REVIEW

Nursing management of psychiatric emergency or urgency: acute amphetamine-induced psychosis. A review of the literature

Gestione infermieristica dell'emergenza-urgenza psichiatrica: la psicosi acuta indotta da anfetamine. Una revisione della letteratura

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Abstract: This study examines the management of acute amphetamine-induced psychosis in psychiatric emergency settings, focusing on the role of nurses. A systematic literature review was conducted, analysing thirteen qualitative and quantitative studies published within the last five years, as well as academic handbooks and regional guidelines. The results highlight variability in care approaches and operational difficulties in managing agitation and mechanical restraint. Nurses play a pivotal role in the early identification of symptoms and de-escalation interventions, yet they encounter significant challenges pertaining to training and working conditions. The study emphasises the need for standardised protocols and targeted training to improve clinical management and the well-being of healthcare personnel.

Riassunto - Questo studio esamina la gestione della psicosi acuta indotta da anfetamine nei contesti di emergenza psichiatrica, con particolare attenzione al ruolo infermieristico. È stata condotta una revisione sistematica della letteratura, analizzando 13 studi qualitativi e quantitativi pubblicati negli ultimi 5 anni, oltre a manuali accademici e linee guida regionali. I risultati evidenziano la variabilità degli approcci assistenziali, le difficoltà operative nella gestione dell'agitazione e il ricorso alla contenzione meccanica. Gli infermieri svolgono un ruolo chiave nel riconoscimento precoce e negli interventi di de-escalation, ma affrontano criticità legate alla formazione e alle condizioni lavorative. Lo studio sottolinea la necessità di protocolli standardizzati e percorsi formativi mirati per migliorare la gestione clinica e il benessere del personale sanitario.

Key words: Acute induced psychosis, substance abuse, nursing management, aggression management, work environment.

Key messages:

- Effectiveness in caring for patients with acute amphetamine-induced psychosis depends on timely clinical assessments and coordinated therapeutic approaches.
- The quality of care depends on the training of nursing staff and appropriate organisational conditions.

Introduction

Amphetamine-induced psychosis is a psychiatric condition characterised by psychotic symptoms such as paranoid delusions and visual and auditory hallucinations that occur during or immediately after amphetamine use. These symptoms differ from those of primary psychotic disorders, which may precede the onset of substance use or occur during periods of prolonged abstinence. Once initiated, the psychotic symptoms continue for as long as the substance is used. Amphetamine use is widespread globally, with rates of up to 1.3% of the adult population in some areas. Among chronic methamphetamine users (an

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amphetamine derivative), 26%–46% develop psychotic symptoms during their lifetime. Psychosis is more prevalent among regular users and individuals who take high doses. Risk factors include an early age of onset and prolonged abuse. Amphetamine psychosis is mainly associated with drug-induced dopaminergic and glutamatergic dysfunction. Amphetamines stimulate the release of dopamine and inhibit its reabsorption, leading to excessive activity in brain circuits involved in perception and thinking. The duration of use and the amount of the drug taken are strongly correlated with the risk and severity of psychosis. In addition, genetic factors, such as predispositions linked to dopaminergic genes, may contribute to individual vulnerability. Managing acute amphetamine-induced psychosis in psychiatric emergency settings is a complex clinical area requiring specific relational and technical skills (15). The analysed studies highlight significant critical issues in the assessment and treatment of patients, with particular emphasis on the crucial role of nurses. Existing literature emphasises the ethical and operational challenges associated with managing agitation risks, using restraints, and implementing de-escalation interventions (7).

Materials and Methods

The study aims to analyse recent nursing methods in emergency contexts, which are integral to the management of acute aggression. A literature review was conducted based on the following research question: 'What specific assessments, interventions and techniques should nurses apply when managing psychiatric emergencies related to acute amphetamine-induced psychosis?' The

Tab. 1 - PICO method formulated from the primary research question.

Population	Intervention	Comparison	Outcomes
Patients with acute amphetamine-induced psychosis in emergency-emergency settings	Specific nursing assessments and techniques	//	Management and stabilisation

Tab. 2 - Overview of the search strategy adopted.

