Management of Psychotic Illnesses in Primary Care Settings

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Lessons Learned at the Interface of Medicine and Psychiatry

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever struggled to manage patients who were acting strangely? Have you wondered how best to approach treatment when your patient was suspicious or paranoid? Have you been frustrated by patients who failed to adhere to their medical regimen due to a psychiatric illness? If you have, the following case vignette and discussion should prove useful.

CASE VIGNETTE

Mr A, a 45-year-old man with type 2 diabetes mellitus (with an A1c of 14%), hypertension (despite multiple medications), multiple cerebrovascular accidents (due to uncontrolled hypertension), and more than 40 drug allergies, returned for a primary care follow-up appointment. His medication regimen included opioids for chronic pain, lorazepam for chronic gastroparesis and nausea, and multiple medications for metabolic conditions. His health care providers believed that Mr A was medication nonadherent, despite visiting the clinic frequently.

As was his routine, Mr A's brother accompanied him to his appointment. At each visit, Mr A wore sunglasses and weather-inappropriate clothing (such as sweatpants and a sweatshirt on a 100 °C day), although he appeared well nourished and clean. He offered multiple excuses for not meeting with a social worker or a psychiatrist and was suspicious regarding questions about new health care providers and trainees. Psychiatry was consulted because Mr A's primary care provider (PCP) thought that psychotic symptoms were interfering with adherence to medical recommendations.

DISCUSSION

How Can Psychosis Present in Primary Care Settings?

Individuals with psychosis present to primary care settings with myriad problems. Often, they complain about physical ailments or arrive with alterations in their mood or behavior.[1] One study that used administrative claims data found that two-thirds of patients who were ultimately diagnosed with a psychotic disorder made contact with a PCP for a mental health reason in the 4 years before to receiving their first diagnosis of psychosis.[2]

In general, patients and/or their families seek help from their PCPs in the years before patients are ultimately diagnosed with a psychotic illness. Those who present to primary care clinics during the prodromal phase of a first episode of psychosis may not manifest overt signs of psychosis, which makes them diagnostically challenging.[1] The prodromal phase can last for weeks to years.[3] Signs and symptoms associated with the prodromal period are often nonspecific; they include mood-related symptoms (eg, depressive symptoms and anxiety), substance misuse, social isolation or withdrawal, poor personal hygiene, poor grooming, blunted or odd affect, strange beliefs or magical thinking, and sleep disturbances.[4,5] For example, an adolescent might be brought to their appointment by family members due to their social isolation from family and friends, poor school

Clinical Points

- Since symptoms associated with the prodromal phase of psychotic illnesses are often nonspecific (eg, involving substance misuse, social isolation or withdrawal, poor personal hygiene, poor grooming, blunted or odd affect, strange beliefs or magical thinking, and disturbances of mood, behavior, and sleep), a broad differential diagnosis and assessment plan should be created so that timely and effective treatment can be initiated.
- Primary care providers should ask about psychotic symptoms (by asking about auditory hallucinations, visual hallucinations, delusions, thought insertion/broadcasting, and ideas of reference or by using the Prime Screen-Revised or the Primary Care Checklist).
- The presence of "red flags" (eg, thoughts of suicide or homicide, delusions that involve potential harm to another person, and psychotic symptoms that interfere with one's ability to manage their own health) suggests that involuntarily hospitalization may be necessary.
- Support of family members and the assistance of mental health professionals can be invaluable to facilitate adherence with medical/psychiatric treatment and to reduce the risk of premature death from suicide and comorbid medical conditions.

performance, and shortened sleep, or a young adult may be seen for worsening depression with an increase in self-injurious behaviors and thoughts of suicide, with reports of spending most of each day alone in their room. Therefore, it is useful to inquire about how much time such individuals spend alone and about their activities (eg, devoting time to a newfound interest in worshipping Satan or showering excessively), as this may offer further evidence that something is amiss. Moreover, roughly one-fourth of patients who present to primary care clinics seeking help for emotional problems report psychotic symptoms.[6]

