. If that overlap is significant, then the person's diagnosis may be changed to schizoaffective disorder, one of the other CARE Act-eligible diagnoses.
- Persons with schizophrenia are also at risk for exposure to trauma, and thus are at risk for symptoms of post-traumatic stress disorder (PTSD).

- Persons with schizophrenia are at high risk of developing a substance use disorder, including tobacco use (individuals with schizophrenia spectrum and other psychotic disorders are five times more likely to use tobacco).

The presence of additional diagnoses often makes assessment of schizophrenia more complicated.

Keep in mind distinguishing between the presence of multiple *correct* diagnoses versus the risk of accumulating one or more *incorrect* diagnoses. As mentioned, early and accurate diagnosis is important because misdiagnoses are unfortunately common and can lead to confusion and to providing the wrong treatments. And, as mentioned, a mistaken diagnosis that is recorded in a person's clinical record can linger for years, continually clouding the person's treatment options.

For more on the association between schizophrenia and other disease states, see articles on comorbidities and schizophrenia, misdiagnosis, and the links to substance use disorders, depression, and bipolar disorders.

Associated Risks & Complications

- Persons with schizophrenia may experience various complications:
  - Depressed mood
  - Reduced self-care
  - Self-harm or suicide
  - Social detachment
  - Homelessness
  - Incarceration
  - Substance Use and/or Dependence
  - Risk of poorer health outcomes (including early death)

For more on the association between schizophrenia and associated diagnoses, risks, and complications, see article on the links to suicide and homelessness. For more information on the impacts of trauma (including social isolation, incarceration, and homelessness), see the Trauma-Informed Care training materials on CARE-Act.org.

DHCS | HMA

20

[Slide Image Description: This slide shows an image of Darin and lists associated risks and complications that can occur.]

There are other complications that persons with schizophrenia may experience as a result of their illness. In addition to treating the symptoms mentioned earlier, treatment and support of persons with schizophrenia is often focused to help reduce the impact of various complications of the condition that persons can experience.

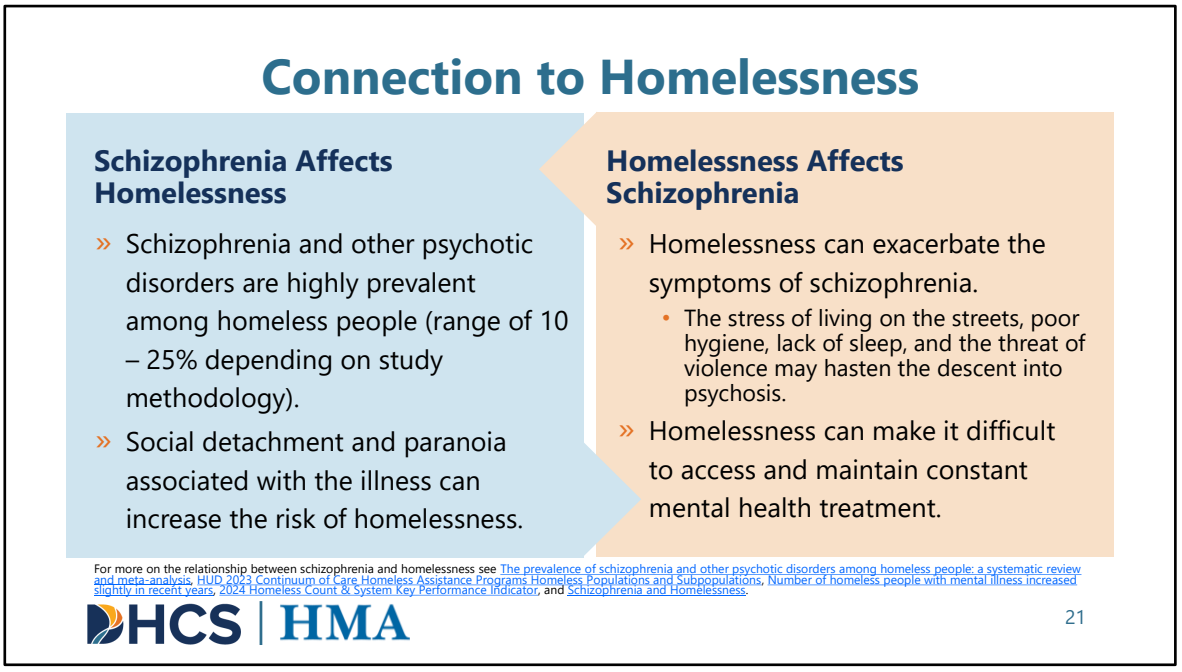
- **Depressed mood:** A certain amount of sadness is very common in individuals with schizophrenia, with or without a formal separate diagnosis of depression.
- **Reduced self-care:** Individuals with schizophrenia can also begin to neglect basic elements of self-care, such as their diet, personal hygiene, and overall health.
- **Self-harm or suicide:** Persons with schizophrenia are generally at higher risk of suicide as compared to the general population. The overall lifetime risk is about 10%, with the risk being highest in younger persons and young adults with schizophrenia.
- **Social detachment:** Letting go of important family, friends, and other supportive persons in their lives.
- **Homelessness:** Consider that 30% of the 582,000 unhoused individuals in the U.S. reside in California and at least 25% of those individuals are living with a serious

