



# Psychosis

## Identification and management for Canadian primary care professionals

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# Psychosis

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# Understanding Psychosis in Primary Care

## Epidemiology

- Childhood-onset primary psychotic illnesses (i.e. schizophrenia, schizoaffective disorder, delusional disorder, etc.) are very rare and warrant referral to psychiatry and possible inpatient assessment.
- It is estimated that 1/10,000 children develop schizophrenia (compare to 0.5-1% of adults).
- The peak age of onset for schizophrenia is between 15 and 30 years of age. (DeBello and Grcevich, 2004)

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# History and Information Gathering

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## Consider secondary psychosis or mimics

- Secondary psychosis or states that mimic psychosis are most common so think of:
  - Anxiety
  - Trauma
  - Substance use
  - Mood disorder with psychotic features
  - Developmental delay
  - Medical conditions
- Free domain tools for screening for various mental illnesses
  - [T-CAPS](#)
  - [Weiss Symptom Record](#)
- Please refer to other sections of this website for more details on other disorders

(DelBello and Grcevich, 2004)

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# Symptoms to consider

Psychotic disorders are usually associated with:

- Gradual loss of function
- Positive symptoms (see [next page](#)):
  - Hallucinations, delusions, inability to put thoughts together in organized fashion, and abnormal behaviour
- Negative symptoms
  - Loss of facial expression, loss of modulation in tone of voice, little speech, and loss of motivation

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# Examples of Common Positive Symptoms

- Ask about voices and sounds:
  - True hallucinations usually described as coming from the space around someone and not from inside their head
- Ask about beliefs of thought control:
  - Example: Do you believe that people can read your thoughts?
- Ask about ideas of reference:
  - Example: Do you receive messages through the television or radio?
- Ask about persecutory ideas:
  - Example: Is there any person or group of people acting against you? Do you feel safe?
- Ask about grandiosity:
  - Example: What are some of your talents?
- Bizarre thoughts may come out in conversation especially with good rapport

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# Assess Functional Impairment

- Psychotic illnesses are usually associated with a loss of function
- The degree of functional impairment along with the severity of symptoms will guide your management plan. Some free domain tools are listed below:
  - [Teen Functional Assessment](#) (TeFA) (self-report)
  - [Weiss Functional Impairment Scale](#) (self-report)
  - [Weiss Functional Impairment Rating Scale](#) (parent report)

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## Safety Assessment and Planning

- In psychosis it is important to assess for suicidal ideation, homicidal ideation, and the ability of the person to care for themselves
  - Ask about command hallucinations and need to protect themselves from anyone
- **Develop and implement a safety plan when there is a risk of self-harm, harm to others, or suicide.** [Click here](#) for a guide to developing and implementing a safety plan from “Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference”.
- **If there are any safety concerns, you can arrange to have the person assessed in the closest emergency department. The options available to have someone assessed vary from province to province. Common options include (1) a physician certifying a patient in their office, (2) the police bringing a patient into hospital, or (3) the family seeking an order from a Justice of the Peace to have an assessment completed. Please check your provincial Mental Health Act to determine what options are available in your province.**

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## Consider medical causes

- Many medical conditions can cause delirium (acute onset and often fluctuating course of alterations in level of consciousness and cognition often associated with psychosis)
- In schizophrenia untreated psychotic illness may be more persistent and there is no decreased level of consciousness unless attributable to substance abuse or other medical causes
- “Patients with schizophrenia are at high risk for underrecognition and undertreatment of physical illnesses ... Common comorbid illnesses include cardiovascular disease, obesity, type II (adult onset) diabetes mellitus, hyperlipidemia, and sexual dysfunction.” (Canadian Psychiatric Association, 2005)

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## Treatment Basics

- If the patient is safe for outpatient management then a referral should be made to your local early psychosis program for assessment. If such a program is not available, refer to a general psychiatrist.
- Non-medication strategies like family involvement, psychoeducation, group interventions, and individual therapy are all important for those with primary psychotic illnesses.
- Antipsychotic medications are important components of the treatment plan.
- [Antipsychotic basics](#)
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# Antipsychotic Basics

- Atypical antipsychotics are first-line medications for the treatment of primary psychotic disorders and their management will require long-term collaboration between primary care provider and mental health provider
- They are chosen over older antipsychotics because of their lower risk for causing tardive dyskinesia (TD). However, some are associated with significant risk of metabolic problems and all require regular metabolic monitoring.
- Atypical antipsychotics can still cause neurological side effects and patients should be monitored for TD and other neurological side effects.
- [AIMS \(Abnormal Involuntary Movement Scale\)](#) is a clinician-administered tool that can be used to detect and monitor tardive dyskinesia in patients receiving neuroleptic medications.

