Acute psychotic disorders

Acute psychotic disorders - F23.9 Includes first-episode psychosis, acute schizophrenia-like psychosis, acute delusional psychosis and other acute and transient psychotic disorders. (Clinical term: Acute and transient psychotic disorders Eu23)

Presenting complaints

Patients might experience:

- hallucinations, eg hearing voices when no one is around, seeing visions
- strange beliefs or fears
- apprehension, confusion
- perceptual disturbances.

Families and other agencies (eg schools, social workers, probation and housing services) might ask for help with behaviour changes that cannot be explained, including strange or frightening behaviour (eg withdrawal, suspiciousness, self-neglect and threats).

Young adults, particularly when experiencing their first episode of psychosis, may present with persistent changes in functioning, behaviour or personality (eg multiple physical complaints, withdrawal or deterioration in social, academic or occupational performance), but without florid psychotic symptoms.

Diagnostic features

Recent onset of:

- hallucinations (false or imagined sensations, eg hearing voices when no-one is around, seeing visions)
- delusions (firmly held ideas that are often false and not shared by others in the patient's social, cultural or ethnic group, eg patient believes they are being poisoned by neighbours, receiving messages from television, or being looked at by others in some special way)
- disorganized or strange speech
- agitation or bizarre behaviour
- extreme and labile emotional states.

These symptoms may be preceded by a period of deteriorating social, occupational and academic functioning.

Differential diagnosis

- Physical disorders that can cause psychotic symptoms include:
  - drug-induced psychosis (especially stimulants such as amphetamine or cocaine)
  - alcoholic hallucinosis
  - infectious or febrile illness
  - Epilepsy - G40, G41 (or other organic intracranial pathology).
- Refer to Delirium for other potential causes.

To exclude organic conditions it may be useful to perform urine and blood investigations.

Essential information for patient and family

- Agitation and strange behaviour can be symptoms of a mental disorder.
- Acute episodes often have a good prognosis, (ref 1) and it is important to remain positive in view of the proven benefits of treatments and support from various agencies.
- The long-term course of the illness can be difficult to predict from an acute episode.
- The sooner psychotic symptoms are identified and treated, the better the outcome.
- Advise patient and family about the importance of medication, how it works and possible side-effects. (see Coping with the side effects of medication)
- Continued treatment may be needed for several months after symptoms resolve.
- Psychotic illness is no-one's fault and has nothing to do with parenting.

If the patient requires treatment under the Mental Health Act, advise family about related legal issues (see guide to the Mental Health Acts, (under Legal issues).

References

1 World Health Organization. Schizophrenia: An International Follow-up Study. Chichester: John Wiley & Sons, 1979. (AIV) Large outcome study with two-year follow-up, showed that only 10-15% of patients did not recover from their illness in that two-year period. Another shorter-term follow-up study (Lieberman J, Jody D, Geisler S et al. Time course and biologic correlates of treatment response in first episode schizophrenia. Arch Gen Psychiatry 1993, 50: 369-376) showed that 83% of first-episode psychotic patients treated with antipsychotic medication remitted by one year post-inpatient admission.

General management and advice to patient and family

(see Acute episode of psychosis)

- Ensure the safety of the patient and those caring for them:
  - family or friends should be available for the patient if possible
  - ensure that the patient's basic needs (eg food, drink and accommodation) are met.

- Minimize stress and stimulation: do not argue with psychotic thinking (you may disagree with the patient's beliefs but do not try to argue they are wrong).

- Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behaviour (ref 2).
- If there is a significant risk of suicide, violence or neglect, admission to hospital or close observation in a secure place may be required. If the patient refuses treatment, legal measures may be needed.
- The DVLA must be notified in all cases. Advise patient to inform DVLA: driving should cease during the acute illness (cars and motorbikes) and until patient has been stable and well for at least 3 years with insight into their condition (LGV/PSV driver) (ref 3)
- Encourage resumption of normal activities as soon as possible.
- It is important to offer psychological and social support to both patient and family/carer. This may include advice about benefits and housing. Specific referral for family intervention may also be appropriate.

References

2 Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. Br J Psychiatry 1992, 160: 601-620. (AIII) Family support and education, which promotes a more supportive family environment, can reduce relapse rates substantially.

