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.

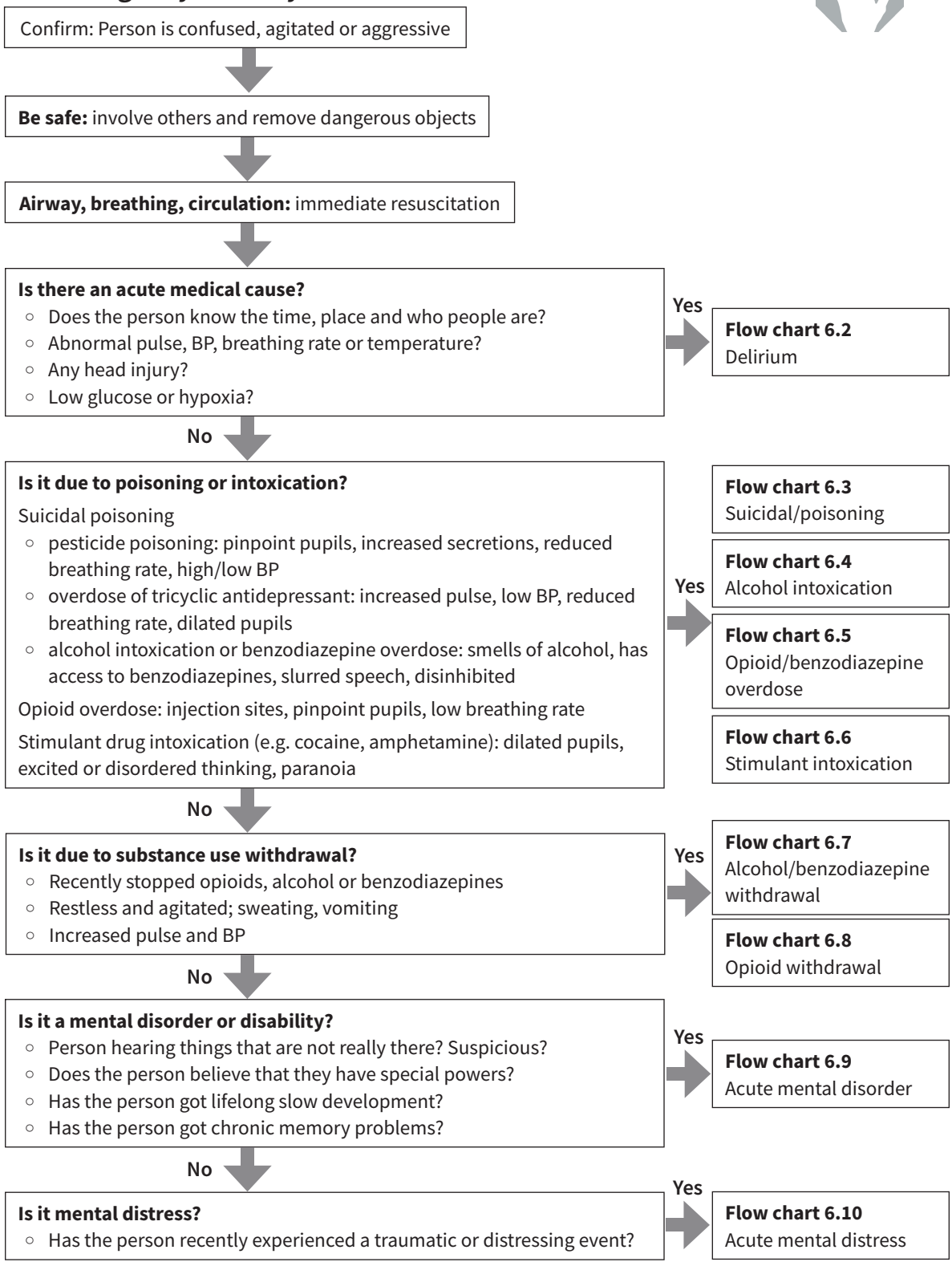
After addressing the emergency, you can then refer to other sections of the book (as indicated) for the further non-emergency management of the problem.