Database	Mesh terms	n articles	selected articles	Articles
MEDLINE [via PubMed].	(amphetamine psychosis) AND (pathophysiology)	15	1	Cohen-Laroque J, et al. *Positive and negative symptoms in methamphetamine-induced psychosis compared to schizophrenia: A systematic review and meta-analysis*. 2024, *Schizophr Res*.
	(amphetamine psychosis)	170	1	Dimy Fluyau, Paroma Mitra and Kervens Lorthe *Antipsychotics for Amphetamine Psychosis. A Systematic Review*. 2019, Frontiers in Psychiatry
	(induced psychosis) AND (differential diagnosis)	28	2	Fiorentini A, Cantù F, Crisanti C, Cereda G, Oldani L, Brambilla P. *Substance-Induced Psychoses: An Updated Literature Review*. 2021, Frontiers in Psychiatry.
				Cambra Almerge J, Sánchez-Romero S, Arias Horcajadas F. *Differences between substance-induced psychotic disorders and non-substance-induced psychotic disorders and diagnostic stability*. 2023, Adicciones.
	(((emotional impact) AND (mental health of nurses)) AND (psychiatric care)) AND (psychiatric nurse)	26	1	Bekelepi N, Martin P. *Support interventions for nurses working in acute psychiatric units: A systematic review*. 2022, Health SA Gesondheid.
	(psychiatric units) AND (resource limitations)	55	1	Johnson S, Dalton-Locke C, Baker J, Hanlon C, Salisbury TT, Fossey M, Newbigging K, Carr SE, Hensel J, Carrà G, Hepp U, Caneo C, Needle JJ, Lloyd-Evans B. *Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care*. 2022, World Psychiatry.
	((De-escalation Techniques) AND (Aggression Management)) AND (Psychiatric)	16	3	Celofiga A, et al. *Effectiveness of De-Escalation in Reducing Aggression and Coercion in Acute Psychiatric Units. A Cluster Randomized Study*. 2022, *Front Psychiatry*.
				Fernández-Costa D, et al. *Alternatives to the Use of Mechanical Restraints in the Management of Agitation or Aggressions of Psychiatric Patients: A Scoping Review*. 2020, *J Clin Med*.
				Price O, et al. *De-escalating aggression in acute inpatient mental health settings: a behaviour changes theory-informed, secondary qualitative analysis of staff and patient perspectives*. 2024, *BMC Psychiatry*.
	((triage) AND (emergency psychiatric services)) AND (nursing)	3	2	Rajab Dizavandi F, Froutan R, Moonaghi HK, Ebadi A, Fayyazi Bordbar MR. *Mental Health Triage from the Viewpoint of Psychiatric Emergency Department Nurses; a Qualitative Study*. 2023, Archives of Academic Emergency Medicine.
				Stigter-Outshoven C, Van de Glind G, Wieberdink LJ, van Zelm R. *Competencies Emergency and Mental Health Nurses Need in Triage in Acute Mental Health Care: A Narrative Review*. 2024, *Journal of Emergency Nursing*.
CINAHIL [via Ebsco].	verbal de-escalation AND psychiatric emergency	65	1	Hodzic V, Johnson SE. *Crisis Management in Psychiatry*. 2023, Advances in Psychiatry and Behavioral Health.
	psychiatric nursing AND emergency	34	1	Corbetta M, Corso B, Camuccio CA. *Rules and ward climate in acute psychiatric setting: Comparison of staff and patient perceptions*. 2022, *International Journal of Mental Health Nursing*.

Medline and Cinahl databases were consulted, as well as the following manuals:

- Lara Weiss Roberts (2019) Textbook of Psychiatry, Seventh Edition, American Psychiatric Association Publishing
- Tony Thrasher (2023) Emergency Psychiatry, Oxford University Press.
- M.D. Boland, Robert Joseph (2021), Synopsis of Psychiatry, 12th edition, Kaplan & Sadock's
- *Regione Lazio & Salute Lazio (2022) - Manuale regionale triage intra-ospedaliero modello Lazio a cinque codici (Regional intra-hospital triage manual Lazio five-code model).*

The PICO method was applied to define the literature search ***(Tab.1).***

Boolean operators were used to define the literature search, which included the following MeSH terms: *amphetamine, psychosis, induced psychosis, differential diagnosis, mental health of nurses, psychiatric nursing and de-escalation techniques*. All relevant full-text articles published within the last 5 years, including both experimental and non-experimental studies, were included in the search. The articles had to focus on the nursing management of acute amphetamine-induced psychosis in patients of either sex, aged between 18 and 65 years. Studies dealing with primary psychosis or the clinical histories of specific psychiatric disorders, such as bipolar disorder and schizophrenia, were excluded from the search. Furthermore, studies focusing on drugs not previously mentioned or not directly related to the treatment of induced psychosis were excluded.

