DESCRIPTION

A lifelong illness which may have an episodic, variable course with the presenting episode being manic, hypomanic, mixed, or depressive (according to accepted diagnostic criteria). An episode of mania is typically characterised by an elevated mood where a patient may experience extreme happiness, lasting days to weeks, which might also be associated with an underlying irritability. Such mood is associated with increased energy/activity, talkativeness, and a reduction in the need for sleep, and features may be accompanied by grandiose and/or religious delusions.

The diagnosis of bipolar disorder should be confirmed by a specialist. It may present with any mood state, e.g. with treatment resistant depression. The diagnosis requires either a current or previous episode of mania (bipolar I disorder) or hypomania (bipolar II disorder), but this history is not always clear, in which case a trial of treatment may be indicated.

Comorbid substance use is common. It may confuse the clinical presentation and may cause poor adherence to medication. The 'dual diagnosis' of bipolar disorder and an addiction requires referral to a specialist and ongoing monitoring after discharge.

GENERAL MEASURES

» Provide reassurance and support of the patient and family.
» Psychoeducate regarding the nature of bipolar disorder, the importance of treatment adherence, and early signs of recurrent episodes.

MEDICINE TREATMENT

For manic, agitated, and acutely disturbed patients:

» Stop antidepressants if prescribed.
» Manage as for the aggressive or disruptive patient. See Sections 16.1.2: Aggressive disruptive behaviour in adults and 16.1.3 Aggressive disruptive behaviour in children and adolescents.

For stable patients:

» Support treatment adherence and manage comorbid medical conditions - See Section 16.6: Psychiatric patients - general monitoring and care.

REFERRAL

» All patients.

16.5 PSYCHOSIS

DESCRIPTION

Psychosis is characterised by a loss of contact with reality, and may present with:

» Delusions: Fixed, unshakeable, false beliefs which are not in keeping with a person's society, culture, or religion. Beliefs may be persecutory, referential, grandiose, religiose, erotic, or bizarre in nature.
» Hallucinations: Perceptual disturbances, e.g. auditory hallucinations, which are heard as voices distinct from the patient's thoughts.

» Disorganised thinking: Manifests as disordered flow of speech, such that the person does not make sense.
» Grossly disorganised or abnormal motor behaviour (including catatonia).
» Negative symptoms: reduced emotional expression, apathy, avolition, lack of speech, lack of social interaction.

Psychosis occurs in psychotic disorders (which may be acute, transient, or chronic), other psychiatric conditions such as bipolar disorder or depression, medical conditions (e.g. certain types of epilepsy), or substance use (intoxication or withdrawal).

Psychosis is often accompanied by a lack of insight into the symptoms and poor judgement. The risk to self and others must always be assessed. It may be necessary to treat as an Assisted or Involuntary User under the MHCA.

16.5.1 ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

F23.0-F23.9/F24/F28/F29 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/Z81.8)

DESCRIPTION

Sudden onset of ≥ 1 psychotic symptoms (usually delusions, hallucinations, or disorganised thinking) which resolves spontaneously, usually within 1 month, with a full return to premorbid social or occupational functioning. Stressful events may precede the psychotic episode. Within 3 years, 40-50% will have a recurrent episode or develop schizophrenia or bipolar disorder.

LoE:IIb[22]

GENERAL MEASURES

» Refer all new onset psychosis to hospital for a medical, substance use, and mental health evaluation (see Adult Hospital STG Section 15.5.1: Acute and transient psychotic disorders).
» For agitated and acutely disturbed patients, manage as for the aggressive or disruptive patient. See Section 16.1.2: Aggressive disruptive behaviour in adults and 16.1.3 Aggressive disruptive behaviour in children and adolescents.
» Ensure the safety of the patient and those caring for them.
» Minimise stress and stimulation.
» Do not challenge what appear to be false statements or delusions.

<u>After hospital discharge/ on return to PHC:</u>

» Provide active follow-up with 6-monthly visits for three years with mental health and substance use screening and general health promotion.
» Psychoeducate the patient and their family regarding the condition and red flags to watch for if the psychosis worsens or recurs.
» Address psycho-social stressors – refer to social worker, counselling services.

<u>Women of childbearing potential:</u>

» Ensure family planning