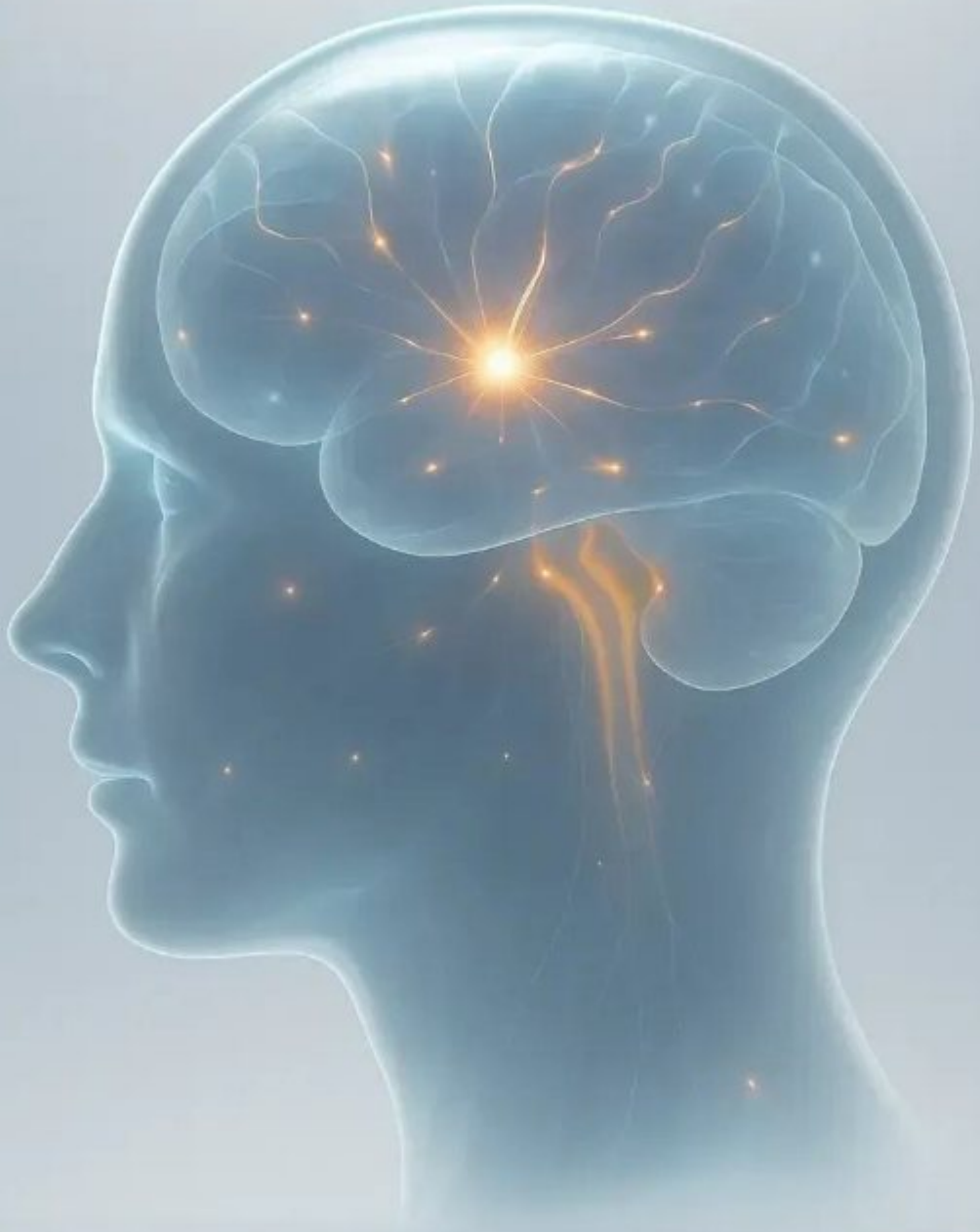
ACUTE PSYCHOSIS

National Standard Treatment Guideline



Ministry of Health
Republic of Maldives

ADB

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Japan Fund for Prosperous and Resilient Asia and the Pacific

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World Health Organization
Maldives

National Standard Treatment Guidelines

- Acid Peptic Disease
- Acute Anxiety
- Acute Pancreatitis
- Acute Psychosis
- Acute kidney Injury
- Arrhythmia
- Chronic Liver Disease
- Chronic Pancreatitis
- Chronic kidney disease
- Congenital Heart Diseases
- Dementia
- Depression
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Gestational Diabetes
- Epilepsy
- Heart Failure
- Hyponatremia
- Hypernatremia
- Hypokalemia
- Hyperkalemia
- Interstitial Lung Disease
- Liver Failure
- Obesity
- Obstructive Sleep Apnoea
- Osteoarthritis
- Ovarian Cancer
- Pneumonia
- Stroke
- Upper Gastrointestinal bleed
- Unstable Angina

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GUIDELINES DEVELOPMENT METHODOLOGY

The development of the Maldives Standard Treatment Guidelines (STGs) followed a structured, evidence-informed, and consensus-driven methodology adapted from internationally accepted guideline-development standards and the Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) model. The process combined systematic evidence retrieval, critical appraisal, contextual adaptation, and multidisciplinary expert review to ensure feasibility, clinical relevance, and national ownership.

1. Determining Scope and Priority Conditions

Priority clinical conditions were identified through consultation with national programme managers, specialty clinicians, and health-system stakeholders. Selection criteria included: (i) major causes of morbidity and mortality, (ii) observed variation in clinical practice or prescribing patterns, (iii) potential to improve patient outcomes, and (iv) the feasibility of implementation across health-facility levels in Maldives. The final list of diseases reflected national epidemiology, service-delivery capacity, and essential-medicine availability.

2. Identification of Existing Evidence and Source Guidelines

A targeted search strategy was used to identify high-quality existing clinical guidelines. Searches were conducted across international guideline repositories (e.g., WHO, NICE, SIGN and other intergovernmental bodies, international and national guideline repositories, specialty societies and professional associations.

3. Quality Appraisal of Source Guidelines

Retrieved guidelines were screened for transparency of development, methodological rigour, clarity of recommendations, applicability to health-system reality, editorial independence. Guidelines were included if they met the Institute of Medicine (IOM) definition of a clinical guideline and addressed treatment or management of priority conditions. Guidelines that did not meet minimum quality standards, review articles, diagnostic criteria, or technical standards were excluded.

4. Adoption, Adaptation, and Contextualization

The guideline-development team employed an adopt–adapt–contextualize model:

- **Adoption**: High-quality recommendations that aligned with Maldivian health-system realities were retained without modification.
- **Adaptation**: Recommendations were modified when local considerations such as diagnostic capacity, medicine availability, workforce skills, referral pathways, or cost constraints affected feasibility.

- **Contextualization**: Where evidence was absent or inconclusive, conditional recommendations were formulated based on expert consensus, with explicit consideration of pragmatism, safety, and local workflows.
  Medicines were selected in alignment with the Maldives National Essential Medicines List (NEML), based on suitability, efficacy, safety, and availability.

5. Expert Consensus and Multidisciplinary Input

Draft recommendations were initially prepared by experts from the DSPRUD, India, providing a strong methodological foundation for the process. Building on this, a collaborative and participatory process brought together clinicians from internal medicine, paediatrics, obstetrics-gynaecology, surgery, emergency medicine, endocrinology, cardiology, general practitioners, and public health representing different levels of healthcare. Consensus was achieved through moderated discussions, iterative revisions, and resolution of divergent views. For topics lacking strong evidence, recommendations were derived from expert clinical judgment grounded in extensive practice experience.

6. Drafting, Peer Review, and Validation

Each guideline section was organized in a standard format including key clinical features, essential investigations, non-pharmacological management, pharmacological therapy (with step-up/step-down options where relevant), referral criteria, paediatric considerations, and follow-up requirements. Drafts were peer-reviewed by senior clinicians and national experts. Reviewer comments were systematically integrated to strengthen clarity, accuracy, and applicability.

7. Addressing Conflicts of Interest

All contributors declared the absence of conflicts of interest. Individuals with potential or perceived conflicts were excluded from authorship or decision-making roles.

8. Updating and Future Revisions

The STGs were conceptualized as a living document. Future updates will incorporate new scientific evidence, changes in essential-medicine availability, national programme priorities, and user feedback from clinicians. Periodic review cycles will ensure the continued relevance and reliability of recommendations.

