

Aim: To standardize the assessment, diagnostic workup, management, and overall care of patients presenting with first episode of symptoms of psychosis.

Patient presents with first episode of:

1. Psychotic symptoms including delusions, hallucinations, thought disorder, and/or disorganized behavior

OR

2. Acute mania including not sleeping for several days, grandiose thinking, hypersexuality, increased risk-taking behaviors (see Note 1)

History and Physical (see Note 2 and 3)

Initial labs (to be done in ED): Urine pregnancy, Urine Drug Screen

- SW Mental Health Crisis assessment and ED assessment
- ED to consult Psychiatry (when available, check AMION) to discuss labs/imaging/further work up (see Notes 4 and 5) if needed
- Consider starting medication (scheduled or PRN). See page 5 and 6 for Medication Options

Patient meets discharge criteria as they are not at imminent risk to self/others and can be safely managed at home.

Referrals to safety planning page 8, outpatient resources page 9-10, and/or have patient return to their outpatient team

Is admission needed?

No

Yes

Consider Admit location (see Note 7).
Is patient appropriate for IPMH admission?

No

Yes

IPMH:

- See page 5 and 6 for Medication Options
- See page 7 and 8 for Behavioral and Safety planning

Med/Surg

- Complete further work up and medical stabilization. See Note 4 and 5.
- See page 5 and 6 for Medication Options
- See page 7 and 8 for Behavioral and Safety planning.
- Disposition determination with SW and psychiatry (IPMH vs discharge home)

Exclusion guidelines:

- Patients with known psychotic disorder do not require additional work-up unless requested by Psychiatry
- Psychotic symptoms clearly secondary to a neurological process or substance induced

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Note 1: Definitions:

- **Delusions:** fixed false beliefs not consistent with the patient/family's cultural or religious beliefs nor developmentally appropriate imagination.
- **Hallucinations:** wakeful sensory experiences of content not actually present and not consistent with developmentally appropriate imagination. Can occur with any of the five senses.
- **Thought Disorder:** disorganization of thoughts or loosening of associations (thoughts no longer connect in a way that makes sense), thought blocking, poverty of content, word salad, perseveration, etc
- **Disorganized Behavior:** behavior that is purposeless, odd, self-contradictory or inconsistent. Patient may be impulsive or shift behavior rapidly.
- **Mania:** abnormally and persistently elevated, expansive, or irritable mood; abnormally and persistently goal-directed behavior; increased energy. Symptoms present for at least 1 week. Often with decreased need for sleep. Patients may or may not be grossly psychotic. May see increased risk-taking behaviors, hypersexual behaviors and/or grandiose thinking.
- **Prodromal Symptoms:** period of time prior to active/clear symptoms in which patients experience a decline in functioning, subsyndromal psychosis and negative symptoms
- **Negative Symptoms:** decreased expression, flat affect, apathy, anergic. May present as social withdrawal, decreased motivation, decreased completion of ADLs.

Note 2: History to Obtain:

- Timeline of symptom onset and presence of any prodromal symptoms
- Substance use or other ingestion/overdose?
 - Consider Toxicology Consultation
- Recent medication addition/change/discontinuation?
- Presence of physical complaints/findings?
- Any known medical history or genetic disorder?
- Family history of psychiatric illness (especially psychosis or bipolar disorder)?
- Trauma history and post-traumatic symptoms?
 - Dissociative symptoms?
- Developmental history
 - Developmentally appropriate imagination can appear to be delusions or hallucinations
 - Some children will call ego-dystonic thoughts "voices"
 - Dysmorphia and developmental delay may warrant neurological assessment first
- Caution with isolated auditory or visual hallucinations in the absence of other psychotic symptoms or neurocognitive symptoms
 - Visual hallucinations are often more related to trauma/anxiety or medical issues
 - Hallucinations when waking or falling asleep are typically better explained by a potential sleep disorder

SW to assess need and patient's capacity. Patients DO NOT need full C-SSRS while in a psychotic/manic state – this can delay care.

