6

Emergency management

This chapter contains 11 flow charts to assist you with assessing and treating the most common mental health emergencies. The first flow chart (6.1) is a master flow chart for acutely disturbed behaviour. By following this flow chart you can work out which of the other flow charts you then need to use for the specific cause of acutely disturbed behaviour (flow charts 6.2 to 6.10).

As you can see from the master flow chart, when a person has acutely disturbed behaviour it is important to first of all check airway, breathing and circulation, and provide immediate resuscitation if needed. The next step is to work out whether the disturbed behaviour has a physical cause (if so, go to flow chart 6.2), or is caused by substance use (intoxication or withdrawal) or poisoning (flow charts 6.4–6.8).

Only after excluding those causes of disturbed behaviour should you start to consider mental health causes. This is the case even if the person has a known mental health problem: you still need to exclude these other causes of disturbance first. If the disturbance is due to a mental health problem, the next step is to decide whether it is related to a mental disorder or disability (e.g. psychosis, mania, dementia, developmental disability) (flow chart 6.9) or is due to mental distress (flow chart 6.10). The last flow chart (6.11) covers the emergency management of a person having a seizure.

Try to learn these emergency flow charts so that they are easier to use in an emergency situation.

After addressing the emergency, you can then refer to other sections of the book (as indicated) for the further non-emergency management of the problem.

These flow charts can be photocopied and displayed in a place where they can be easily seen in an emergency. If you do this, always display the master flow chart (6.1) alongside the other flow charts.

The following symbols were used in the flow charts:

BP, blood pressure i.m., intramuscular i.v., intravenous p.o., orally p.r., rectally.

6.1 Emergency: acutely disturbed behaviour

Confirm: Person is confused, agitated or aggressive



Be safe: involve others and remove dangerous objects

Airway, breathing, circulation: immediate resuscitation

Is there an acute medical cause?

- Does the person know the time, place and who people are?
- Abnormal pulse, BP, breathing rate or temperature?
- o Any head injury?
- Low glucose or hypoxia?



Is it due to poisoning or intoxication?

Suicidal poisoning

- pesticide poisoning: pinpoint pupils, increased secretions, reduced breathing rate, high/low BP
- overdose of tricyclic antidepressant: increased pulse, low BP, reduced breathing rate, dilated pupils
- alcohol intoxication or benzodiazepine overdose: smells of alcohol, has access to benzodiazepines, slurred speech, disinhibited

Opioid overdose: injection sites, pinpoint pupils, low breathing rate Stimulant drug intoxication (e.g. cocaine, amphetamine): dilated pupils, excited or disordered thinking, paranoia



Is it due to substance use withdrawal?

- o Recently stopped opioids, alcohol or benzodiazepines
- o Restless and agitated; sweating, vomiting
- o Increased pulse and BP



Is it a mental disorder or disability?

- Person hearing things that are not really there? Suspicious?
- Does the person believe that they have special powers?
- Has the person got lifelong slow development?
- Has the person got chronic memory problems?

Yes

Yes

Flow chart 6.2

Delirium

Flow chart 6.3

Suicidal/poisoning

Flow chart 6.4

Alcohol intoxication

Flow chart 6.5

Opioid/benzodiazepine overdose

Flow chart 6.6

Stimulant intoxication

Yes Alco

Flow chart 6.7

Alcohol/benzodiazepine withdrawal

Flow chart 6.8

Opioid withdrawal

Yes

Flow chart 6.9

Acute mental disorder

No

Is it mental distress?

• Has the person recently experienced a traumatic or distressing event?

Yes

Flow chart 6.10

Acute mental distress

6.2 Emergency flow chart: delirium



Confirm: the person is confused (doesn't know the correct time or place or doesn't recognise people) but is not intoxicated with alcohol or drugs



Monitor airway, breathing and circulation and resuscitate if needed.