3 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL http://www.dvla.gov.uk. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

Medication

- Antipsychotic medication can reduce psychotic symptoms over 10-14 days. Where access to a specialist is speedy and symptoms relatively mild, especially for a first referral, the specialist may prefer to see the patient unmedicated.
- If you decide to treat prior to the patient seeing a specialist, then the first-line treatment should be an atypical antipsychotic (ref 4). Examples include olanzapine (5-10 mg a day) if sedation is required or risperidone (4-V6 mg per day) which is relatively non-sedating (BNF section 4.2.1). The use of a typical drug (eg haloperidol) as first-line treatment is no longer recommended. Patients experiencing a first episode of psychosis require lower doses of medication and should be prescribed an atypical drug (ref 5). In a case of relapse where the patient has previously responded to a drug, restart that drug. The dose should be the lowest possible for the relief of symptoms (ref 6).
- Anti-anxiety medication may also be used for the short term in conjunction with neuroleptics to control acute agitation (BNF section 4.1.2). Examples include diazepam (5-V10 mg up to four times a day) or lorazepam (1-V2 mg up to four times a day). If required, diazepam can be given rectally or lorazepam IM (although this must be kept refrigerated).
- In a first episode, continue antipsychotic medication for at least 6 months after symptoms resolve (ref 7). Close supervision is usually needed in order to encourage patient agreement.
- Be alert to the risk of co-morbid use of street drugs (eg amphetamines) and alcohol.
- Monitor for side-effects of medication:

  - acute dystonias or spasms may be managed with oral or injectable antiparkinsonian drugs (BNF section 4.9.2), eg procyclidine (5 mg three times per day) or orphenadrine (50 mg three times per day)
  - Parkinsonian symptoms (eg tremor, akinesia) may be managed with oral antiparkinsonian drugs (BNF section 4.9.2), eg procyclidine (5 mg three times per day) or

orphenadrine (50 mg three times per day). Withdrawal of antiparkinsonian drugs should be attempted after 2-3 months without symptoms, as these drugs are liable to misuse and may impair memory.

- Akathisia (severe motor restlessness) may be managed with dosage reduction or beta-blockers (eg with propranolol [30-80 mg a day]) (BNF section 2.4). Switching to a low-potency antipsychotic (eg olanzapine or quetiapine) may help
- Tardive dyskinesia is a particularly important side-effect to monitor for. It is associated with longer term use of traditional antipsychotic medication, is severely disabling and can be irreversible
- Other side-effects, eg weight gain and sexual dysfunction, are under-reported and are important reasons for poor adherence. Quetiapine (an atypical antipsychotic) is least likely to elevate serum prolactin and lead to weight gain and should be considered when these side-effects become troublesome.

More detail on antipsychotic drugs and their differing side-effect profiles can be found in the Maudsley Prescribing Guidelines and the UKPPG (ref 8,9)

References

4 Atypical antipsychotics appear to be better tolerated, with fewer extrapyramidal side-effects, than typical drugs at therapeutic doses. Even at low doses, extrapyramidal side-effects are commonly experienced with typical drugs. Whether or not atypicals improve the long-term outcome has yet to be established. Risperidone, amisulpride and possibly olanzapine have a dose-related effect. Selected references:

4a American Psychiatric Association. Practice guidelines: schizophrenia. Am J Psychiatry 1997, 154(Suppl 4): 1-49. (BII) This reports 60% of patients receiving acute treatment with typical antipsychotic medication, develop significant extrapyramidal side-effects.

4b Mir S, Taylor D. Issues in schizophrenia. Pharmaceut J 1998, 261: 55-58. (CV) This work reviews evidence on efficacy, safety and patient tolerability of atypical antipsychotics. 4c Duggan L, Fenton M, Dardennes RM et al. Olanzapine for schizophrenia (Cochrane Review). In: The Cochrane Library. Oxford: Update Software, 1999. (CI) Twenty-one studies were analysed. Olanzapine was found to be an effective antipsychotic that produced fewer movement side-effects. It did tend to cause more weight gain than the older drugs, however.

4d Hunter RH, Joy CB, Kennedy E et al. Risperidone versus typical antipsychotic medication for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software (C1) Twenty-three studies were analysed. Risperidone might be equally clinically effective as relatively high doses of haloperidol. It causes fewer adverse effects than the side-effect-prone haloperidol.

5 National Institute for Clinical Excellence. Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. Clinical Guideline 1. December 2002. URL http://www.nice.org.uk. (AI)

6 Bollini P, Pampallona S, Orza MJ. Antipsychotic drugs: is more worse? A meta-analysis of the published randomized control trials. Psychol Med 1994, 24: 307-316. (AI) For most patients, higher than moderate doses of antipsychotic drugs bring increased side-effects but no additional therapeutic gains.

7 Dixon LB, Lehman AF, Levine J. Conventional antipsychotic medications for schizophrenia. Schizophrenia Bull 1995, 21(4): 567-577. (AI) This paper produces overwhelming evidence that continuing maintenance therapy reduces risk of relapse. The authors conclude that it is appropriate to taper or discontinue medication within six months to a year for first-episode patients who experience a full remission of symptoms.

