Background

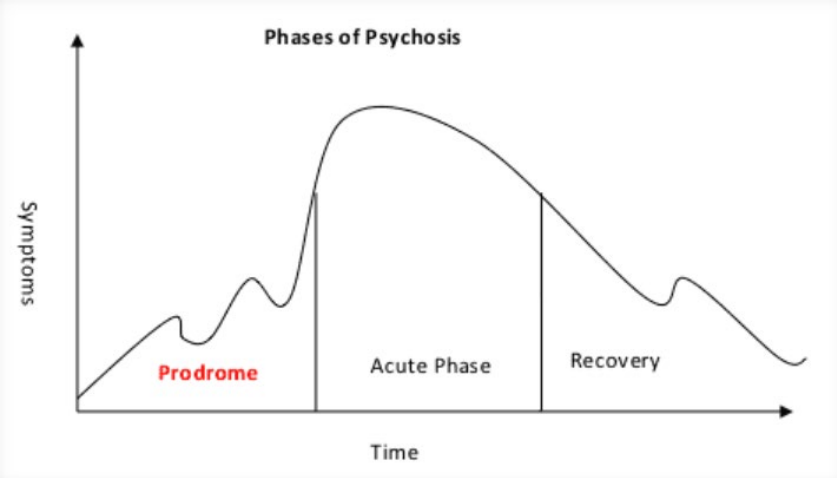
Psychosis is, "a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not."[i] Symptoms range from positive symptoms, such as hearing someone talking to you when they are not there, negative symptoms, flattened emotional expression, or disorganized symptoms, seemingly random gestures or speech. Psychosis could be temporary, and cause time limited life challenges, or can be prolonged with significant challenges in daily life. About 25% of people who experience psychosis will not experience another episode, 50% will experience an episode and experience recovery, and about 25% will need continual support and treatment.

Psychosis has various underlying causes; primary psychosis is a symptom of a psychiatric disorder. It is critical to establish a differential diagnosis to offer appropriate treatment for underlying cause. Not everyone with underlying conditions will develop psychosis – psychosis symptoms are a combination of biological vulnerability and stress that trigger their development.

Psychiatric causes of psychosis	Other disorders where symptoms of psychosis can occur
• Schizophrenia • Schizoaffective disorder • Schizophreniform disorder • Brief psychotic disorder • Delusional disorder • Mood disorder: bipolar disorder, major depressive disorder with psychotic symptoms	• Posttraumatic stress disorder • Dissociative identity disorder • Personality disorders: paranoid, schizotypal, schizoid, borderline personality disorder • Eating disorders: anorexia nervosa • Delirium/altered mental status

Schizophrenia is the 11th leading cause of global disability.[ii] People with schizophrenia-spectrum disorders experience shortened life expectancy,[iii] and comorbid substance use increases risk of all-cause mortality.[iv] Estimated economic burden to the United States in 2019 from schizophrenia was $343.2 billion, including $62.3 billion in direct health care costs and $35 billion in indirect health care costs.[v]

Phases of Psychosis:



Psychosis caused by schizophrenia exists in three phases: prodrome, acute phase and recovery. In the prodromal phase, the person begins to experience changes, but do not yet have clear-cut psychotic symptoms. Early signs of emerging psychosis include getting easily distracted/decreased concentration, changes in perceptual experiences, decreased motivation, sleep disturbances, social isolation, anxiety, depression, suspiciousness, diminished performance at work, school or family/social life, and odd beliefs/behaviors. These symptoms vary from person to person, and some may not experience any changes. Prodromal psychosis can exist for several months to years.

The acute phase is when characteristic symptoms – such as hallucinations, delusions and disorganized speech and behavior – are more noticeable. Experiences are often very distressing, and appropriate treatment that is aligned with the person's wants and needs should be started as soon as possible.

Within the first weeks to months of starting treatment, most individuals begin to recover. Recovery phase is marked by generally less intense symptoms or disappearance of symptoms, and improvement in coping with daily life. Recovery is possible!