9. Distinctive Features of the Guidelines

Developed through a collaborative process involving a large group of multidisciplinary experts from different levels of healthcare, the guidelines incorporate the following distinctive features:

- **Diagnostic Assumption and Confirmation**: While assuming that an initial diagnosis has been established by the healthcare provider, the guidelines provide essential information for confirming diagnoses. This includes a comprehensive overview of major signs and symptoms, descriptions of confirmatory tests, and clear guidance on practices that are prohibited, discouraged, or unreliable—promoting evidence-based medicine supported by relevant references.
- **Comprehensive Treatment Approach**: The guidelines offer a systematic, up-to-date framework for managing medical conditions across the continuum of care. They begin at the primary care level and extend to secondary and tertiary care, incorporating protocols for treatment response assessment and referral criteria as integral components.
- **Diverse Treatment Modalities**: Recommendations encompass both non-pharmacological and pharmacological interventions and surgical intervention where applicable, providing flexibility for individualized treatment plans. Cautionary notes are included where necessary to ensure safe and effective use of therapies.
- **Assessment and Referral Criteria**: Clear criteria and goals for evaluating patient response to treatment are provided, along with guidance on when referral to higher levels of care is warranted ensuring continuity and comprehensiveness in patient management.

ACKNOWLEDGEMENTS

The Government of the Republic of Maldives is committed to ensuring universal access to quality health services for all citizens. The Constitution of Maldives mandates the progressive realization of rights, including the right to good standards of health care for the population. In line with this national commitment, standardized quality health services are regarded as the foundation of a strong and equitable healthcare system.

This important work would not have been possible without the cooperation and support of many individuals and institutions. We express our sincere appreciation to the Honourable Minister of Health, Abdullah Nazim Ibrahim, for his leadership, commitment, and continuous guidance throughout the development process. We are grateful to WHO and ADB for their significant contribution, support, and technical assistance.

Our heartfelt gratitude is extended to the technical lead and editor, Dr. Sangeeta Sharma, Professor, Neuropsychopharmacology, IHBAS and President, Delhi Society for Promotion of Rational Use of Drugs (DSPRUD), and her team. We express our deepest appreciation to the Maldivian and DSPRUD experts and contributors who played a pivotal role in this process. Their technical expertise and dedication to adapt the standards to the Maldivian context have been instrumental in the development and finalization of these guidelines. The time, experience, generous sharing of knowledge and insights contributed by all parties have not only enriched the work but also have been invaluable in making these standards practical, locally acceptable, and aligned with the needs of the resident population.

It is important to acknowledge the immense efforts, involvement, timely coordination, collaboration, and dedication of the Quality Assurance and Regulation Division team who made it possible for these Clinical Treatment Guidelines to come into existence.

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ACUTE PSYCHOSIS

QUICK REFERENCE GUIDE

Acute psychosis is a psychiatric emergency with a lifetime prevalence of about 3%, and roughly 0.21% of cases are due to medical or substance-related causes. It most commonly affects adolescents and young adults, though it can occur across all age groups. The condition carries significant morbidity, including risks of self-harm, violence, functional decline, and complications from delayed treatment, making early recognition and intervention critical for better outcomes.

Definitions & different types

- Acute psychosis: sudden onset of delusions, hallucinations, disorganized thinking/behavior, or negative symptoms causing functional risk.
- Types: brief psychotic disorder / Acute and Transient Psychotic Disorder (ATPD); first-episode psychosis (FEP); substance-induced psychotic disorder; psychosis due to medical/neurological illness; mood disorder with psychotic features; schizophrenia/ schizoaffective (chronic).

Causes, risk factors & precipitating factors

- Primary psychiatric: schizophrenia spectrum, bipolar mania, severe depression.
- Substance: cannabis, amphetamines/ cocaine/MDMA, alcohol (intox/ withdrawal), hallucinogens, synthetic cannabinoids; high-dose steroids, dopaminergics.
- Medical/neurological: delirium, infection (encephalitis/meningitis), autoimmune encephalitis, epilepsy (post-ictal), stroke/tumor, metabolic/ endocrine (thyroid, glucose, sodium), B12/folate/niacin deficiency.
- Risks: family history, prior episodes, neurodevelopmental disorders, adolescence, substance use, social stressors/isolation.

Evaluation for diagnosis

- Clinical features: Positive symptoms, negative symptoms, disorganization, severity/trajectory, agitation and safety risk; substance timeline; mood symptoms.
- Physical examination: Vitals, hydration, full systemic exam; focused neuro exam (focal deficits, meningism); injuries/ingestions.
- Laboratory investigations: Complete blood count (CBC), electrolytes/renal function, liver function tests (LFTs), glucose, thyroid-stimulating hormone (TSH), urinalysis; toxicology screen (urine/serum as available); pregnancy test where applicable; creatine kinase (CK) if rigidity/fever (rule out Neuroleptic Malignant Syndrome – NMS).
- Imaging (CT/MRI) – when indicated: New focal neuro signs, head trauma, immunosuppression, fever/ encephalopathy, atypical late onset (>40), refractory delirium.

Confirmation of diagnosis

- Meet DSM-5-TR/ICD-11 psychotic-disorder criteria after excluding delirium, substances, and medical causes.

Classification / severity assessment

- Duration: <1 mo (ATPD/brief), 1–6 mo (schizophreniform/FEP), >6 mo (schizophrenia/schizoaffective).
- Severity: danger to self/others, profound functional loss, inability to self-care, severe agitation/catatonia, psychosis with medical instability.

Differential diagnosis

- Delirium, substance-induced states, mood disorders with psychotic features, personality disorders in crisis, autism/ID with stress behaviors, dementia/Lewy body disease, seizure-related states.

Management goals & principles

- Immediate safety, rapid symptom control, treat reversible causes, start antipsychotics low and slow, prevent complications (NMS, EPS, metabolic), plan follow-up and relapse prevention with family involvement.

Approach to management

1. Safety first: calm low-stimulus room; remove hazards; constant observation if risk.
2. De-escalation: simple language, one speaker, offer choices; avoid confrontation.
3. Treat medical causes/delirium promptly.
4. Start antipsychotic (oral preferred). For severe agitation, use short-acting IM per doses below.
5. Hydration, sleep, nutrition, manage constipation; begin psychoeducation with family.
6. Document baseline vitals, weight/BMI, waist, electrocardiogram (ECG) if QT risk/typicals, and metabolic labs when feasible.

Non-pharmacological interventions

- Verbal de-escalation; structured routine; orienting cues; family presence for reassurance.
- Psychoeducation (illness is treatable; adherence; warning signs).
- Telepsychiatry for remote islands; standardized agitation and referral checklists; community health worker (CHW) follow-ups.

Pharmacological therapy

(Indications: dangerous agitation, significant distress, or clear psychosis after basic exclusion of medical emergencies. Start low, titrate to effect; prefer one antipsychotic at a time.)

Drug (class)	Use	Start → Titrate	Usual/Max daily dose	Route	Key cautions
Olanzapine (Second-generation antipsychotic, SGA)	First-line acute agitation/ psychosis	PO 5–10 mg → +5 mg q24–48h	10–20 mg/day	PO/ODT; IM 5–10 mg may repeat (q2–4h; max per local protocol)	High metabolic risk (weight, glucose, lipids); sedation/ orthostasis. Do not give IM olanzapine within ~1 hour of IM benzodiazepine (respiratory depression).
Risperidone (SGA)	First-line oral	1 mg/day → ↑ by 1 mg q24–48h	2–6 mg/day (max 8)	PO	EPS/akathisia at higher doses; ↑prolactin; orthostasis; adjust in renal/hepatic impairment.
Quetiapine (SGA)	If prominent insomnia/ anxiety	50 mg HS → +50–100 mg/ day	300–600 mg/ day	PO	Sedation/orthostasis; metabolic effects; not ideal for severe agitation.
Aripiprazole (SGA, partial D2 agonist)	Alternative first-line	10–15 mg/day	10–30 mg/day	PO	Akathisia/insomnia; fewer metabolic effects; avoid in severe agitation if paradoxical activation.
Haloperidol (First-generation antipsychotic, FGA)	Severe agitation; when IM needed	PO 2–5 mg; IM 2.5–5 mg, repeat q2–4h PRN	PO 5–20 mg/ day	PO/IM	QT prolongation (get ECG if risk), EPS/acute dystonia—co-admin benztropine 1–2 mg PO/ IM or promethazine 25–50 mg IM if using IM haloperidol.
Lorazepam (Benzodiazepine)	Agitation, catatonia, severe anxiety	1–2 mg q4–6h PRN	2–8 mg/day typical	PO/IM/IV	Respiratory depression (avoid with alcohol/opioids); delirium risk in elderly; avoid close-timing with IM olanzapine. Useful in catatonia (2 mg IV/IM test).
Benztropine/ Trihexyphenidyl (Anticholinergic)	Treat/prevent EPS	1–2 mg once; then 1 mg BID PRN	1–6 mg/day	PO/IM/IV	Anticholinergic effects, confusion in elderly—short courses only.
Clozapine (SGA)	Treatment-resistant (after ≥2 adequate trials)	Per specialist protocol	200–600 mg/ day	PO	Agranulocytosis (ANC monitoring), myocarditis, seizures, sialorrhea, severe metabolic effects—specialist-only.

