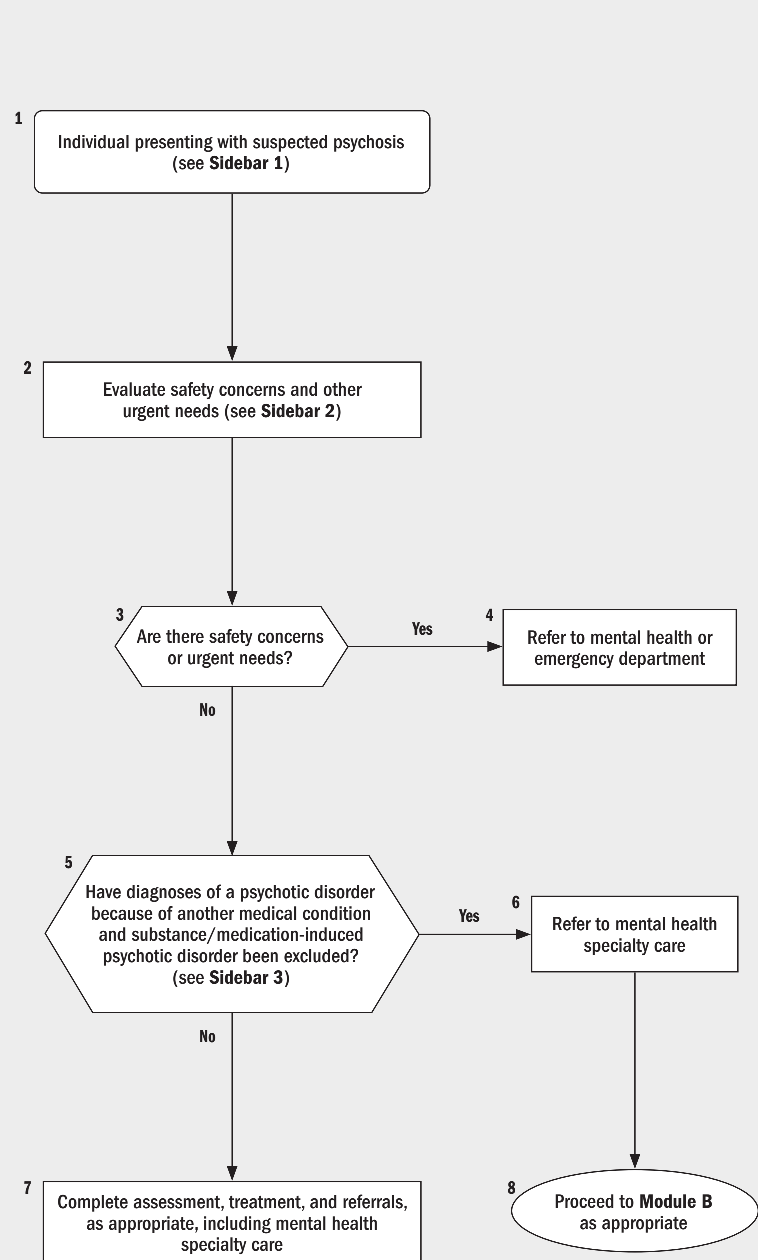
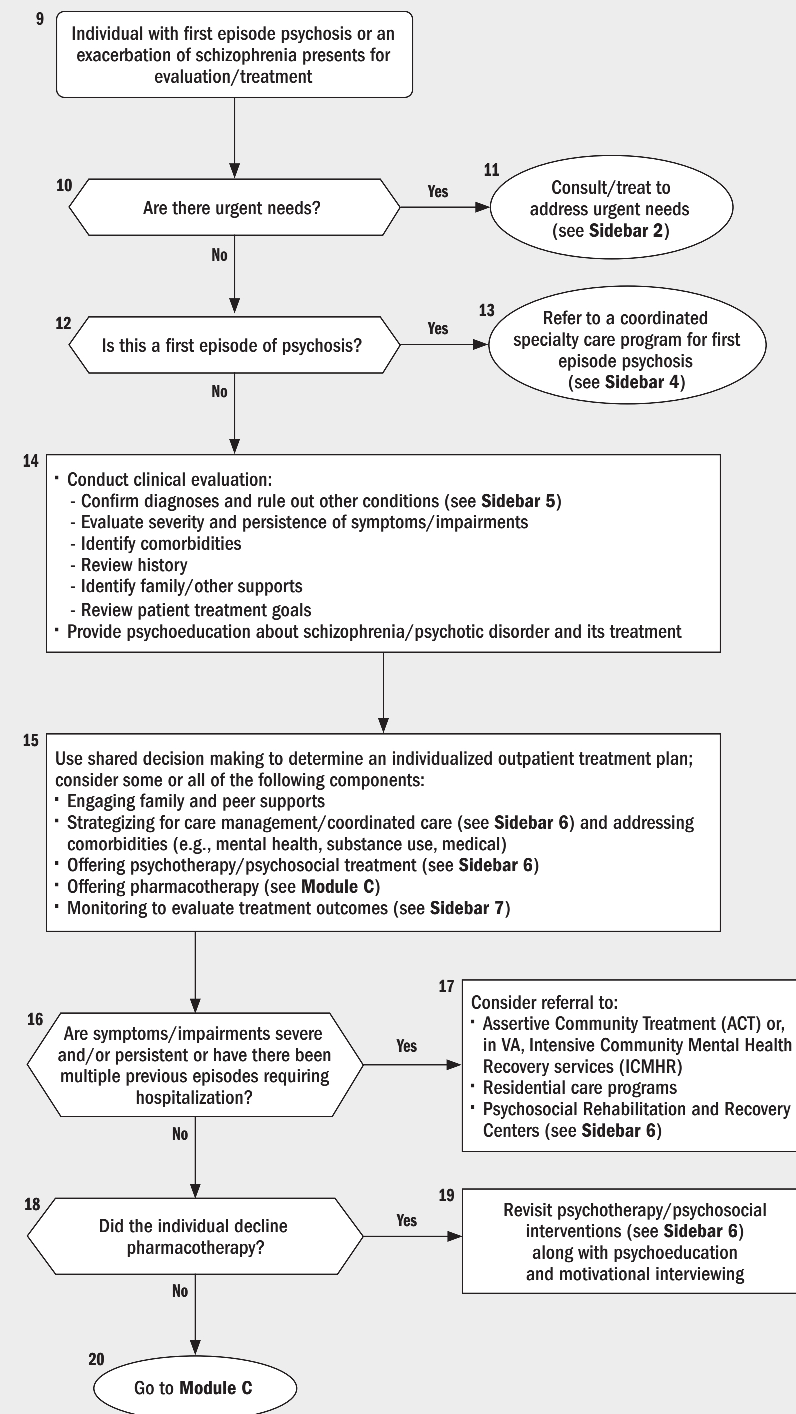
First Episode Psychosis and Schizophrenia

