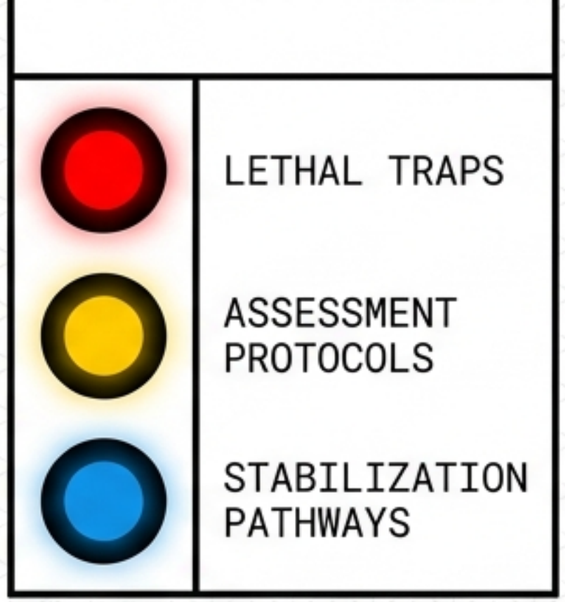
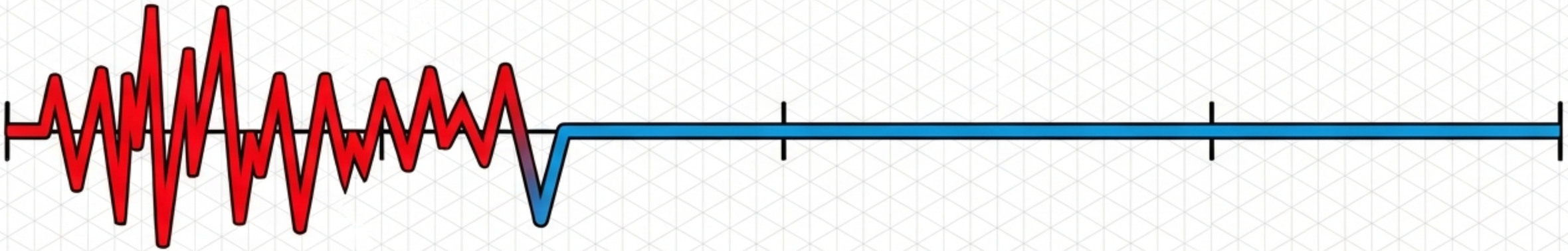


Emergency Psychiatry: The Clinical Playbook

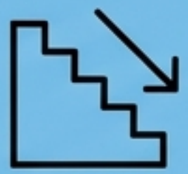
Assessment, De-escalation, and Management of Acute Crises



THE CLINICAL FLIGHT MANUAL: EMERGENCY FRAMEWORK

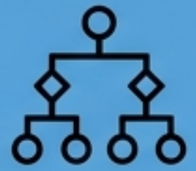
1. MEDICAL CLEARANCE

Rule out organic and lethal medical mimics before psychiatric diagnosis.



2. BEHAVIORAL STABILIZATION

De-escalate the acute crisis using the least restrictive interventions.



3. ACUTE CRISIS MANAGEMENT

Assess and treat specific presentations (Psychosis, Suicidality, Substances).

4. DISPOSITION & LEGAL

Secure safe holding, legally defensible documentation, and follow-up.

MEDICAL CLEARANCE: THE DIAGNOSTIC FILTER

THE MINIMUM WORKUP (15-30 MINS)

- Vitals (BP, HR, Temp, RR, O2)
- Blood Glucose
- BMP (Na, K)
- UDS
- BAL
- Pregnancy Test

EXPANDED WORKUP TRIGGERS

- ⚠ Age >40 with first mania
- ⚠ First-Episode Psychosis (FEP)
- ⚠ Altered mental status disproportionate to psych diagnosis
- ⚠ Delirium in elderly

TRUE PSYCHIATRIC EMERGENCY

LETHAL MEDICAL MIMICS

- ⚠ Hypoglycemia
- ⚠ Thyroid Storm
- ⚠ CNS Infection
- ⚠ Toxidromes / Withdrawal
- ⚠ Autoimmune Encephalitis

THE AGITATION ESCALATION STAIRCASE

Principle of Least Restrictive Intervention

STEP 1: VERBAL DE-ESCALATION

STAMP Mnemonic:

- Sit
- Tone of voice
- Announce intentions
- Maintain space
- Plan

70-80% of patients respond to this step alone.

STEP 2: ORAL MEDICATIONS

Patient acceptance is higher. Offer choices.

STEP 3: IM MEDICATIONS

Faster onset (5-15 min) for oral refusal or escalating violence.