Psychotic symptoms can be divided into positive and negative classifications. Common positive psychotic symptoms seen in primary care settings include auditory hallucinations, visual hallucinations, and paranoid beliefs (such as the thought that others are following or spying on them or are trying to poison or plot against them).[7] Signs of experiencing active perceptual disturbance (eg, responding to internal stimuli) may be subtle. Sometimes, speech latency (eg, odd delays in speech or abnormal pauses before an individual responds to questions) is the only indication that someone is hearing voices. Visual hallucinations may be less subtle to detect, as patients may appear obviously distracted or discuss their odd perceptions. In addition, a paranoid patient's psychosis may manifest in their refusing to take medications due to a belief that others may have tampered with their medications. In fact, a paranoid patient may report that they are taking a medication even though serum drug levels reveal poor medication adherence.

Negative symptoms can be remembered as the 5 "A's": alogia, avolition, asociality, anhedonia, and affective blunting. These core symptoms contribute heavily to the social and occupational impairment in patients with schizophrenia. PCPs should be aware that these symptoms (such as avolition) directly impact the patient's ability to engage in self-care, including maintaining employment and complying with medical treatments. Severity of negative symptoms can vary. Treatment of negative symptoms remains a challenge, as they are often nonresponsive to antipsychotic therapies. Psychosocial treatments, discussed later in this article, may offer some benefit in areas of social skills and cognitive functioning.

How Common Are Psychotic Illnesses in Primary Care Settings?

The lifetime prevalence of primary psychotic disorders in the general population is estimated to be about 3%.[8] Estimates of the point prevalence have ranged from less than 1.98 per 1,000 (10th percentile) to more than 6.8 per 1,000 (90th percentile).[9] While the prevalence of patients with psychosis in primary care varies from 1 practice to another, higher rates are typically found in urban settings compared to suburban or rural settings.[1] For instance, in a large, urban primary care population in the United States, roughly 20% of patients reported experiencing at least 1 psychotic symptom, the most common of which were auditory hallucinations (61%), the belief that others were following or spying on them (51%), visual hallucinations (49.5%), the belief that others were trying to poison or plotting against them (32.9%), and hearing others' thoughts (32.9%), inserting thoughts into the minds of others (31.9%), or broadcasting thoughts (31%).[7] The specific rates of primary psychotic illnesses in primary care settings are unknown, as many individuals endorse psychotic symptoms without having received a formal diagnosis of a psychotic illness. Further complicating the issue of diagnostic nomenclature is that several psychiatric illnesses show transient psychotic symptoms but do not represent a primary psychotic illness. For instance, psychotic symptoms can be a feature of depressive disorders, bipolar disorders, substance use disorders, posttraumatic stress disorder, and personality disorders (eg, borderline personality disorder). Psychosis can also be a manifestation of a general medical condition (eg dementia, delirium, endocrine disorders, infections) and medication side effects (eg, steroid-induced psychosis).

Patients with a psychotic illness are more likely to reach out to their PCP compared to those without a psychotic illness.[10] In a sample of individuals between the ages of 14 and 35 years, nearly two-thirds of them

(59%) sought help from their PCP in the 6 months before their initial diagnosis of psychosis.[11] Of those cases, 59% received their diagnosis of psychosis in primary care settings. The same study revealed that in a 10-year period, roughly half of family physicians encountered a patient with their first episode of psychosis within the 6 months prior to making the diagnosis of a psychotic illness.[11]

How Can Health Care Providers Screen for Psychosis?

Several screening methods can detect psychosis, but none are clearly superior in primary care settings, where a balance must be struck between brevity, sensitivity, and specificity. In addition, the accuracy of screening for psychosis in primary care settings remains unknown.[12]

Psychosis can be screened for by asking about auditory hallucinations, visual hallucinations, delusions, thought insertion/broadcasting, and ideas of reference. During interviews of patients in primary care settings, providers can ask several questions[13]:

- "Have you had any strange or odd experiences lately that you cannot explain?"
- "Do you ever hear things that other people cannot hear, such as noises or the voices of others who are whispering or talking?" (auditory hallucinations)
- "Do you ever see things that other people cannot see?" (visual hallucinations)
- "Do you ever feel that people are bothering you or are trying to harm you?" (paranoid delusions)
- "Do you think that you can control the thoughts of others?" (thought insertion/broadcasting)
- "Do you feel that people on TV or the radio are speaking directly to you or that there is some special meaning intended for you?" (ideas of reference)

Patients can also complete the 12-item Prime Screen-Revised (PS-R); despite it being relatively short, it is sensitive (100%), specific (>70%), and easily scored.[14] The items are rated on a Likert scale from 0 to 6; a positive screen occurs when 1 or more items are scored "6" (definitely agree) or if 2 or more items are scored "5" (somewhat agree). The PS-R assesses positive symptoms of psychosis, including unusual thought content, suspiciousness, grandiosity, and hallucinations.[14]

Other screening tools include the Primary Care Checklist, which is easy for patients to complete as items are presented as a checklist (yes/no); the Prodromal Questionnaire-Brief, which has been validated in several countries/languages for the detection of psychosis-spectrum disorders, although there is no definitive consensus on its optimal cutoff scores; and the Youth Psychosis At Risk Questionnaire, which is a rapid 2-item screen with good specificity (96%) but less sensitivity (67%) for active psychosis.[6,15–17]

How Does Untreated Psychosis Affect Medical Outcomes?

The presence of psychosis can indicate a broad range of psychiatric diagnoses (eg, major depressive disorder, bipolar disorder, substance use disorder). Research in bipolar disorder—where psychosis can arise during manic or depressive episodes, is a marker of severity, and is a prognostic indicator—has demonstrated that when left untreated, subsequent episodes occur more easily and frequently and become more severe over time with a kindling effect that is also seen with seizures. Well-validated mechanisms for this include stress sensitization (with an increasing sensitivity to psychosocial stressors) and episode sensitization (with increased vulnerability to recurrence with shorter nonpsychotic intervals as a function of the number of prior episodes).[18]

Patients with severe mental illness (SMI), which refers to psychiatric disorders marked by psychosis, have a significantly decreased life expectancy (from 13 to more than 30 years) compared to those in the general population in the United States.[19] Schizophrenia has a 2.5–3-fold increase in mortality rates and a 10–20 times higher rate of death from unnatural causes than in the general population.[20] Despite estimates of a 13-fold higher rate of suicide and a 10% lifetime risk of suicide in people with schizophrenia compared to those in the general population, the largest cause of death in schizophrenia is due to natural causes, especially cardiovascular disease (CVD), which constitutes 40%–50% of natural-cause mortality in most studies.[20–22] Schizophrenia is associated, directly and indirectly, with a higher rate of risk factors that lead to CVD (such as hypertension, cigarette smoking, dysregulation of glucose and lipids, obesity, and physical inactivity), leading to a 6-fold risk of cardiovascular mortality.[23,24] Traditional methods of primary prevention for CVD are extremely important, as the risk is significantly lower earlier in the course of psychotic disorders; this is in part due to metabolic changes, including glucose dysregulation, being relatively uncommon at earlier illness stages.[25]

Smoking is a particularly potent predictor and the strongest modifiable CVD risk factor of early death in schizophrenia, conferring nearly a 5-fold risk of mortality and a 12-fold risk of cardiac death in smokers relative to nonsmokers.[26,27] The rate of smoking in individuals with schizophrenia is 2- to 4-fold higher than that found in the general population rate, with several studies indicating that 80%–90% of inpatients with schizophrenia smoked cigarettes and were more likely to be heavy smokers.[24,28–30] The high rate of smoking is thought to be a form of self-medication due to possible

positive cognitive effects of nicotine, which normalize impairments from schizophrenia and/or address psychotic symptoms.[28,30,31] Taken together, interventions that facilitate smoking cessation, promote harm reduction, and replace self-medication with the use of antipsychotics are paramount in this population.