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



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

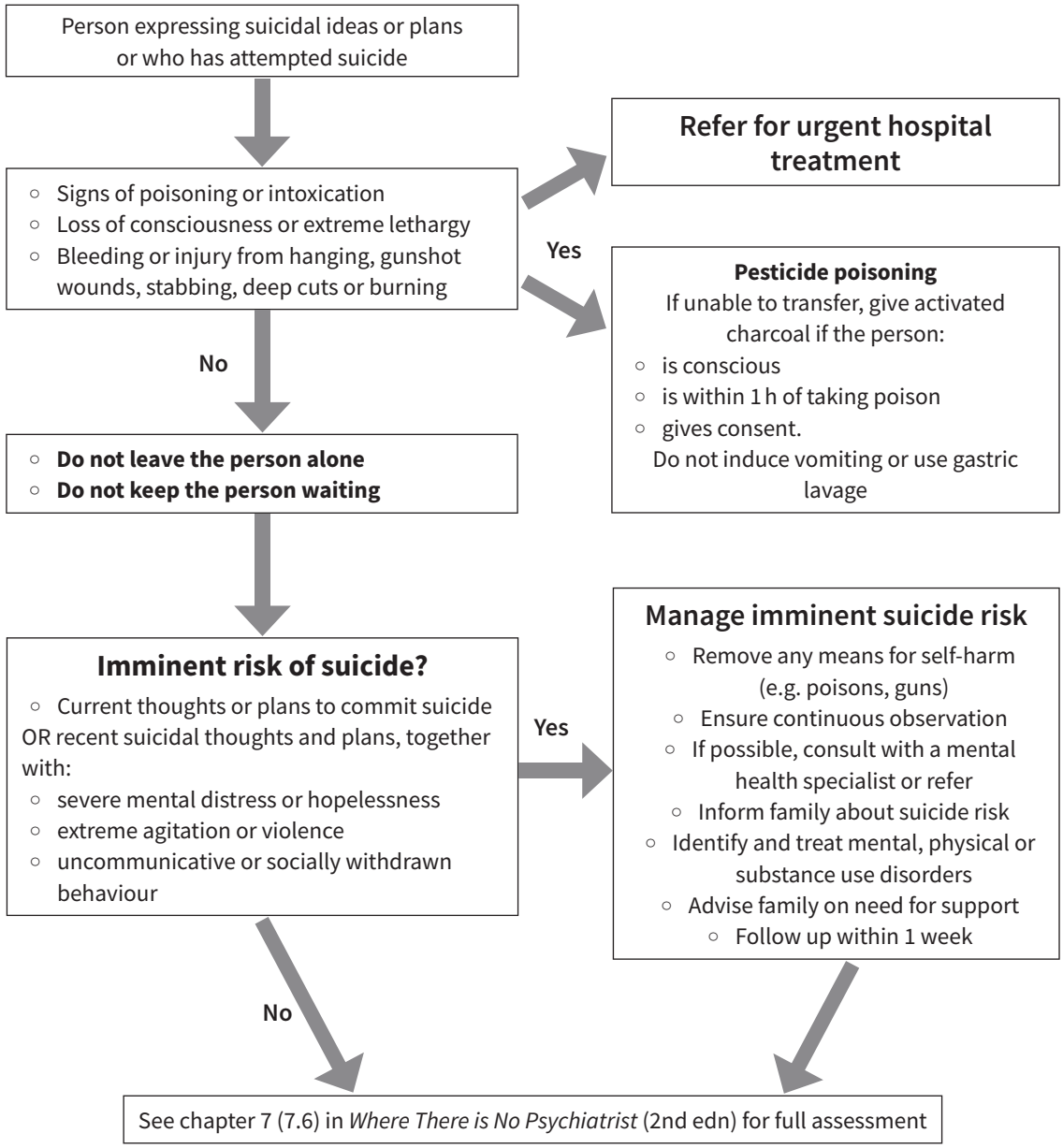
↓

Review response after 30 min. Repeat if needed

↓

Refer urgently if possible

6.3 Emergency flow chart: suicidal ideas or attempts