Then treat any underlying physical health problem



Optimise the environment

- Quiet with adequate, low-level lighting
- o Accompanied by someone known to the person
 - Remove dangerous objects
 - Calm and vigilant health care staff



If the person has disturbed behaviour

• Try to calm the person: give reassurance, explain what is happening, try to understand and address their concerns



If the disturbed behaviour persists AND is:

- o interfering with essential medical procedures
- o putting the person at immediate risk of harming themselves or others



Give low-dose antipsychotic medicine

Offer oral medicine first:

haloperidol 0.5–2.5 mg p.o. or risperidone 0.25–1 mg p.o.

If refuses, restrain safely and give:

haloperidol 0.5–2.5 mg i.m./i.v. or olanzapine 2.5–10 mg i.m.



How to restrain: make sure you have enough people and hold the person down firmly using hands. Always prepare the injection before you restrain someone.



Monitor pulse, BP, breathing rate and temperature every 15 min



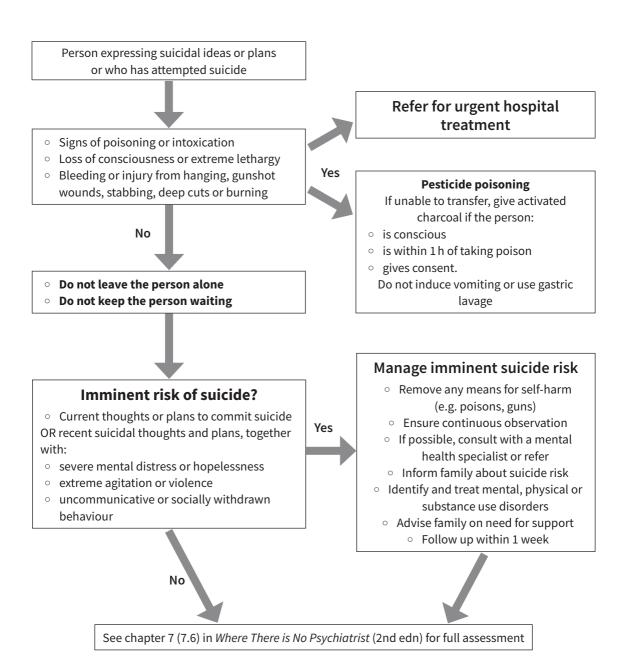
Review response after 30 min. Repeat if needed



Refer urgently if possible

6.3 Emergency flow chart: suicidal ideas or attempts





6.4 Emergency flow chart: alcohol intoxication



Confirm alcohol intoxication: smells of alcohol, slurred speech, disinhibited, agitated or aggressive AQ. if needed? Assess airway, breathing and circulation: give immediate resuscitation if needed Check that no physical problem is ALSO present (e.g. infection, head injury, stroke, low blood glucose, hypoxia, liver failure) → Treat the physical problem If **methanol** poisoning is suspected, refer urgently for hospital treatment Try to avoid medications if at all possible If disturbed behaviour AND the patient is risking the safety of themselves or others → haloperidol 2.5–5 mg (oral, i.m. or i.v.) Monitor airway, breathing and circulation Place on side to prevent choking if the person vomits Observe until the effects of alcohol wear off

See chapter 9 in Where There is No Psychiatrist (2nd edn) for full assessment

6.5 Emergency flow chart: opioid or benzodiazepine overdose



For opioid overdose: look for injection sites, pinpoint pupils, low breathing rate, whether known user of opioids

For benzodiazepine overdose: look for history of taking benzodiazepines, slurred speech, whether disinhibited, agitated or aggressive



Airway, breathing, circulation: immediate resuscitation



If breathing rate < 10 per min OR oxygen saturation < 92%



If opioid overdose:

- o give naloxone 4 mg subcutaneous, i.m. or i.v.
 - observe for 1 to 2 h after administering
- o if long-acting opioid overdose (e.g. methadone), transfer to hospital



If benzodiazepine overdose, transfer urgently to hospital for support with breathing

See Where There is No Psychiatrist (2nd edn) for full assessment of suicidal behaviour in chapter 7 (7.6) and substance use problems in chapter 9

6.6 Emergency flow chart: stimulant intoxication



Look for features of stimulant intoxication: dilated pupils, excited or disordered thinking, paranoia, disturbed behaviour



○ Give diazepam 10 mg p.o.

