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

- Individual presenting with suspected psychosis (see Sidebar 1)
- Evaluate safety concerns and other urgent needs (see Sidebar 2)
- Are there safety concerns or urgent needs? (see Sidebar 2)
- Refer to mental health or emergency department
- Is this a first episode of psychosis? (see Sidebar 4)
- Review patient treatment goals
- Identify family/other supports
- Identify comorbidities
- Consider referral to:
  - Psychosocial Rehabilitation and Recovery
  - Residential care programs
  - Recovery services (ICMHR)
- Consult/treat to address urgent needs (see Sidebar 2)
- Complete assessment, treatment, and referrals, as required, including mental health specialty care

**Sidebar 1: Early Warning Signs of Psychosis (65)**

Changes that suggest possible delusions, hallucinations, disorganization, functional impairments, unexplained deteriorations in performance, cognition, or both:
- Worsening drop in grades or job performance.
- New troubles thinking clearly or concentrating.
- Sudden changes in a person’s ideas, or occurrence of new ideas, suspiciousness, or unprovoked ideas.
- 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 hallucinations.

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

- Complete assessment, treatment, and referrals, as required, including mental health specialty care
- Consider referral to a coordinated specialty care program for first episode psychosis (see Sidebar 4)
- Use shared decision making to determine an individualized outpatient treatment plan; consider some or all of the following components:
  - Engaging family and peer supports
  - Strategies for care management/coordination care (see Sidebar 6) and addressing comorbidities (e.g., mental health, substance use, medical)
  - Offering psychopharmacological treatment (see Sidebar 6)
  - Monitoring to evaluate treatment outcomes (see Sidebar 7)

**Sidebar 2: Indications for Urgent Specialty Care Consultation**

- Serious homicidal ideation or aggression or violent behaviors or both.
- Serious suicidal ideation (e.g., suicidal plan with a high intent, history of sustained behavior).
- Self-harm or behavior that might be preparatory for suicide.
- Comorbid hallucinations that might impair safety (e.g., commands to harm yourself 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)**

- Neurological conditions (e.g., multiple sclerosis, brain tumor, HIV infection, seizures, stroke).
- Endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism).
- Metabolic conditions (e.g., hypoglycemia, hyperglycemia, vitamin B12 deficiency, fluid or electrolyte imbalances, hepatic or renal diseases).
- Infectious conditions (e.g., meningitis, encephalitis).
Module C: Pharmacotherapy for Treatment of First Episode Psychosis and Schizophrenia by Mental Health Providers (continued)

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. Core psychosocial interventions include those that are linked to the individual’s identified needs, preferences, and life goals. Psychosocial interventions include, but are not limited to the following:

- Clinical trials for youth (CTCy): if the individual has had a prior course of CTR or CTP, consider booster sessions or another psychosocial, such as acceptance- or mindfulness-based therapies, positive psychotherapy, or meta-cognitive therapy.
- Skills training for impairments in social skills.
- Cognitive training, cognitive remodelling, or both for cognitive deficits.
- Support-led education for individuals with educational goals.
- Time self-management approaches (e.g., illness management and recovery).
- Evidence-based psychosocial interventions for comorbid disorders.
- Congregate-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 forming First, other supportive housing models, or both for individuals with housing instability as who are uninsured.
- Other 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.
- Consider reimbursements for pharmacotherapy and reintegration-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 pharmacological treatment leads to increased impairments.

Sidebar 6: Monitoring Response to Intervention

Consider the following monitoring parameters.

- Vital signs: temperature, systolic/diastolic blood pressure, heart rate, respiratory rate, and body weight.
- Laboratory: complete blood count, electrolytes, liver function tests, renal function tests, coagulation, and lipid profile.
- Neurological: examination, cognitive testing, and mental status.

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 or schizoaffective disorder with suicidality or, possibly, schizophrenia with persistent agitative behavior.
4. Evaluate symptoms and impairments with standardized assessment instruments.
5. Consider whether the patient might be defined as 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 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 toxicity, as an adverse effect.
13. Consider prescribing bowel regimens to prevent clozapine-related gastrointestinal toxicity, as an adverse effect.
14. Monitor symptoms, impairments, and side effects.
15. Evaluate blood levels and adjust doses as appropriate to evaluate non-responsiveness, possible idiosyncratic reactions, and drug-drug interactions and to support management of side effects.

Notes:
- Monitoring response timeframe varies during an acute episode, stabilization period or both, versus during a recovery period or period of chronic symptomatic stability. Monitoring of vital, mental status functioning, and movement status are recommended at each follow-up visit as per common everyday practice standards. The timing and length between follow-up appointments naturally vary with current status and circumstances. Phase of life, reproductive status or sexual behavior, relative youth, comorbidity, and advanced age considerations are frequently overlooked, yet have large effects on individuals when assessed and historically addressed.
- Patients in an inpatient status should be monitored daily in accordance with an established hospital treatment plan. Life circumstances, life functioning, and durable planning needs should be managed at a minimum during times of significant 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 structure, or both, or the legal system).
- Abbreviations: CYP: cytochrome P450; REMS: Risk Evaluation and Mitigation Strategy; QTc: corrected QT interval; ACC: atrial fibrillation; HR heart rate; TB: tinnitus.

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