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%

↓

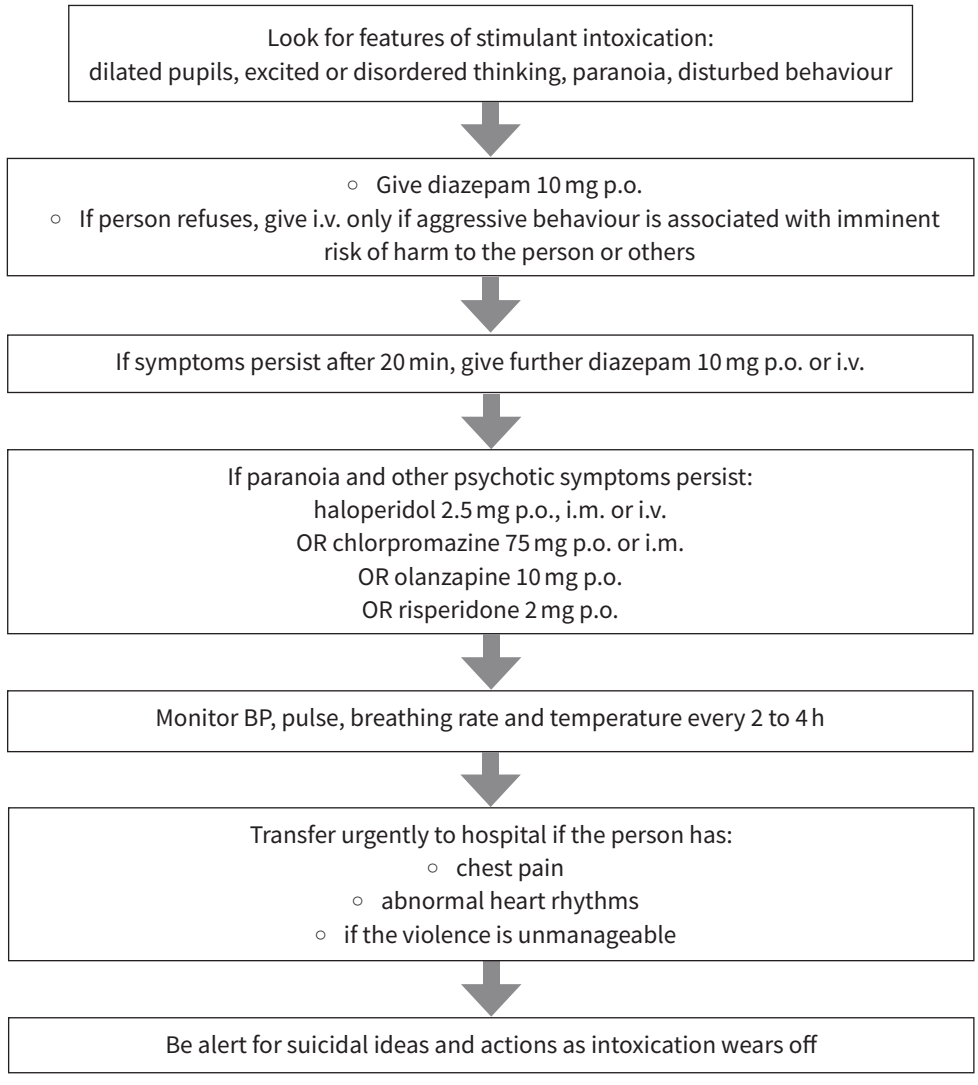
If opioid overdose:
- give naloxone 4 mg subcutaneous, i.m. or i.v.
- observe for 1 to 2 h after administering
- if long-acting opioid overdose (e.g. methadone), transfer to hospital