• If person refuses, give i.v. only if aggressive behaviour is associated with imminent risk of harm to the person or others



If symptoms persist after 20 min, give further diazepam 10 mg p.o. or i.v.



If paranoia and other psychotic symptoms persist:
haloperidol 2.5 mg p.o., i.m. or i.v.
OR chlorpromazine 75 mg p.o. or i.m.
OR olanzapine 10 mg p.o.
OR risperidone 2 mg p.o.



Monitor BP, pulse, breathing rate and temperature every 2 to 4 h



Transfer urgently to hospital if the person has:

- o chest pain
- o abnormal heart rhythms
- o if the violence is unmanageable



Be alert for suicidal ideas and actions as intoxication wears off

See chapter 9 in *Where There is No Psychiatrist* (2nd edn) for full assessment of substance use

6.7 Emergency flow chart: alcohol withdrawal



Identify alcohol withdrawal: history of heavy alcohol drinking or recently stopped, restless and agitated; sweating, vomiting, increased pulse and BP Yes Any physical health complications? Treat physical problem Low glucose, head injury, infection, stroke, Refer to hospital liver failure Yes Signs of alcohol withdrawal-related delirium? Treat for physical withdrawal o Confusion, fear, seeing or believing things o Consider haloperidol 2.5–5 mg p.o., i.m. or that are not real i.v. up to three times per day Yes Signs of Wernicke's encephalopathy? o Give thiamine 100 mg i.m. or i.v. three Confusion, unsteady walking, eyes not times per day for 3 to 5 days moving together No Treat for alcohol withdrawal Treat immediately with oral diazepam 10 mg p.o. (5 mg if liver is damaged and monitor carefully) If no improvement after 1 h, give another 10 mg diazepam p.o. Use up to 40 mg in 24 h. If more is needed, refer to hospital Give oral thiamine 100 mg (once per day for 5 days) For alcohol withdrawal-related seizures treat with diazepam (or another benzodiazepine) only

See chapter 9 (9.1) in *Where There is No Psychiatrist* (2nd edn) for further management of alcohol use disorder

6.8 Emergency flow chart: opioid withdrawal



Identify opioid withdrawal: history of using opioid and recently stopped, restless and agitated, sweating, vomiting, increased pulse and BP

Give reassurance
Opioid withdrawal is unpleasant but not life-threatening

If specialist support is available, treat with opioid replacements (methadone or buprenorphine)

If no specialist support is available, consider: clonidine OR lofexidine 0.1 to 0.15 mg p.o. (up to three times per day)

Treat specific symptoms as needed, e.g.:

loperamide 2 mg p.o. for diarrhoea
domperidone 10 mg p.o. for vomiting
paracetamol 1 g p.o. for muscle pain
promethazine 25 mg p.o. for insomnia

See chapter 9 (9.2) in *Where There is No Psychiatrist* (2nd edn) for further management of substance use disorder

6.9 Emergency flow chart: acute mental disorder



Identify symptoms of psychosis, mania, dementia or developmental disability



Treat in a quiet place and remove dangerous objects



If trying to calm the person is unsuccessful, offer oral medicine first:

- o antipsychotic medicine: haloperidol 2.5 mg p.o. OR chlorpromazine 75 mg p.o. OR olanzapine 10 mg p.o. OR risperidone 2 mg p.o.
 - AND/OR diazepam 10 mg p.o. OR lorazepam 1–2 mg p.o.
 - o Do not use medication to treat behavioural disturbance in a child
 - Avoid benzodiazepines for dementia
 - Use lower doses in elderly and people with medical conditions



If the person refuses oral medicine, only treat against their will if there is an immediate risk of harm to them or to others

Restrain the person in a safe way (see flow chart 6.2)

Antipsychotic: haloperidol 5 mg i.m. OR olanzapine 10 mg i.m. OR chlorpromazine 25 to 100 mg i.m. AND/OR diazepam 10 mg i.v. or p.r. OR lorazepam 1–2 mg i.m. AND/OR promethazine 50 mg i.m.



