

When Should a GP Refer Patients with Psychosis to Secondary Care?

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Abstract.

We discuss the decision-making process of the GP when considering the referral of patients with psychotic illness to secondary care. We argue for the referral of all such patients to secondary care for evaluation and treatment.

Keywords: psychotic illness, primary care, secondary care.

Schizophrenia is a relatively common condition with about 1% lifetime risk. It occurs in all cultures of the world. The prognosis is variable and it has been suggested that, as a rough guideline, one third recover following the first episode, one third have residual symptoms remaining for life and one third have a relapsing and remitting course. This implies that some patients will require lifelong treatment. It is suggested that all patients may require treatment for at least one year after onset to prevent relapse.

Schizophrenia is one of a spectrum of psychotic illnesses. It can be difficult, initially, to distinguish schizophrenia from the others. The initial identification of patients with psychosis in primary care lies largely in the hands of the general practitioner, although some patients choose a different pathway for management of the psychosis, one that tends to bypass the GP completely. Out of 1200 patients admitted to the mental health assessment unit, Bedford, it was observed that a substantial number were diagnosed with first-episode psychosis (Haq et al., 2010), and many of these came through the accident and emergency department, not through their general practitioner. However, many such patients will present to the GP, who may experience difficulty in making the diagnosis. There are many reasons for this, including the difficulty in carrying out a full assessment during a standard surgery appointment. These issues might leave the general practitioner asking some key questions, not only about when to refer the patient with a psychotic illness to specialist care but also whether delay in such a referral will lead to a deterioration in the condition to the detriment of the patient.

Psychosis does not always present with the “textbook” symptoms of delusions and hallucinations. It can manifest as changes in behaviour, such as isolation, irritability, perplexity and guardedness, in some cases. Delusions and hallucinations can usually be detected fairly readily but the more subtle behavioural changes may take longer to identify and this may be problematic for the GP. Psychosis can result from various causes, some of which need thorough investigation to identify possible underlying factors; for example a psychosis from an organic cause may need further investigation and a brain tumour presenting with behavioural change may even be life threatening. Neurodevelopmental disorders, for example Prader-Willi syndrome and velocardiofacial syndrome also fall into the category of being organic disorders with a propensity to develop features of psychosis. Although schizophrenia is a common cause of psychotic symptoms there are many other disorders that can also present with these symptoms, including schizo-affective disorder and psychotic depression. Drug-induced psychosis has become increasingly common and needs to be distinguished from primary mental illness. Borderline personality disorder may present with auditory hallucinations, causing diagnostic confusion. Although not common, mono-symptomatic delusional disorders should also be considered in the differential diagnosis of schizophrenia. Psychotic symptoms can broadly be characterised into three main groups.

Hallucinations.

Delusions.

Negative symptoms.

Hallucinations are abnormal symptoms of any sensory modality which are perceived without a stimulus. Auditory hallucinations are the most common, comprising two thirds of all hallucinations. They are often accompanied by hallucinations from other modalities. It can sometimes be difficult to differentiate true hallucinations from pseudo-hallucinations. Some of the characteristics of hallucinations have diagnostic significance. If the voices are heard from outside the head rather than from inside the head they may have greater significance. Third-person auditory hallucinations, talking about the individual, rather than second-person hallucinations, talking to the individual, are counted as first-rank symptoms of schizophrenia. It is important to enquire about command hallucinations and how difficult it is to resist these. Command hallucinations may involve considerable risk and this could indicate that urgent referral to secondary care is required.

Delusions are abnormal beliefs which are held strongly against all information to the contrary and are not purely in keeping with the patient's cultural and religious background. Distinction needs to be made from obsessions and over-valued ideas; the patient may recognise these as being inappropriate/abnormal, in contrast to the firmly-held nature of delusions, which are resistant to rational argument. Persecutory delusions are reported to be the most common type. For persecutory delusions there are three main features that assist in risk assessment.

Whether the alleged persecutor is known to the patient.

Whether the patient has shared the belief with anybody else.

Whether the patient has confronted the alleged persecutor and how much control the patient has against acting on the belief that they have (threat override control – TOC).