Note: Duration: continue acute antipsychotic through stabilization; maintenance 1–2 years after first episode (longer if risk high). Avoid chronic benzodiazepines.

Assessment of response, review & adjustment

- Monitoring schedule: weekly for 4–6 weeks, then every 2–4 weeks to stabilization; 1–3 months in maintenance.
- Measure: symptom change (use Positive and Negative Syndrome Scale – PANSS or Brief Psychiatric Rating Scale – BPRS if available), side effects (Extrapyramidal Symptoms – EPS, weight, glucose/lipids), functioning, adherence, substances.
- Before step-up: verify adherence, check side effects, screen comorbidities/substances, address stressors.
- Step-up: optimize dose to upper therapeutic range; switch antipsychotic if minimal/no response at 6–8 weeks; consider long-acting injectable (LAI) for adherence; specialist input for clozapine.
- Step-down: after sustained remission 6–12 months, consider gradual dose reduction with close monitoring; never abrupt stop.

Referral (tiered pathway)

- Primary → Secondary: moderate–severe symptoms, safety risk, medical red flags (seizures, focal deficits, altered consciousness), non-response to first steps, any child/adolescent first episode.
- Secondary → Tertiary: treatment-resistant psychosis (≥2 trials), need for clozapine, severe aggression, complex medical/diagnostic cases.
- Handover: concise summary of timeline, medicines/doses/durations, response, adverse effects, comorbidities, labs/ECG, safety plan.

Complications

- NMS: fever, rigidity, confusion, autonomic instability - stop antipsychotic, supportive care, urgent referral.
- EPS: dystonia/akathisia/parkinsonism/tardive dyskinesia- adjust/switch; short anticholinergic; propranolol for akathisia if no asthma.
- Metabolic syndrome: weight, lipids, glucose—monitor and manage.
- Suicide risk, violence, malnutrition/dehydration—safety plan and supports.

Patient education & caregiver instructions

- Psychosis is treatable; adherence prevents relapse—don't stop abruptly.
- Report side effects early (urgent if fever/rigidity/confusion).
- Avoid alcohol/cannabis/illicit drugs; keep regular sleep, meals, light activity.
- Families: help with routines, watch relapse signs (sleep change, withdrawal, rising suspiciousness), seek care early.
- Know emergency contacts and referral steps; use telepsychiatry/CHW follow-ups where available.

INTRODUCTION

Acute psychosis is a psychiatric emergency with sudden delusions, hallucinations, and disorganized thinking. Lifetime risk for psychotic disorders is ~3%, with ~0.21% due to medical or substance causes; adolescents are especially vulnerable. Early recognition and treatment improve recovery and reduce relapse, while delays raise risks of self-harm and functional decline. Avoid both under- and over-treatment: inadequate care prolongs symptoms and suicide risk; excessive antipsychotic dosing or sedation causes movement and metabolic adverse effects.

SCOPE OF THE GUIDELINES

These guidelines address the recognition, diagnosis, and initial management of acute psychosis in both adults and pediatric/adolescent populations and similar low-resource settings. They are designed for primary care clinicians, general physicians, pediatricians, nurses, and community health workers who often serve as the first point of contact in mental health emergencies where psychiatrists and mental health specialists are scarce. These guidelines standardize assessment and management, define clear referral triggers, and use telehealth and task-sharing to extend care in remote and resource-limited settings.

Objectives are early recognition, safe stabilization, appropriate pharmacologic/non-pharmacologic care, and timely referral—especially where specialists are scarce. They also serve as a practical training and reference tool for non-specialists, enabling consistent, evidence-based care in all age groups.

Applicability by level

- ### Primary care
  - **Adults**: identify early, rule out medical emergencies, ensure safety, start first-line medication only if needed, arrange urgent referral for moderate–severe cases.
  - **Pediatric/adolescent**: watch for subtle/atypical signs, exclude delirium/organic causes, maintain constant supervision, involve guardians, **urgent referral.**
- ### Secondary facilities
  - **Adults:** confirm diagnosis, start/adjust medication, monitor adverse effects, provide psychoeducation, decide on escalation.
  - **Pediatric/adolescent:** age-appropriate assessment, start meds only when urgent using pediatric doses, begin psychological support, liaise with family/school.

- **Tertiary centers**
  - **Adults:** manage complex/resistant cases (e.g., clozapine with monitoring), multidisciplinary rehab and relapse prevention.
  - **Pediatric/adolescent:** specialist evaluation, neurodevelopmental workup, integrated pharmacotherapy/ psychotherapy/ education/ community reintegration.

DEFINITIONS

Acute psychosis is a clinical syndrome characterized by a sudden onset (usually hours to days, and less than 1 month in duration) of symptoms such as delusions, hallucinations, disorganized thinking or speech, and grossly abnormal behavior, with or without mood disturbances. It represents a psychiatric emergency requiring prompt evaluation to exclude medical causes and initiate treatment to prevent harm to self or others.

1. Core features of psychosis (all ages)	
Delusions	Fixed false beliefs (paranoid, grandiose, somatic) not changed by evidence
Hallucinations	Perceptions without stimulus—commonly auditory; also visual, tactile, olfactory, gustatory
Disorganized thinking	Incoherent, illogical, tangential speech
Disorganized/abnormal motor behavior	Agitation, catatonia, unpredictable actions, inappropriate affect
Negative symptoms	Blunted affect, poverty of speech, social withdrawal, apathy

2. Adult acute psychosis (ICD-11/DSM-5 aligned)			
	Duration of symptoms	**Common precipitating factors /associations**	**First steps**
Brief Psychotic Disorder / Acute & Transient Psychotic Disorder (ATPD)	<1 month	Severe stress	Safety, rule out medical/substance causes, short-term antipsychotic, close follow-up
First-Episode Psychosis (FEP)	≥1 week to <6 months	Schizophrenia-spectrum onset	Full workup, start antipsychotic, early intervention services
Substance-induced psychosis	During intoxication/ withdrawal	Amphetamines, cannabis, alcohol, others	Tox screen, manage withdrawal/ intoxication, avoid offending agent
Secondary to medical/ neurological illness	Variable	Delirium, CNS infection, autoimmune encephalitis, metabolic derangements	Treat underlying cause urgently; neuro workup as indicated
Psychotic episode in mood disorders	With mood episode	Severe depression or mania	Mood-congruent evaluation; treat mood episode ± antipsychotic

3. Pediatric/adolescent acute psychosis		
	Key features	**Notes / priorities**
Children <13 yrs	Psychosis is rare; may show regression, irritability, bizarre play, sudden academic decline; hallucinations more often visual	Exclude organic causes first; broad medical/neurologic workup; involve guardians; constant supervision
Adolescents 13–18 yrs	Adult-like presentations; mood lability; substance-related triggers common	Screen for depression/mania and substance use; early referral
Early-Onset Schizophrenia (EOS)	Onset <18 yrs	Rare; poorer outcomes—specialist care
Childhood-Onset Schizophrenia (COS)	Onset <13 yrs	Extremely rare—extensive medical workup required
Brief psychotic disorder / acute transient psychosis	Often stress-linked	Better prognosis; ensure follow-up
Substance-induced psychosis (youth)	Cannabis, amphetamines, synthetics	Tox screen; cessation counseling
Secondary to medical/ neurological causes	Autoimmune, infectious, metabolic, epileptic, endocrine	Targeted investigations; treat primary illness

4. Acute vs chronic psychosis		
	Definition & duration	**Implications**
Acute	Sudden onset (hours–days); short course (<1 month ATPD; <6 months FEP)	Rapid identification improves remission; prioritize ruling out delirium/substances/ medical causes
Chronic	Persistent >6 months (e.g., schizophrenia, schizoaffective)	Long-term maintenance, psychosocial rehab, relapse prevention

Accurate definition and classification of acute psychosis guide how urgently and how widely to investigate, life-threatening medical or neurological causes aren't missed. Clear differentiation reduces misdiagnosis (for example, delirium vs primary psychosis), informs referral timing, and helps avoid unnecessary long-term antipsychotics when symptoms are transient or medically reversible.