While CVD causes of death were 6 times higher than in the general population, other major causes of elevated natural death rates in patients with SMI are generally chronic health conditions, which have an increased risk or prevalence in SMI patients compared to those in the general population.[32] These chronic conditions include respiratory diseases (eg, chronic obstructive pulmonary disease, pneumonia, influenza, tuberculosis) with a 5-fold increase; human immunodeficiency virus (HIV) infection with a 10-fold increase; hepatitis B and C infection with a 2-fold and 3-fold increase, respectively; type 2 diabetes with a 2- to 5-fold increase; and cerebrovascular disease (stroke) with a 2-fold increase.[26,32–38] Patients with schizophrenia also have a 50% increased risk of death from cancer compared to age- and gender-matched counterparts, and causal genetic links have been found specifically with lung, thyroid, colorectal, ovarian, and breast cancers.[39–41]

People with psychosis are also at greater risk of death from non-natural causes (eg, suicide, homicide, and accidents), with possible contributions from patient-centered factors (eg, risky behavioral patterns, self-neglect, and decreased treatment adherence).[37,42] Cigarette smoking and other forms of substance use that are found in higher rates in patients with psychosis undoubtedly affect medical outcomes via cardiovascular, neoplastic, and infectious pathways. However, other factors, such as patients with psychosis having fewer resources and reduced access to health care due to the disability caused by psychosis, must be considered.

System-related factors may also explain health disparities (eg, extensive under-detection, under-diagnosis, and/or under-treatment) in patients with psychosis despite having more contacts with the health care system.[37] Patients with schizophrenia who died from ischemic heart disease or cancer were significantly less likely to be diagnosed early in the illness course.[37] Myocardial infarctions are less likely to be recognized and more likely to be fatal in individuals with psychosis; this may be due to patients with schizophrenia being nearly 50% less likely to receive interventions (eg, percutaneous coronary interventions or coronary artery bypass grafting).[43–45] This disparity does not seem to be isolated to diagnoses or acute interventions, but it can be in primary prevention or symptomatic treatment approaches. Patients with psychosis and comorbid hyperlipidemia had an approximately 75% reduction in the odds of being prescribed statins, and those with comorbid arthritis had a 41% reduction in the odds of being prescribed a nonsteroidal anti-inflammatory drug.[46]

How Can Effective Medical and Psychiatric Treatment Be Encouraged in the Context of a Psychotic Illness?

Given that medical comorbidities are major contributors to early mortality in people with psychosis, PCPs serve a central role in managing chronic medical illnesses, encouraging lifestyle modifications, and providing primary prevention. PCPs are integral in clarifying with the patient and their family their goals, aspirations (in academic, occupational, and social domains), and how treatment fits into the picture. PCPs can help to establish a realistic plan to pursue and support progress towards these goals; this can include identifying and connecting community and social service resources, such as helping patients qualify for social security income. Conceptualizing these goals as one of many treatment targets can help frame or inform clinical decision-making, medical comorbidity management, and preventative care in the context of SMI. For instance, in women with SMI, this could look like choosing long-acting contraceptive methods.

PCPs also play a key role in helping to mitigate the risks of antipsychotic nonadherence and subsequent downstream consequences in this vulnerable population. Antipsychotic medications shorten the duration of the initial psychotic episode, allow patients to recover sooner, reduce long-term morbidity, and decrease relapses and the number of rehospitalizations.[47] Antipsychotic medications are by and large effective, with only 5%–10% of patients being categorized as not gaining any benefit.[48] Furthermore, despite the risk of metabolic side effects, antipsychotics have consistently failed to show an increase in cardiovascular causes of morbidity and mortality in patients with schizophrenia; in fact, antipsychotics have been associated with a reduced all-cause mortality, and a lack of antipsychotic treatment was associated with elevated mortality rates in those with schizophrenia.[20,37]