Results

The results of the selected articles are shown in ***Table 2***. The search strategy resulted in 412 articles being found, but only 13 of these met the search objective. Analysis of the selected articles (see ***Table 3***) revealed different techniques for assessing and managing patients with acute-phase-induced psychotic episodes, as well as the critical issues involved.

Regarding the three previously introduced psychiatric manuals in the

Tab. 3 - Articles selected for critical literature analysis.

Article	Study design	Sample	Methodology	Results
Cohen-Laroque J, et al. *Positive and negative symptoms in methamphetamine-induced psychosis compared to schizophrenia: A systematic review and meta-analysis.* 2024, *Schizophr Res.*	Systematic review and meta-analysis	Clinical studies comparing methamphetamine-induced psychosis and schizophrenia. n74	Comparative analysis of positive and negative symptoms in both conditions	Methamphetamine-induced psychosis has positive symptoms comparable to schizophrenia, but less pronounced negative symptoms and a greater tendency to recover after abstinence. It is useful to help the nurse understand how best to differentiate them and decide how to act.
Dimy Fluyau, Paroma Mitra and Kervens Lorthe *Antipsychotics for AmphetaminePsychosis. A Systematic Review.* 2019, Frontiers in Psychiatry	Systematic review	Clinical trials of 314 participants on antipsychotic drugs for the treatment of amphetamine psychosis	Comparative analysis of the pharmacological effects of different antipsychotics on positive and negative symptoms of the psychotic episode	The use of the different antipsychotics had the effect of reducing and controlling the psychotic episode without establishing a clinical superiority of one drug over the other
Fiorentini A, Cantù F, Crisanti C, et al. *Substance-Induced Psychoses: An Updated Literature Review.* 2021, *Frontiers in Psychiatry.*	Updated Literature Review	54 studies	Examines various types of substance-induced psychosis	Overview of neurobiological mechanisms and treatment options for substance-induced psychosis.
Cambra Almerge J, Sánchez-Romero S, Arias Horcajadas F. *Differences between substance-induced psychotic disorders and non-substance-induced psychotic disorders and diagnostic stability.* 2023, *ADICCIONES.*	Comparative observational study	Patients with substance-induced psychosis and non-substance-induced psychosis. n 48	Evaluation of diagnostic stability and distinguishing factors	Substance-induced psychoses tend to be less stable diagnostically and respond more rapidly to treatment than primary psychoses.