Note 3: Physical exam:

- Signs of acute medical illness
- Focal neurological signs
- Signs of toxidrome
- Musculoskeletal changes: odd movements, rigidity, dystonia

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Note 4: Psychosis Labs/imaging recommended for first episode: ideally after discussion with psychiatric consultant if available (labs can also be done after admission to either IMPH or med-surg if no on-call psychiatrist to discuss labs with and deemed non-urgent by evaluating clinician)

- Complete Blood Count + differential
- Comprehensive Metabolic Panel + Magnesium + Phosphorus
- Lipid Panel, fasting if possible
- Thyroid Stimulating Hormone with reflex T4
- Urine Drug Screen and Comprehensive Urine Toxicology
- Folate
- Vitamin B12
- Rapid Plasma Reagin (RPR)
- Ceruloplasmin
- Hepatitis (Anti HCV, Anti HBV, HBsAg)
- Human Immunodeficiency Virus (HIV)
- Anti-nuclear Antibodies (ANA)
- Erythrocyte Sedimentation Rate (ESR)
- Head MRI with and without contrast – may be deferred to outpatient. Consider CT in the ED if concerning neurologic changes (this can/should be done when needed and does not require discussion with psychiatry)

Note 5: Additional work-up that could be considered based on history and physical:

- Psychiatry Consultation
- Neurology Consultation
 - Lumbar Puncture – fever? rapid onset of symptoms?
 - EEG – concern for seizure? Episodic?
 - Urine Porphyrins – neurovisceral symptoms? abdominal pain? delirium?
- Psychological Testing – SIPS (see note 6)
- Toxicology Consultation if concern for Heavy Metal Exposure, Substance Use (ingestion or intoxication) or other potential ingestion (ie anti-cholinergic)
- Check for Wilson's Disease if abnormal liver function and abnormal ceruloplasmin
- Serum auto immune encephalitis panel
- Lyme Screen with reflex
- RSV/Influenza/SARS-CoV-2 if current or recent upper respiratory illness

Note 6: Structured Interview for Psychosis-Risk Syndromes (SIPS):

- To be completed by a trained psychologist (Psychiatric consultant can order) typically completed on an outpatient basis
- A measure designed to assess the presence of emerging psychosis symptoms, assess symptom severity, and differentiate between psychotic disorders.
- Used in combination with other assessment measures to clarify diagnosis and aid in treatment planning.
- Assessment process takes about 1.5 hours.
- Good candidates for testing are experiencing hallucinations or delusions, are not floridly psychotic (can engage in assessment), and don't have a known diagnosis that accounts for symptoms.

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Note 7: Admission Location

- If psychosis with a clear or suspected medical reason (uncontrolled seizures, fever, neurological changes) - admit to med/surg
- If psychosis without clear medical reasons, can be reviewed for admission to IPMH. Please note that IPMH acuity and patient acuity/behavior will be considered for each patient. If possible, get MRI Brain prior to admission
 - If patient remains in ED or on medical/surgical floor, work to i to get the lab work started and consider olanzapine scheduled at night

First Line

Olanzapine (Zyprexa®) (Preferred)
Risperidone (Risperdal®)
Quetiapine (Seroquel®)
Aripiprazole (Abilify®)

Second Line

Any of the other first line agents
Lurasidone (Latuda®)
Ziprasidone (Geodon®)
Haloperidol (Haldol®)
Chlorpromazine (Thorazine®)
Paliperidone (Invega®)

Third Line

Any of the above agents that have not yet
been tried

Fourth Line

Clozapine (Clozaril®)

Considerations

Mood Based?

- Quetiapine, Aripiprazole, Lurasidone

Potential need for dissolving tab?

- Olanzapine, Risperidone

Potential need for IM?

- Olanzapine, Aripiprazole, Haloperidol, Chlorpromazine

Potential need for LAI (long acting injectable)?

- Risperidone, Aripiprazole, Haloperidol Decanoate, Paliperidone
- Paliperidone (Invega Sustenna®) and haloperidol decanoate are the only LAI options to start at Children's MN IPMH.