Module A: Primary Care Evaluation and Management of Suspected Psychosis or Possible Schizophrenia



Module B: Evaluation and Management of First Episode Psychosis and Schizophrenia



Sidebar 1: Early Warning Signs of Psychosis (65)

Changes that suggest possible delusions, hallucinations, disorganization, functional impairments, unexplained deteriorations in performance, cognition, or both.

- Worrisome drop in grades or job performance.
- New trouble thinking clearly or concentrating.
- Suspiciousness, paranoid ideas, or uneasiness with others.
- Social withdrawal or more time spent alone than usual.
- Unusual, overly intense new ideas, strange feelings, or no feelings at all.
- Decline in self-care or personal hygiene.
- Difficulty telling reality from fantasy.
- Confused speech or trouble communicating.

Sidebar 2: Indications for Urgent Specialty Care Consultation

- Serious homicidal ideation or aggressive or violent behaviors or both.
- Serious suicidal ideation (e.g., suicidal ideation with plan or intent, history of suicide-related behavior).
- Self-harm or behavior that might be preparatory for suicide.
- Command hallucinations that might impair safety (e.g., commands to harm oneself or others or to engage in dangerous activities).
- Catatonia or grossly disorganized speech or behaviors.
- Serious self-neglect or apparent inability to meet basic needs.

Signs of delirium, including an altered level of consciousness, require a comprehensive evaluation (including toxicology and drug screens and consideration of medical illness, infection, or injury) performed before behavioral health referral.

Sidebar 3: Medical Conditions, Medications, Toxins, and Substances That Can Cause Psychoses (65)

Medical conditions

- Neurological conditions (e.g., neoplasm, cerebrovascular disease, Huntington's disease, Parkinson's disease, multiple sclerosis, epilepsy, auditory or visual nerve injury or impairment, deafness, migraine, central nervous system infection).
- Endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism).
- Metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia, vitamin B12 deficiency, fluid or electrolyte imbalances, hepatic or renal diseases).
- Autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus, N-methyl-d-aspartate [NMDA] receptor autoimmune encephalitis).

Medications, toxins, and substances of abuse

- Specific classes of medications (i.e., anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents [e.g., cyclosporine, procarbazine], corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications (e.g., phenylephrine, pseudoephedrine], antidepressant medications, and disulfiram).
- Specific classes of toxins (i.e., anticholinesterase, organophosphate insecticides, sarin and other nerve gases, carbon monoxide, carbon dioxide, and volatile substances such as fuel or paint).
- Intoxication with substances of abuse (i.e., alcohol; cannabis; hallucinogens, including phencyclidine and related substances; inhalants; sedatives, hypnotics, and anxiolytics; stimulants, including cocaine).
- Withdrawal from substances of abuse (i.e., alcohol; sedatives, hypnotics, and anxiolytics).

Sidebar 4: Coordinated Specialty Care (66)

Early intervention services for individuals experiencing FEP include coordination of the evidence-based treatments described below.

Team-Based Care – All CSC providers are trained in the principles of team-based care for youth and young adults with FEP and participate in weekly team meetings to improve coordination and quality of care. Team members receive ongoing supervision, consultation, or both to maintain fidelity to the CSC model.

Recovery-Oriented Psychotherapy – Individual psychotherapy for FEP is based on cognitive behavioral treatment principles. It emphasizes resilience training, illness and wellness management, and general coping skills pertinent to young adults experiencing a first psychotic episode. Psychological interventions are essential for symptomatic and functional recovery and might aid in the prevention of comorbidities, such as SUDs.

Family Psychoeducation and Support – FEP can devastate the individual's relatives and other support persons, who struggle to adjust to changed circumstances and new demands. Family psychoeducation and support teaches family members or other individuals providing support about psychosis and its treatment and strengthens their capacity to aid in the individual's recovery.

Supported Employment Services – For young adults, FEP can impede attempts to obtain or maintain employment. Supported employment services are offered to all clients who want to work to help them choose and get a job that aligns with their career goals. Supported employment emphasizes rapid job placement in the client's preferred work setting. Ongoing supports are also available to help the individual maintain employment.

Supported Education Services – The experience of FEP can disrupt school attendance and academic performance. Supported education services facilitate an individual's return to school as well as the attainment of expected educational milestones. Supported education emphasizes rapid placement in the individual's desired school setting and provides active coaching and support to ensure the individual's educational academic success.

Pharmacotherapy and Primary Care Coordination – Guideline-based use of medication optimizes the speed and degree of symptomatic recovery by individuals with FEP and minimizes the likelihood of side effects. Pharmacotherapy is best initiated following a thorough medical evaluation to assess for all possible causes of psychosis. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for symptom response, side effects, and attitudes toward medication at every visit. Consideration of use of a long-acting injectable as part of a holistic approach is common practice.