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Article	Study design	Sample	Methodology	Results
Bekelepi N, Martin P. *Support interventions for nurses working in acute psychiatric units: A systematic review.* 2022, *Health SA Gesondheid.*	Systematic review	122	Analysis of support programmes for psychiatric nurses	Support programmes, such as continuing education and psychological support, improve crisis management and the well-being of nurses in acute psychiatric units.
Johnson S, Dalton-Locke C, Baker J, et al. *Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care.* 2022, *World Psychiatry.*	Literature review	88	Proposals to improve access and quality of care for acute psychiatric disorders	Identified models for expanding acute psychiatric services, emphasising accessibility, integration with other health services and a personalised approach to care.
Celofiga A, et al. *Effectiveness of De-Escalation in Reducing Aggression and Coercion in Acute Psychiatric Units. A Cluster Randomized Study.* 2022, *Front Psychiatry.*	Cluster-randomised study	Patients in acute psychiatric units. 33	De-escalation techniques to reduce aggression and coercive measures	De-escalation techniques have significantly reduced aggression and the use of coercive measures, improving the management of patients in critical situations.
Fernández-Costa D, et al. *Alternatives to the Use of Mechanical Restraints in the Management of Agitation or Aggressions of Psychiatric Patients: A Scoping Review.* 2020, *J Clin Med.*	Literature review	44 studies	Examines alternatives to mechanical restraints to manage agitation and aggression	Alternatives to mechanical restraint, such as psychological intervention and environmental modification, are effective in improving the management of psychiatric patients without the use of coercion.
Price O, et al. *De-escalating aggression in acute inpatient mental health settings: a behaviour change theory-informed, secondary qualitative analysis of staff and patient perspectives.* 2024, *BMC Psychiatry.*	Secondary qualitative analysis	Patients and staff in acute psychiatric settingsn.14	Evaluation of staff and patient experiences with de-escalation techniques	De-escalation techniques are considered effective, but require continuous training and a structured approach to improve results.
Rajab Dizavandi F, Froutan R, Moonaghi HK, et al. *Mental Health Triage from the Viewpoint of Psychiatric Emergency Department Nurses; a Qualitative Study.* 2023, *Archives of Academic Emergency Medicine.*	Qualitative studyprimary	Psychiatric emergency department nurses. n 10	Analysis of psychiatric triage practices and their perception	Nurses believe that key competencies for effective triage include risk assessment, resource management and the ability to respond to critical situations.
Stigter-Outshoven C, Van de Glind G, Wieberdink LJ, van Zelm R. *Competencies Emergency and Mental Health Nurses Need in Triage in Acute Mental Health Care: A Narrative Review.* 2024, *Journal of Emergency Nursing.*	Narrative revision	21 studies	Examines the skills required of psychiatric emergency nurses	Core competencies include risk assessment and patient management in critical situations.
Hodzic V, Johnson SE. *Crisis Management in Psychiatry.* 2023, *Advances in Psychiatry and Behavioral Health.*	Literature review	33 studies	Discussion of psychiatric crisis management methods	Proposals to improve psychiatric crisis management through systematic and structured approaches.
Corbetta M, Corso B, Camuccio CA. *Rules and ward climate in acute psychiatric setting: Comparison of staff and patient perceptions.* 2022, *International Journal of Mental Health Nursing.*	Comparative observational study	Staff and patients in an acute psychiatric ward. n 24	Analysis of the perception of the climate and rules within the department	Differences in perceptions between staff and patients regarding the rules and climate of the ward.

Manuale regionale triage intra-ospedaliero modello Lazio a cinque codici (Regional Intra-hospital Triage Manual Five-Code Lazio Model), edited by Regione Lazio & Salute Lazio (2022), some indications on the management of

	STATO DI AGITAZIONE PSICOMOTORIA - ALTERAZIONE DELLO STATO MENTALE				
CODICE TRIAGE	1	2	3	4	5
Parametri Vitali	Da codice 1	Da codice 2	Da codice 3	Da codice 4	
Caratteristiche del Sintomo/Segno Principale	Grave disturbo del comportamento con minaccia immediata di violenza pericolosa per sé stesso e per gli altri Estrema agitazione con aggressività fisica e/o verbale TSO Tentato suicidio Atti autolesivi associati a idee suicidarie manifeste Manifestazioni suicidarie Alto rischio di fuga	Estrema agitazione, irrequietezza Alterazioni del pensiero Allucinazioni, comportamento, bizzarro, non contenibile. Etilismo acuto con comportamento non controllabile ma senza aggressività Disorientamento spazio-temporale Confusione mentale ma con capacità di cooperare	Agitazione contenibile Disturbo del comportamento ma paziente controllabile Alterazioni del tono dell'umore in senso euforico/stato di agitazione o in senso depressivo senza ideazione suicidaria Etilismo cronico senza disturbi comportamentali	Irritabile senza aggressività Riferito Attacco di panico Paziente noto per crisi sociale Problemi sociali di alloggio, o di relazione Richiesta di farmaci	
Sintomi/Segni Associati		Cefalea /Febbre/Abuso di sostanze, Ipoglicemia			
PROCEDURE DI TRIAGE	1	2	3	4	5
Attività (Secondo protocollo locale)	Sorveglianza visiva continua con rapporto 1:1. Richiedere l'intervento del personale di sicurezza. Fornire un ambiente sicuro per i pazienti, accompagnatori e operatori.	Osservazione regolare a un massimo di intervalli di 15 minuti Non lasciare il paziente in sala d'attesa senza supporto di una persona. Richiedere l'intervento del personale della sicurezza se necessario. Fornire un ambiente sicuro per i pazienti, gli accompagnatori e gli operatori	Osservazione regolare a un massimo di intervalli di 30 minuti. Non lasciare il paziente in sala d'attesa senza supporto di una persona. Richiedere l'intervento del personale della sicurezza se necessario Fornire un ambiente sicuro per i pazienti, accompagnatori e operatori	Controllo di routine in sala d'attesa ad un massimo di intervalli di 1 ora	
Attivazione Consulenza (Secondo protocollo locale)	Allertare immediatamente personale medico e consulente psichiatra.	Allertare personale medico e consulente psichiatra in caso di attesa superiore a 60 minuti. Definire protocolli condivisi di presa in carico precoce con gli psichiatri.			
Rivalutazione		Osservazione diretta o video- mediata con monitoraggio costante delle condizioni	Ripetizione di parte o tutte le fasi di valutazione su decisione del triagista, a richiesta del paziente, una volta trascorso il tempo di attesa massimo raccomandato		
Altro	Definire percorsi locali per i pazienti che richiedono un colloquio con lo psichiatra, con lo scopo di ridurre al minimo l'attesa e agevolare la presa in carico.				