CAUSES, RISK FACTORS, AND TRIGGERS

Acute psychosis has many causes; management hinges on finding the driver. In low-resource settings, precise history, focused exam, and targeted basic tests are key when advanced diagnostics aren't available.

Category	Subtype / Examples	Features / clues	Notes / first steps
Primary psychiatric disorders	Schizophrenia spectrum (schizophrenia, schizoaffective, schizophreniform, delusional disorder)	Persistent psychosis; onset often late adolescence/early adulthood	Full psychiatric assessment; start antipsychotic; rule out medical/substance causes

	Bipolar disorder (mania/ depression with psychotic features)	Psychosis during mood episodes; content often mood-congruent	Treat mood episode ± antipsychotic; assess suicide risk
	Severe major depressive disorder with psychotic features	Delusions of guilt, nihilism, persecution	Consider antidepressant + antipsychotic or ECT; safety plan
	ATPD / Brief psychotic disorder	Sudden onset after stress; duration <1 month; full remission	Ensure safety; short-term antipsychotic; close follow-up
Substance-induced psychosis	Cannabis (esp. high-potency)	Acute paranoia, hallucinations; higher risk in adolescents	Toxicology screen; cessation counselling
	Amphetamines, cocaine, MDMA	Intense paranoia, agitation, tactile/visual phenomena	Manage intoxication/withdrawal; avoid stimulants
	Alcohol	Intoxication or withdrawal (delirium tremens)	Treat withdrawal; thiamine; monitor vitals
	Hallucinogens (LSD, psilocybin)	Prominent perceptual distortions	Supportive care; rule out co-ingestants
	Synthetics ("Spice," methcathinone)	Unpredictable, severe reactions	Supportive care; harm-reduction
	Medications (high-dose steroids, anticholinergics, dopaminergics)	Onset after drug start/dose change	Review meds; taper/stop culprit if possible
Medical & neurological causes	Delirium	Acute fluctuating attention, disorientation with psychotic features	Medical emergency: find/treat cause (infection, metabolic, drug toxicity)
	CNS infections	Encephalitis/meningitis, HIV-related	Neuro workup; urgent treatment
	Autoimmune	Anti-NMDA encephalitis, lupus cerebritis	Autoimmune panel; neurology consult
	Seizure disorders	Post-ictal psychosis, temporal lobe epilepsy	EEG/neurology review
	Metabolic/endocrine	Thyroid, Cushing's/Addison's, hypo-/hyperglycemia, hepatic/ renal failure, electrolytes (hyponatremia)	Correct underlying disorder; labs/ECG
	Nutritional	B12, folate, niacin deficiency	Replace deficiency; search cause
	Intracranial pathology	Tumor, stroke, demyelination	Neuroimaging when indicated
Psychosocial stressors	Bereavement/loss; trauma/ violence; isolation/migration; academic/occupational stress	Temporal link to stressor; may meet brief psychotic criteria	Ensure safety; psychosocial supports; consider short-term antipsychotic

Risk factors increasing vulnerability	Genetic load (schizophrenia/ bipolar/psychotic depression); prior psychosis; neurodevelopmental disorders (ASD, intellectual disability); adolescent brain; chronic medical illness (HIV, epilepsy, metabolic); substance use (esp. early adolescence)	Low threshold for screening and early intervention	Family history, developmental history, and substance screen are key
Age-specific considerations	Adults	Primary psychiatric illness and substance-induced psychosis most common	Standard medical/substance workup; early antipsychotic if indicated
	Children/adolescents	Higher likelihood of organic causes; presentations more behavioral (regression, irritability, academic decline); adolescent substance-related cases increasing	Rule out delirium/medical causes first; involve guardians; pediatric-safe dosing; urgent referral for specialist evaluation

EVALUATION & DIAGNOSIS

- Clinical assessment: psychiatric history, substance use, medical conditions.
- Physical & neurological exam: vital signs, skin signs (e.g., lupus rash), pupil changes, focal neurological deficits suggest organic etiology.
- Lab tests: CBC, electrolytes, glucose, LFTs, TFTs, B12/folate, HIV, syphilis, drug screens (e.g. steroids, anticholinergics, stimulants).
- Imaging & EEG as indicated, especially to rule out intracranial pathology

DIAGNOSIS CONFIRMATION & SEVERITY CLASSIFICATION

Accurate diagnosis of acute psychosis requires a systematic assessment to confirm that symptoms meet the criteria for a psychotic disorder and to determine the severity and urgency of intervention.

1. Systematic assessment

Assessment domain	Finding	Likely classification	Action / urgency
Duration of symptoms	< 1 month	Brief Psychotic Disorder (DSM-5) / Acute & Transient Psychotic Disorder (ICD-11)	Check for stressors/substances/ medical causes; short-term treatment; close follow-up (good prognosis if cause addressed)

	1–6 months	Schizophreniform disorder / early schizophrenia-spectrum	Full workup; initiate antipsychotic; early intervention referral
	> 6 months	Schizophrenia / Schizoaffective disorder	Long-term treatment plan; psychosocial rehab; specialist care
Organic precipitating factors	Psychosis with medical/ neurological illness	Psychotic Disorder Due to Another Medical Condition	Treat underlying cause urgently; targeted labs/imaging; admit if unstable
	Onset with intoxication/ withdrawal	Substance-Induced Psychotic Disorder	Toxicology; manage withdrawal/ intoxication; cease offending agent; safety monitoring
	Psychosis only during delirium	Not primary psychosis (delirium)	Manage delirium cause (infection, metabolic, drugs); avoid mislabeling
Predominant mood symptoms	Psychosis only during mood episode (mania/severe depression)	Mood Disorder with Psychotic Features	Treat mood episode ± antipsychotic; suicide risk plan
	≥2 weeks psychosis without mood symptoms	Consider Schizoaffective Disorder	Specialist assessment; antipsychotic ± mood stabilizer/ antidepressant as indicated
Psychosocial & developmental context	Recent major stress/trauma (adolescents/young adults)	Brief/acute psychotic episode more likely	Ensure safety; short-term antipsychotic; psychosocial supports; follow closely
	Children: regression, unusual fears, abrupt behavioral change	Higher likelihood of organic cause	Urgent medical/neurologic workup, involve guardians; pediatric-safe management and rapid referral

2. Severity Classification

Severity is determined by symptom intensity, risk to self/others, level of functioning, and the presence of medical complications.

Severity Level	Clinical Features)	Urgency/Management Approach
Mild	Psychotic symptoms present but patient retains partial insight, is cooperative, and functioning is mildly impaired. No immediate risk to self/ others.	Outpatient or primary care management with close monitoring if organic causes are excluded.
Moderate	Prominent delusions/hallucinations, disorganized thought, reduced self-care, partial insight. No aggression or suicidal intent but functioning significantly impaired.	Requires referral to secondary facility for diagnostic confirmation, treatment initiation, and observation.
Severe	Intense psychotic symptoms, no insight, marked behavioral disturbance, risk to self/ others, refusal of food/fluids, or medical instability.	Emergency stabilization, urgent pharmacologic intervention, and immediate referral to tertiary care or inpatient psychiatric unit.
Critical (Psychiatric Emergency)	Acute psychosis with suicidal behavior, violent aggression, severe agitation, catatonia, or life-threatening medical complication (e.g., neuroleptic malignant syndrome).	Emergency intervention at nearest facility with capacity, rapid transfer to specialist care.

3. Key Points for Confirmation in Low-Resource Settings

- Rely on detailed history from patient and informants; symptom chronology is critical.
- Perform targeted physical and neurological examination to identify organic triggers.
- Use brief validated screening tools (e.g., Brief Psychiatric Rating Scale [BPRS], Positive and Negative Syndrome Scale [PANSS] – shortened versions) to support symptom quantification.
- Always document duration, onset pattern, triggers, and impact on functioning.

DIFFERENTIAL DIAGNOSIS

Acute psychosis must be distinguished from other conditions to guide correct treatment:

- Delirium: Rapid onset, fluctuating course, impaired attention and orientation; usually due to medical illness or drug toxicity. Treat underlying cause urgently.
- Mood Disorders with Psychotic Features: Psychosis occurs only during severe mania or depression and is mood-congruent; if psychosis persists ≥2 weeks without mood symptoms, consider schizoaffective disorder.
- Substance-Induced Psychosis: Linked to intoxication or withdrawal (e.g., cannabis, amphetamines, alcohol, steroids); symptoms often resolve after cessation.
- Neurological/Medical Causes: CNS infections, autoimmune encephalitis, epilepsy, tumors, metabolic/endocrine disorders, nutritional deficiencies; look for neurological signs, systemic illness, or atypical age of onset.
- Pediatric Considerations: In children/adolescents, organic causes are more common; suspect if there is developmental regression, sudden academic decline, or new neurological symptoms.