- Aripiprazole (Abilify Maintena®) may be used if patient has an approved Prior Authorization to continue treatment outpatient

Side Effects / Monitoring Issues

- Metabolic Syndrome
 - fasting lipids/glucose before starting and every 6 months
 - consider HgbA1C
 - weight checks weekly in hospital
 - add Metformin XR for weight gain or elevated lipids
 - Can consider starting with neuroleptic if patient has pre-existing obesity or already elevated triglycerides
- Constipation
- Extrapyramidal Side Effects (EPSE)
 - Dystonia
 - Akathisias
 - Dyskinesias
 - Parkinsonism
- Neuroleptic Malignant Syndrome (NMS)
 - Fever
 - Rigidity
 - Elevated WBC and CK

Medication	Typical Total Daily (Maximum) Dose	Formulation	Notes
Aripiprazole (Abilify®)	2-30 mg (30 mg) (PO)	PO/IM/LAI	LAI dose – start at 300mg qMonth
Chlorpromazine (Thorazine®)	25-100 mg (300 mg)	PO/IM	
Clozapine (Clozaril®)	12.5-450 mg (700 mg)	PO	Weekly CBC check for agranulocytosis Non-formulary at Children's Minnesota
Haloperidol (Haldol®)	2-20 mg (30 mg)	PO/IM/LAI	Monitor for dystonia, check temperature if change in mental status, check CK if change in mental status or noted rigidity in movement (to monitor for rhabdomyolysis) Give with diphenhydramine to minimize risk of EPSE/dystonia, though be mindful of anticholinergic burden
Lurasidone (Latuda®)	20-120 mg (160 mg)	PO	Take with 400 calories to be adequately absorbed
Olanzapine (Zyprexa®)	2.5-20 mg (30 mg)	PO/dissolving/IM	Exercise caution with co-administration of parenteral olanzapine with parenteral benzodiazepines within 60 minutes, due to increased risk of respiratory suppression. Consider risks vs benefits and utilize alternatives if appropriate.
Paliperidone (Invega®)	3-12 mg (12 mg) (PO)	PO/LAI	LAI dose – 234mg IM, then 156mg IM in 7 days
Quetiapine (Seroquel®)	25-800 mg (1800 mg)	PO	
Risperidone (Risperdal®)	0.25-3 mg (6 mg)	PO/dissolving/LAI	Can increase prolactin, leading to amenorrhea and galactorrhea LAI: Non-formulary at Children's Minnesota
Ziprasidone (Geodon®)	20-160 mg (160 mg)	PO	EKG before starting and with dose changes due to increased effect on QTc

PO – oral IM – intramuscular LAI – long-acting injection

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Shared Understanding

- Mental Health is a Pediatric Issue
- Time is Brain
 - The longer we wait to treat the symptoms, the longer it takes to recover and we increase risk for future episodes
- Patients in psychosis feel unsafe and that everyone is against them. They often lash out to protect themselves
 - They are not aware of their tone or volume. They will say cruel things to those around them
 - This is not typically an accurate representation of their true self
 - It is encouraged to switch out with a coworker if you are getting overwhelmed
- While patients with psychosis may be engaging in disorganized behaviors, we don't need them to act "normal" at all times. We can focus feedback on behaviors that are likely to lead to harm to themselves or others

Supervision

1. Video Monitoring when possible, to decrease paranoia and aggression risk
2. Staff should be mindful of wearing badges where patients can grab them
3. When possible/safe, Security should be out of sight, but close during escalations
4. If presenting with sexual behaviors, consider if camera can be turned off during masturbation

Clear, direct, simple statements
Calm demeanor
Maintain appropriate distance
Ask permission to engage/approach
One staff as main communicator

Schedule

1. A simple schedule for meals, showering, bedtime can help orient a patient to the day
2. Work to keep patient awake in day, to help sleep at night and to normalize sleep/wake cycle (unless otherwise directed by physician)
3. Low stimulation environments (low lights/sounds) are best
4. Shades up and lights on during the day, give simple/task-oriented activities during day (coloring, games, sorting)
5. Shades down and lights low/off at night
6. Patients will look best in the morning and decline as the day progresses as they improve