Fig. 1 - Table provided by the Lazio Region in "Manuale regionale triage intra-ospedaliero modello Lazio a cinque codici".

psychiatric emergencies emerged. These emergencies were classified and merged in a very generic manner with the treatment of psychomotor agitation and altered mental status. However, a detailed and specific approach to the assessment and management of acute psychosis is lacking here, which highlights the general absence of clear, structured national guidelines on this subject.

Discussion

Managing acute amphetamine- and methamphetamine-induced psychosis in a nursing context is a complex challenge that requires clinical expertise, aggression management skills, pharmacological knowledge and ethical sensitivity. As this phenomenon is becoming more prevalent, nurses are playing a crucial role in the assessment, management and treatment of patients in psychiatric emergencies. Triage is essential for managing psychiatric emergencies promptly. The five-code model enables effective classification based on clinical criteria and vital parameters, using a methodology that includes:

- Immediate assessment to identify signs of clinical instability.
- Allocation of a priority code based on pre-defined protocols and specific tools for psychiatric emergencies.
- Continuous reassessment of the patient to monitor any changes in clinical condition.

This requires clinical 'insight', supported by standardised diagnostic tools and continuing education. Nurses must be able to quickly detect danger signs, such as extreme agitation or potentially aggressive behaviour. The Emergency Safety Implementation Measures provide a table ***(Fig. 1)*** to give a more precise indication of the signs and symptoms that must be present for a patient to be assigned a specific colour code.

It is crucial for nurses to be able to swiftly recognise patients exhibiting acute symptoms of amphetamine or methamphetamine intoxication and differentiate them from individuals experiencing primary psychosis. However, the overlap of symptoms between substance-induced and primary psychotic disorders can make this distinction challenging.

Psychoses induced by substances, such as those caused by amphetamine and methamphetamine use, tend to be less stable in diagnosis than primary psychoses. This manifests as intense but transient psychotic symptoms that respond more quickly to drug treatment and abstinence from the substance (2).