- CSC places special emphasis on monitoring and managing cardiometabolic risk factors, such as smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes. Prescribers maintain close contact with primary care providers to ensure optimal medical treatment for risk factors related to cardiovascular disease and diabetes.

Case Management – Case management assists clients with solving practical problems and coordinates services across multiple areas of need. Case management involves frequent in-person contact between the provider and the individual and family members, with sessions occurring in clinic, community, and home settings, as required.

Abbreviations: CSC: coordinated specialty care; FEP: first episode psychosis; SUD: substance use disorder

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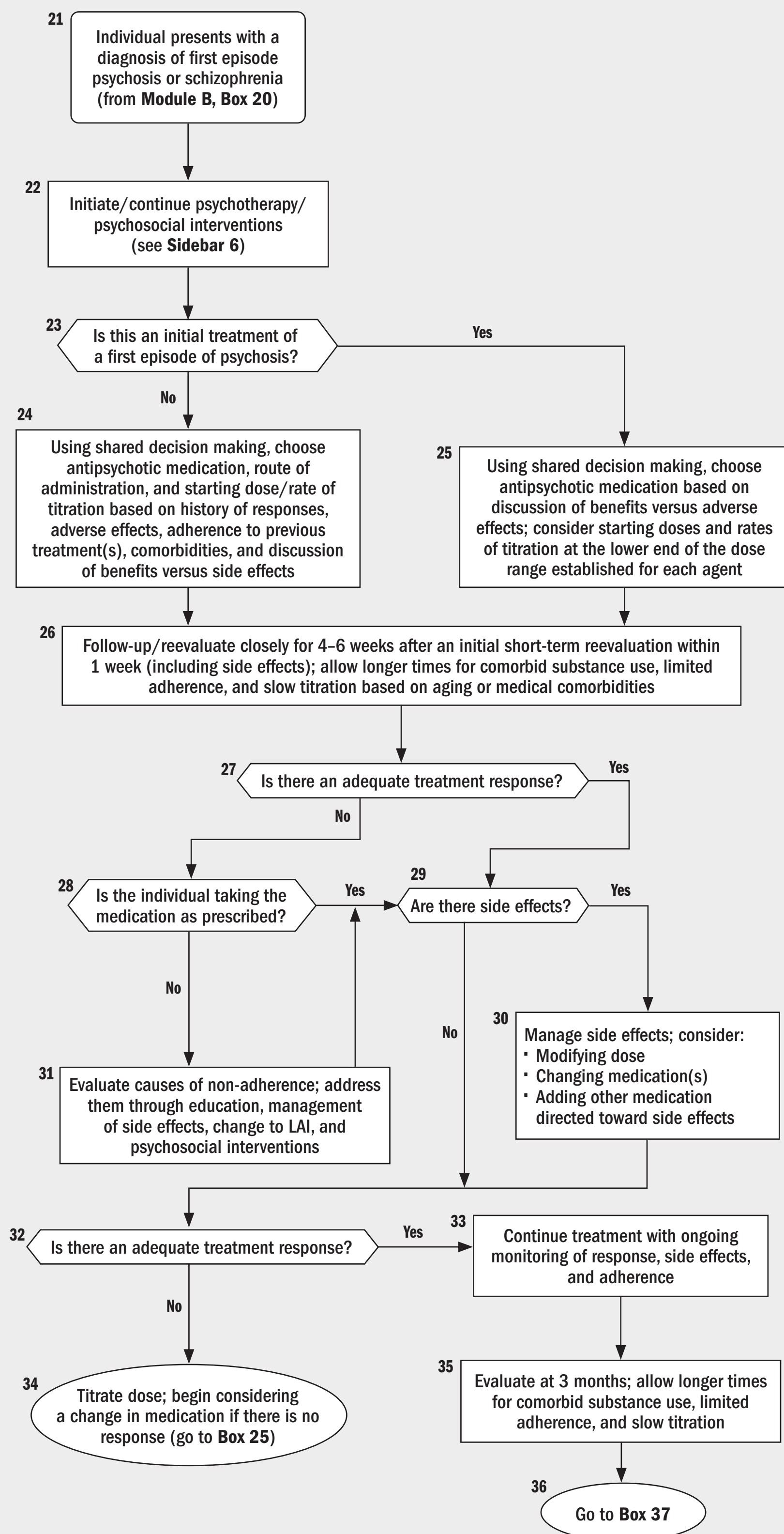
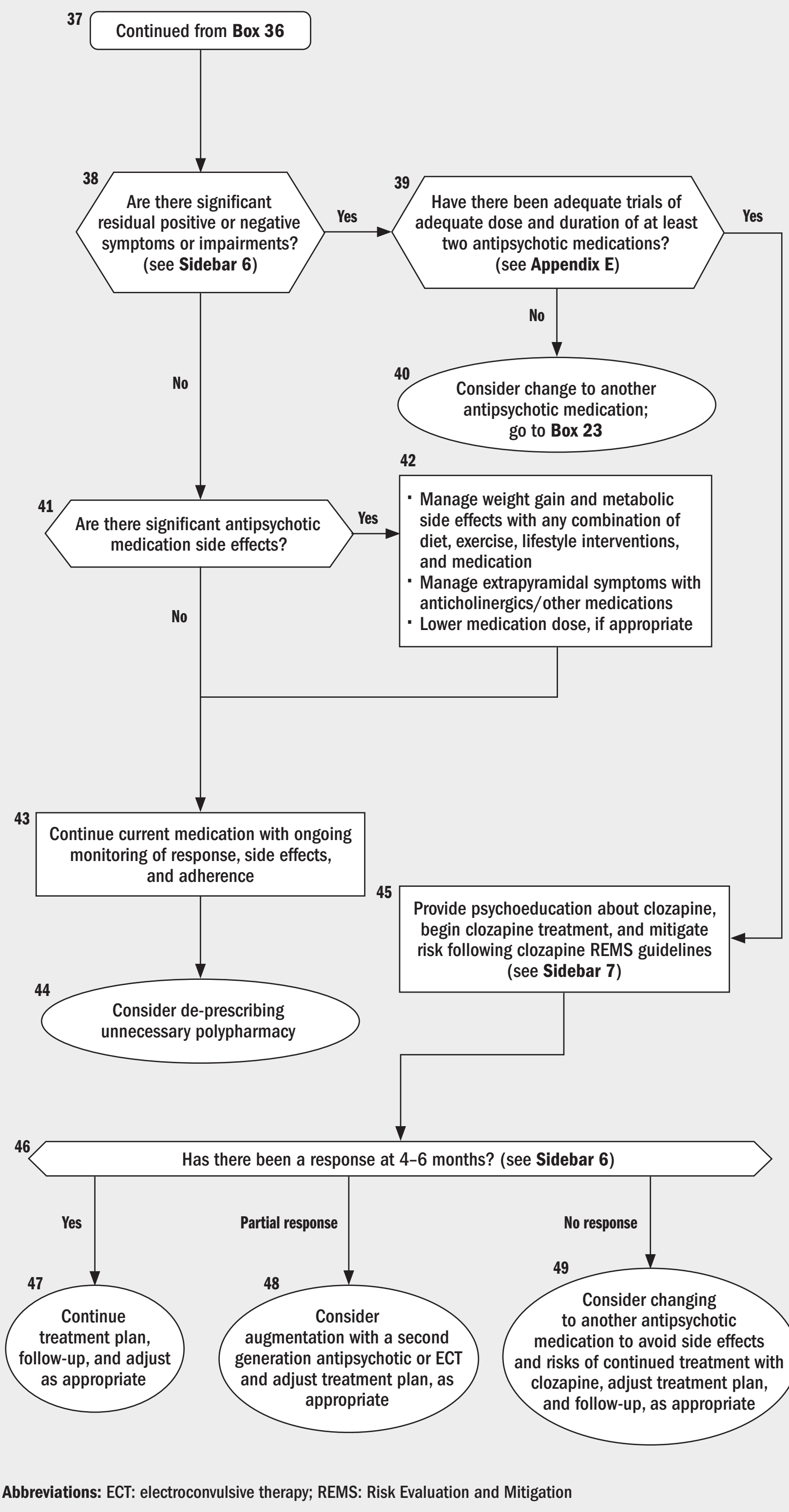
Module C: Pharmacotherapy for Treatment of First Episode Psychosis and Schizophrenia by Mental Health Providers