8 Taylor D, McConnell D, McConnel H, Kerwin R. The Bethlem and Maudsley NHS Trust Prescribing Guidelines 2001. London: Martin Dunitz Ltd, 2000.

9 United Kingdom Psychiatric Pharmacy Group (UKPPG). URL http://www.UKPPG.co.uk.

Referral

Referral should be made under the following conditions:

- As an emergency, if the risk of suicide, violence or neglect is considered significant.
- Urgently for ALL first episodes to the early intervention service, to confirm the diagnosis and arrange care planning and appointment of key worker. A home visit may be required. Specific interventions for people experiencing their first episode of psychosis, including specific psychoeducation of the patient and family, (ref 10) is one of the requirements of the National Service Framework for Mental Health (ref 11)
- For ALL relapses, to review the effectiveness of the care plan, unless there is an established previous response to treatment and it is safe to manage the patient at home.
- If there is non-adherence with treatment, treatment resistance, problematic side-effects, failure of community treatment, or concerns about co-morbid drug and alcohol misuse.

Particularly on relapse, referral may be to the Community Mental Health Team or to a member of it, such as a community mental health nurse (community psychiatric nurse [CPN]), as well as to a psychiatrist.

If there is fever, rigidity and/or labile blood pressure, stop antipsychotic medication and refer immediately to the on-call physician for investigation of neuroleptic malignant syndrome.

References

10a Mental Health Commission. Early Intervention in Psychosis: Guidance Note. Wellington, New Zealand, 1999.

b Falloon I, Coverdale J, Laidlaw T et al. Family management in the prevention of morbidity of schizophrenia: social outcome of a 2-year longitudinal study. Psychol Med 1997, 17: 59-66. (AII) Involvement of the family is vital. Education is important for engaging individuals and families in treatment and promoting recovery. Psychological therapies may be helpful.

11 Department of Health. National Service Framework for Mental Health. London: HMSO, 1999.

Special considerations in children and adolescents

Acute disturbance in children and teenagers is usually due to causes other than psychosis, and anxiety symptoms may masquerade as hallucinations or delusions. The diagnosis of psychosis should be made by a specialist and the appropriate specialist referral will usually be to the Child and Adolescent Mental Health Service.

Resources for patients and families

What you may expect after an acute episode of psychosis

Coping with the side-effects of medication

Rethink (formerly the National Schizophrenia Fellowship)
England: 020 8974 6814 (Advice line: 10am–3pm, Monday–Friday)
Email: advice@rethink.org; website: http://www.rethink.org
Scotland: 0131 557 8969
Northern Ireland: 02890 402 323
Monthly social groups for clients with schizophrenia living in the community and support for relatives.

Schizophrenia Association of Great Britain 01248 354 048
Email: info@sagb.co.uk; website: http://www.sagb.co.uk
Offers information and support to sufferers, relatives, friends, carers and medical workers.

MINDinfoLINE 08457 660 163 (Helpline 9.15am–5.15pm, Monday–Friday)
Email: info@mind.org.uk; website: http://www.mind.org.uk
Information service for matters relating to mental health.

SANELine 08457 678000 (Helpline 12noon–2.00am)
Website: http://www.sane.org.uk
A helpline offering information and advice on all aspects of mental health for those experiencing illness, or for their families or friends.

Hearing Voices Network 0161 228 3896 (10.30am–3pm, Monday–Wednesday, Friday)
Website: http://www.hearing-voices.org.uk
Self-help groups to allow people to explore their voice-hearing experiences.

The UK NHS Portal for Schizophrenia
Website: http://www.nhs.uk/schizophrenia
A web-based information resource for people with schizophrenia and their carers. The site contains a number of user-friendly sections: Evidence-based treatment summaries; What is schizophrenia? How is schizophrenia diagnosed? Managing schizophrenia; Living with schizophrenia; Support for carers; and Legal issues.

Mental Health Care
Website: http://www.mentalhealthcare.org.uk
This site provides mental health information and research news from the Institute of Psychiatry and the South London and Maudsley NHS Trust in partnership with Rethink.

The Mental Health Foundation produces the information booklet Understanding Schizophrenia. Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW, UK. Tel: 020 7802 0304. Website: http://www.mentalhealth.org.uk.

Living With Schizophrenia: a Holistic Approach to Understanding, Preventing and Recovering from Negative Symptoms by John Watkins. South Yarra, Australia: Hill of Content Publishing (now Michelle Anderson Publishing), 1996.

Working with Voices by R Coleman and M Smith. Handsell Publishing, Gloucester, UK, 1997 Workbook to help voice-hearers manage their voices.

Hearing Voices: A Common Human Experience by John Watkins. South Yarra, Australia: Hill of Content Publishing (now Michelle Anderson Publishing),1998.