

The first psychotic episode

Navigating early-stage schizophrenia and other psychoses

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Psychosis is a clinical syndrome which may signal the onset of a serious mental illness, such as schizophrenia, and impact a young person over their lifetime. Early recognition, compassionate engagement and timely referral are critical in shaping long-term outcomes and supporting recovery.

Psychosis denotes a state in which a person's experience of reality is markedly distorted. Core features of psychosis include hallucinations (perceptions experienced without external stimuli), delusions (fixed false beliefs) and disorganised thinking or speech. Isolated or transient psychotic

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symptoms may occur in states of bereavement or intoxication and are experienced in up to 17% of children and around 8% of adults.¹ A psychotic disorder is diagnosed when such symptoms are sustained and impairing. The *Diagnostic and Statistical Manual of Mental Disorders* and *International Classification of Diseases* classification systems for psychotic disorders include schizophrenia spectrum disorders (schizophrenia, schizophreniform, brief psychotic disorder, delusional disorder, schizotypal personality), secondary psychoses (substance- or medication-induced), psychosis due to medical conditions and mood disorders with psychotic features.

A diagnosis of a first episode of psychosis (FEP) refers to the first time a person meets the criteria for a psychotic disorder. During the initial period of follow-up for FEP, efforts ought to be made to provide a more definitive diagnosis, such as schizophreniform disorder or bipolar disorder, as this is useful in treatment planning. This article focuses on the clinical

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KEY POINTS

- Psychosis is a critical syndrome requiring urgent attention, referral and escalation.
- Engagement of the young person presenting with psychosis may be difficult; however, a therapeutic alliance focusing on collaborative care can yield many long-term benefits.
- Early and consistent treatment with antipsychotic medication remains the cornerstone of recovery in psychotic disorders.
- The local Mental Health Act may need to be applied in enforcing treatment if there are acute concerns for safety and a likelihood or actuality of disengagement from treatment.
- The patient's regular GP can play a vital role in monitoring adverse effects, especially in the setting of cardiometabolic risk.
- Despite the stigma associated with schizophrenia, functional recovery is possible. Actively partnering with the patient in management, monitoring treatment response and risk of relapse enhances the patient's likelihood of a positive outcome longitudinally.

1. CASE STUDY, PART 1: PRESENTATION

Sarah, a 22-year-old Honours student, is brought in to see you by her concerned mother, Lizzie. You recall having seen Sarah previously for a review of anxiety symptoms in the setting of her university examinations a few years ago. Sarah is only passively engaged in the review, and so, Lizzie does most of the talking. Sarah is described as a caring, bright and sociable young woman looking forward to a move interstate for a postgraduate role with an esteemed organisation. However, over the past two months, Sarah has become increasingly withdrawn, has lost some weight and has lost interest in her own appearance. Despite spending all her time absorbed in her laptop, Sarah has fallen behind with deadlines for her thesis submission. She is stressed and easily frustrated about things at home, such as the family having to cut back on meals out and other 'frills' as a result of some financial pressures. Lizzie expresses particular concern at Sarah's apparent change in mood, and states that Sarah does not appear to care about anything anymore.

As Lizzie completes her recount, Sarah suddenly snaps at her and says there is nothing to be worried about and leaves the consultation room. After Sarah has left, Lizzie confides to you about having looked through her daughter's journal. She expresses concern in what she found: rambling passages purporting to make connections between Sarah's thesis and the introduction of HIV to the Australian population. Lizzie also found a bong while trying to clean Sarah's room and asks whether Sarah has a 'drug problem'.

commanding) and disorganised thoughts or behaviours, as well as negative symptoms (Box 2). Of note, these negative symptoms are seen as the core pathology inherent to schizophrenia and, along with cognitive symptoms, are responsible for the severe functional deficits seen in many people with schizophrenia. Many patients also have comorbid mood or anxiety disorders. Notably, insight is often poor; patients may not recognise these experiences as abnormal.

presentation of psychosis in the general practice setting and holistic treatment and care in the initial stages of schizophrenia. A companion article in a future issue of *Medicine Today* will discuss treatments for chronic schizophrenia.