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# Atypical Antipsychotics

- Atypical antipsychotics with the exception of Clozapine are clinically indicated but used off-label in children and adolescents with psychosis in Canada
- Aripiprazole, Risperidone, Olanzapine, and Clozapine have been studied in placebo-controlled trials or in head-to-head studies in children and adolescents
- Initial doses and titration schedules are usually conservative but adult maximums are often required, especially in adolescents (Dulcan, 2010)

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Clear guidelines for paediatric dosing of atypical antipsychotics are not available – adult dosing is included as a reference

Drug	Comments	Start (mg)	Target (mg)	CPS Max (mg)
Risperidone (Risperidal)	Available in tabs, dissolving M-tabs, liquid	0.5-1	2-6	8
Olanzapine (Zyprexa)	Available in tabs, dissolving Zydis, and IM	5-10	10-20	20
Quetiapine (Seroquel)		100	600	800
Quetiapine XR (Seroquel XR)		300	600	800
Paliperidone (Invega)	~2/3 excreted without liver metabolism	3-6	6-12	12
Arpiprazole (Abilify)	3 day ½ life	10-15	10-30	30
Ziprazidone (Zeldox)	Give with food	20-40 BID	80 BID	100 BID
Risperidone long-acting injectable (Consta)	Oral required for 3 wks after injectable started	25 IM q2wk	25-37.5	50
Clozapine (Clozaril)	***special monitoring required	12.5-25	300-600	900

Prepared from product monographs, Compendium of Pharmaceuticals and Specialties (CPS), 2010

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# Some Adverse Effects of Antipsychotics

- Neurological:
  - Acute dystonia, akathisia, parkinsonism tardive dyskinesia/dystonia
  - Lower seizure threshold: significant in those with epilepsy and for Clozapine
- Cardiac:
  - orthostatic hypotension, long QTc, other with Clozapine
- Anticholinergic effects
- Sedation
- Agranulocytosis
  - Very significant with Clozapine
- High prolactin and sequelae
- Hepatic effects
- Weight gain, glucose and lipid regulation problems
- Neuroleptic malignant syndrome (NMS)

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# Monitoring for individuals on antipsychotics

- Baseline bloodwork should include CBC, liver tests, kidney tests, electrolytes, +/- ECG, +/- prolactin, +/- pregnancy test
- Canadian guidelines for monitoring for antipsychotic side effects in children and youth are found at <http://comesaguideline.org>.

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## Follow-up and Referral

- Patients with a psychotic illness should be assessed by an early psychosis team if possible and by a general mental health professional if such a team is not available and they will likely follow patient until some stability is obtained.
- Urgent/emergent referral is required for significant/acute suicidality, homicidality, or psychosis.
- Depending on the severity/situation, follow-up might be required as frequently as weekly.
- There is agreement on close follow-up when antidepressants are started. The guidelines are copied from the National Alliance on Mental Illness (NAMI):
  - Weekly for the first month, every two weeks for the second month, at 3 months, and then as clinically indicated.
- To meet metabolic monitoring requirements a patient should be monitored at least monthly for the first 3 months and then every 3 months if stable after a new antipsychotic is introduced or significant dose change is made.
- [Click here](#) for a guide to making referrals from the [GLAD-PC Guidelines](#).

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## Freely available comprehensive guides

- For a comprehensive guide to schizophrenia in children and youth download the [American Academy of Child and Adolescent Psychiatry Practice Parameters](#) (2013).
- For a comprehensive guide to schizophrenia in adults please refer to [Canadian Psychiatric Association Guidelines](#) (2005).
- For comprehensive guides to child and youth mental health in primary care, see "[Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference](#)" (includes general mental health, depression, suicide and self-harm, anxiety, disruptive behaviour disorders, parental mental illness and infant mental health) or [3<sup>rd</sup> edition](#) (includes fetal alcohol spectrum disorder, childhood trauma, autism spectrum disorder and eating disorders) by Healthy Minds/Healthy Children and the Southern Alberta Child & Youth Health Network, or visit the [Healthy Minds Healthy Children](#) website.

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