Nonadherence to antipsychotics is a substantial problem; approximately 40% of patients stop using antipsychotics within the first year and 75% stop them within 2 years.[49] Nonadherence is a driver for relapse, with studies showing that roughly three-fourths (77%) of patients who discontinued their antipsychotic medications after their first episode of psychosis relapsed within 12 months of being off their medication compared to 3% who continued to take medication; 95% of patients who discontinued their medications relapsed within 24 months.[50] Unfortunately, the advent of more tolerable, second-generation antipsychotics has not improved adherence.[51] A primary determinant of nonadherence is thought to be the patient's assessment of

the medications' perceived treatment benefits and illness risks versus the "costs" of treatment, including side effects.[49] Other risk factors of medication nonadherence include a history of medication nonadherence, recent substance use, difficulty recognizing their own symptoms, a weak alliance with health care providers, and an unengaged family.[52]

PCPs are crucial in providing consistent psychoeducation about psychotic illnesses to facilitate acceptance of the diagnosis and its treatments. They can bolster support systems, including forging alliances with health care providers and involving family or significant others in treatment planning.[53] PCPs should also be aware of nonpharmacologic therapies available to patients with psychosis, including the gold standard psychotherapy for psychosis, cognitive-behavioral therapy for psychosis (CBTp), as well as social skills training, which emphasizes independent living skills in patients with more severe symptoms.[24]

Timely, consistent pharmacotherapy with adjunctive psychotherapy is an effective treatment approach for psychosis, and it is a prognostic indicator. If a patient in the primary care setting expresses a desire to stop their use of antipsychotics, it is important to understand why the patient wishes to discontinue them. Given the importance of medication adherence and medication maintenance, time should be allotted for this discussion. Statements to initiate the conversation can include the following:

- "I hear you that you don't want to take the medications; it must be hard to take the medication every day." (demonstrating reflection, that their desire was heard, empathy/compassion, and inquiring about adherence)
- "Could you help me understand why you'd like to stop taking the medications?" (requesting assistance to understand their perspective, demonstrating curiosity, exhibiting collaboration)
- "Do you feel like taking the medication says something about you?" (exploring changes in self-identity, gauging acceptance of diagnosis, thinking about stigma)

A common reason for a patient's wanting to discontinue their antipsychotic medication is having untoward side effects. While side effect management is typically best handled in a collaborative manner, PCPs can play a key role in eliciting these symptoms, mitigating their impact, and relaying concerns to mental health providers. Sedation, a common side effect, vastly improves by moving daytime doses to the evening. Patients on an antipsychotic who report anxiety should be screened for akathisia (an extrapyramidal symptom; an inner sense of restlessness and a desire to move). Weight gain is another common side effect; it can be mitigated by making lifestyle modifications, such as changing one's diet and exercising. However, if lifestyle modifications are insufficient, antipsychotics that are known to be more weight neutral (such as aripiprazole, lurasidone, or ziprasidone) can be substituted. Emotional blunting is also a side effect that becomes a cause for discontinuation and is worsened by some antipsychotics. Different antipsychotics have different impacts on negative symptoms, and it may be important to obtain collaborative practice psychiatric input.

Another common reason for nonadherence is that psychosis, with its resultant thought-disordering symptoms, can get in the way of the ability to take a medication consistently. In these cases, long-acting injectables (LAIs) can be considered. LAIs can be administered on a monthly to half-year basis depending on the antipsychotic and formulation, significantly reducing the possibility of nonadherence. The decision to transition to and selection of an LAI would be a specific point of discussion with the collaborative. These injections can be ordered to pharmacies or even administered in primary care settings, potentially decreasing stigma when administered with other regularly scheduled health care maintenance.

If a patient continues to express a desire to stop taking their antipsychotic, psychiatric consultation is appropriate. PCPs can help frame the potential risks of stopping an antipsychotic as follows:

> "I hear that you want to stop the medications, and I want to respect your ability to make decisions for yourself. We know these medications help protect your brain by preventing psychotic episodes. If you and your psychiatrist decrease the medications, if you start to feel a worsening of symptoms, I hope you could be honest with yourself and me. If your symptoms re-emerge or worsen, we may need to return to the previous dose. Does that make sense?"

What Might an Approach to a Patient With Delusions or Paranoia Involve?

