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?
- Any head injury?
- Low glucose or hypoxia?

No

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

No

Is it due to substance use withdrawal?
- Recently stopped opioids, alcohol or benzodiazepines
- Restless and agitated; sweating, vomiting
- Increased pulse and BP

No

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?

No

Is it mental distress?
- Has the person recently experienced a traumatic or distressing event?

Yes

Flow chart 6.10
Acute mental distress

No

Flow chart 6.7
Alcohol/benzodiazepine withdrawal

Yes

Flow chart 6.8
Opioid withdrawal

Yes

Flow chart 6.9
Acute mental disorder

No

Flow chart 6.4
Alcohol intoxication

Yes

Flow chart 6.5
Opioid/benzodiazepine overdose

Yes

Flow chart 6.6
Stimulant intoxication

Yes

Flow chart 6.3
Suicidal/poisoning

No

Flow chart 6.2
Delirium
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
- 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:
- Interfering with essential medical procedures
- 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

Person expressing suicidal ideas or plans or who has attempted suicide

- Signs of poisoning or intoxication
- Loss of consciousness or extreme lethargy
- Bleeding or injury from hanging, gunshot wounds, stabbing, deep cuts or burning

Refer for urgent hospital treatment

No

- Do not leave the person alone
- Do not keep the person waiting

Pesticide poisoning
If unable to transfer, give activated charcoal if the person:
- is conscious
- is within 1 h of taking poison
- gives consent.
Do not induce vomiting or use gastric lavage

Manage imminent suicide risk
- Remove any means for self-harm (e.g. poisons, guns)
- Ensure continuous observation
- If possible, consult with a mental health specialist or refer
- Inform family about suicide risk
- Identify and treat mental, physical or substance use disorders
- Advise family on need for support
  - Follow up within 1 week

Yes

Imminent risk of suicide?
- Current thoughts or plans to commit suicide OR recent suicidal thoughts and plans, together with:
  - severe mental distress or hopelessness
  - extreme agitation or violence
  - uncommunicative or socially withdrawn behaviour

No

See chapter 7 (7.6) in Where There is No Psychiatrist (2nd edn) for full assessment
6.4 Emergency flow chart: alcohol intoxication

Confirm alcohol intoxication: smells of alcohol, slurred speech, disinhibited, agitated or aggressive

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:
- give naloxone 4 mg subcutaneous, i.m. or i.v.
- observe for 1 to 2 h after administering
- 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:
- chest pain
- abnormal heart rhythms
- 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

Any physical health complications?
- Low glucose, head injury, infection, stroke, liver failure
  - Yes
    - Treatment for physical problem
    - Refer to hospital
  - No

Signs of alcohol withdrawal-related delirium?
- Confusion, fear, seeing or believing things that are not real
  - Yes
    - Treatment for physical withdrawal
    - Consider haloperidol 2.5–5 mg p.o., i.m. or i.v. up to three times per day
  - No

Signs of Wernicke’s encephalopathy?
- Confusion, unsteady walking, eyes not moving together
  - Yes
    - Give thiamine 100 mg i.m. or i.v. three times per day for 3 to 5 days
  - 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

Oral or i.v. rehydration as needed

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:
- 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.
- 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
- **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

If head injury or infection of brain or meningitis

- **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)

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