Special Considerations

1. Patients may be paranoid about medications – if able, open the medications in front of the patient
2. Patients may be paranoid about food/drink – consider prepackaged food/drink that they can open themselves
3. Use of protective PPE (spit shields, protective sleeves, bite guards, gowns, etc.) may be necessary if a patient is escalating. Consider having these items on hand

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Goal:
Decrease the number of psychotic episodes and length of episodes

Triggers:

- Arguments/Conflict
- Stress at School/Work/Home
- Substance Use
- Sleep Changes
- Not Taking Medication Consistently
- Traumatic Events

	What I Am Feeling/Thinking	What Others Might Notice/Warning Signs
Red	<ul style="list-style-type: none"> • Very confused • Fearful • Not aware of time/space 	<ul style="list-style-type: none"> • Not eating/drinking/moving • Nonsensical conversations • Fixated on odd things • Responding to internal stimuli
Orange	<ul style="list-style-type: none"> • Racing thoughts • Intrusive Thoughts • Auditory/Visual Hallucinations 	<ul style="list-style-type: none"> • Paranoia • Decline in self-care/hygiene • Restless • Talking faster • Irritable/Agitated
Yellow	<ul style="list-style-type: none"> • Difficulty concentrating • Anxious • Confused • Sad or Euphoric 	<ul style="list-style-type: none"> • Sleep changes • Appetite changes • Confusion • Missing school/work • Isolating
Green	<ul style="list-style-type: none"> • Coherent • Stable mood 	<ul style="list-style-type: none"> • Engaged • Able to care for self • Sleeping/eating regularly

What I Can Do	What Family Can Do	How I will Get Help
Take medications as prescribed	Provide reassurance	Let family know if I notice signs of psychosis or start to feel confused/fuzzy
Do not miss doses or stop my medication	Parents give daily medications, so I do not forget	Ask for help/breaks when needed
Attend all appointments	Help schedule appointments with providers	Let my outpatient team know about my symptoms
Pay attention to any symptoms	Decrease stimulation (conflict, noise)	
Keep a fairly consistent schedule	Lock up sharps, medications and weapons	
Do not use substances	Encourage self-care: eating, sleeping, hygiene	

Printable Safety Plan: [Psychosis Safety Plan](#)

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First Episode Psychosis Programs

Child/Adolescent Strengths (CASP) - Ages: any - 18

Location: Masonic Institute for the Developing Brain (MIDB)

Program schedule: Individual appointments

Services Provided: medication management, psychological testing

Psychiatrists: Dr. Anjum

P: 612-301-0115 Ext. 1 OR P: (612) 365-8400 and F: 612-365-9050

Early Strengths Program (Clinically High Risk for Psychosis) - Ages 12 - 25

Location: M Health Fairview Riverside Psychiatry Clinic

Program schedule: Weekly therapy appointments, bi-weekly family sessions, medication check-ins

Services Provided: Individual therapy, family education & support, medication management

Psychiatrists: Dr. Anjum

P: 612-273-8700, option 2 and F: 612-273-8727

Program Contact: Melissa Schedler, LGSW, mschedle10@umphysicians.umn.edu

UMN NAVIGATE - Ages: 15+

Location: 5775 Wayzata Blvd., St. Louis Park, MN 55416

Program schedule: weekly therapy, medication management appointments, groups

Services Provided: CM, therapy, school/employment/peer support, medication management

Psychiatrists: Dr. Felicia Hansell and Psychiatry Residents

P: 952-525-4500 and F: 952-525-1560

Intake can be completed by unit staff if admitted and under 18.

Radias Health/Compass – Ages 14-20

Services Provided: CM, therapy, school/employment/peer support, medication management

Referral Process: Complete Youth ACT Referral Form (found on Radias Health website).