MANAGEMENT GOALS

- **Restore safety:** protect patient/others; control severe agitation and distressing psychosis.
- **Treat reversible causes**: identify and manage medical, neurological, or substance triggers.
- **Start antipsychotics safely:** begin at the lowest effective dose, monitor effects, titrate to response.
- **Prevent complications:** self-harm/violence, dehydration, malnutrition, adverse drug reactions.

- **Plan recovery:** engage patient/caregivers, arrange follow-up, provide psychoeducation to support adherence and relapse prevention.

Management principles

- **Medical emergencies first:** rule out delirium, infection, metabolic crisis before labeling primary psychosis.
- **Low-dose, gradual titration:** especially in first-episode, older adults, and those with comorbidities.
- **Crisis de-escalation and support:** calm setting, clear non-threatening communication, verbal de-escalation.
- **Family involvement:** early collateral history, adherence support, relapse-warning sign monitoring, and caregiver education.

NON-PHARMACOLOGICAL INTERVENTIONS

Non-pharmacological management is a vital part of acute psychosis care, complementing medication to stabilize the patient, support recovery, and prevent relapse.

1. **Brief Psychosocial Support and Psychoeducation** to reduce distress, improve understanding of the illness, enhance cooperation with treatment, and empower caregivers.
    - Provide information on symptoms, causes, and treatment options in clear, culturally appropriate language.
    - Address myths and misconceptions about psychosis to reduce stigma.
    - Explain early warning signs of relapse (e.g., sleep disturbance, social withdrawal, suspiciousness).
    - Discuss medication benefits and possible side effects to improve adherence.
    - Offer basic coping strategies, such as maintaining a regular daily routine, avoiding substance use, and stress-reduction techniques.

In Pediatric/Adolescents

- Family involvement is central—psychoeducation, structured home environment, and adherence monitoring.
- School collaboration for reintegration planning and symptom monitoring.
- Use psychosocial interventions early (CBT for psychosis, supportive therapy).
- Address bullying, stigma, and peer relationships, which have a larger impact on prognosis than in adults.

2. Low-Resource Adaptations: Given geographical spread and limited mental health workforce, flexible delivery methods are crucial:

- Community Support Networks: Engage local health volunteers, religious/community leaders, or trained lay counselors for patient monitoring and emotional support. Link patients to community-based rehabilitation programs if available.
- Family-Based Monitoring: Train caregivers to observe and document changes in mood, behavior, sleep, and self-care. Involve them in ensuring medication adherence and attending follow-up visits.
- Telepsychiatry and Remote Supervision: Use phone or video consultations for specialist input in remote islands. Incorporate tele-mentoring for primary care staff to discuss difficult cases.

PHARMACOLOGICAL THERAPY

In acute psychosis, oral antipsychotics are the preferred starting point when the patient is cooperative and can take medication safely. The choice should be guided by efficacy, side-effect profile, patient history, and availability in the setting.

1. Atypical Antipsychotics (Preferred) due to better tolerability, lower risk of extrapyramidal side effects, and evidence-based effectiveness in acute episodes.

   Olanzapine: 10–20 mg orally once daily; increase gradually by 5 mg/day as needed (max 20 mg/day in most patients). Or **Risperdone:** 2 mg/day in 1–2 divided doses; titrate up to 4–6 mg/day. Or **Aripiprazole:** 10–15 mg orally once daily; may increase to 30 mg/day based on response

   Cautions: Monitor for metabolic side effects (weight gain, dyslipidemia, hyperglycemia), sedation, and orthostatic hypotension. Avoid combining olanzapine with parenteral benzodiazepines due to respiratory depression risk.

2. Typical Antipsychotics are effective and often more affordable; but higher risk of extrapyramidal symptoms (EPS).

   Haloperidol: Start at 2–5 mg orally 2–3 times/day; adjust based on clinical response (usual total daily dose 5–20 mg). **Cautions:** Monitor for EPS (dystonia, akathisia, parkinsonism), QT prolongation, and neuroleptic malignant syndrome (NMS).

   Duration of Therapy: Continue antipsychotic treatment for at least 1–2 years after the first episode to reduce relapse risk; longer maintenance may be required for recurrent episodes.

Parenteral Antipsychotics in Acute Psychosis

Immediate calming in patients who are violent, highly agitated, uncooperative, or unable to take oral medication.

Goal: Short-term stabilization — transition to oral medication as soon as feasible.

A. Short-Acting Parenteral Antipsychotics (for rapid control of severe agitation)

Indications:

Drug	Dose	Repeat/Frequency	Key Cautions
Olanzapine IM (atypical, preferred)	10 mg IM	Repeat once after ≥2 h; max 20 mg/24 h	Avoid with parenteral benzodiazepines within 1 h; monitor for sedation, hypotension
Haloperidol IM (typical)	2–5 mg IM	Repeat every 4–8 h; max 20 mg/24 h	High EPS risk, QT prolongation; consider prophylactic anticholinergic

B. LAIs- Long-Acting Parenteral (Depot) Antipsychotics (for maintenance therapy)

Indications:

- Poor adherence to oral medication despite adequate response.
- Recurrent relapses linked to non-compliance.
- Patient preference for less frequent dosing.
- Should only be initiated after an adequate oral trial to confirm tolerability and efficacy.

Note: LAIs should not be used for acute agitation — onset is too slow. Initiate once patient is stabilized on oral therapy.

Drug	Starting Dose	Dosing Interval	Key Cautions	Relative Cost	Relative Advantage
Haloperidol decanoate	25–50 mg deep IM (gluteal)	Every 4 weeks	EPS, QT prolongation; test dose first to assess tolerance	Low	Inexpensive, widely available, long track record; effective in chronic psychosis
Fluphenazine decanoate	12.5–25 mg deep IM	Every 2–4 weeks	EPS risk; avoid in Parkinson's disease	Low	Low cost, flexible dosing interval, effective for maintenance in stable patients
Risperidone microspheres	25 mg deep IM (gluteal or deltoid)	Every 2 weeks	Needs 3 weeks' oral overlap after first injection; monitor prolactin and metabolic profile	Moderate–High	Atypical profile with lower EPS risk, better tolerated in some patients
Paliperidone palmitate	150 mg day 1, 100 mg day 8, then monthly	Every 4 weeks	No oral overlap needed; monitor for metabolic effects	High	Convenient monthly dosing, stable plasma levels, useful for adherence issues
Olanzapine pamoate	150–300 mg every 2 weeks OR 300–405 mg every 4 weeks	2–4 weeks depending on dose	Risk of post-injection delirium/sedation syndrome — observe ≥3 h post-injection	High	Effective for patients stable on oral olanzapine, strong sedative effect for agitation control

General Principles for Long-Acting Injectables (LAIs)

- Initiation: Only after confirming tolerability with oral form (except paliperidone palmitate, which can be given after allergy check).
- Administration: Deep intramuscular injection by trained personnel; alternate injection sites.
- Monitoring:
  - Vital signs post-injection for short-acting atypicals used in rapid tranquilization.
  - For LAIs: metabolic monitoring (weight, glucose, lipids), EPS checks, prolactin if indicated.
- Education: Counsel patients and caregivers on expected onset, benefits, side effects, and the importance of not missing doses.
- Low-Resource Adaptation: LAIs can be administered at island or atoll hospitals by nurses trained in injection technique, with telepsychiatry oversight for initiation and dose adjustment.

Treatment-resistant schizophrenia or persistent symptoms despite adequate trials of at least two different antipsychotics.

Clozapine Initiation**:** Only under specialist supervision. Oral (tablets or orally disintegrating tablets) Starting Dose: 12.5 mg once or twice daily (to minimize risk of orthostatic hypotension, sedation, and seizures), Increase by 25–50 mg/day as tolerated; Target Dose: 300–450 mg/day in divided doses (morning + evening) and a maximum dose Up to 900 mg/day (rare; only if well tolerated and necessary). Given once daily at night for sedation management, or split doses if higher total dose is used to reduce side effects

Cautions:

- Avoid rapid titration to reduce risk of hypotension, seizures, and myocarditis
- Always check baseline WBC/ANC, ECG, and metabolic profile before starting
- Do not start if ANC <1500/µL (or <1000/µL in benign ethnic neutropenia)

MANAGEMENT OF ACUTE PSYCHOSIS IN PEDIATRIC/ADOLESCENT PATIENTS

Pediatric psychosis is more likely to be secondary to organic causes (e.g., autoimmune encephalitis, epilepsy, metabolic disorders, substance use) compared to adults. Extensive medical workup is warranted before labeling a primary psychiatric disorder. Developmental and behavioral disorders (e.g., autism spectrum disorder, ADHD with psychotic features) should be considered.

