Acute psychosis

Safe management of a frightening presentation

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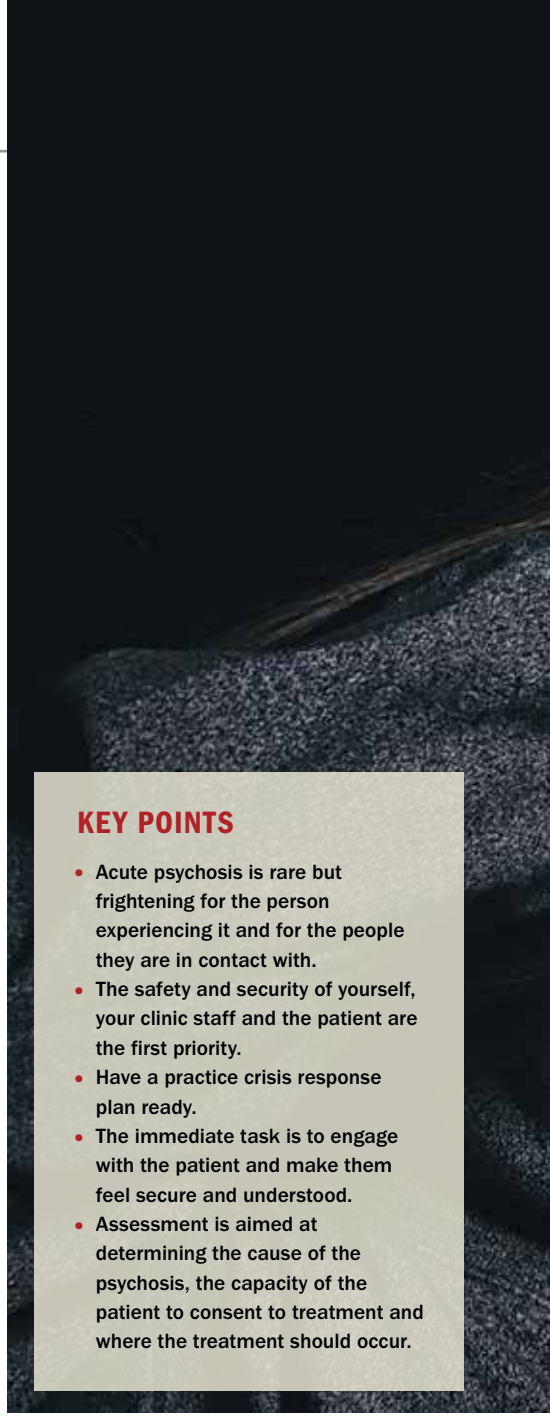
Acute psychosis is a rare presentation in general practice. Safe management requires preparation and a team response from everyone in the practice. An accurate assessment, aimed at determining the cause of the psychosis, the capacity of the patient to consent to treatment and where treatment should occur, as well as emergency management, will significantly improve the outcome in this difficult situation.



KEY POINTS

- Acute psychosis is rare but frightening for the person experiencing it and for the people they are in contact with.
- The safety and security of yourself, your clinic staff and the patient are the first priority.
- Have a practice crisis response plan ready.
- The immediate task is to engage with the patient and make them feel secure and understood.
- Assessment is aimed at determining the cause of the psychosis, the capacity of the patient to consent to treatment and where the treatment should occur.

Acute psychosis is a rare and frightening presentation. With its auditory hallucinations and delusions, acute psychosis is disorienting and terrifying, especially if it is occurring for the first time. Although specialist mental health services, emergency departments and the police see many of these presentations, most GPs will see few such presentations in their career. In any one year about 4.5 out of 1000 people in Australia are treated for a psychotic disorder, many by their GP.[1] In fact, people with a psychotic disorder are more likely than other people in the community to visit their GP, mostly because of their well-documented problems with other physical illnesses such as cardiovascular disease.[2] However, rarely, they will see their GP in an acutely psychotic state, and it is important that their GP has a framework for treating such an emergency. The events around such a presentation can have a profound effect on the person with the disorder and their family, but can also affect your staff members, other patients who were in the surgery at the time and you, their GP.