This implies that nurses must be particularly vigilant when collecting medical histories, considering substance use as a potential trigger, and continuously reassessing patients to adapt therapeutic interventions (3). It is crucial to recognise that patients with substance-induced psychosis may subsequently develop primary psychosis or latent vulnerability to more enduring psychotic disorders. This emphasises the importance of careful follow-up, even after the acute phase, to prevent underestimating the problem and ensure more precise diagnostic framing over time (3). Checking the patient's risk of aggression is also crucial in the triage and assessment phase. Several analysed studies emphasise the importance of using standardised tools and a structured methodology to categorise the level of risk. These tools include observing the patient's body language, tone of voice, and willingness to cooperate. Collecting anamnestic information on possible triggers helps create a comprehensive clinical picture, which is essential for preventing new incidents of violence. A structured approach to triage enables the anticipation of risky behaviour and the adoption of more effective management strategies (4). Combining these competencies enables nurses to ensure a timely diagnosis and personalised, patient-centred care. Through interdisciplinary collaboration and adherence to guidelines, nursing triage can be a vital means of improving clinical outcomes and reducing the risks associated with managing psychiatric patients in emergency situations (4, 5). It should be noted that triage is not merely a technical act; it also requires advanced communication skills in order to swiftly establish a therapeutic relationship with the patient, reduce agitation, and ensure appropriate intervention. The ability to balance clinical assessment with an empathic approach is key to ensuring patient safety and well-being (5). However, the increasing complexity of psychiatric emergencies requires healthcare personnel to constantly update their skills. Training should include simulated cases and courses on risk assessment and managing communication with agitated patients, as well as insights into the diagnostic differences between primary and substance-induced psychosis. Only through an integrated, evidence-based approach can the effectiveness of psychiatric triage and the quality of care provided be further improved (3, 4). De-escalation is a vital technique for managing aggression, reducing the need for coercive measures, and fostering a more positive therapeutic environment. It is based on a communicative and relational approach that aims to calm the patient and encourage active cooperation. Interventions include the use of clear and calm language, maintaining a non-threatening posture, and identifying the patient's needs. This approach has been shown to significantly reduce both aggression and the use of physical restraints, as demonstrated by the randomised study analysed. However, its effectiveness hinges on the continuous training of healthcare personnel, who must be able to adapt the approach to different situations. This requires well-defined protocols and regular simulations to improve staff skills and operational readiness (6, 7). A central aspect of de-escalation is how patients perceive the techniques used. Patients tend to react better to interventions that respect their personal space and are perceived as non-threatening. An empathic approach that considers the patient's subjective experiences can prevent further escalation and improve collaboration. Therefore, adopting flexible strategies that include active listening and involving patients in decision-making is essential for successful de-escalation (6). Furthermore, some de-escalation techniques have been shown to be more effective than others. Elements such as a reassuring tone of voice, reducing environmental stimuli, maintaining an appropriate distance, and using clear, direct language have been shown to significantly reduce aggressive episodes. Systematic implementation of these strategies through specific training programmes can therefore increase the overall effectiveness of interventions in acute psychiatric wards (7). Historically, physical restraint has been used in psychiatric settings to manage highly agitated or aggressive patients. However, this practice carries significant risks, including physical and psychological harm to the patient, as well as a deterioration of the therapeutic relationship. Modern guidelines therefore promote alternatives, such as psychological intervention and environmental modification, which may include reducing external stimuli and creating a safe space. These interventions have been shown to be effective in managing agitation without the need for coercion. Although restraint is sometimes necessary in extreme situations, it must be used as a last resort in accordance with strict ethical and clinical protocols. Detailed documentation and continuous monitoring of the patient are essential to ensure the appropriate and justified use of restraint (8). Recent research has identified several practical alternatives to mechanical restraint that can be implemented in psychiatric wards to reduce the use of coercive measures. These include strategies such as sensory rooms, guided relaxation techniques,

targeted psychological interventions, and agitation prevention protocols. Sensory rooms, in particular, offer a safe and controlled environment in which patients can calm down without forced intervention from staff. Systematically adopting these alternatives can help create a therapeutic environment that is less coercive and more centred on the patient's dignity (8). Second-generation antipsychotics, such as olanzapine and risperidone, are the primary choice of treatment for acute psychotic symptoms. These drugs act mainly as antagonists of dopaminergic D2 receptors and partly on serotoninergic 5-HT2A receptors, helping to modulate the excessive mesolimbic dopaminergic activity caused by amphetamines. Initial administration may be by the intramuscular (IM) route in emergency situations to ensure rapid efficacy, followed by a switch to oral administration for maintenance (9, 10).

For example, IM olanzapine has been shown to effectively control psychotic symptoms within 15–30 minutes. Subsequently, switching to oral therapy is recommended to allow long-term control and improve adherence to treatment. Regular monitoring of vital parameters, cardiovascular function, and sedation levels is crucial to prevent serious side effects (10, 11).