Schizophrenia – a brief overview

Psychotic disorders manifest with symptoms across several domains and can cause significant impairment to an individual's ability to engage with loved ones and wider society. Schizophrenia is the prototypical chronic psychotic disorder. It typically presents in late adolescence or early adulthood, with females tending towards a later presentation. A case study is introduced in Box 1. Diagnosis requires at least six months of symptoms (including at least one month of active-phase symptoms, such as hallucinations or delusions) plus functional decline. Typical clinical features include positive symptoms, such as persecutory delusions, auditory hallucinations (voices commenting or

Epidemiology and course

The lifetime prevalence of schizophrenia in high-income countries is about 0.7 to 1%. Schizophrenia is a leading cause of disability among young adults; it ranks ninth in burden and healthy life years lost (disability-adjusted life years) among men aged 25 to 44 years in Australia.² Only about 10 to 15% of patients regain full social and occupational functioning.³ The illness course is variable; up to one-third of patients achieve sustained remission of psychotic symptoms after their first episode of acute illness. However, a larger proportion (around 50%) experience recurrent relapses, which are commonly the result of medication nonadherence, concurrent substance use (especially cannabis or stimulants) or psychosocial stress. Meanwhile, the remaining roughly 20% of patients experience a chronic, function-impairing illness.

People with schizophrenia live 25 fewer years than the general population (primarily because of the presence of cardiometabolic

2. COMMON FEATURES OF SYMPTOM PROFILES IN PSYCHOSIS

Positive (abnormal experiences added to perception or thought)

- Hallucinations: abnormal sensory perceptions in the absence of an external stimulus, most typically auditory voices
- Visual illusions
- Delusions: fixed and false beliefs not able to be shifted by conflicting evidence and that may take on paranoid, referential, grandiose, somatic or misidentification themes
 - A referential delusion involves the false belief that an inconsequential stimulus has special meaning or a message for the patient, such as believing that a television newsreader shuffling her papers indicates a secret wartime message
 - A delusion of misidentification may involve the patient believing their spouse has been replaced by an identical-looking imposter (also known as Capgras delusion)

Disorganised

- Formal thought disorder: loose associations, tangentiality, incoherence
- Neologisms
- Unpredictable or socially inappropriate behaviour

Negative (diminished normal functions; often persistent and disabling)

- Blunted or flat affect
- Alogia: poverty of speech
- Avolition: lack of motivation, neglect of self-care
- Anhedonia: no pleasure in activities
- Social withdrawal
- Apathy

Cognitive (may precede the psychotic break and strongly predict functional outcome)

- Impaired attention or concentration
- Poor short-term memory
- Slowed information processing
- Executive dysfunction: difficulty with planning, abstraction and problem-solving
- Deficits in social cognition, such as an impaired ability to recognise the emotions inherent to the facial expressions of others

Affective or anxiety

- Mood disturbances: frequently accompany psychosis
- Dysphoria and hopelessness in a young person: should raise clinical suspicion of emerging psychosis
- Depression, hopelessness, anxiety or irritable mood
- Manic or hypomanic episodes: can co-occur with the first episode of psychosis
- Affective symptoms: can colour delusions (e.g. nihilistic depression with psychosis)

comorbidities and suicide).⁴ The economic burden of mental illness and, in particular, that of schizophrenia is significant and extends far beyond the direct costs of health care to the societal costs of support and the lost opportunity of employment.

Pathophysiology and hypotheses

Although the widely accepted biopsychosocial stress–vulnerability model frames psychosis as a product of genetic and environmental interactions, diagnosis and monitoring still rely solely on clinical judgement. The biology of psychosis is complex and not fully understood, but key theories highlight neurotransmitter changes, especially dopamine hyperactivity in mesolimbic pathways and hypoactivity in the prefrontal cortex, as drivers of positive and negative symptoms. The efficacy of dopaminergic antagonists in treating positive symptoms is linked to this basic hypothesis.

Inflammation and oxidative stress may be important in a subgroup of patients, but there are currently no therapies associated with their possible role. A small

proportion of patients have an autoimmune psychosis, such as anti-N-methyl-D-aspartate (NMDA) encephalitis, which would require careful identification and specific multispecialty treatment, including input from immunology and neurology.⁵ By some estimations, up to 12% of patients with a FEP may test positive for serum immunoglobulin G antibodies against NMDA receptors; however, other studies have not consistently determined any difference in antibody frequency or titre compared with healthy controls.^{5,6}

Assessment

Building rapport and trust is critical. A young adult experiencing psychotic symptoms may be frightened, confused or suspicious. Practical tips for GPs are listed in Box 3.

