CME LIVE OPEN ACCESS

Journal of
Mental Health and Psychiatry Research

Review Article

Emergency Management of Psychosis in the Psychiatric Assessment Unit.

Yesiru Adeyemi KAREEM, FWACP (Psych) *

Directorate of Clinical Services, Neuropsychiatric Hospital, Aro, Abeokuta.

Corresponding Author: Yesiru Adeyemi Kareem, Directorate of Clinical Services, Neuropsychiatric Hospital, Aro, Abeokuta.

Received: 2024 Jan 30 **Accepted:** 2024 Feb 18 **Published:** 2024 Mar 11

Abstract

Psychosis is one of the major priority conditions (second only to depression) in the Mental Health Gap Action Programme (mhGAP) for mental, neurological, and substance use disorders. It poses a significant global health concern, with a usual concern for urgent intervention. This review article examines acute management, focusing on the presentation, diagnosis, aetiologies, assessment and the principles of care. Psychosis can range from abnormal behaviour, disorganised behaviour, delusions and hallucinations to other variants of psychosis which can be positive or negative symptoms. Addressing this demands a comprehensive approach involving a patient-centred, multistaged, multidisciplinary and biopsychosocial model. This review advocates for a concerted global effort to manage psychosis effectively to avert the complications in the affected populations. It is imperative for intervention Psychiatrists to regularly improve on assessment and management skills in the emergency to reduce the burden of psychosis.

Keywords: Acute, Assessment, Emergency, Management, Psychosis.

1. Introduction

The word 'psychosis' was derived from the Greek 'psyche' for mind/soul and oasis for the abnormal condition. Psychosis is a generic psychiatric term representing psychopathologies such as hearing voices of unseen people in clear consciousness, unusual beliefs held tenaciously, oddities of behaviours, and disorganized movements. Though typically, people may not attribute their presentation to a mental illness. Acute psychosis is a common psychiatric emergency described as an abnormal state of mind and a disorder of perception and thinking involving a loss of contact with reality. The causes are multifactorial, symptoms diverse, and the management is multidisciplinary [1].

1.1. Clinical Presentation

It could present with positive psychotic symptoms (exaggerations or distortions of normal thoughts, emotions, and behaviour) such as formal thought disorder, hallucinations, delusions, disorganised thinking (typically manifesting as disorganized speech), grossly abnormal behaviour, catatonic behaviour and experiences of control or passivity. It can also present with negative symptoms (functioning below normal behaviour), including alogia, anhedonia, impoverished speech, blunted or flat affect, avolition, apathy, perplexity, and social withdrawal. It is usually of sudden onset, mostly lasting from a few days to one month (DSM V) and maximally not exceeding three months (ICD 11) [2, 3].

1.2. Causes and Differential Diagnoses

The commonest causes of acute psychosis include Mental disorders such as acute and transient psychotic disorder, bipolar affective disorder (especially manic episode with psychosis), schizophrenia (especially the first episode), delusional disorder, severe depressive episode with psychosis, post-traumatic stress disorder, and attention deficit hyperactivity disorder, etc. Other differential diagnoses include:

Substance abuse disorders: intoxication, withdrawal from the effects of alcohol, benzodiazepines, stimulants, especially amphetamines, hallucinogens such as phencyclidine, lysergic acid diethylamide.

Neurological disorders: Temporal lobe Epilepsy, cerebrovascular disease, Encephalitis, Meningoencephalitis, Brain tumour, Huntington's disease, Multiple sclerosis.

Physical causes may be due to acute infections (UTI, Enteric fever, Meningitis), Chronic conditions (HIV, SLE, Huntington's disease), Drugs/Toxins (steroids, narcotics, heavy metals, anaesthetics such as ketamine), Metabolic (fluid imbalance, electrolyte derangement), Endocrinopathies (Thyrotoxicosis, Hyperparathyroidism, Cushing's syndrome), Trauma (traumatic brain injury, post-operative).

An underlying predisposition can be precipitated by acute illness, pain, dyselectrolaemia, hypoxemia, anaemia, fre-

quent hospital procedures, sensory deprivation, sensory overstimulation, and adverse life events such as loss, acute stressful life events, or psychosocial trauma [4].

1.3. Initial Assessment of Acute Psychosis

Early intervention in Psychosis (EIP) is a goal of the initial assessment focused on immediate concerns. Often, it may be challenging to establish an evident history initially. The risk they currently pose to themselves - acts of suicide or deliberate self-harm, and as a result of other traits of their behaviour (family relationships, work). Secondly, there could be the risk of aggression or violence towards others, which may be due to delusions about a particular person or groups of individuals; what the 'voices' are commanding them to do. Also, there can be risks to the environment too in terms of destruction of properties and disorganisation of the environment.