mental illness (National Alliance to End Homelessness). More on the connection to homelessness is listed on the next slide.

- **Incarceration:** Individuals with schizophrenia are also at risk for incarceration and justice involvement.
- **Substance use or Dependence:** Risk of unhealthy substance use is very common in persons with schizophrenia.
- **Risk of poorer health outcomes (including early death):** One final concern is the long-term risk of health conditions in persons with serious mental illnesses including schizophrenia – who often experience dramatically reduced life expectancy due to complications of medical conditions that are often treatable, including diabetes, weight gain, high cholesterol, and cardiovascular illness.

Let's look at Darin. The complications he's facing are social detachment and reduced self-care, and with his recent behavior he may be at risk of legal arrest. As Darin participates in the CARE process, it's helpful to understand the full context of Darin's diagnosis and additional complications. Understanding these complications can help all members of the CARE team—including courts and counsel—identify and eliminate biases that might be triggered by these associated diagnoses, risks, and complications.

For more on the association between schizophrenia and associated diagnoses, risks, and complications, see article on the links to suicide and homelessness. For more information on the impacts of trauma (including social isolation, incarceration, and homelessness), see the Trauma-Informed Care training materials on CARE-Act.org.



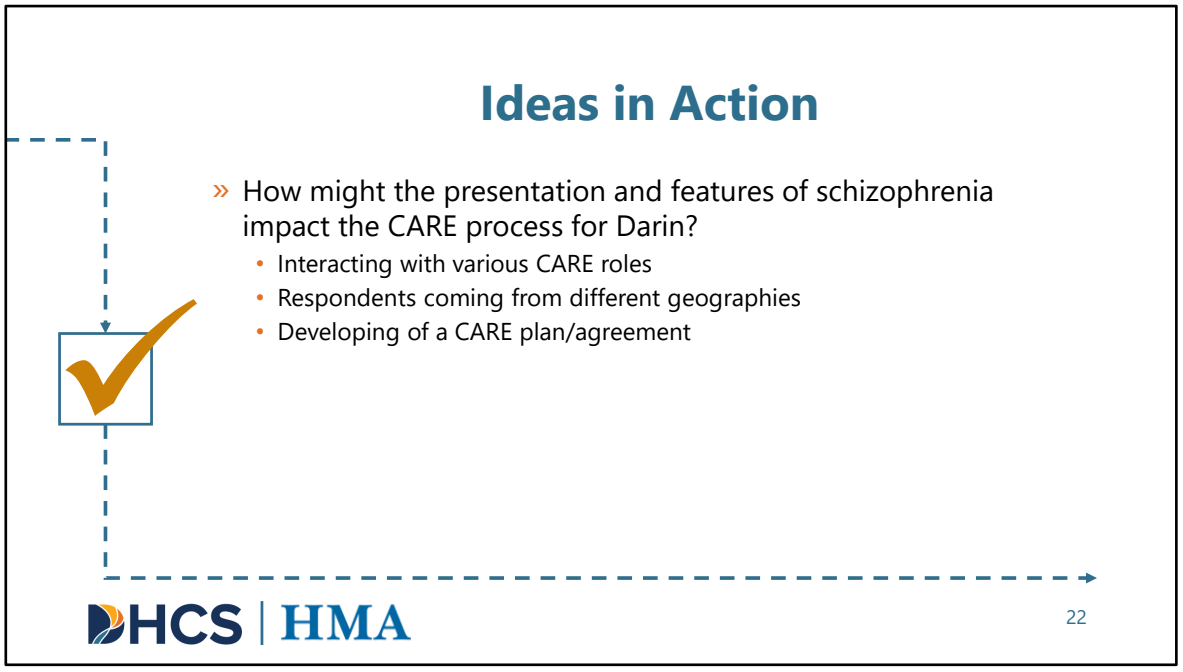
[Slide Image Description: This slide shows two boxes and details how schizophrenia and homelessness impact each other.]