History, examination and investigations

An outpatient assessment must be thorough and systematic. The domains of assessment include history taking, a Mental State

Examination and physical examination; these are further detailed in Box 4. Further investigations as recommended in the Royal Australian and New Zealand College of Psychiatrists guidelines for the management of schizophrenia and related disorders are listed in Box 5.^{7,8}

Referral and risk management

A high index of suspicion should be maintained, and a low threshold for specialist referral is advised, given that a longer duration of undiagnosed and untreated psychosis correlates with poorer recovery. GPs should arrange urgent assessment by an early-psychosis or early-intervention service or psychiatrist. Outcomes for people treated by a specialist early psychosis team are improved compared with outcomes after treatment via standard services across all areas (e.g. treatment adherence, rate of hospitalisation, symptom severity and functional outcome).⁹ The national early psychosis guidelines recommend that a person with a suspected FEP be evaluated by specialist services

3. PRACTICAL TIPS FOR GPs TO APPROACH A PATIENT EXPERIENCING PSYCHOTIC SYMPTOMS

Establish a safe, private setting:

- sit at eye level and allow a family member or friend (if the patient wishes)
- if there are signs of escalating agitation, consider the safety of staff (e.g. by sitting close to the exit)

Use nonjudgemental, normalising language:

- e.g. say 'Some people have experiences that are unusual or hard to understand. Do you ever have any strange sounds or experiences?' or 'Have you noticed anything that feels off, or makes you worried?'
- this opens up the discussion without directly labelling psychosis

Ask open-ended, gentle questions:

- e.g. 'What goes through your mind when you see [blank] or hear [blank]?' or 'Do you ever feel that people are talking about you?' and 'Do you think that messages are hidden in things you see?'

Be empathetic and patient:

- validate their fear or confusion (e.g. 'That sounds very scary or confusing' without confirming delusions)
- avoid arguing about reality and instead explore meanings (e.g. 'What do you make of these experiences?')

Explore safety diplomatically:

- with genuine concern, inquire about self-harm or command hallucinations (e.g. 'Sometimes when people hear voices or believe others want to harm them, it can be overwhelming. Have these thoughts ever made you feel unsafe or think of hurting yourself or others?')

Involve family and caregivers:

- they often provide collateral history and can help engage the patient
- family understanding of the patient's perspective is also key and can activate and maintain allies through recovery

within 48 hours of referral.¹⁰ A provisional diagnosis of FEP should be revised longitudinally, as the pattern of symptoms over time should provide clarification as to the

definitive diagnosis.¹¹ We acknowledge the difficulties present in many regional and rural areas in patients receiving tertiary care for early psychosis.

Risk

Urgent hospitalisation (emergency department or psychiatric unit) is indicated if there is any evidence of active suicidality (including severe depression with psychotic features), severe self-neglect (e.g. not eating or drinking), violent behaviour or homicidal ideation, or severe incapacity (e.g. catatonia). These features would likely necessitate involuntary care under the local Mental Health Act and collaboration between the GP, emergency services and a hospital-based facility. If risk is present but assessed to be lower (e.g. fleeting suicidality without plan, moderate disorganisation), urgent referral may still be appropriate. However, such cases can often be managed through outpatient care, supported by a comprehensive safety plan, close follow-up and a low threshold for escalation to hospital-level care if needed.

Community resources

Family and community supports must be involved early. Case management by a specialist team (from community mental health services) can help ensure safety and co-ordinate pharmacological and psychosocial interventions, functional assessment, housing options and care more broadly.

Treatment of early schizophrenia symptoms

Pharmacological treatments

Antipsychotic medications remain the mainstay of treatment for psychosis. The newer second- or third-generation antipsychotics are first-line treatments for schizophrenia. Common oral choices in Australia include amisulpride, aripiprazole, quetiapine, risperidone and ziprasidone (Table 1).¹² These are recommended by existing guidelines; however, all available antipsychotics are effective for the FEP.⁷ Olanzapine is not initially recommended because of the high