STEP 4: PHYSICAL RESTRAINT

Last resort. Imminent danger only. Requires continuous monitoring (q15m circulation checks).

AGITATION PHARMACOTHERAPY MATRIX

ORAL REGIMENS

- **Olanzapine ODT 5–10 mg**
  Fast onset, ~20 min
- **Risperidone 2 mg + Lorazepam 2 mg**
  Adds rapid anxiolysis
- **‘B52’ PO: Haloperidol 5 mg + Lorazepam 2 mg + Diphenhydramine 50 mg**

IM REGIMENS

- **Olanzapine 10 mg IM**
  Clean, effective
- **Haloperidol 5 mg + Lorazepam 2 mg IM**
  Dystonia risk; keep Diphenhydramine 25-50 mg handy
- **Ziprasidone 20 mg IM**
  Requires dilution

LETHAL TRAP: NEVER combine IM Olanzapine + IM Benzodiazepine. Combined CNS depression carries massive risk of respiratory depression and death.

Acute Psychosis & The Catatonia Trap

Acute Psychosis

Path A: Standard Psychotic Agitation

Ensure safety. Haloperidol 5mg IM for acute control -> transition to atypicals. Avoid benzos alone (disinhibition risk).

Path B: The Catatonia Pathway

Identify the Tetrad
Immobility | Mutism | Waxy Flexibility | Negativism

→

Lorazepam Challenge
(1-2mg IV/IM)

→

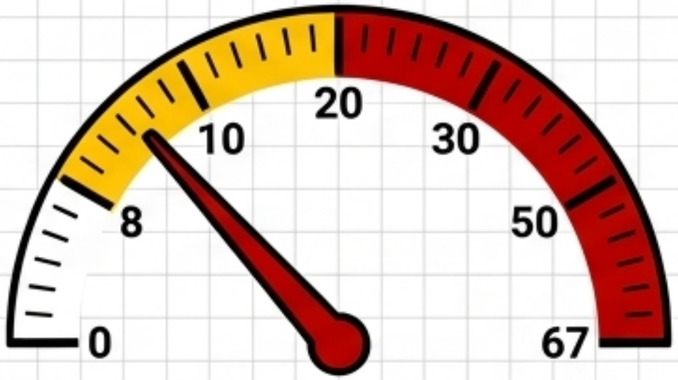
Dramatic response (minutes/hours) = Catatonia. Continue Benzos.

LETHAL TRAP: Giving antipsychotics for Catatonia before the Lorazepam challenge can precipitate fatal Neuroleptic Malignant Syndrome (NMS).

Substance Emergencies: Alcohol & Sedatives

LETHAL TRAP: ALWAYS administer Thiamine 100mg IV/IM BEFORE Dextrose in suspected alcohol dependence to prevent **Wernicke's Encephalopathy.**

Alcohol Withdrawal



CIWA Scale: >8-10 triggers intervention. >20 indicates severe risk.

Symptom-Triggered	Scheduled Dosing
Lorazepam PRN for mild/moderate.	Safer in severe withdrawal or unreliable monitoring.

Sedative / Benzo Withdrawal

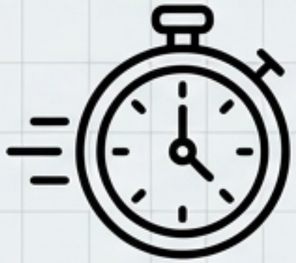
Life-threatening condition (seizures, autonomic instability).

Pathway: Use longer-acting benzos (Diazepam, Phenobarbital) for stabilization.

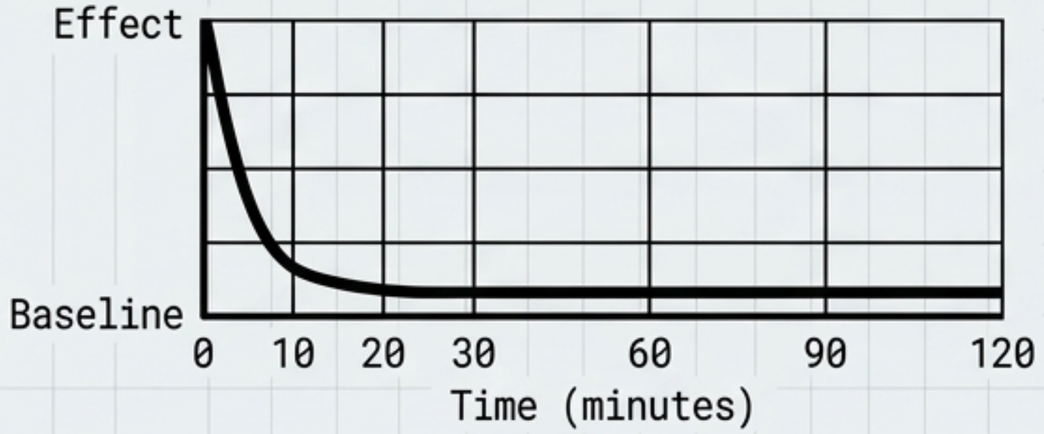
Avoid Flumazenil: Can precipitate refractory seizures in dependent patients.