Key considerations for pharmacological therapy:

- Lower starting doses of antipsychotics (often 25–50% of adult dose) due to higher sensitivity and reduced hepatic enzyme maturity in younger children.
- Slower titration to minimize side effects such as weight gain, sedation, and extrapyramidal symptoms.
- Preferred agents:
  - Risperidone: Often first-line for acute psychosis in children/adolescents (start 0.5–1 mg/day; titrate every 3–7 days).
  - Aripiprazole: Good tolerability, lower metabolic risk (start 2–5 mg/day).
  - Olanzapine: Reserved for severe agitation, but high metabolic risk.
- Avoid long-acting injectables unless adherence is a critical issue and the diagnosis is firmly established.
- Clozapine use in children requires specialist input, restricted to treatment-resistant cases.
- More frequent monitoring for metabolic side effects, weight gain, and prolactin-related symptoms (menstrual irregularities, galactorrhea, gynecomastia).
- Monitor for academic decline and cognitive impact during treatment.
- Early-onset psychosis often has a poorer functional prognosis than adult-onset, requiring early intervention to prevent chronicity.
- Greater emphasis on early detection of relapse through caregiver and school reports.
- Transition planning to adult services for adolescents approaching 18 years.

MANAGEMENT OF ACUTE PSYCHOSIS IN THE ELDERLY

Acute psychosis in older adults requires a modified approach due to higher likelihood of medical causes, increased drug sensitivity, and vulnerability to side effects.

1. Diagnostic Approach

- Higher index of suspicion for organic causes:
  - Delirium, dementia (especially Lewy body dementia), metabolic disturbances, infections (e.g., UTI, pneumonia), stroke, Parkinson's disease, or medication-induced psychosis.
- Comprehensive medical evaluation before starting antipsychotics, including review of current medications (anticholinergics, steroids, dopaminergic agents).
- Neurocognitive assessment is important to differentiate psychosis from behavioral and psychological symptoms of dementia (BPSD).

2. Pharmacological Management

- Start low, go slow: Use the lowest effective dose, titrating gradually. Elderly patients are more sensitive to antipsychotics due to reduced hepatic metabolism, renal clearance, and blood–brain barrier permeability.
- Preferred agents:
  - Risperidone (0.25–0.5 mg once daily; titrate slowly).
  - Olanzapine (2.5–5 mg/day) for agitation if metabolic profile allows.
  - Quetiapine (12.5–25 mg/day) in Parkinsonism/Lewy body dementia, as it has lower EPS risk.
- Avoid high-potency typical antipsychotics unless short-term control of severe agitation is needed (e.g., haloperidol in delirium with careful ECG monitoring).
- Avoid clozapine unless under specialist supervision for treatment-resistant psychosis.
- Avoid long-acting injectables unless adherence is a major issue and risks are carefully considered.

3. Non-Pharmacological Management

- Prioritize delirium prevention and treatment: Maintain orientation cues, optimize sensory aids (glasses, hearing aids), ensure hydration and nutrition, and avoid unnecessary polypharmacy.
- Environmental modifications: Quiet, well-lit rooms, familiar caregivers, and minimal disruptions.
- Family involvement: Encourage family presence for reassurance and to help detect subtle changes in mental state.

4. Monitoring

- Close monitoring for side effects such as orthostatic hypotension, sedation, anticholinergic effects, extrapyramidal symptoms, and cardiac arrhythmias (QT prolongation).
- Metabolic monitoring (weight, glucose, lipids) is still necessary but cognitive decline and falls risk often take priority in the elderly.

5. Prognosis & Long-Term Care

- Prognosis depends largely on the underlying cause—psychosis secondary to delirium can resolve fully, while psychosis in dementia often persists.
- Long-term use of antipsychotics in dementia is linked to increased mortality; use the lowest dose for the shortest time possible.
- Early deprescribing should be planned once symptoms stabilize.

Drug	Starting Dose	Titration / Max Dose	Route	Key Cautions
Olanzapine	10–20 mg once daily	Increase by 5 mg/day (max 20 mg/day)	Oral	Weight gain, sedation, metabolic syndrome; avoid with parenteral benzodiazepines
Risperidone	2 mg/day in 1–2 doses	Titrate to 4–6 mg/day	Oral	EPS at higher doses, prolactin elevation
Haloperidol	2–5 mg 2–3×/day	Usual 5–20 mg/day	Oral	EPS, QT prolongation, NMS risk
Aripiprazole	10–15 mg once daily	Increase up to 30 mg/day	Oral	Akathisia, insomnia; monitor for agitation in early phase
Clozapine (specialist use only)	12.5 mg once or twice daily	Gradual titration to effective dose (200–450 mg/day)	Oral	Agranulocytosis (WBC/ANC monitoring), myocarditis, seizures, metabolic effects

Management of Extrapyramidal Symptoms (EPS)

Trihexyphenidyl: 1 mg orally once daily, preferably in the morning after food. Increase by 1 mg every 3–5 days based on symptom control and tolerability. Usual Maintenance Dose: 2–6 mg/day in 2–3 divided doses. If multiple doses, schedule last dose before 6 PM to prevent sleep disturbance. Maximum: 15 mg/day (rarely needed in drug induced psychosis (DIP).

Cautions: Avoid in narrow-angle glaucoma, prostatic hypertrophy, or elderly with cognitive impairment. Monitor for anticholinergic toxicity: dry mouth, blurred vision, constipation, urinary retention, confusion. Avoid prophylactic use unless high risk and short-term.

Note: Continue only as long as symptoms persist. In first-episode psychosis, symptoms often improve within 4–12 weeks; begin gradual taper once DIP resolves. Long-term use is discouraged due to risk of cognitive impairment, constipation, urinary retention, and glaucoma, especially in elderly patients.

Management of Other Adverse effects

Table . Management of adverse effects

Adverse Effect	First-Line Management	Alternative Options	Key Cautions
Sedation	Give dose at night; reduce dose	Switch to less sedating drug (e.g., aripiprazole)	Caution with driving, machinery
Metabolic effects (weight gain, hyperlipidemia, hyperglycemia)	Diet, exercise, monitor BMI/ glucose/lipids	Switch to low metabolic risk antipsychotic	Treat metabolic abnormalities per standard guidelines
Anticholinergic effects (dry mouth, constipation)	Hydration, sugar-free gum; high-fiber diet	Mild laxatives for constipation	Monitor for urinary retention in elderly males
Orthostatic hypotension	Slow titration; advise slow posture changes	Switch to agent with lower alpha-blockade	Monitor BP especially in elderly
Akathisia (restlessness)	Reduce dose; propranolol 20–60 mg/day	Short-term lorazepam 0.5–2 mg BID–TID	Avoid propranolol in asthma, heart block
Drug-induced parkinsonism (tremor, rigidity)	Reduce dose; switch to atypical	Trihexyphenidyl 2–6 mg/day	Use lowest effective dose of anticholinergics to avoid cognitive side effects
Hyperprolactinemia	Reduce dose; switch to prolactin-sparing drug	Add low-dose aripiprazole	Evaluate for pituitary adenoma if persistent

Acute dystonia (neck, jaw, eye spasms)	IM/IV benztropine 1–2 mg OR promethazine 25–50 mg	Oral trihexyphenidyl 2–6 mg/day for prevention	Rule out seizure; avoid in narrow-angle glaucoma
Tardive dyskinesia	Reduce dose; switch to **clozapine**	VMAT2 inhibitors (if available)	Avoid routine anticholinergics — may worsen symptoms
Neuroleptic malignant syndrome (NMS)	Stop antipsychotic; hospitalize; IV fluids, cooling	**Dantrolene** or **bromocriptine** if available	Do not rechallenge with high-potency typical antipsychotics without specialist input

ASSESSMENT OF RESPONSE

Evaluating treatment response in acute psychosis is essential to determine whether the chosen interventions are effective, to detect side effects early, and to guide further management decisions.