Module C: Pharmacotherapy for Treatment of First Episode Psychosis and Schizophrenia by Mental Health Providers (continued)



Abbreviations: ECT: electroconvulsive therapy; REMS: Risk Evaluation and Mitigation

Sidebar 5: Psychosocial Interventions and Supportive Services

All individuals with schizophrenia should have access to a range of psychosocial interventions and supportive services fully integrated into their care. Individuals should make decisions about participation in interventions as part of a treatment planning process using shared decision making in which interventions are linked to the individual's identified needs, preferences and life goals. Psychosocial interventions include, but are not limited to, the following:

- CBT, CBT for psychosis (CBTp), or both. (If the individual has had a prior course of CBT or CBTp, consider booster sessions or another psychotherapy, such as acceptance- or mindfulness-based therapies, positive psychotherapies, or meta-cognitive therapy.)
- Skills training for impairments in social skills.
- Cognitive training, cognitive remediation, or both for cognitive deficits.
- Supported employment for individuals with a goal of employment.
- Supported education for individuals with educational goals.
- Ilness self-management approaches (e.g. illness management and recovery).
- Evidence-based psychotherapies for comorbid disorders.
- Caregiver-directed psychosocial interventions for family, others with whom the individual with schizophrenia maintains close contact and chooses as family, or both.
- Peer support and peer support groups (e.g., Vet-to-Vet).
- Interventions to assist individuals with coping with stigma, addressing self-stigma, and issues of disclosure.

Supportive services should be available to assist with additional sequelae to living with psychiatric disability and offered as needed.

- Consider Housing First, other supported housing models, or both for individuals with housing instability or who are unhoused.
- Offer case management, other supportive services, or both to assist with unstable housing or lack of access to food, clothing, and other basic needs.
- Offer benefits counseling and support for financial management (e.g., assistance with banking, budgeting).
- Provide informal caregiver support, as needed.
- Offer parenting assistance.
- Provide legal support, including assisting in transitions with the legal system.
- Coordinate reevaluations of psychotherapy and rehabilitation- or recovery-oriented treatments with reevaluations of pharmacotherapy.
- Consider increasing the intensity of psychosocial treatments to address increased needs when responses to medication have been inadequate and in response to increased opportunities when pharmacologic treatment leads to decreases in impairments.

Abbreviation: CBT: cognitive behavioral therapy

Sidebar 6: Monitoring Response to Intervention

Consider the following monitoring parameters.

- Reduction core symptoms of psychosis, schizophrenia, or both.
- Lab parameters (per REMS requirements, QTc, or both; leukocytes; neutrophils; agranulocytes; sodium; glucose; hemoglobin A1C; triglycerides; high-density and low-density cholesterol; prolactin, if risperidone or paliperidone is used; prolactin, if unexpected breast tissue changes occur; CPK in the case of new-onset movement disorder and as appropriate through the course of movement disorders)–measure at baseline, three months (for clozapine and olanzapine) and at least annually thereafter if treated with antipsychotic medications.
- Extrapyramidal movements (cogwheel rigidity, akathisia, parkinsonism, TD, acute and painful muscle tone changes).
- Vitals (weight, temperature, blood pressure, HR changes, orthostatic hypotension, autonomic instability, unexplained fever).
- Functioning (social functioning, intimacy, sexuality, parenting, workplace, education, family or other primary support group, interpersonal baseline changes).
- Durable planning needs (financial; guardianship; medical, legal, or both; will).
- Patient goals and preferences.
- Life circumstances changes.