↓

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

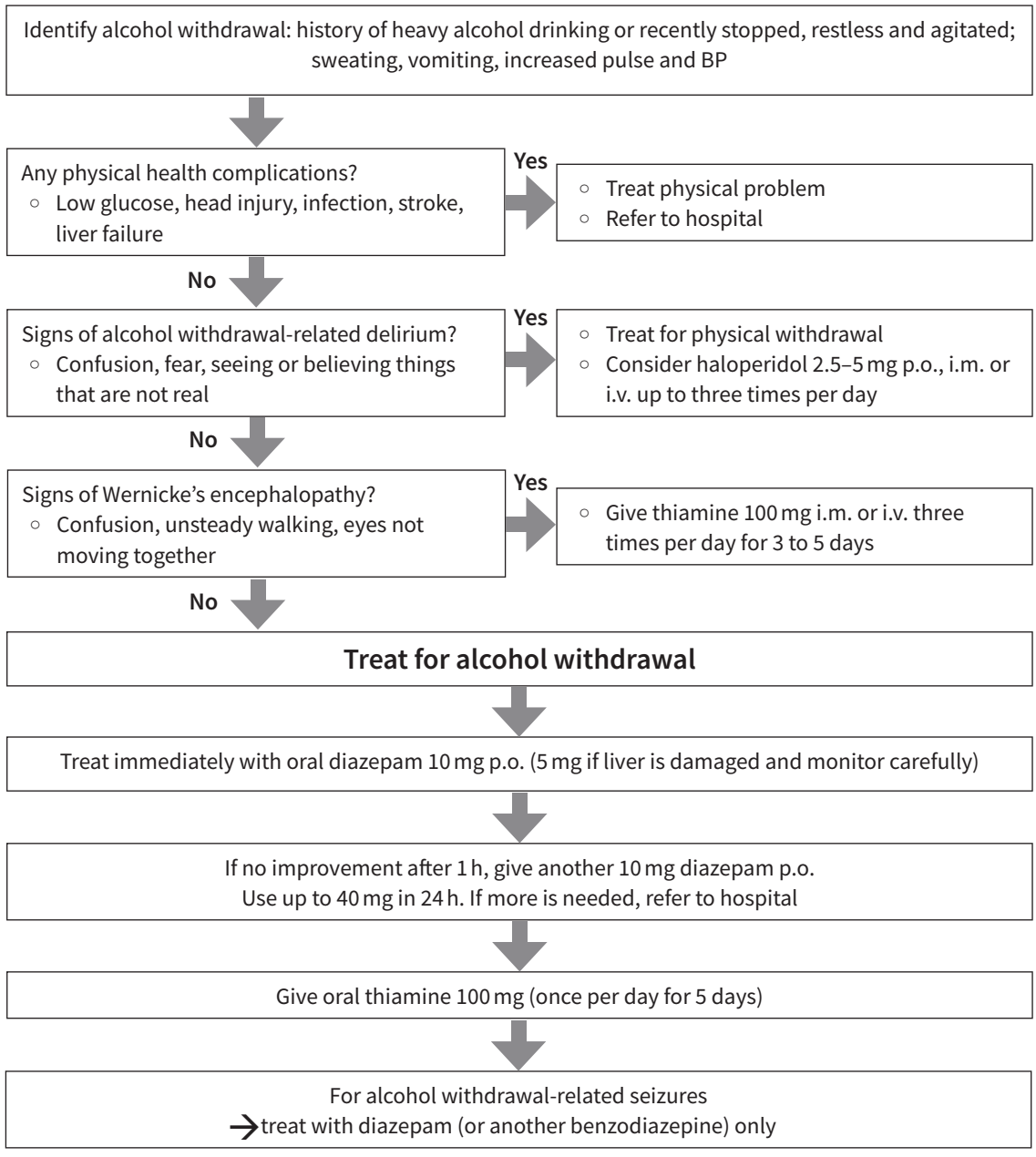
See *Where There is No Psychiatrist* (2nd edn) for full assessment of suicidal behaviour in chapter 7 (7.6) and substance use problems in chapter 9

6.6 Emergency flow chart: stimulant intoxication



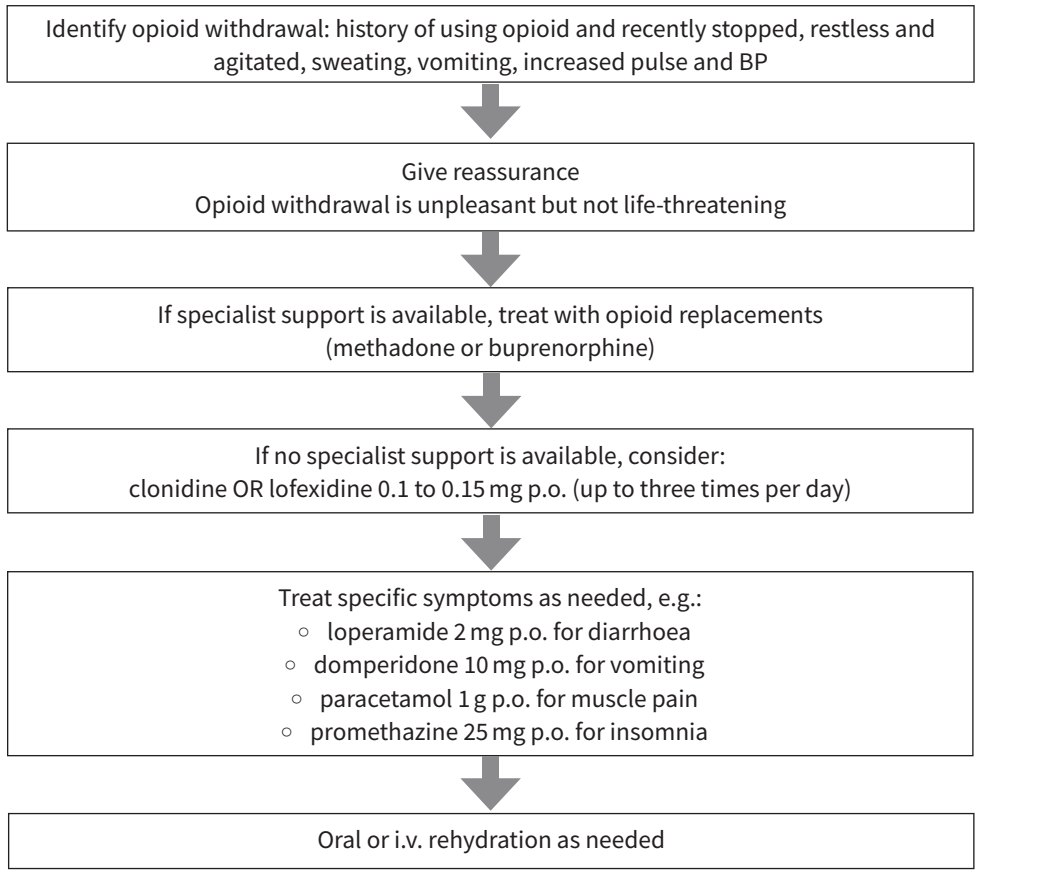
See chapter 9 in *Where There is No Psychiatrist* (2nd edn) for full assessment of substance use