Early Identification and Treatment:

Once an individual is experiencing psychosis, it is critical to reduce the duration of untreated psychosis (DUP) as much as possible. **The earlier a person accesses treatment, the better their outcomes.** Individuals with psychosis are often first identified in settings outside the medical system. Family and friends are often the first to notice early warning signs and symptoms of people with psychosis. Settings like schools, youth programs, pediatricians/primary care providers, inpatient facilities, emergency rooms, crisis services and jail systems are areas where individuals might first interact before accessing treatment. To support decreasing the duration of untreated psychosis, individuals working in these systems should understand the emerging signs and symptoms of psychosis and have the knowledge of where to refer individuals to seek care.

Coordinated specialty care (CSC) is the recommended, evidence-based recovery oriented team approach to treating early psychosis, promoting easy access to care and shared decision-making among specialists, the person experiencing psychosis and family members.[vi] Compared to usual care, CSC is more effective at reducing symptoms, improving quality of life, and increasing involvement in work or school.[vii]

Tenets of Coordinated Specialty Care Model[1]

- **Individual and/or group psychotherapy:** evidence-based cognitive or behavioral therapy to reduce symptoms and improve functioning
- **Family education and support**: outreach and education to help families support members with FEP. Families are involved regardless of client age with consent of client.
- **Case management**: coordination with other medical and behavioral health services to support access to needed medical, educational, social and other services
- **Medication management**: prescribing and monitoring medications to help manage symptoms and improve functioning
- **Supported employment and education services**: skill-building and supports to achieve and maintain educational and vocational functioning which may include services such as educational coaching, tutoring, and/or developing accommodations with schools
-

New Journeys adds peer support services and a registered nurse care manager as a core service.

Systematic reviews of CSC programs in the U.S. and internationally found that early intervention services found reduction in total costs or cost effectiveness through reducing high cost adverse outcomes and healthcare utilization (e.g., hospitalizations and emergency room visits).[viii]

Health Equity in First Episode Psychosis.

Access to care, treatment engagement and outcomes are different for people from different backgrounds, racial/ethnic groups, and socioeconomic groups. Black individuals are diagnosed with schizophrenia-spectrum disorders at higher rates than other groups and are likely due to bias in diagnosis and environmental stressors.[ix] Neighborhoods with lower socioeconomic resources, higher percentage of Black individuals and rural communities have lower access to mental health services. Geographic distribution of CSC. Even within CSC programs, people from different racial/ethnic backgrounds have varying levels of access to different treatment components, not related to difference in symptoms.[x] Culture also influences the perspective and interpretation of experience with illness and symptoms, and where and who to seek help from; the culture of the clinicians providing treatment also influences treatment for people

[1] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf

from different communities. It is important for healthcare delivery systems and Washington state agencies to address inequities through targeted, tailored outreach, policies promoting parity in mental health, and integrate culturally affirming and competent care practices that support all individuals and families experiencing FEP.

Population	Treatment
Age 15-40 Primary diagnosis of a psychotic disorder IQ>70 Not related to substance use or secondary cause	Coordinated Specialty Care (NJ in Washington) See below for details about CSC model
Late Onset Psychosis (40+) and Very-Late Onset Psychosis (45+)[2]	First step is elimination of possible causes of secondary psychotic symptoms • Medications • Neurological disorders • Delirium • Substance intoxication/withdrawals contributing to/exacerbating psychosis If psychotic symptoms are due to primary psychotic disorder, combination pharmacotherapy and psychosocial modalities are recommended. Caution in prescribing antipsychotics in elderly is advised. Treatment is psychosocial and
Psychosis due to substance use	Treat underlying substance use, often also with psychiatry but CSC doesn't make sense for that
Psychosis due to medical condition	Treat underlying medical condition (delirium)
Postpartum psychosis	Referred to OB/psychiatrist
Depression with psychotic features[3]	Treatment with combination antidepressive and antipsychotic medications (sertraline

[2] Tampi RR, Young J, Hoq R, Resnick K, Tampi DJ. Psychotic disorders in late life: a narrative review. Ther Adv Psychopharmacol. 2019 Oct 16;9:2045125319882798. doi: 10.1177/2045125319882798. PMID: 31662846; PMCID: PMC6796200. Tampi RR, Young J, Hoq R, Resnick K, Tampi DJ. Psychotic disorders in late life: a narrative review. Ther Adv Psychopharmacol. 2019 Oct 16;9:2045125319882798. doi: 10.1177/2045125319882798. PMID: 31662846; PMCID: PMC6796200.