(continued from Sidebar 6)

Notes: Monitoring response timeframe varies during an acute episode, stabilizatrion period or both, versus duringe a recovery period or period of chronic symptomatic stability. Monitoring of vitals, mental status functioning, and movement status are recommended at every follow-up as part of common everyday practice standards. The timing and length between follow-up appointments naturally vary with current status and circumstance. Phase of life, reproductive or sexuality status or both, relative youth, comorbidity, and advanced age considerations are frequently overlooked yet have large quality impacts on individuals when assessed and holistically addressed. Patients in an inpatient status should be monitored daily in accordance with an established hospital treatment plan. Life circumstance, life functioning, and durable planning needs should be reassessed at a minimum during times of significant of major status change (e.g., as part of a hospital discharge process; at times of community capability changes; at the request of the patient, the significantly involved members of the care and support structures, or both; or the legal system).

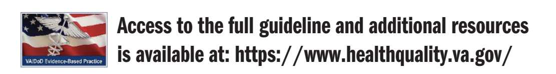
Abbreviations: CPK: creatine phosphokinase; REMS: Risk Evaluation and Mitigation Strategy; QTc: QT corrected QT-interval; A1C: glycated hemoglobin; HR heart rate; TD: tardive dyskinesia

Sidebar 7: Clozapine Management

1. Provide the patient (and, where appropriate, the family) education about benefits and risks of clozapine and ensure their understanding and consent.
2. Ensure that the prescriber and the pharmacy are registered with Clozapine REMS.
3. Confirm indications for clozapine: treatment-resistant schizophrenia; schizophrenia or schizoaffective disorder with suicidality; or, possibly, schizophrenia with persistent aggressive behavior.
4. Evaluate symptoms and impairments with standardized assessment instruments.
5. Consider whether the patient might have BEN as defined by Clozapine REMS.
6. Register the patient with Clozapine REMS (see note).
7. Obtain and provide Clozapine REMS with a within-range absolute neutrophil count before prescribing and dispensing (see note).
8. Prescribe clozapine starting at low doses with gradual titration to therapeutic doses and blood levels.
9. Monitor absolute neutrophil counts weekly for six months, then once every two weeks for six months, then monthly, thereafter; report results to Clozapine REMS (see note).
10. Follow Clozapine REMS protocols for below-threshold absolute neutrophil counts indicating neutropenia or agranulocytosis.
11. Obtain troponin and c-reactive protein levels at baseline and monitor them weekly for at least the first month of treatment to support the early identification of myocarditis as an adverse effect.
12. Consider prescribing bowel regimens to prevent clozapine-related gastrointestinal hypomotility and ileus, especially when the patient is also receiving other anticholinergic medications.
13. Monitor symptoms, impairments, and side effects.
14. Evaluate blood levels and adjust doses as appropriate to evaluate non-response, possible non-adherence, pharmacokinetic drug-drug or drug-smoking interactions and to support management of side effects.

Note: In VA, the National Clozapine Coordinating Center (NCCC) serves as an intermediary between prescriber and Clozapine REMS for registration of patients starting clozapine and reporting of absolute neutrophil levels. For addtional information, see https://www.newclozapinerems.com/home#.

Abbreviations: BEN: benign ethnic neutropenia; REMS: Risk Evaluation and Mitigation Strategy



Access to the full guideline and additional resources is available at: https://www.healthquality.va.gov/