4. KEY ELEMENTS OF ASSESSMENTS FOR PSYCHOSIS

History

- Onset, duration and course of symptoms (e.g. fluctuations)
- Changes in sleep, appetite or functioning
- Level of insight into symptoms
- Presence and type of hallucinations and delusions
- Disorganised thoughts or behaviours
- Mood symptoms: depression, mania, anxiety
- Substance use: alcohol, cannabis, amphetamines, hallucinogens, tobacco, vaping
- Recent stressors or precipitating events
- Collateral history from family or friends (function, self-care, socialisation)
- Risk assessment: suicidality, self-harm, aggression, neglect
- Family psychiatric history

Mental State Examination

- Appearance and behaviour
- Affect and emotional expression
- Speech characteristics (e.g. pressured, tangential)
- Thought form (e.g. loose associations, derailment)
- Thought content (e.g. delusions, preoccupations)
- Perceptual disturbances (e.g. auditory hallucinations, illusions)
- Judgement and insight
- Cognitive screening (e.g. orientation, memory, concentration)

Physical examination

- General physical examination
- Neurological examination (to exclude organic causes)
- Vital signs
- Baseline weight and body mass index

risk of metabolic side effects. Although it is commonly prescribed in acute hospital settings for its sedating properties, long-term use is problematic for patients because of its side-effect burden, and so, stabilisation and maintenance of remission on alternative

agents is preferred. Haloperidol and other first-generation drugs are seldom used as they have a higher risk of extrapyramidal side effects. Long-acting injectable formulations (e.g. aripiprazole, paliperidone and risperidone) are available and can be considered early, including in the setting of the first episode of illness (when the primary differential diagnosis is that of a schizophreniform illness or schizophrenia). Clozapine is reserved for third-line treatment because of the risk of agranulocytosis, requiring consistent monitoring of the white cell and neutrophil counts.

Dosing

Patients with a FEP are likely to be more sensitive to medication. The approach should be to start low and titrate slowly; typical effective doses for the FEP are about half of those used in chronic illness. For example, risperidone may be started at 0.5 to 1 mg/day and aripiprazole at 5 mg/day. The patient must be reassessed weekly for the treatment response and side effects. Improvement often begins after one to two weeks of treatment. If there is no clear response, the dose can be raised cautiously every one to two weeks until efficacy is evidenced on clinical assessment. Rapid escalations in dose are to be avoided, as this increases the risk of adverse effects and neuroleptic malignant syndrome. Most patients who will respond to a single agent do so within three to four weeks.¹³ It is important to monitor and assess for adherence, as one of the most common reasons for treatment failure is, sometimes insidiously, poor adherence to prescribed treatment.¹⁴

Duration and monitoring

After symptom remission is achieved, maintenance treatment with antipsychotic medication is recommended. Many experts advise continuing the chosen agent for at least two to five years after the FEP before tapering, given the high early relapse rates. If there is good recovery with no loss of function (i.e. the person is diagnosed with a schizophreniform disorder), then

a slow reduction in antipsychotic medication over six to 12 months, while proactively monitoring for early warning signs of relapse, is almost always requested by the patient and may be considered.¹⁵ Continued symptomatology or functional decline would not support this course of action and, therefore, consistent vigilance is required of the therapeutic partnership formed between the patient, carer and clinician. The monitoring response includes regular psychiatric review (weekly initially, then monthly). Rating scales should be used if available (e.g. Clinical Global Impression) for more clarity on progression and avenues for further symptom improvement, as well as for communication around deterioration.¹⁶

[...] effective and safe pharmacotherapy remains the primary treatment modality for schizophrenia and associated illnesses

The patient must be screened frequently for side effects, including metabolic parameters (weight, body mass index, waist circumference, fasting blood glucose levels and lipid levels every three to six months) and movement disorders (Parkinsonism, dystonia or tardive dyskinesia). Serum prolactin levels need monitoring, as many antipsychotics (e.g. first-generation antipsychotics, amisulpride, paliperidone and risperidone) cause hyperprolactinaemia (inducing galactorrhoea or amenorrhoea), and prolonged periods of hyperprolactinaemia increase the risk of osteoporosis and breast cancer.^{17,18} ECG is advised at baseline as antipsychotic drugs may prolong the QTc (especially ziprasidone, amisulpride and haloperidol), and then repeated annually or more frequently depending on the agent prescribed. Clozapine requires additional monitoring secondary to the uncommon risks of agranulocytosis, myocarditis and cardiomyopathy. An overview of the monitoring schedule is provided in Table 2.¹² The case study is revisited in Box 6.