- Schizophrenia and other psychotic disorders are highly prevalent among homeless people (range of 10 – 25% depending on study methodology).
- Social detachment and paranoia associated with the illness can increase the risk of homelessness.
- Homelessness can exacerbate the symptoms of schizophrenia.
- The stress of living on the streets, poor hygiene, lack of sleep, and the threat of violence may hasten the descent into psychosis.
- Homelessness can make it difficult to access and maintain constant mental health treatment.

You may also see individuals from out of state or not from your county because of the general proclivity to wander.

For more on the relationship between schizophrenia and homelessness see The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, HUD 2023 Continuum of Care Homeless

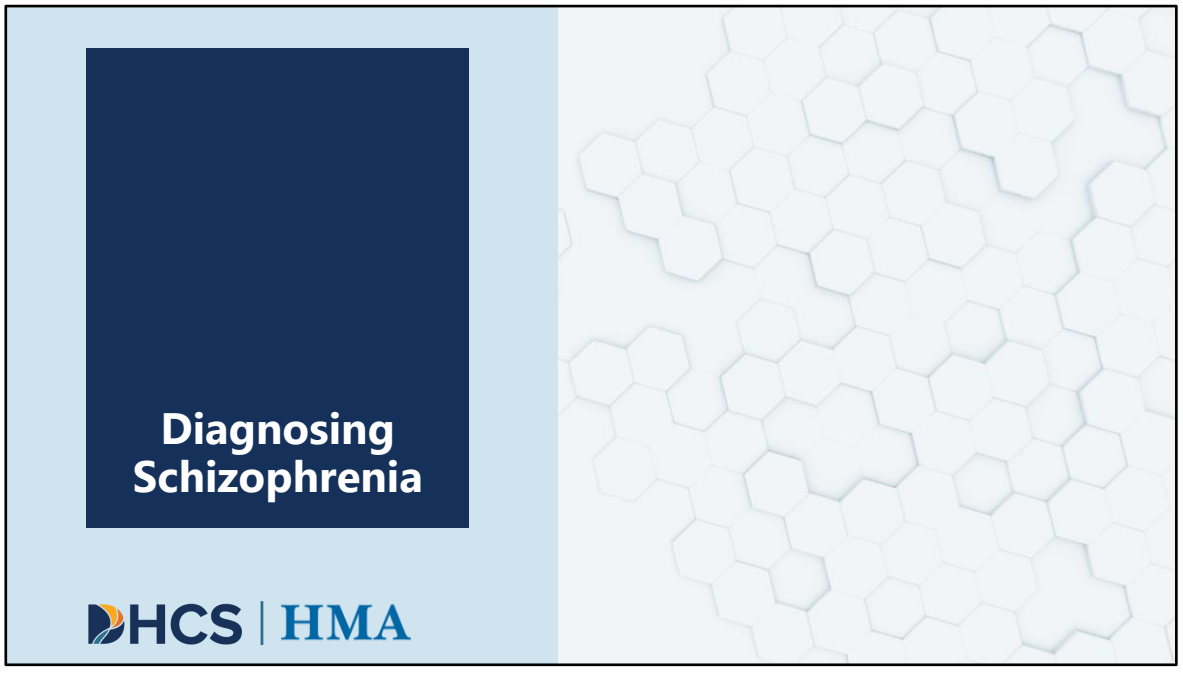
Assistance Programs Homeless Populations and Subpopulations, Number of homeless people with mental illness increased slightly in recent years, 2024 Homeless Count & System Key Performance Indicator, and Schizophrenia and Homelessness.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

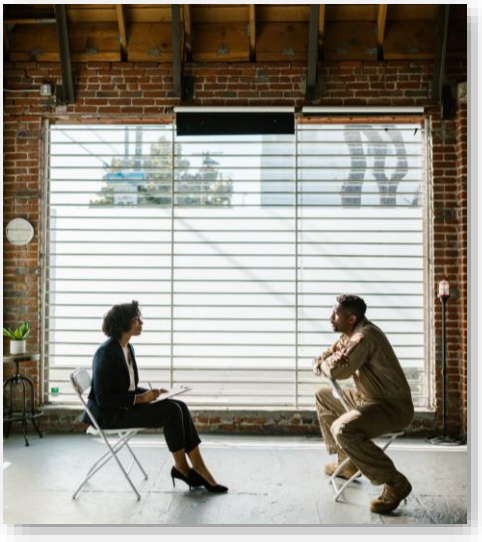
Take a moment to consider how Darin's individual circumstances might affect his clinical presentation and experience with CARE.