[3] https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd-1410197717630.pdf

	with olanzapine, fluoxetine with olanzapine, venlafaxine with quetiapine)[4]
Clinical High Risk for Psychosis[5]: Help-seeking individuals with prodromal stages of psychosis	• *Family-aided assertive community treatment?* • Recommended treatment includes psychological interventions (CBT) as first psychotherapeutic option • Pharmacological agents mixed advice – not recommended for treatment in CHR-P • Some guidelines suggest it can be prescribed in special cases[6]* • Other medications for co-occurring depression/anxiety (antidepressants, mood stabilizer, benzodiazepines) considered for treatment of comorbid conditions
Developmental delay or autism spectrum disorder (ASD)	• Outpatient mental health center, • Applied Behavioral Analysis (ABA) is evidence-based treatment for ASD
PTSD or OCD	• Acute treatment for symptoms of psychosis • Transition to treatment for underlying OCD/PTSD in general
Chronic psychosis	• Chronic specialty behavioral healthcare (PACT/ACT team)

[4] Rothschild AJ. Treatment for Major Depression With Psychotic Features (Psychotic Depression). Focus (Am Psychiatr Publ). 2016 Apr;14(2):207-209. doi: 10.1176/appi.focus.20150045. Epub 2016 Apr 7. PMID: 31975804; PMCID: PMC6519655.

[5] https://www.sciencedirect.com/science/article/pii/S1876201824002351#ai-components-toc-id

[6] In case of accelerated deterioration, high risk of suicide, treatment with other anti-depressants has not been effective or if increasing aggression and hostility endanger other people; in case of ineffectiveness of psychological interventions, and in cases where CBT is insufficient and in which attenuated psychotic symptoms are occurring.

Draft Early Detection & Rapid Access Guidelines

Primary Care Settings

- Providers should know the signs and symptoms of first episode psychosis and how to ask about symptoms and experience in a nonjudgmental, non-stigmatizing manner.
    - Screen for psychosis when: the patient has a positive behavioral health screen (PHQ-9, GAD-7) and new or worsening functional decline or cognitive difficulties and/or disclosure or observance of:
        - Atypical perceptual experiences
        - Thought disturbance or delusions
        - Speech or behavior that is disorganized
    - Identify if there is a safety concern. If so, perform a same-day assessment of symptoms and suicide risk. Follow up to date guidelines on management of suicide risk and safety planning.
    - Identify if the experience is odd for the patient, not explained by cultural, medical or developmental context. If so, consider referral for specialty services for differential diagnosis.
- Clinicians should know where to refer patients to be evaluated if they are experiencing a first episode of psychosis (psychiatrist, CSC models). Practice settings can support this through strategies such as keeping a directory easily accessible of CSC programs in your area.
- Rule out medical causes of suspected psychosis without delaying referral for comprehensive psychiatric evaluation. See Table X for details.
- For language differences, including a trained, bicultural interpreter is important for evaluating mental health conditions (AFP)

Behavioral Health Agencies

- Train staff to identify patients experiencing a first episode of psychosis, and how to ask about symptoms and experience in a nonjudgmental, non-stigmatizing manner
- Know where to refer patients to be evaluated if they are experiencing a first episode of psychosis (psychiatrist, CSC models). Keep a directory easily accessible of CSC programs in your area.
- Provide a warm handoff when possible involving patient and support system to specialty behavioral health when needed.

Coordinated Specialty Care Programs

- Engage organizations in the community such as schools, CBOs, universities/colleges, primary care offices, correctional facilities and crisis care providers in community education on basic signs and symptoms of prodromal and acute psychosis