Antipsychotics can prolong the QTc interval, thereby increasing the risk of potentially fatal ventricular arrhythmias such as torsade de pointes. This risk is particularly high with drugs such as haloperidol, droperidol, ziprasidone and iloperidone. For patients at high cardiovascular risk, safer options may include antipsychotics with less impact on the QTc interval, such as aripiprazole and lurasidone (9, 10). Quetiapine is often chosen for patients displaying high levels of anxiety and agitation due to its sedative effects. This has been observed in clinical guidelines for the treatment of psychotic agitation (10, 11). Benzodiazepines such as lorazepam or diazepam can be used to control extreme agitation. These drugs act as GABA-A receptor agonists, helping to rapidly reduce agitation and anxiety. They are particularly useful for calming patients without excessively suppressing cognitive function, although they must be administered with caution and their use monitored to avoid side effects such as excessive sedation (11, 12).

It is important to avoid taking drugs that could increase dopaminergic or adrenergic activity, as these could exacerbate psychotic symptoms. For example:

- Amphetamines and their derivatives would be contraindicated as a treatment for substance use disorder in the acute phase due to their stimulating effect on the central nervous system.
- Tricyclic antidepressants and other drugs that increase norepinephrine or serotonin non-selectively may worsen agitation and increase the risk of hypertensive crisis.
- Non-selective beta-blockers such as propranolol are not recommended in cases of acute adrenergic hyperactivation, as they can reduce peripheral vasodilation and increase central arterial pressure (10, 12, 13).
- This is because amphetamines increase the release of, and block the reabsorption of, dopamine and norepinephrine at the synaptic level. This causes excessive stimulation of the brain circuits involved in perception and thinking. Antipsychotics counteract these effects, particularly in mesolimbic pathways, thereby alleviating delusions and hallucinations. Benzodiazepines act on GABA-A receptors to potentiate synaptic inhibition and promote a calming effect (12, 13).

The healthcare environment in which acute psychiatric emergencies are managed plays a crucial role in the quality of care and the well-being of patients and staff. Well-structured organisation accompanied by continuous staff training can significantly improve access to services, crisis management, and the ward climate (14, 15). The atmosphere of a psychiatric ward directly influences the effectiveness of treatment and the patient experience. Significant discrepancies often exist between patients' and staff members' perceptions of the rules and the ward climate. Patients may view the rules as rigid and punitive, whereas staff tend to see them as vital for maintaining safety and order. This misalignment can damage the therapeutic relationship and increase the risk of conflict (16).

Based on the information available, it can be concluded that fostering dialogue, mutual understanding, and adapting rules to individual needs can improve the overall climate, promoting a calmer state of mind for patients. A common criticism of psychiatric emergency settings is the shortage of staff. Inadequate nurse-to-patient ratios can lead to work overload, compromising the quality of care and increasing the risk of burnout among healthcare workers. Logistical and organisational difficulties represent a further obstacle to optimal care (17). In fact, professional training alone is insufficient:

nurses also need psychological support to cope with the stress of long shifts and managing highly emotional situations (17).

The various analysed articles emphasised the importance and necessity of broadening the range of knowledge, focusing mainly on the following points:

- Standardisation of protocols: Uniform implementation of national and regional guidelines.
- Continuing education: Refresher courses on triage, pharmacology, and de-escalation techniques.
- Psychological support for operators: Specific programmes to reduce stress for staff.
- Increasing human resources to ensure an adequate staff-to-patient ratio to improve the effectiveness of interventions.
- Facilitated access to health services, including dedicated pathways for psychiatric emergencies and stronger links to primary care services.

Conclusions

This literature review revealed that nursing the management of acute amphetamine-induced psychosis is a complex challenge that requires a multidimensional, integrated approach. The literature review clearly shows that there is a need to develop standardised protocols to guide clinical practice, from initial triage assessment through to pharmacological and behavioural management. Although de-escalation techniques have been shown to be effective in reducing aggression and the use of restraints, their implementation requires ongoing training and adequate organisational resources. Second-generation antipsychotic pharmacotherapy is the mainstay of treatment, but must be customised to the individual characteristics of each patient. It is particularly important to consider the working conditions of nurses, who require psychological and organisational support to effectively manage these emergencies. It is fundamental to bridge the gap between staff and patient perceptions of the rules and climate of psychiatric wards, and this can be achieved by promoting a therapeutic environment that fosters collaboration. Future studies should focus on implementing specific training programmes and evaluating organisational models that optimise available resources, thereby improving the quality of care and reducing the use of coercive practices.

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