- Darin currently appears restless and afraid. Individuals supporting Darin through the CARE process should be compassionate and patient when interacting with him.
- Darin is an immigrant from Somalia; consider how his cultural practices and preferences might impact his engagement in services and supports. He may also have additional trauma from his experiences of bias. CARE team members should consider ways they can use a trauma-informed approach.
- In developing a CARE plan/agreement, consider Darin's preferences. For example, he recently stopped his medications due to concerns and fears he had. Developing a Psychiatric Advanced Directive (PAD) with Darin may support him moving forward, both throughout the CARE process and beyond.



[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

Next, we will shift our focus to a high-level discussion about diagnosing schizophrenia.



Schizophrenia Diagnosis

Who

- Schizophrenia is diagnosed by a mental health professional or licensed clinician trained in assessing for the diagnostic criteria for this condition (contained in the DSM-5).

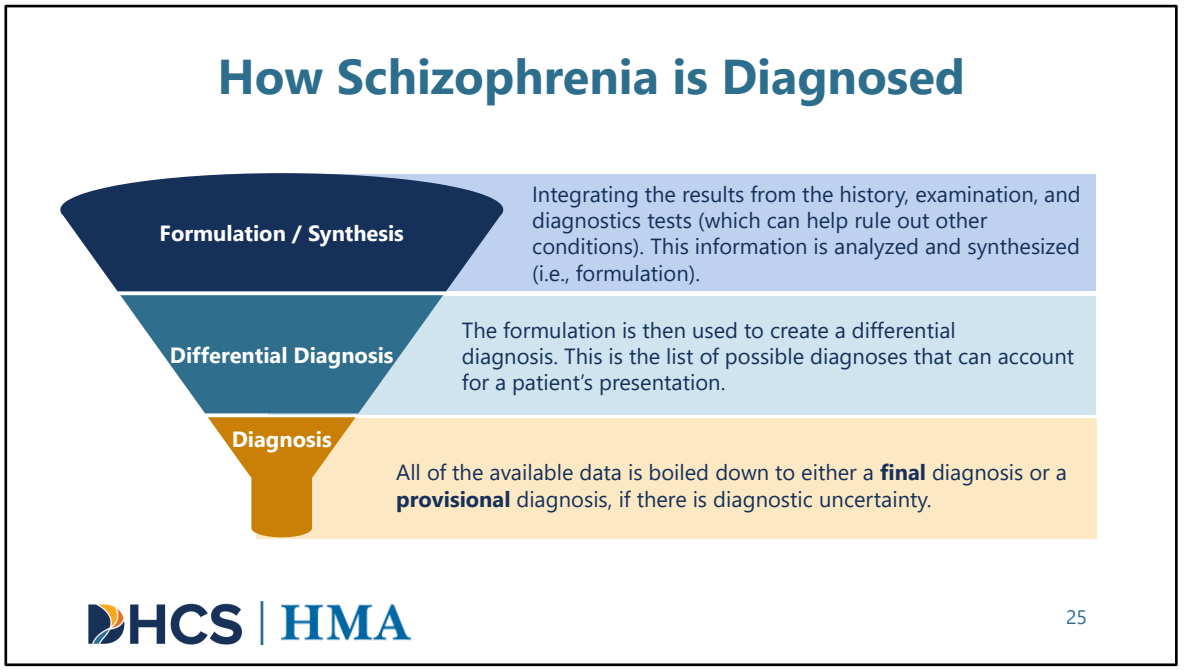
DHCS | HMA

24

[Slide Image Description: This slide shows an image of two individuals sitting in chairs talking with a description of how schizophrenia is diagnosed.]

Let's start with who can diagnose someone schizophrenia.

- Schizophrenia is diagnosed by a mental health professional who is trained in the use of the diagnostic criteria for mental health condition (contained in the DSM-5).
- The diagnosis is made by collecting information and talking to the person and after all other possible causes of the symptoms have been ruled out.



[Slide Image Description: This slide shows a graphic of a funnel split into three sections, depicting formulation/synthesis, differential diagnosis, and diagnosis of schizophrenia.]

Making an accurate diagnosis for schizophrenia is crucial, as the treatment and prognosis can vary significantly depending on the underlying cause of the symptoms. To that end, it's recommended that clinicians follow a protocol of forming a "differential diagnosis," which involves a process of gathering information from a review history and examination, synthesized through formulation, ruling out other possible diagnosis, and then a final determination of diagnosis.

Let's take a look at what this looks like.

Formulation / Synthesis is the process of integrating the results of patient interview(s), examination(s), and diagnostic tests. This may include:

History Taking and Symptom Analysis
- Presentation
- Detailed Medical History: Collecting information on the patient's symptoms, duration, onset, and any precipitating factors.