Health Plans

- Cover core coordinated specialty care services through a model that allows for and supports integrated team-based care (e.g., PMPM + encounter rate, episode of care model tied to quality metrics, etc.
- Incorporate billing codes for coordinated specialty care. The per encounter rate is intended to provide reimbursement for members who do not meet service utilization criteria for those wanting to bill per month.
    - H2040: Coordinated specialty care, team-based, for first episode psychosis, per month
    - H2041: Coordinated specialty care, team-based, for first episode psychosis, per encounter
- Provide reimbursement levels that support time dedicated to education and outreach for families, patients and community members about first episode psychosis.
- Provide coverage for evidence-based treatments for patients that experience psychotic symptoms but do not qualify for coordinated specialty care (e.g., clinical high risk for psychosis) including but not limited to psychological interventions such as CBT and pharmacological interventions for comorbid concerns (e.g., antidepressants, mood stabilizers, etc)
- Provide regular education to members and dependents on available behavioral health services, including specialty behavioral health on a regular basis.
- Evaluate internal claims data to identify and reduce duration of untreated psychosis, including reducing disparities in access to specialty behavioral health by race/ethnicity, language data, income level and geographic location.

State Agency: HCA

- Consider partnering with OSPI to develop standardized education and recommended pathway for school nurses to refer students to coordinated specialty care

Schools

- Develop pathway for referral to coordinated specialty care programs for students with concern for potential psychosis.
- Consider requiring continuing education related to psychosis for school nurse and counselor staff.

Academic Institutions

- Implement measures to support students who experience a first episode of psychosis while in college with academic and administrative accommodations, addressing on-campus stigma against mental health concerns, and preparing campus counseling and healthcare staff to identify and engage students with early psychosis.

Draft Treatment Improvement Guidelines

Primary Care Providers/Clinics

- Consider competency to prescribe low-dose antipsychotic medications to patients in conjunction with behavioral health treatment providers as appropriate

Behavioral Health Agencies

- Conduct assessment of your communities' needs for a coordinated specialty care program.
- Provide or refer to coordinated specialty care for patients experiencing a suspected or diagnosed first episode of psychosis caused by primary psychotic condition. Engage in a shared decision-making conversation around the benefits and
    - If coordinated specialty care is not available or not aligned with the patient

BHAs with Coordinated Specialty Care Programs

- Ensure you are meeting the core functions of coordinated specialty care, including:
    - Access to clinical providers with specialized training in first episode psychosis. Maintain a "no wrong door," policy for referrals.
    - Easy entrance to the first episode psychosis program through active outreach and engagement
    - Provision of services in home, community and clinic settings as needed
    - Acute care during or following a psychiatric crisis
    - Transition to step-down services with the CSC team or discharge to regular care as appropriate, depending on client's level of symptomatic and functional recovery
    - Assurance of program quality through continuous monitoring of treatment fidelity
- Initial contact with the person and/or family are to establish rapport, identify decision makers and support system, describe key elements of the clinic services, determine level of interest and proceed with prescreening if able.
    - If person was referred via a clinician, review all available medical records to gain insight into appropriate treatment plans
    - If CSC is not appropriate, make alternative referral plans with the referring provider.
    - Ensure transition of care is made after the patient is accepted into the CSC program

- Prescreen the patient before a full evaluation to identify individuals that are not likely to meet eligibility criteria. The goal of prescreening is to be responsive to the needs of the person seeking services and determine if they meet the basic eligibility requirements (e.g., age, duration of psychosis, eetc)
    - Provide brief psychoeducation around first episode psychosis and why early intervention is important.
    - Provide a brief description of the specialty clinic services and team members
- uate for admission using an evidence-based tool or form (e.g., Structural Clinical Interview for DSM, PQ-B) Incorporate as appropriate principles of the Cultural Formulation Interview or other cultural adaptations of tools into assessments.
    - If diagnosis is unclear, consider consultation with additional psychiatry expertise (e.g., UW Central Assessment of Psychosis Service). Consider provisional admission if it will take time to further evaluate symptom presentation.
    - When possible, conduct evaluations in person.
    - If the person meets the eligibility criteria, initiate intake processes as soon as possible.
    - If the person is not eligible, or does not want to engage with services, ensure a warm handoff occurs to the most appropriate care (e.g., outpatient programming, specialized programs such as WISe, Program of Assertive Community Treatment (PACT))
- Active Phase
    - At intake, introduce the person to the team and engage their natural supports in the various aspects of coordinated specialty care.
    - Engage peer support specialists early to support person and natural supports
    - Begin family education sessions, individual resiliency training, medication management and supported education and employment services within the first month
    - Medication management considerations:
        - For most causes of psychosis, even those in which the psychiatric disorder or underlying medical condition causing the psychosis has not yet been established, initial symptomatic treatment with an antipsychotic medication is recommended.
- Alternative treatment options
    - If Coordinated Specialty Care cannot be provided or is not aligned with the patient's wishes, consider recommending CBT for Psychosis in addition to medication management for psychosis symptoms.