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Be prepared

An important issue, especially for young GPs starting out in a new practice, is to be aware of how your practice deals with psychosis or aggression.[3] This is much more than a written protocol and should include thought about the design and decoration of the practice and safety features built into the consulting rooms. Walk through the procedures with the front desk staff and a senior colleague. If your senior colleague has never done this, then the practice has some talking to do. This sort of briefing is essential for good functioning under the pressure of a real event. In the event of a

crisis you need to be able to call on the resources of your practice (Box 1).[3]

The availability of local mental health services varies widely across Australia. Some practices have access and regular contact with skilled community mental health teams who can react to emergency situations. Unfortunately, most parts of Australia do not have this type of service immediately available; however, knowledge of the availability and process of emergency mental health services in your practice area is important. Many will ask you to send the person to the local emergency department; however, some will respond to your call and may attend the practice to assess the patient.

The presentation of an acutely psychotic person

Acute psychosis is a medical emergency and unless you have experience in mental illness or the situation is well known with this particular patient, accessing specialist care is advisable (see Box 2 for an example). This still leaves you with much to do.

Your front desk staff may warn you that your next patient is behaving differently as acute psychosis is often accompanied by agitation and disorganisation. Check the

1. SAFETY FEATURES IN A GENERAL PRACTICE*

Prepare a plan
- Does your practice have a crisis response plan?
- Does your practice run through this plan with new staff and all staff annually, or does the plan sit on the shelf?

Create a welcoming environment
- Is your practice welcoming to people with a mental illness?
- Is information about mental health prominently displayed along with other material?
- Do staff work in a nonstigmatising way with people with a mental illness?

Think about design
- Do you have a well-lit and spacious waiting room?
- Do you have furniture that is difficult to throw about, both in the waiting room and consulting room?
- Are you positioned closest to the door in the consulting room, or do you have another way out?
- Do you have a duress alarm and do people know what to do if it is set off?
- Could you press the duress alarm if you needed to?
- Are there blind spots in the building?
- Is there a clear demarcation between patient areas and staff areas?

Think about communication
- Is there regular contact between the front desk and consulting rooms?
- Can you easily and discreetly contact front desk staff or colleagues via your computer or phone?
- Are the emergency numbers of local police, ambulance and the local mental health service easily available?

Optimise medical records
- Are difficult patients flagged?
- Is past aggression flagged?
- Is adherence with long-acting injectable medications tracked?
- Would you know if a patient had failed to attend for their regular injection?

* Adapted from Rowe AM, Morris-Donovan B, Watts I. General practice – a safe place: tips and tools. South Melbourne: The Royal Australian College of General Practitioners; 2011.[3]

2. CASE VIGNETTE

Dr A was examining a child, when he heard a commotion at the front desk. He recognised the man as a patient with known bipolar I. Dr A asked the mother and child to move to the next room, and ushered the patient causing the commotion into his consulting room. The patient was very agitated, talking loudly and at times incoherently, about some perceived slights from his neighbour, and saying that he was going to burn his neighbour's house down. He paced back and forth incessantly, talking continually, then abruptly left the practice. Dr A called the police, and the patient was arrested at his neighbour's house, with a can of petrol in his hands. He was taken to hospital under the Mental Health Act. It subsequently emerged that he had been sleeping poorly, one of his early relapse signs, and then abruptly stopped taking his lithium, leading to a manic episode. He responded well to antipsychotic medication and uptitration of his lithium. After a prolonged period of stabilisation and rehabilitation, he has remained well and is back in full-time professional work.

past history of the person. Psychotic disorders recur and the patient may be well known to the practice. This will give you an idea about what medication might be useful.