5. INVESTIGATIONS AND RATIONALES FOR EARLY PSYCHOSIS^{7,8}

- Full blood count: to check for anaemia or infection
- Measurement of electrolytes and calcium levels: to rule out metabolic abnormalities
- Liver and renal function tests: to assess baseline function; useful for monitoring
- Thyroid function tests: to rule out thyroid-related causes
- Measurement of vitamin B12 and folate levels: to check for deficiencies that may mimic psychosis
- Measurement of glucose and lipid levels: baseline metabolic screening, especially before starting antipsychotics
- Syphilis serology: to rule out neurosyphilis
- HIV and hepatitis screening: to assess for neuropsychiatric manifestations and encephalopathies
- Urine drug screen: to check for substance-precipitated psychosis
- Autoimmune panels (e.g. anti-N-methyl-D-aspartate receptor antibodies): to check if clinical history or examination suggests autoimmune encephalitis (may only be rebate-eligible if ordered in hospital or by a non-GP specialist)
- Brain imaging (CT or MRI): if focal findings, abrupt onset or atypical age are present; CT of the brain may exclude obvious findings (e.g. space-occupying lesions) and MRI of the brain may attract a rebate only if ordered in hospital or by a non-GP specialist
- Outpatient EEG: if seizures or cataplexy are suspected

Ongoing management and developments

Considerations in pregnancy and breastfeeding

Proactive discussions with patients should be had around contraception and family planning, as well as preconception and antenatal psychotropic use. Mothers with psychotic disorders are best placed to parent their children if their illness is well managed in sustained

TABLE 1. PHARMACOLOGICAL TREATMENTS FOR PSYCHOSIS¹²

Medication	Approximate frequency of adverse effects					
	Anticholinergic effects	Cardiometabolic effects	Extrapyramidal side effects	Hyperprolactinaemia	Sedation	QTc prolongation
<i>Newer-generation treatments</i>						
Amisulpride	-	+	+	+++	+	++ to +++
Aripiprazole	- to +	- to +	+	-	- to +	- to +
Asenapine	+	+	+ to ++	+	+	+
Brexiprazole	- to +	- to +	+	-	- to +	- to +
Cariprazine	- to +	- to +	+	-	- to +	- to +
Clozapine	+++	+++	-	-	+++	+ to ++
Lurasidone	- to +	- to +	+ to ++	+	+	- to +
Olanzapine	++	+++	- to +	+	++	+ to ++
Paliperidone	+	++	+	+++	++	+
Quetiapine	+++	++ to +++	- to +	- to +	++ to +++	+ to ++
Risperidone	+	++	+	+++	+	+ to ++
Ziprasidone	+	+	+	+	++	+++
<i>First-generation treatments</i>						
Chlorpromazine	++	++ to +++	++	++	++ to +++	++
Haloperidol	+	+ to ++	+++	++	+	+++
Flupentixol	++	++	++ to +++	- to +	+	++
Periciazine	+++	++	+	+++	+++	Limited or no data
Zuclopenthixol	++	++	++ to +++	+++	+++	Limited or no data

Key: - = negligible or absent; - to + = negligible or absent to infrequent; + = infrequent; + to ++ = infrequent to moderately frequent; ++ = moderately frequent; ++ to +++ = moderately frequent to frequent; +++ = frequent.

remission and they have strong support from family and a multidisciplinary team throughout the perinatal period and beyond. For information and support, the MotherSafe (<https://www.seslhd.health.nsw.gov.au/royal-hospital-for-women/services-clinics/directory/mothersafe>) and MotherToBaby (<https://mothertobaby.org/>) resources and other equivalent resources provide information about medications in the setting of pregnancy and breastfeeding. Different antipsychotics have varying safety profiles in these settings, and use of these resources and psychiatrist involvement are recommended in such cases.

Challenges with ongoing treatment

Many patients, especially young people, struggle with medication adherence, and this is not limited to those with very poor insight. Stigma, side effects, an itinerant or chaotic lifestyle and a lack of social support are all factors that can reduce adherence. By simplifying treatment plans and timing, engaging in ongoing attempts to build and maintain rapport, offering ongoing education, utilising available family supports and using long-acting injectables proactively, the patient may improve their resilience to relapse. Other strategies to improve adherence include carefully listening to

and responding to patient concerns about side effects, communicating empathetically about the management of any side effects, implementing cognitive behavioural approaches and applying motivational interviewing techniques. It is often helpful to establish a good therapeutic alliance as a basis for open and frank medication discussions. The GP Psychiatry Support Line (1800 16 17 18) may aid GPs in supporting their patients while optimising their treatment.