- Psychiatric history including inquiry about family history of mental illness.
- Substance Use History: Evaluating for alcohol, drugs, and medication use

Examination
- Physical Examination and Neurologic evaluation to determine overall health and possible related physical conditions
- Mental Status Examination: Detailed assessment of the patient's cognitive functions, thought processes, mood, and perception.

Diagnostic Testing as indicated
- Laboratory Tests: Conducting blood tests to rule out metabolic, infectious, or endocrine conditions
- Toxicology Screen: Testing for drugs or toxins
- Imaging Studies: Ordering brain imaging (MRI or CT scans) to rule out structural brain abnormalities, tumors, or lesions.

All of this information is analyzed and synthesized—a process known as formulation.

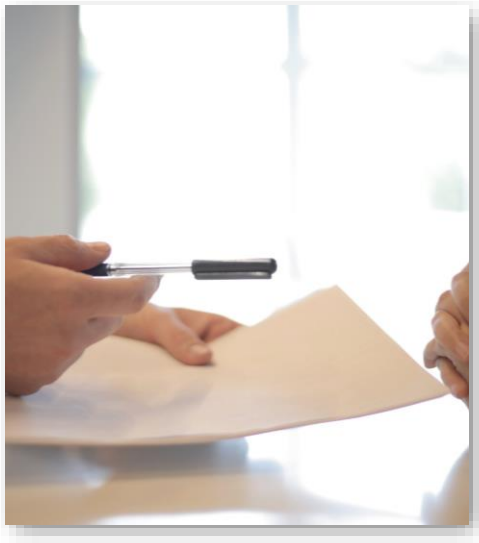
Differential Diagnosis

The formulation is then used to create a differential diagnosis**.** This is the list of possible diagnoses that can account for a patient's presentation:
- **Substance-Induced Psychotic Disorder**: Psychosis caused by alcohol, drugs (e.g., cannabis, amphetamines, hallucinogens), or withdrawal from substances.
- **Mood Disorders with Psychotic Features**: Major depressive disorder or bipolar disorder with psychotic features.
- **Schizoaffective Disorder**: Symptoms of schizophrenia combined with mood disorder symptoms (depression or bipolar).
- **Delusional Disorder**: Presence of delusions without the other major symptoms of schizophrenia.
- **Brief Psychotic Disorder**: Sudden onset of psychotic symptoms that last for less than a month.
- **Psychotic Disorder Due to Another Medical Condition**: Psychosis secondary to conditions like epilepsy, brain tumors, infections (e.g., HIV, syphilis), or autoimmune disorders.
- **Personality Disorders**: Severe cases of borderline, schizotypal, or paranoid personality disorders might present with psychotic-like features.
- **Neurocognitive Disorders**: Dementias (e.g., Alzheimer's disease), Huntington's disease, or other degenerative brain diseases.
- **Autism Spectrum Disorder**: Severe autism can sometimes be mistaken for schizophrenia due to social withdrawal and odd behaviors.

Diagnosis

That data is boiled down to a final diagnosis. Sometimes clinicians are not able to make an absolute diagnosis right away—a situation known as “diagnostic uncertainty”. There are a few ways to document this uncertainty—for instance by indicating the diagnosis is “provisional” or by selecting a more non-specific diagnosis while other, more specific diagnoses are ruled in or out.

For instance, let’s consider Darin. He presented to the Emergency Room with what appeared to be an acute exacerbation of schizophrenia. The ER psychiatrist obtained as much history as possible, reviewed the physical exam and available lab testing that day—but did not have access to all the clinical records to verify that other causes of psychosis (such as bipolar disorder) were ruled out. They formulated their findings as acute episode of psychosis and listed the possible diagnoses in a differential diagnosis. They ultimately diagnosed the person as Unspecified SS or other psychotic disorder until more information could be obtained.



Schizophrenia Diagnosis

Symptoms

» **Characteristic Symptoms**
At least two of the following symptoms, present for a significant portion of time during a 1-month period (or less if successfully treated).

- Delusions
- Hallucinations
- Disorganized speech

(At least one of these symptoms must be present)

- Grossly disorganized or catatonic behavior
- Negative symptoms

» **Social/Occupational Dysfunction**
One or more major areas of functioning have declined sharply since onset.

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

DHCS | HMA

26

[Slide Image Description: This slide shows an image of an individual holding a pen and paper and describes schizophrenia diagnostic criteria related to symptoms.]

What are the requirements for schizophrenia diagnosis?