Wait for 30 min

If disturbed behaviour persists, repeat the dose



Monitor pulse, BP, breathing rate and temperature every 30 min



Refer to hospital if still no response

See chapter 10 in *Where There is No Psychiatrist* (2nd edn) for further management of aggressive/violent behaviour

6.10 Emergency flow chart: acute mental distress



Person who has recently experienced a traumatic or stressful event and is distressed

- Speak to the person in a calm voice
 - Find a quiet and private place
- Do not force the person to speak about their experiences
 - Offer your support through listening



If the person has been the victim of a physical or sexual assault, follow local guidelines for physical examination and reporting to police



Only if the person cannot be calmed and remains extremely distressed, give diazepam 10 mg p.o.



Screen for suicide risk and manage the risk (see flow chart 6.3)



Identify someone who can be with the person while they remain acutely distressed



Offer an appointment to review within 1 to 2 days

6.11 Emergency flow chart: seizure

Person who loses consciousness, with sudden muscle contraction, rigidity, jerking movements

Emergency assessment

BP, temperature, breathing rate Signs of head or back trauma or focal deficits Signs of intoxication: pupils dilated/pinpoint Signs of meningitis (stiff neck, rash)

Emergency treatment Check airway, breathing and circulation:

Immediate resuscitation
Protect from injury
Put person on side (recovery position)
Do not put anything in their mouth

If pregnant or <1 month postpartum

If no history of epilepsy, suspect eclampsia

- Give magnesium sulphate 10 g i.m.
- Give 5 g (10 ml of 50% solution) i.m. deep in upper outer quadrant of each buttock with 1 ml of 2% lignocaine in the same syringe.
- If diastolic BP is
 >100 mmHg: give
 hydralazine 5 mg i.v.
 slowly (3–4 min). If i.v.
 is not possible, give
 i.m. if diastolic BP
 remains >90 mmHg,
 repeat dose at 30 min
 intervals until diastolic
 BP is around 90 mmHg.
- Do not give more than 200 mg in total.
- Refer woman urgently to hospital and follow local guidelines for management of pregnancy, childbirth and postpartum care.

For all other seizures

- Insert an i.v. line, take blood and give fluids slowly (30 drips/min)
- Glucose i.v. (adults 5 ml of 50% glucose, children 2–5 ml/kg of 10% glucose)
- Diazepam i.v. 10 mg slowly (child: 1 mg/year of age)
- If cannot get i.v. access: give diazepam p.r. (same dose as above) OR intranasal midazolam (adult 10 mg, child 0.2 mg/kg) OR buccal or i.m. midazolam
- o **DO NOT** give i.m. diazepam

If seizure does not stop after 10 min, give second dose of diazepam/midazolam and

REFER URGENTLY TO HOSPITAL DO NOT give >2 doses

For people who have:

repeated seizures without regaining consciousness OR seizures that don't stop with 2 doses of diazepam

- consider conversion disorder (triggered by emotional stress) (\$\sigma 8.6\$)
- o administer oxygen
- check need for intubation/ventilation

Give: phenytoin 15–18 mg/kg i.v. (through different line to diazepam) over 60 min OR phenobarbital 10–15 mg/kg i.v. (rate of 100 mg/min). A good i.v. line is essential. If seizures continue: give the other drug (if available) OR additional phenytoin 10 mg/kg i.v. (through different line to diazepam) over 30 min.

Monitor for respiratory depression

If possible medical problem or drug use

Screen for:

- pesticide or tricyclic antidepressant poisoning (flow chart 6.3)
- stimulant intoxication (flow chart 6.6)
- alcohol or benzodiazepine withdrawal (flow chart 6.7)

If head injury or infection of brain or meningitis

Manage the seizures as for 'all other seizures'

REFER URGENTLY TO HOSPITAL:

- If head or neck injury: DO NOT move neck because of possible cervical spine injury. Log-roll person when moving.
- Brain infection or meningitis: manage the infection according to local guidelines.

If seizure resolves, see chapter 7 in Where There is No Psychiatrist (2nd edn) for further management