Delusions (fixed, false beliefs that can be bizarre [and immediately identifiable as impossible or highly improbable] or nonbizarre [plausible beliefs]) can be highly disruptive. Paranoia, feelings of distrust and suspicion, is usually tied to a type of delusion—a persecutory delusion—that explains beliefs of being punished, pursued, conspired against, surveilled, or followed. Whether a belief is delusional is highly dependent on one's reality testing and corroboration; a belief can evolve from being plausible to impossible. For example, a new patient may spend most of his appointment time talking to his PCP about how he believes his wife is cheating on him, which, at face value, appears like a plausible belief. Later, the PCP learns from

family members that the patient has never been married, which now makes this belief a plausible delusion. When the PCP subsequently asks about his wife, the patient responds that nobody knows he's married because his wife is an alien who communicates with him telepathically from another planet; this now becomes a bizarre delusion.

Collateral information from family members is critical to obtaining an accurate clinical presentation for individuals with psychosis, who due to the nature of their illness can be unreliable historians. Family members can be instrumental in helping to identify delusional thought patterns in their loved ones. Family members and partners are also essential in obtaining key pieces of personal and family history that can affect diagnosis and treatment.

When collateral information is unavailable and delusions and/or paranoia are suspected, careful history taking is critical to determine the extent of a patient's symptoms. Many higher-functioning people with psychosis, who can be found in outpatient primary care settings, have some preserved self-awareness or insight and may understand that their beliefs or behaviors are abnormal. As a result, they may seek to hide these symptoms from practitioners by providing vague responses or by refusing to respond. When patients respond in this way, further questioning is crucial. Ways to probe for suspected delusions or paranoia include the following:

- "Can you help me understand how you came to believe that?"
- "Sometimes people feel suspicious and mistrustful of others. Have you ever felt that way, and you can't seem to shake the feeling?"

It is important to identify discrepancies in the patient's story. Many people with covert delusions and/or paranoia rationalize the discrepancies or assimilate explanations into a narrative to make it make sense; however, patients tend to have a much harder time doing this repeatedly in a global context and across time. As a result, attempting to reconcile discrepancies, potentially across clinic visits, can be essential to identify delusions or paranoia that patients could be attempting to hide.

Although it is helpful to educate patients about psychotic experiences (thereby destigmatizing psychosis), it is not useful to challenge a patient's delusions, as this can impede the therapeutic alliance. Instead, it is more effective to validate the reality of an individual's emotional experience. If, for instance, a patient describes being chased by the Federal Bureau of Investigation because they could access technologies that could read minds, one could validate the patient's fear and build upon the therapeutic relationship. This approach may also open the door to a patient being willing to start antipsychotic medication if it were framed as a means of reducing the patient's distress about the delusion, rather than "fixing" their thinking.

Who Can You Turn to for Help When Treating a Patient With Psychosis?

Typically, the first step in managing a patient with psychosis is to refer them to a psychiatrist. Subspecialty clinics that focus on the treatment of psychosis exist in many parts of the country and are often affiliated with academic institutions. These programs frequently focus on the care of children, teenagers, transitional age youth, and young adults after their first psychotic break, and they often provide access to wrap-around programs.

Although the gold standard for the management of psychosis involves direct psychiatric care, psychiatrists are in short supply nationwide; almost all (96%) counties in the United States have some level of psychiatric prescriber shortage, and three-fourths of counties have a severe shortage.[54] Instead, integrated behavioral health models, such as the collaborative care model (CCM), can provide access to mental health care, especially in areas where psychiatric services are limited or overwhelmed.[55] Collaborative care, often involving a patient registry and care management services, can improve access and treatment for those with mental health conditions, increasing the use of both primary and specialty mental health care as well as increasing medication adherence, especially of antipsychotics.[56,57] In this model, the PCP maintains the role of prescriber with guidance from the psychiatric consultant on pharmacologic changes. The psychiatric consultant is available for virtual or in-person consultation, with or without the patient. This collaboration allows for improved communication between providers and improves preventative care for the vulnerable patient. For example, the psychiatric consultant can guide the PCP in mitigating antipsychotic-associated metabolic dysfunction or facilitate discussions regarding contraceptive options for patients who are able to become pregnant.