- Schizophrenia is diagnosed by a mental health professional who is trained in the use of the diagnostic criteria for mental health condition (contained in the DSM-5).
    - The diagnosis is made by collecting information and talking to the person and after all other possible causes of the symptoms have been ruled out.
    - Keep in mind that there are no blood test or brain scans that are used for diagnosing schizophrenia. Blood tests and other procedures are often ordered to rule out those other conditions that might mimic the symptoms of psychosis (such as delirium due to infection or other medical causes); however, there is no specific lab test or procedure that specifically helps diagnose schizophrenia.
- The DSM-5 outlines the following symptoms as part of the diagnostic criteria for schizophrenia:
    - **Characteristic Symptoms:** At least two of the following symptoms, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., diminished emotional expression or avolition)

- **Social/Occupational Dysfunction:** One or more major areas of functioning have declined sharply since onset (e.g., work, interpersonal relations, or self-care).

There are also some specifications about duration, which we will address next.

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

Schizophrenia Diagnosis

Duration

- Continuous signs persist for at least 6 months, with at least one month of "active" symptoms, including delusions, hallucinations, or disorganized speech.
- During the prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by "active" symptoms that are less pronounced (e.g., odd beliefs, unusual perceptual experiences).

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

DHCS | HMA

27

[Slide Image Description: This slide shows an image of calendar dates and describes schizophrenia diagnostic criteria related to duration.]

The DSM-5 also stipulates some criteria related to duration of symptoms required for a diagnosis of schizophrenia.

- Continuous signs of the disturbance persist for at least 6 months, with at least one month of "active" symptoms, including delusions, hallucinations, or disorganized speech.
- During the prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by "active" symptoms that are less pronounced (e.g., odd beliefs, unusual perceptual experiences, less motivation, blunted or inappropriate emotion).

There are also some specifications about exclusions and distinctions, which we will address next.

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

Schizophrenia Diagnosis

Exclusions & Distinctions

- Must be able to rule out or distinguish from other psychiatric conditions:
  - Schizoaffective and mood disorders
  - Substance/general medical condition
  - Developmental disorders

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

DHCS | HMA

28

[Slide Image Description: This slide shows an image of two people sitting on a couch and describes schizophrenia diagnostic criteria related to exclusions and distinctions from other psychiatric conditions.]

Finally, the DSM-5 describes several exclusions and distinctions from other psychiatric conditions for a diagnosis of schizophrenia. To be diagnosed with schizophrenia, the following criteria must also be met to rule out other psychiatric conditions:

- **Schizoaffective and Mood Disorder Exclusion:** Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either:
  - No major depressive or manic episodes have occurred concurrently with the active-phase symptoms; or
  - If mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- **Substance/General Medical Condition Exclusion:** The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

- **Relationship to a Pervasive Developmental Disorder:** If there is a history of autism spectrum disorder or a communication disorder beginning in childhood, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated)

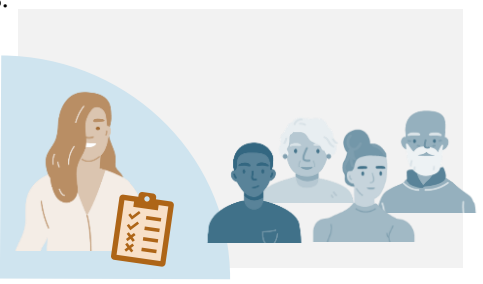
These criteria help clinicians accurately diagnose schizophrenia, distinguishing it from it from other psychiatric conditions.

Read more about the most recent updates to DSM requirements for schizophrenia diagnosis here.

Mitigating Bias During Diagnosis

Implicit bias can impact our assessment when diagnosing schizophrenia spectrum or other psychotic disorders. To mitigate these biases during diagnosis, consider the following strategies:

- Use standardized and validated diagnostic criteria.
- Engage in cultural competence training.
- Develop awareness of your own potential biases.
- Seek second opinions from colleagues.
- Stay engaged in continuous education on diagnosis best practices.
- Adopt a patient-centered approach to care.



For more information, visit the Addressing Implicit Bias for Behavioral Health Agencies training materials.

DHCS | HMA

29

[Slide Image Description: This slide shows an individual with a clipboard along with five other people.]

In a few of our other trainings on mitigating bias and trauma-informed care, we've talked about how bias can influence our ability to make an assessment. Implicit bias can impact our assessment when diagnosing schizophrenia spectrum or other psychotic disorders. To mitigate these biases during diagnosis, consider the following strategies:

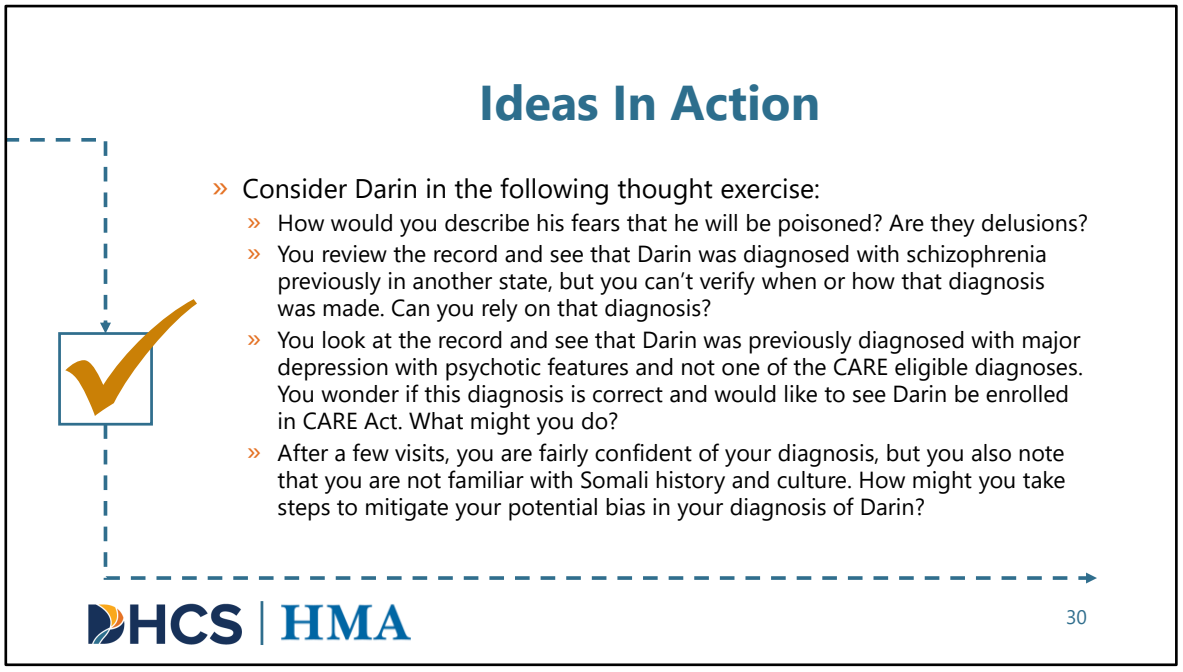
- **Standardized Diagnostic Criteria:** Utilize standardized and validated diagnostic criteria, such as those outlined in the DSM-5 or ICD-10. This ensures that diagnoses are based on objective criteria rather than subjective judgment.
- **Cultural Competence Training:** Engage in cultural competence training to understand and appreciate cultural differences in the presentation of symptoms and communication styles. This reduces the likelihood of misinterpreting culturally specific behaviors or expressions.
- **Awareness and Reflection:** Be aware of your own potential biases and reflect on how they might affect your judgment. Regular self-reflection and discussions with colleagues can help in recognizing and addressing implicit biases.
- **Second Opinions:** Seek second opinions from colleagues, especially when there is

uncertainty about a diagnosis. This can provide a more balanced and less biased perspective.

- **Education and Training:** Continuously educate yourself and undergo training on implicit bias and its effects on clinical decision-making. Keeping up-to-date with the latest research and best practices can improve diagnostic accuracy.
- **Patient-Centered Approach:** Adopt a patient-centered approach that involves active listening and ensures that the patient's voice is heard and respected. Encourage patients to express their concerns and symptoms in their own words.
- **Use Clear and Effective Communication:** Ensure clear and effective communication, avoiding medical jargon and checking for understanding. This helps patients better understand the diagnostic process and reduces misunderstandings.
- **Document rationale:** Carefully document the rationale for your diagnostic decisions. This provides a transparent record that can be reviewed and helps ensure that diagnoses are based on consistent and fair criteria.

By implementing these strategies, clinicians can mitigate the impact of implicit bias and make more accurate diagnoses of schizophrenia spectrum and other psychotic disorders.

For more information, visit the Addressing Implicit Bias for Behavioral Health Agencies training materials.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