6.7 Emergency flow chart: alcohol withdrawal



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



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

↓

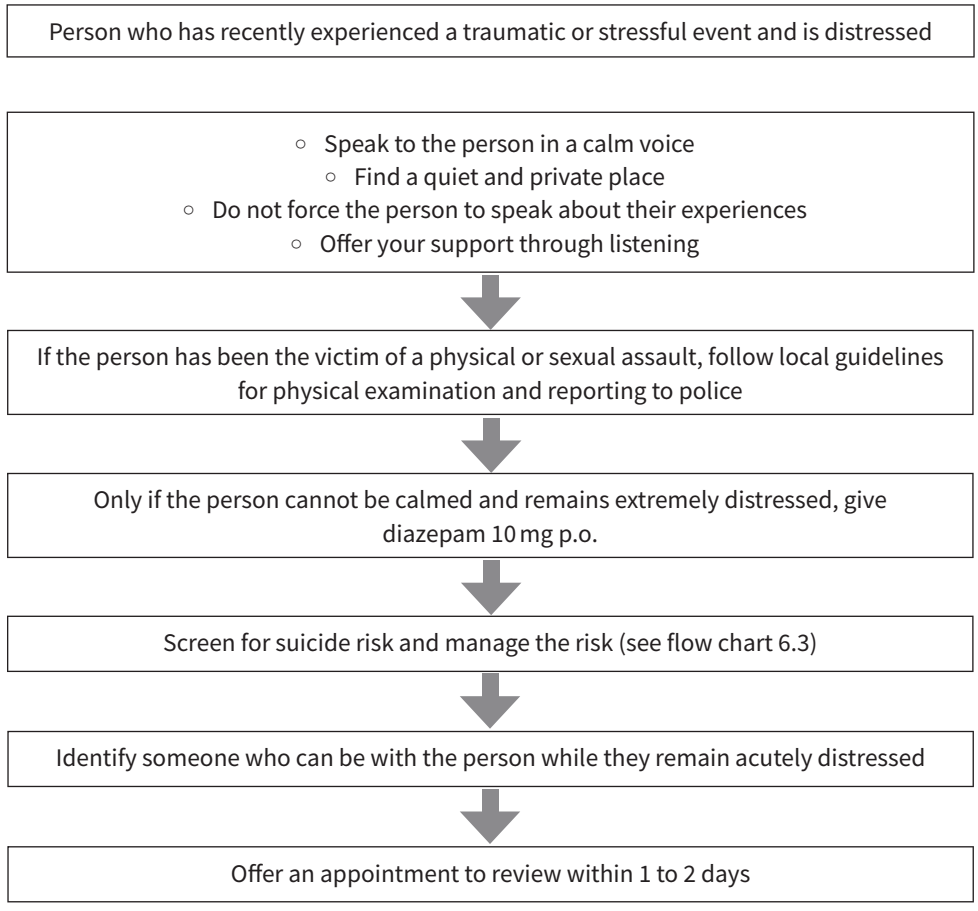
Monitor pulse, BP, breathing rate and temperature every 30 min

↓

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



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

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) (☞8.6)
- 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