Barriers to care

Patients with psychosis face multiple care barriers. Stigma and lack of insight often

TABLE 2. SUGGESTED MONITORING SCHEDULE FOR PATIENTS PRESCRIBED ANTIPSYCHOTICS¹²

Monitoring step	Prior to commencing agent	At one month	At two months	At three months	At six months	At 12 months and thereafter
Blood pressure and heart rate	✓				✓	✓ (and repeat every six months)
Weight, waist circumference and body mass index	✓	✓	✓	✓	✓ (and repeat every three months)	✓
Blood glucose and HbA _{1c} concentration	✓			✓	✓	✓ (and repeat every six months)
Fasting lipid levels, including triglycerides	✓				✓	✓ (and repeat every six months)
Physical activity level	✓					
Movement assessment (involuntary or voluntary)	✓					
Full blood count	✓					✓ (and repeat annually)
Blood prolactin level	✓	✓			✓	✓ (and repeat annually)
ECG	✓					✓ (and repeat annually)
Extrapyramidal side effects*		✓			✓	✓ (and repeat every six months)
Sexual and reproductive problems		✓			✓	✓ (and repeat annually)

* Assessed using clinical examination or standardised Abnormal Involuntary Movement Scale.

delay help-seeking. Rural and remote regions have fewer specialist services, a lack of dedicated local early psychosis teams and long travel distances. Even in urban regions, wait times for psychiatric assessment can be lengthy.¹⁹ In relation to service structure, youth services often cease at 25 years of age, and adult services may not be youth-friendly or may be overwhelmed by case numbers, causing young adults to fall through service cracks. Cultural and linguistic barriers affect migrants

and Aboriginal and Torres Strait Islander communities disproportionately. Socio-economic disadvantage, homelessness, trauma and comorbid substance abuse further impede engagement with care along with the gap between Medicare payments and doctor's fees. GPs can help overcome barriers by continuing to play a vigilant role and offering supportive counselling, co-ordinating with local support agencies (headspace outreach, homelessness services, drug and alcohol clinics) and

continuing to advocate for the patient's care needs if barriers are present.

Substance use

Co-occurring substance use disorders are very common (up to 40 to 60% over a lifetime). Smoking cessation must be addressed, as smoking rates are higher than 60% among people with schizophrenia, contributing to physical health decline and worsening of the cardiovascular risk profile. Cannabis and methamphetamine use can

6. CASE STUDY, PART 2: TREATMENT

Sarah and Lizzie return to see you with a progress update from the early intervention in psychosis service since her diagnosis with psychosis three months ago. Sarah has not yet recommenced her Honours year but has worked with an occupational therapist in preparation for the following semester. She has noticed some weight gain since commencing paliperidone, but otherwise appears calm and optimistic, although somewhat distant in the engagement. Additionally, Sarah has remained abstinent from cannabis following her engagement with the community drugs and alcohol service that you had referred her to. Lizzie, too, reports relief and is hopeful that Sarah will only continue to improve. After Lizzie leaves to the waiting room, Sarah confides in you that her periods have ceased and that her breasts have begun leaking milk. Sarah states she would like to cease paliperidone and wishes to continue engaging with the early intervention team and you, but without any medication.

worsen psychosis or trigger relapses. Alcohol misuse may mask symptoms. GPs should screen and address substance use assertively via brief interventions, the use of nicotine replacement or other pharmacotherapy (such as varenicline or bupropion), referral of the patient to counselling or rehabilitation services and consideration of integrated dual-diagnosis programs.²⁰ Reducing substance use can improve outcomes substantially.

Other psychiatric comorbidities

Depressive and anxiety disorders frequently co-occur. Depression is not merely a reaction to having a psychotic illness diagnosed and must be managed independently. Comorbid depression and anxiety may be treated with selective serotonin reuptake inhibitors or psychotherapy, as appropriate.

Suicide

Worryingly, patients with schizophrenia have a rate of suicide 10 times that of the general population.²¹ The risk is especially high in the first five years of illness. Risk factors include male gender, previous suicidal behaviour, depressive symptoms, hopelessness, recent loss, sudden cessation of medication and the FEP itself. Every young person with psychosis should be assessed for suicidal ideation and provided with a safety plan. This includes identifying warning signs (e.g. insomnia, withdrawal), coping strategies and emergency contacts. GPs should ask openly about suicidal thoughts

at each visit, maintain a low threshold for urgency and involve crisis teams or hospital admission if suicidal intent is present.