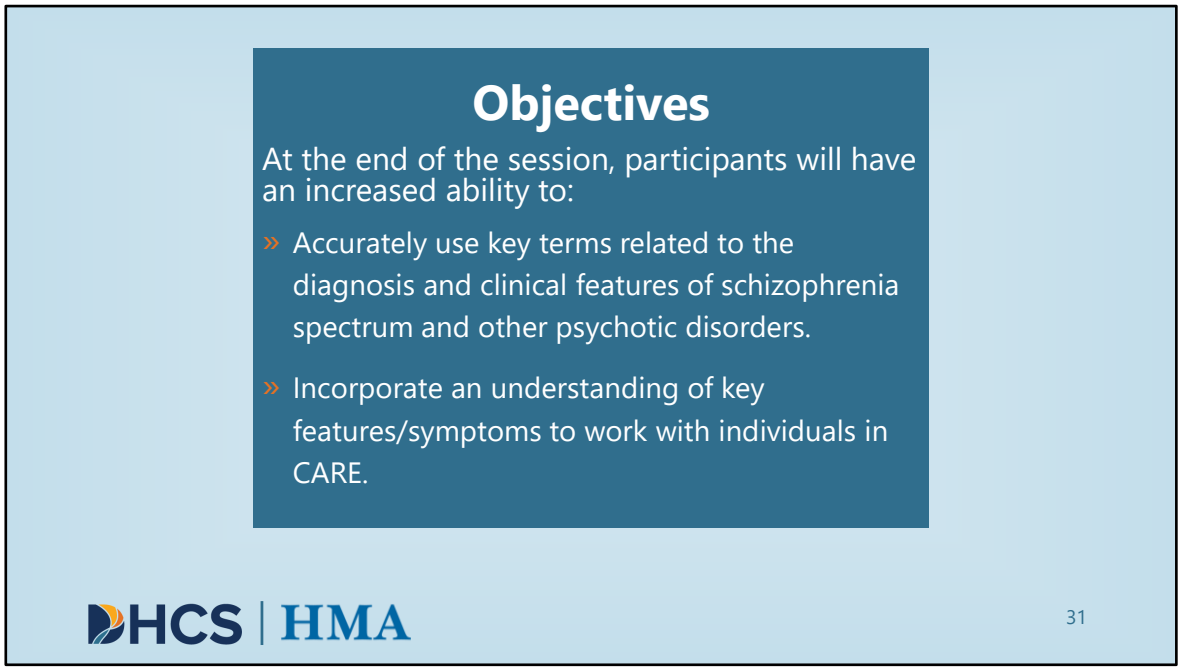
Consider the following thought exercise.

Let's go back to our case example Darin. Imagine you are doing an outpatient psychiatric intake. Darin immigrated from Somalia 15 years ago. He has persistent thoughts that he is being poisoned and is very fearful. You speak to Darin and his father – you welcome him and conduct a safety assessment. You feel you are now ready to start the general assessment process. Here are some potential questions to consider:

1. How would you describe his fears that he will be poisoned? Are they delusions?
    - Possibly; remember delusions are fixed/false beliefs, not just fears.
2. If they indeed are delusions, what type are they—persecutory, paranoid, grandiose, erotomania?
    - If they are delusions—they are paranoid type. However, they might not be delusions at all and might be anxiety, flashbacks, or something else.
3. You review the record and see that Darin was diagnosed with schizophrenia previously in another state—but you can't verify when or how that diagnosis was made. Can you rely on that diagnosis?

- You should never rely on a previous diagnosis, especially when you cannot verify what information was utilized in making that diagnosis and/or what bias those clinicians may have had. This is how erroneous diagnoses keep getting carried forward in charts. The best approach would be to conduct a careful assessment to verify that diagnosis.

1. You look at the record and see that Darin was previously diagnosed with major depression with psychotic features and NOT one of the CARE eligible diagnoses. You wonder if this diagnosis is correct, and would like to see Darin be enrolled in CARE Act. What might you do?
   - Consider requesting a diagnostic reassessment by a MH professional (such as a psychiatrist) who is licensed and experienced in treating similar conditions.
2. After a few visits, you are fairly confident of your diagnosis—but you also note that you are not familiar with Somali history and culture. How might you take steps to mitigate your potential bias in your diagnosis of Darin?
   - Consider getting a second opinion, consulting with a clinician who is expert in Somali culture, use standardized testing, and learning more about Somali culture and history yourself.



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Accurately use key terms related to the diagnosis and clinical features of schizophrenia spectrum and other psychotic disorders.
- Incorporate an understanding of key features/symptoms to work with individuals in CARE.

Next Steps

- Visit CARE-Act.org for resources (including recordings of past trainings) and to submit questions/technical assistance (TA) requests.
- View the other trainings in the Understanding Schizophrenia Spectrum Disorders series:
  - Institutionalization and Criminalization of Persons with Schizophrenia Spectrum Disorders
  - Course and Outcomes
  - Guidelines for Treatment

DHCS | HMA

32

[Slide Image Description: This slide shows bullets with next steps. It contains decorative arrows.]

Please let us know how we can best support your teams. Contact info@CARE-Act.org with questions, join the communications listserv, and submit requests and feedback for CARE Act TTA. Please also visit the CARE Act Resource Center website for training decks and recordings, which will be added two weeks after each training.

[Slide Image Description: This slide shows the CARE-act website and the email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing the CARE Act. The website is **CARE-Act.org** and our email address is **info@CARE-Act.org.**