The immediate task is to engage with the patient and make them feel secure and understood. This can be very difficult to do in the confines of a small consultation room if the patient is agitated and moving about or if you are frightened. Moving to a larger room in the practice and calling in another person to sit with you, so that you feel supported and are able to think clearly, can be important steps early on. If you are familiar with the patient, build on your existing relationship.

Work to de-escalate the situation (Box 3). Be calm and respectful. Place yourself somewhere in the room so that you can get out easily. Try to be aware of your body language. Sit with a relatively open posture, not standing over the patient. Listen to your language and tone of voice. Keep communication simple and avoid jargon. Use Rogerian techniques (i.e. reflecting back to the person their own words to build a sense of connection). It is appropriate to acknowledge their experience of paranoid or persecutory thoughts and the distress these cause, but avoid either confirming or challenging the beliefs. Rarely, you or your staff might be incorporated in the patient's delusional ideas. This could further affect the patient's capacity to consent to treatment, adherence and rapport. Elicit information about their situation and acknowledge that they might be very frightened. Be clear about what is happening, what your diagnosis is and who you are calling to help with the situation – don't lie. Work towards a solution with them that embraces and resolves their fears if possible. If they become so agitated that they need to leave, let them leave the practice, making sure they exit the building. If that occurs, it is mandatory that you contact other services such as the police or mental health team and actively consider detaining the person under the Mental Health Act.

3. DE-ESCALATING TENSION

- Be calm and respectful
- Place yourself in the room in such a way that you can get out easily
- Try to be aware of your body language and sit with relatively open posture, not standing over the patient
- Pay attention to your language and tone of voice
- Keep communication simple and avoid jargon
- Use Rogerian techniques, reflecting back to the person their own words to build a sense of connection
- Acknowledge their fears but do not confirm them
- Be clear about what your diagnosis is and what you are doing to resolve the situation

Assessment

The assessment aims to answer the following questions:

- What do I think is the likely cause of the psychosis?
- Is the patient at risk of harm to themself or to others?
- Does the patient have the capacity to make their own treatment decisions?
- Where should the patient be treated?

What do I think is the likely cause of the psychosis?

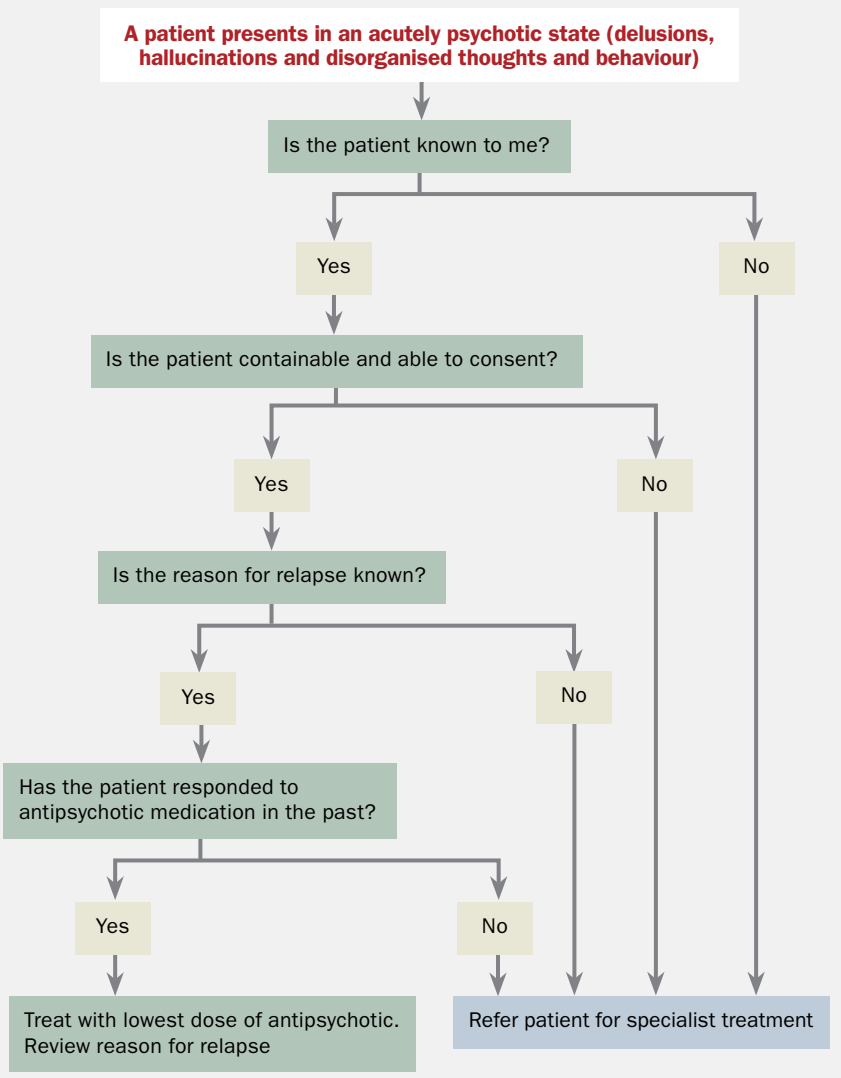
Although there are many possible causes of an acute psychosis, in the moment of presentation in general practice, there is a limited number of options to work through. Your patient is likely to be suffering from one of three broad diagnostic areas:

- a psychiatric illness such as schizophrenia or mania
- a substance-induced state such as amphetamine-induced psychosis or alcoholic hallucinosis
- a delirium or dementia.

Combinations of these three broad categories are also often seen, for example, the patient with schizophrenia who abuses substances. The recognition of a psychotic state is important because failure to treat the underlying cause is associated with a high rate of suicidal ideation, harm and aggression or, in the case of delirium, poor medical outcomes.

A psychiatric illness, such as schizophrenia or mania, is likely to present in the context of a past history of illness. The clinical picture will be dominated by delusions of persecution, reference or passivity along with auditory hallucinations in the case of acute schizophrenia or a schizophreniform disorder. A manic state will be dominated by grandiosity and the person will be activated, with a pressure of speech that makes it difficult to get a word in. Conversely, the psychotic depressed person will usually be elderly and have delusions around disease, worthlessness or poverty. Particularly for schizophrenia or mania, relapse is often precipitated by poor treatment adherence or substance use. Although agitation and distress are almost universal for these patients, violence is relatively uncommon.

APPROACH TO MANAGING A PATIENT IN AN ACUTELY PSYCHOTIC STATE IN GENERAL PRACTICE



A person presenting with a substance use-associated psychotic disorder clearly has a history of substance intoxication or withdrawal in the very recent past. These can be medical emergencies in and of themselves. The symptom picture often includes persecutory delusions or auditory hallucinations but is accompanied by the stigmata of disease that are associated with chronic substance abuse (e.g. track marks or ulcers on the skin). Psychosis associated with illicit stimulant use can result in aggressive behaviour. On rare occasions this can be so severe that any assessment is unsafe, and the only reasonable option is to remove staff and any patients to a place of safety and call the police.

The onset of psychosis in the elderly must bring to mind the possibility of delirium or dementia. The cardinal features of such a presentation include changes in cognitive abilities, especially with a fluctuation in the level of consciousness in delirium. Delirium and dementia are often accompanied by behavioural changes towards carers and in the patient's sleep-wake cycle. A wide range of medical illnesses can cause delirium which, if not addressed, could lead to death.

Is the patient at risk of harm to themself or to others?

During the assessment, it is imperative to ask about thoughts of suicide or aggression. It is unlikely that merely discussing them will precipitate these actions, rather the opportunity to talk is likely to be cathartic and decrease the risk of harm to themself or to others. The assessment should include questions about the presence of these thoughts, their intensity and frequency, and the association with substance use. With aggressive thoughts – are they directed at members of the family or public? Any plans or methods for harm should be discussed and the means to those actions (e.g. possession of firearms) delineated. Delusional beliefs around the issue should be probed (e.g. do you think your family would be better off without you?). A past history of self-harm or violence is an important indicator of possible future acts.