Psychologists, licensed therapists, and other nonprescribing mental health professionals also serve as a source of information and collaboration. Moreover, they are much more accessible in many parts of the United States.[54] Typically, they tend to see patients more frequently than psychiatrists. Further, those who specialize in CBTp can provide targeted recommendations to PCPs on how to manage interpersonal challenges.

Family involvement is also critical in management and outcomes. Family involvement has cut hospitalizations by nearly half in comparison to standard care; moreover, meta-analyses have shown that relapse rates can be reduced by 58% and that functionality has

been improved up to 24 months when family members are involved in the treatment of first-episode psychosis.[58,59] As such, family members should be conceptualized as partners in patient care; they can be invited to attend appointments (medical and psychiatric) after obtaining permission from the patient for collateral information and updates.

When Should You Call for a Psychiatric Consultation?

Since psychotic symptoms can adversely impact medical care, there should be a low threshold for seeking psychiatric consultation. However, certain red flags should prompt an expedited referral and/or consultation, and these include thoughts of suicide or homicide, delusions that involve potential harm to another person, and psychotic symptoms that interfere with one's ability to manage their own health. Less urgent cases include chronic delusions, for example delusions of parasitosis. While these cases warrant discussion with a mental health provider, the lack of threats to others or oneself means these cases can often be managed through the normal referral process. Integrated behavioral health approaches, such as the CCM, offer more accessible and rapid psychiatric consultations. When in-person evaluations are not available, psychiatrists in CCMs can guide PCPs regarding interview strategies and safety planning as a bridge until the patient is formally evaluated by psychiatry.

Individuals with psychosis are often reluctant to see mental health providers, either due to their experiences with the mental health system or to paranoia about providers and their intentions. Building trust in psychiatry is crucial to helping patients remain engaged in care and adherent to treatment. Unfortunately, only half of patients who are referred to psychiatry are seen by the psychiatric consultant, and this number is likely lower for those with active psychosis.[60] PCPs can establish the framework for successful referral and evaluation through thoughtful explanation of how psychiatry can be helpful. In those who have limited insight into their symptoms, one can focus instead on the distress they are experiencing, stating, for example, "It seems like these thoughts about your neighbor are preventing you from sleeping at night and causing you stress during the day. Would you be open to seeing my colleague in psychiatry who can help you manage this distress?" Patients with more insight into their pathology can have more targeted conversations about their symptoms, but a cautious approach is warranted when the level of insight is uncertain.

When Can a Health Care Provider Mandate Psychiatric Hospital Admission or Psychiatric Treatment for Psychosis?

Civil commitment is the legal process of involuntarily hospitalizing a person for mental health treatment. The 1950s and 1960s brought a shift from institutionalization to deinstitutionalization. This was driven in part by the advent of new treatments (antipsychotics) and was the result of a desire for more human psychiatric care.[61] This movement resulted in the development of 3 core civil commitment criteria that are still used today and that focus on the notion of "dangerousness." To be involuntarily hospitalized, a person must have a mental illness and be a danger to themselves, a danger to others, or be gravely disabled due to their mental illness (defined as being unable to provide the necessities for basic survival). Imminent harm is also a consideration, for example, comparing a patient with chronic passive suicidal ideation versus active suicidal intent with a plan. Civil commitment laws vary among states; however, most states adhere to these criteria.

Active thoughts of suicide or homicide are clear examples of meeting criteria for involuntary commitment. Patients with psychosis may deny these symptoms but instead describe having command auditory hallucinations that involve hurting oneself or someone else. These thoughts are particularly worrisome symptoms and should prompt an urgent evaluation. Evaluating for grave disability can be more complex. A straightforward example would be that of a patient who is refusing to eat due to delusional thoughts about his food being poisoned, to the point that they have electrolyte abnormalities and are on the brink of a critical illness. More nuanced cases may involve the need for "detective work" to determine if a patient has shelter and access to food—or if their psychosis is severe enough that even if these resources were provided to them, they would be unable to use them to stay safe and healthy. PCPs should not feel obligated to do these evaluations in isolation; instead, they should reach out to a mental health specialist for assistance.