Fax or email referral form & ROI for review

P: 61-453-4010 and F: 651-67-5714

E: centralaccess@radiashealth.org

** Can see kids in all metro counties

Hennepin Health Care – HOPE – Ages: 15+

Location: 900 S 8th St, Minneapolis, MN 55414, Shapiro 1st Floor

Program schedule: varies per patient

Services Provided: CM, therapy, school/employment/peer support, medication management

Psychiatrists: Dr. Wermager

Main Contact and Program SW: Lindley Braaten, BS

E: lindley.braaten@hcmcd.org Email or fax records & ROI

Direct: 612-873-8526, Clinic: 612-873-5692 Fax: 612-873-6794

Allina Health – Partial Hospital Program – Ages 13-18

Location: West Health Allina

Program Schedule: Monday - Friday 10am-3pm (can do school 8am-10am)

Psychiatrists: Dr. Goerke & Dr. Herickhoff

Referral Process: Fax facesheet, signed ROI, current medication list, labs, diagnostic assessment/H&P, progress notes

P: 763-577-7923 and F: 763-577-7905

CentraCare NAVIGATE - Ages: 15+

Location: Virtual or Midsota Building (3701 12th St N, Ste 206, St Cloud, MN 56303)

Services Provided: Medication Management, Individual Therapy, Family component, case manager, work/school supports (groups potentially in the future), LAI

Length of Program: 1-2 years

Psychiatrists: Dr. Marian Hadid, NP, Dr. Carlson, MD

Referral process: Fax ROI, medication list, labs, diagnostic assessment/H&P, Progress notes

F: 320-650-8768, ATTN NAVIGATE

Program Contacts: Melanie -- referral coordinator P: 320-229-5112

Stephanie Baas – Program Manager P: 320-251-2700, ext. 57630

E: Stephanie.Baas@centracare.com

If patient in hospital, want to set up a virtual or in-person meeting to discuss program and answer any questions before discharge

Goal to have follow up (especially with a psychiatrist if possible) within 2 weeks

May consider Bridging Clinic for Psychiatry, if other referrals are in process
Patients **CANNOT** do a first episode program and have an ACT team at the same time

Patients **CAN** do a first episode psychosis program and PHP/IOP simultaneously and through their admission process

ACT TEAMS

Assertive Community Treatment (ACT) provides integrated mental health services treatment for individuals who have been diagnosed with thought disorders.

Services include psychiatry, therapy, nursing, substance use disorder treatment, vocational services, case management, and peer recovery services.

ACT partners with the patient and their support teams to build the skills needed to manage their illness while also reaching their life goals. This may include finding and maintaining housing, obtaining competitive employment, building social networks, and re-establishing relationships. Teams meet with people in their homes or community location of their choosing and provide services seven days a week, with crisis response services available 24 hours per day.

Guild - Ages 14-21

Referral Process: complete the [Youth ACT Screening Tool](#) form (found on the Guild website) and fax it to 651-209-3259 or email it to ACT@guildservices.org.

Contact: Draysa England: 651-291-0067 Ext. 0184

People Inc. - Ages 18+

Serves only Hennepin County

Contact the Central Access Contact Center for openings and eligibility.

Phone: 651-774-0011

Mental Health Resources - Ages 18+

Serves Ramsey, Hennepin and Dakota Counties

P: (651) 659-2900

SpringPath Mental Health Services - Ages 18+

P: 763.537.6612

Radias Health - Ages 18+

Serves Ramsey, Washington, Anoka, and Hennepin County.

Referral process: A referral form can be completed on Radias Health website) and faxed/emailed to the appropriate county

[Assertive Community Treatment - RADIUS Health](#)

Anoka County

Phone: 763-201-8060

Fax: 763-712-5588

E: anokaactreferrals@radiashealth.org

Hennepin County

Phone: 612-435-7207

Fax: 612-435-7201

E: henactreferrals@radiashealth.org

Ramsey County

P: [651-389-4628](tel:651-389-4628)

F: [651-389-4691](tel:651-389-4691)

E: ramactreferrals@radiashealth.org

Washington County

Phone: 651-783-5410

Fax: 651-783-5411

E: washactintake@radiashealth.org

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