Does the patient have the capacity to make their own treatment decisions?

The assessment of a person with an acute psychosis will need to consider a number of issues beyond the purely medical. These include the capacity of the patient to agree to treatment (or to refuse it). These issues are often addressed by legislation that differs in states and territories across Australia. It is essential that all medical staff have a working knowledge of their local Mental Health Act and guardianship provisions.

Where should the patient be treated?

Most people presenting with an acute psychosis in general practice will require specialist care necessitating transfer to the local emergency department or mental health facility. If your diagnosis is one of a relapse of an established psychiatric disorder, such as schizophrenia, and if there are good community supports from family and a local mental health team, activation of those supports and reinstatement of antipsychotic medication (if they are

willing to take it) may be sufficient. The dose of antipsychotic medication will need to be titrated at least up to the dose to which the patient last responded, and may need to be set at a slightly higher dose.[4,5]

Management

The first priority is the safety and security of yourself, the clinic staff and the patient. Remember to activate your practice's crisis response plan so that people are aware of your situation and can help you. Begin to contain the situation by talking down the patient, making them feel understood and more secure. It is likely that further intervention by the local mental health team or admission to hospital will be required (see Flowchart), so activating that local network is important. If you decide that your patient needs to be detained under the relevant Mental Health Act, you will need to complete that documentation and contact the local ambulance and/or police. Unfortunately, this may terminate your relationship with the patient; however, it is more important that the appropriate care is provided.

If your diagnosis is of a psychotic disorder and the patient is willing to accept some medication that may be needed to help with the level of agitation, a small dose of the antipsychotic that they are already taking is appropriate (e.g. risperidone 1 to 2 mg immediately, if already on risperidone). An alternative to this is oral olanzapine wafer 5 mg. If the patient has never been exposed to antipsychotic medication, then it is safer to give them diazepam 5 mg or lorazepam 1 mg immediately.

If your diagnosis is one of substance withdrawal, then the use of oral diazepam 5 to 10 mg is reasonable. If your diagnosis is one of delirium, the underlying cause needs to be treated as a matter of urgency. Sedation should be avoided. In the case of dementia and marked change in behaviour subsequent to psychotic ideas, a behavioural approach should be instituted first. If that fails, low-dose antipsychotic therapy (e.g. risperidone 0.5 mg) can be used. However, the legal framework of its use (e.g. guardianship) will need to be determined, and there is an increase in morbidity, such as injury from falls, and mortality with use of antipsychotic medications.[6]

Parenteral administration of medication should generally be avoided in general practice. Diazepam intramuscularly is too erratically absorbed to be useful. More appropriate medications, such as droperidol, olanzapine and midazolam, are unlikely to be available. Intravenous administration should only be considered in settings with highly trained staff and the immediate availability of cardiorespiratory resuscitation resources.

After the patient has left

The departure of someone in an acutely psychotic state with the mental health team or ambulance can be distressing for your staff and any other patients who may be in the waiting area of your practice. Checking in with them, placing what has happened in context and discussing any concerns is important.

At a suitable time after the event, it is important to review your practice's crisis response plan that you put into action. Formally debriefing practice staff (and yourself) about what went well and what could be improved on is sensible, as it allows for a better plan to be devised and issues to be brought out into the open. A practice meeting or peer review session could also be useful venues to discuss the events of the day.

Conclusion

The presentation of acute psychosis in general practice is rare. As with most medical emergencies, the quality of the care that is provided is governed by the thought and planning that has gone into the preparation for the response. In providing empathic care to a frightened and psychotic patient, an accurate assessment and emergency management will significantly improve the outcome in this difficult situation. The follow up and further management of patients who have presented with acute psychosis in general practice will be covered in a future article in *Medicine Today*. MT

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