Domain	What to assess	How to measure	Frequency / timing	Notes
Symptom reduction	Hallucinations, delusions, thought disorder, agitation	Clinical interview; PANSS (Positive and Negative Syndrome Scale) or BPRS (Brief Psychiatric Rating Scale)	Weeks 0–6: weekly until clear improvement → post-stabilization: every 2–4 weeks → maintenance: every 1–3 months	Track baseline → trend; document partial vs full response
Side effects	EPS (rigidity, tremor, akathisia), sedation, anticholinergic effects, metabolic (weight, glucose, lipids), NMS red flags (fever, rigidity, confusion, ↑CK)	Exam; vitals/weight/BMI; AIMS/Simpson–Angus if available; fasting glucose/lipids	Same schedule as above; labs at baseline, 3 months, then 6–12 monthly (or per local protocol)	Urgent review if NMS signs; consider dose change/switch
Functioning	Self-care, social interaction, work/school, daily routine	Patient/caregiver report; attendance records; ADL checklist	Same schedule as above	Use simple goals (e.g., hours in class/work, hygiene, meals)
Adherence & safety	Medication adherence, substance use, suicidality/violence risk	Pill counts, pharmacy refill, urine tox (if indicated), risk screen	Every visit	Address barriers; safety plan if risk present
Tools availability (low-resource)	When formal scales unavailable	Qualitative ratings: improved / unchanged / worse + brief notes	Every visit	Keep consistent rater/time when possible
Caregiver input	Sleep, behavior changes, social functioning	Brief collateral history (in person/phone)	Every visit, especially early phase	Helps detect relapse or side effects between visits

TREATMENT ADJUSTMENT

Pre–step-up checklist	What to do	How / notes
Adherence	Confirm regular use	Patient/caregiver report, pill counts, refill history; remove barriers (side effects, stigma, misunderstanding)
Side effects	Identify and manage adverse events	Screen EPS, sedation, metabolic effects; adjust dose/ timing/switch if impairing
Comorbidities	Screen conditions impacting recovery	Physical illness (diabetes, CVD), substance use, other psychiatric disorders
Stressors	Identify ongoing psychosocial stress	Family conflict, housing/financial/academic pressures; link to supports or referral

Treatment adjustment	Criteria	Action	Notes
Optimize current regimen	Partial improvement	Titrate within recommended range while monitoring tolerability	Recheck response in 2–4 weeks
Switch antipsychotic / seek specialist input	Minimal/no improvement after 6–8 weeks at adequate dose and confirmed adherence	Switch to another agent or refer	Ensure cross-taper plan and side-effect monitoring
Evaluate for clozapine	Treatment-resistant (failed ≥2 adequate trials)	Initiate under specialist supervision	Baseline ANC, metabolic and cardiac monitoring per protocol

Documentation (every visit)	Record
Symptom trend (core psychosis features), side effects (EPS/sedation/metabolic), adherence checks, psychosocial factors/stressors	
All medication changes (drug, dose, titration plan), rationale, and follow-up plan to ensure continuity across providers	

Acute Psychosis (Low-Resource, Stepped Care)

Who this is for
Primary care clinicians, pediatricians, nurses, and community health workers on islands with limited access to psychiatrists.

1. First 10 minutes – Safety and Triage

- Ensure scene safety; remove hazards; 1:1 observation if risk.
- Check ABCs, vitals, glucose (treat hypoglycemia immediately).
- Rapid screen for delirium, head injury, seizures, intoxication/withdrawal.
- If violent/agitated: quiet room, verbal de-escalation first; have IM options ready if needed.

2. Minimum Initial Work-Up (order in this priority)

- **Point-of-care:** capillary glucose, temperature, SpO_2.
- **Basic labs (as available):** CBC, electrolytes/creatinine, LFTs, TSH, urine tox (if feasible), pregnancy test (when relevant).
- **Focused neuro exam;** consider EEG/CT only if red flags (new focal deficit, head trauma, first seizure, immunosuppression).

3. Provisional Diagnosis & Severity

- Confirm acute psychosis vs **delirium** (fluctuating attention/orientation).
- Note duration: **<1 month** → consider brief psychotic disorder; **>1 month** → schizophrenia-spectrum likely.
- Grade risk: **severe** if suicidal, violent, catatonic, unable to eat/drink, or medically unstable.

4. First-Line Pharmacotherapy (oral preferred)

- **Aripiprazole** 10–15 mg PO daily; titrate to max 30 mg/day.
- **Olanzapine** 10 mg PO nightly; titrate up to 20 mg/day (avoid with parenteral benzodiazepines).
- **Risperidone** 2 mg/day PO → 4–6 mg/day.
- **Haloperidol** 2–5 mg PO 2–3×/day if atypicals unavailable.
- Use **lowest effective dose**; monitor EPS, QT risk (typicals), and metabolic effects (atypicals).
- **Pediatrics/adolescents**: start at ~½ typical adult starting dose; titrate slower; confirm weight-based dosing from a pediatric reference.
- **Severe agitation (IM)**: olanzapine 10 mg IM (repeat once after 2 h; max 20 mg/24 h) OR aripiprazole 9.75 mg IM (repeat q2h; max 30 mg/24 h). Continuous observation.

Do not initiate clozapine at primary care. Reserve for tertiary care with ANC/WBC monitoring.

5. Non-Pharmacological Core (low-resource fit)

- Calm, low-stimulus environment; hydration, nutrition, sleep routine.
- Brief psychoeducation for patient and family; address myths/stigma.
- Family-based monitoring plan: sleep, behavior, adherence, relapse signs.
- Use simple patient/caregiver education sheet with warning signs and when to seek help.

- **Telepsychiatry:** phone/video consult with regional hub for diagnostic confirmation or dosing questions.
- Link to island council/NGO supports for transport and follow-up.

6. Referral Triggers (escalate island → atoll/district → tertiary)

- Moderate–severe symptoms, high risk, medical red flags, pregnancy, pediatric first episode, poor response after initial stabilization, or diagnostic uncertainty.
- **Treatment resistance:** no meaningful response after 6–8 weeks at adequate dose and good adherence → refer for specialist review (possible clozapine).

7. Follow-up Schedule (reduce DUP; prevent relapse)

- **Week 0–2:** review **weekly** (symptoms, side effects, vitals, weight).
- **Weeks 3–6:** every 1–2 weeks; adjust dose if needed.
- **After stabilization**: every 4–12 weeks; psychosocial supports, adherence checks.
- Use simple ratings (improved/unchanged/worse) if PANSS/BPRS are not available.

8. Pediatric/Adolescent Notes

- Lower threshold to **rule out organic causes** (infection, autoimmune encephalitis, epilepsy, metabolic).
- Involve caregivers from the start; consider school liaison.
- Avoid long-term antipsychotics without specialist plan; prioritize tele-consult.

9. Substance Use Integration

- Screen for cannabis, synthetic cannabinoids, alcohol, stimulants.
- Offer brief intervention, coordinate with National Drug Control Programme for follow-up.

10. Documentation & Handover (use a one-page template)

- Presenting risks, exam findings, meds/doses given, adverse effects, labs done/pending, reason for referral, contact details for receiving facility.
- Provide a written **safety plan** to families (warning signs, emergency numbers).

11. Supplies & Readiness (clinic checklist)

- Aripiprazole/olanzapine/risperidone (PO), haloperidol (PO), olanzapine or aripiprazole (IM).
- Anticholinergic for EPS (e.g., trihexyphenidyl), oral rehydration, glucometer/strips, BP cuff, thermometer, weight scale.
- Private room, observation log, tele-consult contact list.

PROGNOSIS & PROGRESSION

The outlook for acute psychosis varies depending on its underlying cause, the timeliness of intervention, and the presence of supportive resources. Early intervention is one of the most important determinants of outcome—prompt recognition and treatment significantly improve functional recovery, reduce relapse risk, and lower the likelihood of progression to chronic psychotic disorders.

Prognosis factor	Favorable	Poor
Onset & duration	Short DUP (duration of untreated psychosis); sudden onset with clear trigger	Gradual, insidious onset; long untreated duration before first contact
Premorbid function	Good social/occupational functioning	Poor premorbid function; social isolation
Age	-	Early onset, especially childhood-onset
Substance/medical comorbidity	None	Co-occurring substance misuse; chronic medical illness
Support	Strong family/social support	Limited support
Course to date	-	Multiple relapses without sustained remission

Progression pattern	Typical course	Implications
Brief/stress-related episode	Resolves in weeks–months once trigger addressed	Good prognosis; ensure short-term treatment and follow-up
First-episode schizophrenia/ schizoaffective	May remit but needs long-term maintenance	Plan maintenance therapy, relapse-prevention supports
Organic or substance-induced psychosis	Improves with removal of cause; recurrence tied to re-exposure or medical stability	Treat underlying condition; strong emphasis on abstinence/medical control

Relapse prevention	What to do	Remarks
Maintenance pharmacotherapy	Continue 1–2 years after first episode (longer if risk high)	Taper only with close monitoring and a relapse plan
Regular follow-up	Early reviews after stabilization, then spaced as stable	Watch for sleep change, withdrawal, rising suspiciousness
Psychoeducation & supports	Educate patient/family on adherence, coping, and warning signs	Add family involvement, crisis plan, and substance-use counseling where relevant

REFERRAL PATHWAYS

In low-resource settings, where psychiatrists and specialized mental health professionals are scarce, clear and practical referral pathways are essential to ensure that patients with acute psychosis receive timely, appropriate care. The pathway should maximize the use of available primary and secondary health facilities while ensuring that complex cases reach specialist services as quickly as possible.