Substance Emergencies: Opioids & Stimulants

The Clinical Flight Manual

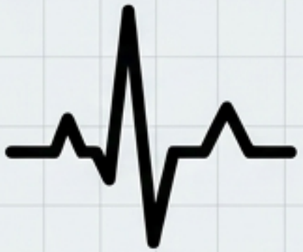


Opioid Overdose (Time-Critical)



Naloxone 0.4–2 mg IV/IM/IN. Onset <1 to 3 mins.

RED ALERT: Duration is ONLY 30-90 minutes. Overdose WILL recur if the long-acting opioid outlasts the reversal agent. Minimum 2-4 hour observation post-reversal required.



Stimulant Intoxication (Cardiac-Critical)

Cocaine, Meth, Amphetamines. Presents as hyperthermia, tachycardia, psychosis.

First-Line: Benzodiazepines (Lorazepam 2-4 mg IV) for agitation.

Avoid: Pure alpha-blockers (reflex tachycardia).
Avoid antipsychotics initially (worsens hyperthermia, sudden cardiac death risk).

COMPARISON MATRIX: NMS vs. Serotonin Syndrome

Feature	NMS	Serotonin Syndrome
Triggers	Recent Antipsychotics (Haldol highest risk)	SSRIs + MAOIs / Tramadol / Linezolid
Onset	24–72 hours	Acute (Hours to 24h)
Neuromuscular Hallmarks	Lead-pipe rigidity	Clonus, Hyperreflexia, Tremor
Treatment	Stop agent, Dantrolene (1mg/kg), Bromocriptine	Stop agent, Cyproheptadine

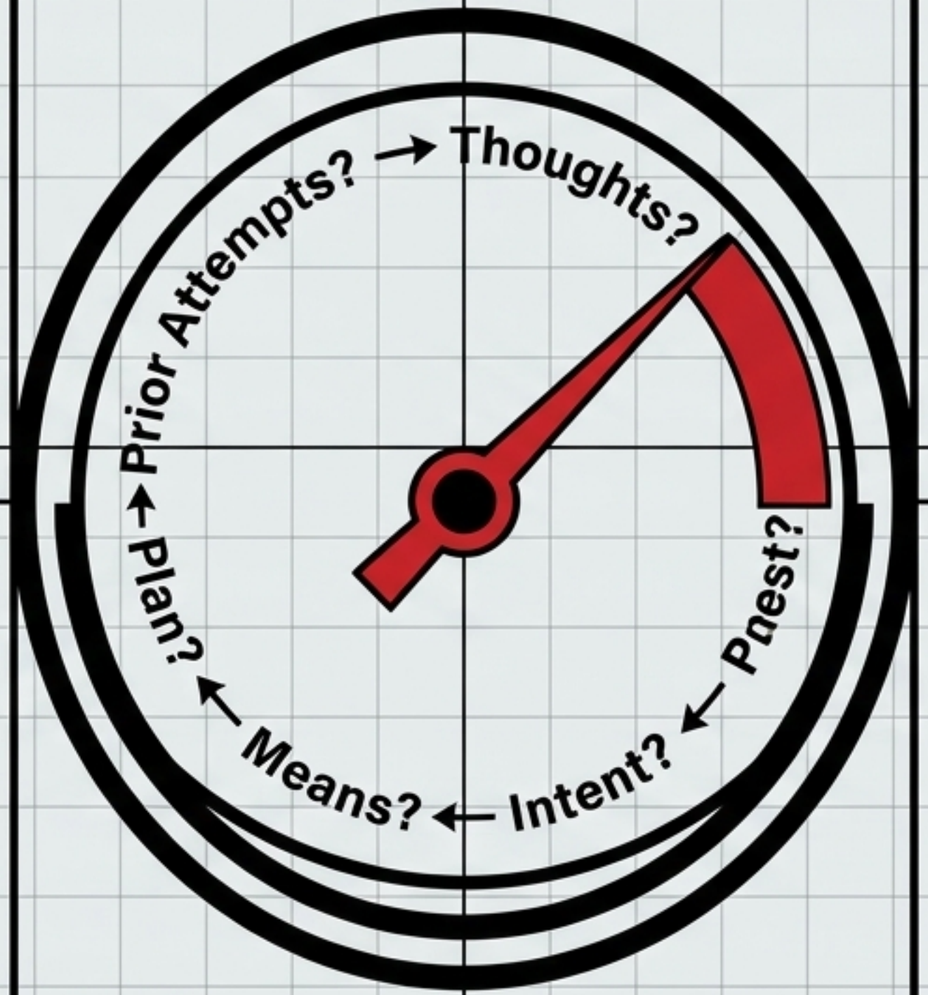
The Hunter Criteria (for SS)
Exposure to serotonergic agent + (Spontaneous Clonus OR Inducible Clonus w/ Agitation OR Ocular Clonus OR Hyperreflexia)