1.4. Brief History

This is crucial to ascertain the presence of psychosis and the symptom characteristics of the illness and to carry out a risk assessment rather than to make a definitive diagnosis. A history of substance abuse is done to determine the risk of psychosis. It is also necessary to evaluate for recent medical illness and interventions while gathering collateral information from family and friends regarding baseline function, personality, and past psychiatric history. Also, association with other events (i.e., medications, illness) and pre-existing impairments of cognition or sensory modalities are to be asked.

1.5. Examination

Mental State Examination is carried out with particular attention to consciousness, behaviour and cooperativeness, and the time course of mental status changes is also crucial. Physical Examination is also essential, especially in the Neurological, cardiovascular, and musculoskeletal systems. Also, checking for vital signs such as blood pressure, respiratory rate, and temperature.

1.6. Investigations

Can include urine drug toxicology, full blood count (can rule out anaemia, while an elevated white blood cell count may suggest an infection), serum electrolytes (identifies precipitants such as electrolyte derangement, renal impairment, and dehydration). Other tests may include urinalysis, HIV testing, Neuroimaging, Electroencephalography, and Liver function tests, among others (where indicated).

1.7. Principles of Management

Management of acute psychosis is best individualised, multistage, and by specialist multidisciplinary early intervention teams that render biopsychosocial interventions. The principles of care include.

Environmental manipulation: Identifying harmful components of the environment and addressing the environmental factors precipitating and perpetuating psychotic symptoms.

Pharmacotherapy: The choice between antipsychotics is between six and half a dozen, with the risk-benefit ratio guiding the choice while considering the side effects.

Some of the options for an emergency armamentarium include [5]:

IM/PO Haloperidol	(extrapyramidal side effects)
IM/PO Chlorpromazine	(anticholinergic side effects)
Tablets Olanzapine	(metabolic syndrome effects)
Tablets Aripiprazole	(cardiac side effects)
Tablets Risperidone	(hyperprolactinaemia)

Adjunct short-term benzodiazepine (e.g., Diazepam, Bromazepam or Lorazepam) in severe life-threatening agitation, sedation at nearly any cost becomes necessary.

Generally, a low-dose, well-tolerated second-generation antipsychotic can improve symptoms, increase medication adherence, and reduce relapses in the future. Especially in the neuroleptic-naïve, the rule of thumb is to "start low, and gom slow".

Psychosocial interventions: These should be started at the earliest opportunity to include cognitive behaviour therapy (which reduces symptoms), Family interventions (prevent relapse), Psychoeducation, and social interventions, e.g., social skills training and supported employment. Housing options, resources, and social support. With more sophisticated treatments, cognitive behaviour therapy (CBT) and family interventions can detect specific presentations, thus improving recovery and reducing relapse from about 40% using antipsychotics alone to 18-20% adopting the biopsychosocial modality.

Treating the underlying cause: appropriate and best using consultation-liaison model, as well as involving an early intervention team and other specialists at the beginning of treatment, not at the end.

Monitoring: Monitoring for occult physical and other mental problems is crucial because comorbidities are frequent and become more prevalent as people age. In the first 72 hours, it is essential to regularly check the situation to determine whether the mental state has improved, how well their medication works, how much supervision is necessary, and whether they can do their legal obligations. This is also a good time to gather information from friends and relatives and set up any required investigations, such as routine checks and physical examinations that might not have been feasible initially.

Documentation of the frequency of nursing observations (blood pressure, temperature, pulse rate) and daily monitoring of fluid balance (input and output) in acutely ill patients is an essential component of the management [6].

2. Conclusion and Recommendation

Psychosis is one of the common presentations in the emergency unit. It can also be primarily (but unusually) due to an identifiable cause which should be unraveled. Every effort should be made to include the standard components of sound medical practice in treating acute psychosis. This entails conducting a thorough assessment of medical and psycho-

logical requirements, involving patients' families in choices regarding their care, and providing patients and caregivers with information that is both verbally and, if necessary, in writing. Early intervention in critical times is invaluable as it can hasten response, enhance remission, reduce hospitalisation period, improve social functioning, and restore into the community to function optimally.

References

1. David. S, Roger. S. Oxford Handbook of Psychiatry Fourth Edition, Oxford University Press, 2019.
2. American Psychiatric Association, D. S. M. T. F., & American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (Vol. 5, No. 5). Washington, DC: American psychiatric association.
3. World Health Organization (WHO). The ICD-11 classification of mental and behavioural disorders: Diagnostic criteria for research. 2022
4. Byrne, P. (2007). Managing the acute psychotic episode. BMJ, 334(7595), 686-692.
5. Taylor, D. M., Barnes, T. R., & Young, A. H. (2021). The Maudsley prescribing guidelines in psychiatry. John Wiley & Sons.
6. Cowen, P., Harrison, P., & Burns, T. (2012). Shorter Oxford textbook of psychiatry. Oxford University Press, USA.