Not every medical provider can civilly commit a patient to a psychiatric hospital. This authority is managed at multiple (eg, state, county, and institution) levels.[61] Examples of professionals who can seek civil commitment of patients are psychiatrists, emergency physicians, psychologists, social workers, registered nurses, and peace officers. PCPs should seek information about the process of civil commitment in their county and state. Many clinics have safety plans (with a workflow that may include immediate social work evaluation, psychiatric consultation, and/or calling local police to assist in the civil commitment process) for managing patients who may need psychiatric hospitalization.

When Must You Involve Adult Protective Services or a Similar Agency if a Patient's Health Is Being Neglected Because of Their Psychotic Illness?

Inadequately treated psychosis can have a devastating impact on patients. As described in the section of civil commitment, determining whether a patient is unable to manage their basic necessities can be difficult. In

patients who refuse psychiatric evaluation and treatment, providers may struggle to answer the question of whether the patient has the capacity to refuse treatment due to the negative impact on the patient's physical health. As with any capacity evaluation, providers should consider the risks that untreated psychosis is imposing on the person's medical status and balance this with the ethical principle of autonomy. Providers should also consider the level of imminent danger to the patient. For example, should a PCP call adult protective services about a patient just seen in their practice who intermittently misses their metformin doses and has a glycated hemoglobin of 8.0%? What about a patient seen virtually with a glycated hemoglobin of 16% who said they were feeling feverish yet did not want to go to the emergency department? One could argue that the first patient is on the road to becoming the second patient, but should providers intervene immediately or wait until care becomes urgent?

Discomfort and uncertainty are normal feelings for PCPs in these situations, especially when harm might not be imminent but when a patient is putting themselves at risk with impaired decision-making. The balance of autonomy with the principles of beneficence and nonmaleficence can be tenuous and leave PCPs feeling powerless; to support PCPs, consultation should be sought early and often. This includes assistance from agencies (like adult protective services) that offer consultation to help providers determine the reportability of a patient's neglecting their own health. While reports may not be accepted for cases deemed to be lower risk, demonstrating a pattern of concern about a patient can increase resource allocation and encourage proactive care planning.

What Happened to Mr A?

Review of Mr A's chart by the consulting psychiatrist revealed a multidecade history of psychotic symptoms, with comments regarding his paranoia and delusional thoughts documented in multidisciplinary notes. The psychiatrist recommended connecting the patient with a mental health care provider and consideration of antipsychotic medication. When this was discussed with Mr A, he became guarded and quiet, and he refused to engage with psychiatry and terminated the visit early. The psychiatrist recommended that Mr A be seen in the clinic, at least at monthly intervals, to build rapport and keep a close watch on his chronic medical conditions. While the trust between the provider and Mr A increased with this tactic, Mr A continued to refuse psychiatric treatment but attended his clinic visits and specialty appointments.

CONCLUSION

Symptoms of psychosis, while often nonspecific (eg, substance misuse, social isolation or withdrawal, poor personal hygiene, poor grooming, blunted or odd affect, strange beliefs or magical thinking, and sleep disturbances), may involve complaints of physical ailments and lead to primary care visits.[62] Nonetheless, these symptoms may be the harbingers of serious mental illness, which is associated with poor medication adherence, a lower quality of life, and a shortened life span.[63] Therefore, it is essential for PCPs to screen for psychotic symptoms (by asking about auditory hallucinations, visual hallucinations, delusions, thought insertion/broadcasting, and ideas of reference or with the PS-R or the Primary Care Checklist), create a broad differential diagnosis, evaluate medical etiologies, and embark upon effective treatments that can be sustained, often with the support of family members and other mental health professionals.[64] Since psychotic symptoms frequently adversely impact medical care, there should be a low threshold for seeking psychiatric consultation, especially when red flags (eg, thoughts of suicide or homicide, delusions that involve potential harm to another person, and psychotic symptoms that interfere with one's ability to manage their own health) suggest that involuntarily hospitalization may be necessary.[65] Fortunately, effective treatment is available for those with SMI from PCPs and a variety of health care professionals.[66]

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