Version 1.0 # The Patient with Bizarre Behaviour, Ideas or Speech 10/06/2012

Most likely psychosis, but delirium, intoxication & other organic causes ruled out. Common precipitants are substance use, non-compliance with medication, psychosocial stressors

Management

Safety
Assessment
Confirmation of provisional diagnosis
Consultation
Immediate treatment
Transfer of care

Safety:

Close observation. Patient may require protection from harming self or others.

Assessment

History:

- Schizophrenia onset most often 15-25y – rare >45y (organic more likely)
- Early manifestations:

↓Work performance	Suspiciousness	Irritability
↓Motivation	Eccentric behaviour	Poor sleep
Withdrawal	Transient psychotic symptoms	Poor concentration
Reduced social interest	Depressed mood	

- Elucidate reason for presentation and any precipitating event or stressor?
- Any mood symptoms?
- Any substance use, recent HI, medical issue, past psychiatric history?
- Patient's explanation for their behaviour. Does it make any sense?

Exam – Physical & Mental State

- Emphasis on any thought disorder, delusions, persecutory ideation, hallucinations.
- Note catatonic stupor (immobile, mute, unresponsive but conscious) or catatonic excitement (uncontrolled and agitated abnormal motor behaviour).
- Organic: encephalitis, intracranial lesions, metabolic disorder & drugs. (e.g. amphetamines).

Confirmation

Corroboration: from GP, family & friends, medical notes.
Investigations: If possible organic cause suspected e.g. UEC, ABG, CT brain, LP, drug screen

Consultation

Consult with mental health team or D&A/Toxicology/Neurology etc. if organic.

Initial treatment

Seek & treat organic illness
Manage suicidal ideation or acute aggression

Transfer of care

Consider admission if

- Danger to self or others
- Highly disturbed behaviour
- Patient distressed
- Illness deterioration
- Need for stabilisation
- Need for further inv/observation
- Dx uncertain