Level	Core actions	Refer up when	Pathway / remarks
Primary care (first contact)	Rapid assess to confirm psychosis and rule out emergencies (delirium, infection, metabolic crisis); stabilize with lowest effective oral antipsychotic + supportive care; ensure immediate safety; brief psychoeducation for patient/ caregivers	Moderate–severe symptoms with self-care or safety risk; no improvement/worsening after initial stabilization; medical/ neurological red flags (seizures, focal deficits, altered consciousness); first-episode in children/adolescents	Urgent referral to nearest secondary facility; call ahead; transfer with a trained health worker or family member
Secondary care (Atoll/ regional)	Confirm diagnosis with detailed history/exam/basic labs; initiate/ adjust antipsychotic and monitor side effects; short inpatient stays if needed; family counseling; build follow-up plan with primary care	Treatment-resistant (≥2 adequate trials failed); persistent severe agitation/ aggression beyond local capacity; medical complexity needing specialized tests; clozapine initiation/monitoring required	Communicate with tertiary center before transfer; arrange safe transport with trained staff if agitation/aggression risk is high
Tertiary care (central/ national)	Comprehensive psychiatric evaluation; multidisciplinary management; supervised clozapine with mandatory labs; manage complex comorbidity/ side effects/diagnostic uncertainty; individualized rehab and relapse prevention; training/ tele-mentoring for lower tiers	-	Provide discharge plan and feedback to referring facilities; support capacity building and shared-care follow-up

Key Adaptations for Low-Resource Settings

- Telepsychiatry Integration: Use video or phone consultations between primary/ secondary care providers and tertiary specialists to reduce unnecessary transfers.
- Standardized Referral Templates: Include patient demographics, history, treatment given, response, and reason for referral to ensure continuity.
- Capacity Building: Train primary and secondary care staff in safe stabilization, medication initiation, and crisis management to bridge the gap while awaiting specialist review.
- Feedback Loop: Ensure tertiary centers provide written feedback to referring facilities to improve local capacity for future cases.

COMPLICATIONS

Acute psychosis, if not promptly and appropriately managed, can lead to a range of complications that affect medical health, psychiatric stability, and social functioning. These complications may arise from the illness itself, its treatment, or the social consequences of the condition.

Complication	Impact	Prevention strategy	Low-resource key points
Medical			
Neuroleptic malignant syndrome (NMS)	Life-threatening reaction: high fever, rigidity, altered mental state, autonomic instability	Start low, titrate slowly; monitor temp/rigidity/mental status after starts or dose increases; educate staff/caregivers on warning signs	Use simple checklists; arrange rapid referral if suspected
Extrapyramidal symptoms (EPS)	Dystonia, akathisia, parkinsonism, tardive dyskinesia → discomfort, non-adherence	Prefer atypical antipsychotics when possible; watch for early signs; use anticholinergics only if indicated	Train non-specialists to spot/ report EPS promptly
Metabolic syndrome	Weight gain, dyslipidemia, insulin resistance → ↑ CV risk	Track weight, waist, BP; counsel on diet/physical activity; check glucose/lipids at baseline and annually if possible	If labs limited, track weight/BMI routinely
Psychiatric			
Suicide risk	Elevated during acute/early recovery phases	Screen every visit; involve family; restrict access to means	CHWs can support monitoring and safety checks
Poor functional recovery	Persistent impairment in social/ work/school roles	Start treatment early; psychoeducation on adherence/ relapse prevention; graded return to roles	Use tele-follow-up/community visits to maintain continuity
Treatment resistance	Diminished response to future therapy	Ensure adequate dose/duration before switching; fix adherence/ side effects early; consider clozapine under specialist care	Use telepsychiatry for early specialist input to avoid delays
Social			
Stigma	Discrimination/shame → delayed help-seeking	Public awareness, culturally tailored materials; engage community leaders	Small group sessions often outperform mass campaigns
Isolation	Withdrawal from community/ supports → worse outcomes	Encourage structured daily activities; peer/support groups; link to community programs	Leverage community centers/ faith networks already in place
Loss of employment / education disruption	Job loss, school dropout, economic hardship	Provide medical leave documentation; coordinate phased return; vocational/ educational support	Partner with local councils/ schools for re-entry support

PREVENTION & HEALTH PROMOTION

Prevention of acute psychosis and promotion of mental well-being must align national program: Community-based care, primary-care integration, stigma reduction, stronger psychosocial supports.

Primary prevention

- Public education on early signs (sudden behavior change, paranoia, hallucinations) in local languages via schools and community/faith leaders.
- Substance-use prevention: Partner with the National Drug Control Programme; curb cannabis/synthetics/alcohol; offer youth alternatives.
- Build resilience in schools: stress management, problem-solving, social–emotional learning.

Secondary prevention

- Routine screening in primary care (e.g., GAD-7 = Generalized Anxiety Disorder-7; WHO mhGAP psychosis modules).
- Train staff to spot early psychosis and start stabilization before referral.
- Clear island→district→tertiary referral pathways to cut DUP (duration of untreated psychosis).
- Use the National Telepsychiatry Network for real-time consults from remote islands.

Tertiary prevention

- Maintenance & follow-up: Support adherence via community health workers (CHWs); family psychoeducation on relapse signs and continuity.
- Rehabilitation: Link to vocational training/supported employment with councils/NGOs; coordinate school re-entry under inclusive education policy.

Cross-cutting (low-resource setting)

- Anti-stigma messages embedded in awareness programs: illness is treatable, not a moral failing.
- Activate Island Women's Committees, youth groups, and faith leaders for community support.
- Align protocols with the Health Master Plan and National Mental Health Strategy for sustainability.

PATIENT EDUCATION

Patient and caregiver education is a core component of acute psychosis management, aiming to improve understanding, encourage adherence, and promote long-term recovery. Education should be clear, culturally appropriate, and adapted to the literacy level of the patient and family. Key Objectives are:

- What psychosis is: A treatable condition with psychiatric, medical, or substance-related causes. Dispel myths and stigma early.
- Adherence matters: Medicines control symptoms and prevent relapse. Don't stop abruptly; discuss changes with your clinician.
- Side effects—when to call: Common—sedation, weight gain, tremors. Urgent—fever, severe muscle stiffness, confusion (possible neuroleptic malignant syndrome).
- Build support: Involve family in monitoring, routines, and appointments. Use community resources, peer groups, and telepsychiatry.
- Spot relapse early: Watch for disturbed sleep, withdrawal, rising suspiciousness, or decline in self-care. Seek medical advice immediately.
- Healthy living: Balanced diet, regular activity, no alcohol or illicit drugs. Practice stress reduction (relaxation, prayer/meditation), keep a structured daily routine.
- Shared decisions: Ensure patients and caregivers understand the plan and help choose treatments.

Instructions to Patients and Caregivers

Do	Don't
Take medicines exactly as prescribed, same time daily; call before making changes.	Skip doses, stop suddenly, or change dose without medical advice.
Keep all follow-up appointments for symptom and side-effect checks.	Miss or delay appointments or lab monitoring.
Make the environment safe: secure sharps, chemicals; keep a calm, supportive setting.	Leave dangerous items accessible or allow chaotic, overstimulating spaces.
Avoid all substances that worsen psychosis (alcohol, cannabis, synthetics, other drugs).	Use or experiment with substances or mix meds with alcohol.
Report side effects early (stiffness, fever, rash, extreme drowsiness, rapid weight change).	Ignore or hide side effects or wait until they become severe.
Watch for relapse signs: poor sleep, withdrawal, suspiciousness, speech/behavior changes—seek help fast.	Dismiss early warning signs or delay seeking medical help.
Keep a healthy routine: regular meals, adequate sleep, light activity, stress-management.	Keep irregular routines, skip meals/sleep, or avoid activity entirely.
Stay involved in care: ask questions, help follow the plan, bring notes to visits.	Disengage from treatment, avoid asking questions, or rely on memory alone.

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