•

Table X. Diagnostic Assessment for First Episode Psychosis[xi]

Domain	Components
Physical Exam	detailed neurologic exam and a complete mental status exam, with the following areas of focus: mood and affect, thought process and content (including an evaluation of delusions, abnormal perceptions, suicidal and homicidal ideation, and insight), and a cognitive exam.
Medical History	review of head injury, seizures, cerebrovascular disease, sexually transmitted infections, and new or worsening headaches. Collateral history from relatives is recommended.
Laboratory/Imaging	CBC CMP Thyroid function tests Urine toxicology Parathyroid hormone, Ca Vit B12 Folate Niacin Based on clinical suspicion, testing for HIV infection and hepatitis C, as well as brain neuroimaging (e.g., CT or MRI), should be considered as part of the initial work-up.

Other Resources

Several resources exist to support the establishment and implementation of a coordinated specialty care team. The original RAISE trial establishing evidence-base for coordinated specialty care has manuals on Outreach and Recruitment, which describes outreach steps and methods to establish and network for referral. It also provides guidance on evaluating and admitting individuals to the specialty care program. The Implementation manual provides recommendations around administrative issues, training and supervision of team members and considerations around meeting fidelity to the model.

[i] https://www.nimh.nih.gov/health/publications/understanding-psychosis

[ii] https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys/

[iii] Life expectancy and years of potential life lost in people with mental disorders: a systematic review and meta-analysis. Chan, Joe Kwun Nam et al. eClinicalMedicine, Volume 65, 102294

[iv] Correll CU, Solmi M, Croatto G, Schneider LK, Rohani-Montez SC, Fairley L, Smith N, Bitter I, Gorwood P, Taipale H, Tiihonen J. Mortality in people with schizophrenia: a systematic review and meta-analysis of relative risk and aggravating or attenuating factors. World Psychiatry. 2022 Jun;21(2):248-271. doi: 10.1002/wps.20994. PMID: 35524619; PMCID: PMC9077617.

[v] Kadakia A, Catillon M, Fan Q, Williams GR, Marden JR, Anderson A, Kirson N, Dembek C. The Economic Burden of Schizophrenia in the United States. J Clin Psychiatry. 2022 Oct 10;83(6):22m14458. doi: 10.4088/JCP.22m14458. PMID: 36244006.

[vi] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf

[vii] Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, Addington J, Brunette MF, Correll CU, Estroff SE, Marcy P, Robinson J, Meyer-Kalos PS, Gottlieb JD, Glynn SM, Lynde DW, Pipes R, Kurian BT, Miller AL, Azrin ST, Goldstein AB, Severe JB, Lin H, Sint KJ, John M, Heinssen RK. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. Am J Psychiatry. 2016 Apr 1;173(4):362-72. doi: 10.1176/appi.ajp.2015.15050632. Epub 2015 Oct 20. PMID: 26481174; PMCID: PMC4981493.

[viii] https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf

[ix] Faber SC, Khanna Roy A, Michaels TI, Williams MT. The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare. Front Psychiatry. 2023 Feb 9;14:1098292. doi: 10.3389/fpsyt.2023.1098292. PMID: 36846217; PMCID: PMC9947477.

[x] Oluwoye O, Stiles B, Monroe-DeVita M, Chwastiak L, McClellan JM, Dyck D, Cabassa LJ, McDonell MG. Racial-Ethnic Disparities in First-Episode Psychosis Treatment Outcomes From the RAISE-ETP Study. Psychiatr Serv. 2018 Nov 1;69(11):1138-1145. doi: 10.1176/appi.ps.201800067. Epub 2018 Aug 28. PMID: 30152275; PMCID: PMC6395511.

[xi] https://www.aafp.org/pubs/afp/issues/2015/0615/p856.html