Patients presenting to the GP with psychosis will do so in two different situations; they may be psychotic for the first time or they may be in a relapse of psychosis. Some patients have repeated psychotic relapses. The patient may typically present with the same symptoms each time a relapse occurs. It is important to identify these symptoms so that the patient, carers and professionals are made aware of the presentation. This constellation of symptoms is referred to as the identifying relapse signature and is discussed in greater detail in the paper on "Using Identification of Early Warning signs to prevent Relapse of Psychosis". The care coordinator will have devised a care plan which will encourage both the patient and the carers to be vigilant in recognising the relapse signature; they should take the appropriate action before the patient becomes seriously ill. In addition to identifying the symptoms, it may be of great value to identify stressors that have led to previous relapses. The care coordinator, with the carers, can then examine each of these potential stressors to plan the best course of action to reduce the chance of relapse in the future. As part of this care plan the patient and carer should be made aware of each professional agency involved, the role of each person and how to contact them.

Taking all these factors together, when should a general practitioner refer a patient with psychosis to secondary care?

We later argue that the GP should refer any patient suspected of having a psychotic illness to secondary care. Patients should usually be referred to secondary care in the following circumstances; in practice, the majority of patients would be referred.

If the GP is unsure of the diagnosis and requires a second opinion.

If adequate treatment cannot be given in primary care, so that there is a risk that the patient's condition could deteriorate.

If treatment which is important to the patient is unavailable in primary care, so that treating the patient in primary care would be suboptimal.

If the patient refuses treatment in primary care, as he refuses to accept that he is ill, and consequently may continue to deteriorate, with a risk to self or harm of others.

If there are insufficient resources in primary care to deal with a patient who is particularly difficult to treat, implying the need for sharing the care.

One of the most important considerations is that the psychotic illness should be treated as early as

possible to prevent deterioration in the patient's condition and the possibility of a worse long-term prognosis. The concept of "duration of untreated psychosis" (DUP) is important in this context. This refers to the duration of untreated psychosis from the point when the patient first became psychotic to the point in time when treatment with antipsychotic medication was commenced. Many studies have shown that the duration of untreated psychosis is directly related to the chronicity of the illness. Because of this the diagnosis of psychosis should be made as promptly as possible and patients with all forms of psychosis should be referred to secondary care as soon as possible to shorten the duration of untreated psychosis. It can be asserted that all patients with the first episode of a psychotic illness should, whether they have been formally diagnosed with schizophrenia or another form of psychosis, be referred urgently for evaluation by secondary care services in order to reduce the duration of untreated psychosis.

Different teams have evolved to deal with different situations in managing psychosis. Early intervention teams deal with first episode psychosis, assertive outreach teams deal with severe enduring forms of psychotic illness and rehabilitation teams work with chronic patients who are lacking life skills. All of these teams comprise psychiatric nurses, social workers, psychologists and occupational therapists as well as doctors. They deliver complex psychological interventions which are programmed to improve outcomes. These interventions may include psycho-education, cognitive behavioural therapy, family interventions, medical management and advice for relapse prevention. The aim of these interventions is to enable patients to become as autonomous as possible in managing their illness. Because these teams are of a specialist nature and are consequently not available in primary care, it is important that general practitioners refer all patients with psychotic illness to secondary care, so that they are able to receive the diagnostic and treatment services they require. This is particularly important for first episode psychosis patients but it is also important for patients with relapsing or chronic illness. When the patients have been adequately treated, understand how to manage their illness, have returned to an active role in society and are adequately supported by those around them, there is no reason why care should not be returned to the GP, with continued access to specialist services, as required, including easy rapid re-referral in case of relapse. Finally, the important issue of patients who refuse to accept treatment, even if they are clearly very unwell, needs to be considered. If the mental illness has reached the level at which the patient does not have the insight to agree to treatment or admission the mental health act may need to be applied to treat/admit the person compulsorily particularly if this is necessary to reduce the risk to themselves or others.

Treating psychotic illness is complex, requiring a number of different types of interventions: medical, psychological and social. Diagnosis can be difficult and is sometimes missed. Because of these factors, if a GP suspects that a patient has a psychotic illness, they should be referred, as a matter of urgency, to secondary care for assessment. Failure to do this, in addition to increasing distress in the individual and family, may lead to delayed, inadequate treatment with suboptimal results and a worse prognosis.

GP comment

What have I learned from this paper?

1. It is appropriate to have a low threshold for referral to a specialist opinion if a diagnosis of schizophrenia seems likely or if there is uncertainty about the diagnosis.
2. Early referral for specialist treatment might avoid serious deterioration of the patient's mental condition.
3. GPs need better access to secondary care for their patients.
4. Better links with local community mental health teams should be established to improve pathways.

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References

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