Safety planning example

Patients must be encouraged and assisted to complete a safety plan that covers who to call if thoughts of suicide recur, removal of means (e.g. storing sharp objects securely), places they feel safe and scheduling of regular follow-up appointments. A web-based application (such as the Lifeline Beyond Now safety plan tool, available online at: <https://www.lifeline.org.au/get-help/beyond-now/>) may assist in this important endeavour. GPs should provide clear crisis contact details (e.g. Lifeline, local mental health crisis teams) and consider involving carers or family members if there is evidence of acute risk. The case study is concluded in Box 7.

Relapse prevention and nonpharmacological interventions

At this early stage in care, psychosocial interventions are primary interventions that support relapse prevention and rehospitalisation. However, all non-pharmacological interventions are important yet adjunctive in nature; effective and safe pharmacotherapy remains the primary treatment modality for schizophrenia and associated illnesses, and they are deemed essential in preventing relapse. Nonmedical interventions are listed below and will be summarised in an article by

Professor Anthony Harris et al. in a future issue of *Medicine Today*.

- **Psychoeducation:** providing information about the illness, its causes, treatment and the mental health system that they are trying to navigate.
- **Assertive community care:** involvement of a community team to provide assertive support for the person with schizophrenia and their family improves satisfaction with services and decreases rates of relapse and rehospitalisation.
- **Cognitive behavioural therapy:** evidence supports its use as an adjunct to antipsychotic medication.²²
- **Family interventions:** family-based therapy and education has strong evidence in the treatment of FEP and schizophrenia. Structured family interventions (psychoeducation, communication skills) significantly reduce relapse rates and rehospitalisation.²³ GPs can play a role in encouraging family participation in treatment and can refer families to educational and carer support programs or nongovernmental organisation programs.
- **Social and vocational support:** early engagement in education, employment or training is crucial. Social skills training and occupational therapy can be valuable.
- **Substance use disorder treatment:** any substance use disorder treatment or intervention is relapse prevention. Ensure alcohol and other drugs specialists are involved if this comorbidity is detected.
- **Personal relapse prevention plan:** GPs can work with the patient (and family) to draft a safety and relapse prevention plan. This might include:
 - identifying personal triggers (e.g. stress, sleep loss)
 - early warning symptoms (e.g. mood changes, thinking speed)

7. CASE STUDY, PART 3: ONGOING MANAGEMENT

With the support of you, her family and the early intervention team, Sarah continues on aripiprazole long-acting injectable and remains relapse free for the next two years. She graduates and moves interstate, and continues her therapeutic relationship with you, as she continues to see you at least every two months whenever she visits her family, while receiving her long-acting injectable administration at a local interstate clinic.

- coping strategies (e.g. maintaining routine, contacting supportive friends)
- a list of emergency resources (e.g. 24-hour crisis line, nearest emergency department, trusted clinician).
- **Medication plan:** documentation of the medication plan (name, dose and where to obtain scripts) and arranging a backup prescriber (if the regular GP is unavailable) is helpful, especially in the setting of social isolation or the cognitive impacts of severe mental illness.

Conclusion

GPs in Australia play a crucial role in the early recognition, initial assessment and ongoing management of individuals experiencing a FEP. Timely identification, accurate assessment and appropriate referral to specialist mental health services are essential for improving long-term outcomes. GPs are also vital in providing continuous care, including monitoring medication adherence and side effects, managing physical and mental health comorbidities and developing relapse prevention plans in collaboration with non-GP specialists and allied health professionals. By understanding the complexities of psychosis and the schizophrenia spectrum, addressing stigma and utilising effective engagement and assessment techniques, GPs can significantly empower their patients on their journey towards

recovery. Collaboration with specialist services and a multidisciplinary approach are key to providing comprehensive and effective care for individuals experiencing this critical stage of illness. **MT**

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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ONLINE CPD JOURNAL PROGRAM

True or false? 'Rapid escalations in the dose of a patient's antipsychotics should be avoided.'



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The first psychotic episode

Navigating early-stage schizophrenia and other psychoses

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