Acute Suicidality Assessment

Static Risk Factors

(The Baseline)

Unchangeable. Prior attempts, family history, older age, male sex.



Modifiable Risk Factors

(The Targets)

Focus interventions here. Current depression, hopelessness, hopelessness, intoxication, access to lethal means.

Safety Planning & Means Restriction

The “10-Minute Window”

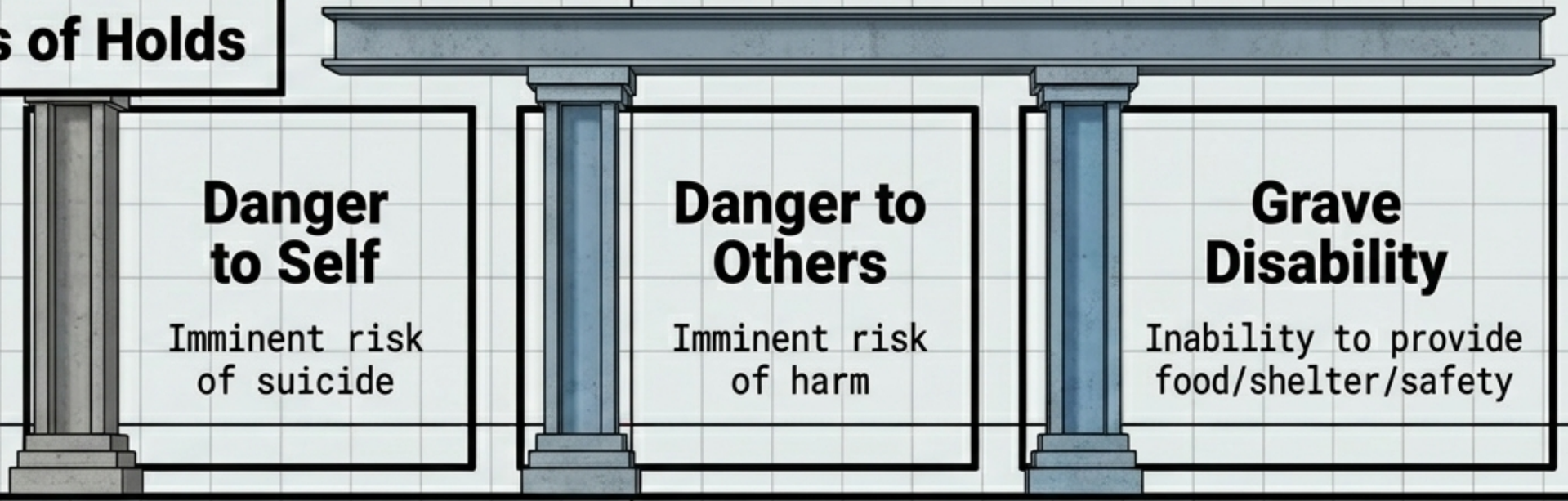
The interval between suicidal impulse and attempt is often under 10 minutes. Means restriction within this window actively saves lives.

Stanley-Brown Safety Plan

1	**Identify Warning Signs** e.g., “I stop eating”
2	**Internal Coping Strategies** distraction, exercise
3	**Social Contacts** people to call
4	**Professionals / Agencies** Therapist, 988
5	**Safe Environment** Removing firearms, blister-packing meds

Involuntary Commitment (The Legal Framework)

The 3 Pillars of Holds



Danger to Self

Imminent risk of suicide

Danger to Others

Imminent risk of harm

Grave Disability

Inability to provide food/shelter/safety

Documentation Do's & Don'ts

✗ **Weak / Vague Documentation**	**Patient has major depressive disorder with suicidal ideation.** Speculative, lacks intent.
✓ **Legally Defensible Documentation**	**Patient states, "I plan to shoot myself tonight." Patient has access to a loaded firearm at home and lacks insight into need for hospitalization.** Specific, imminent, objective.

Disposition Decision Tree

Stabilized ED Patient

ADMIT

- Active suicidality with intent/plan
- Acute psychosis
- Severe impairment
- Danger to others
- Acute substance withdrawal requiring medical monitoring

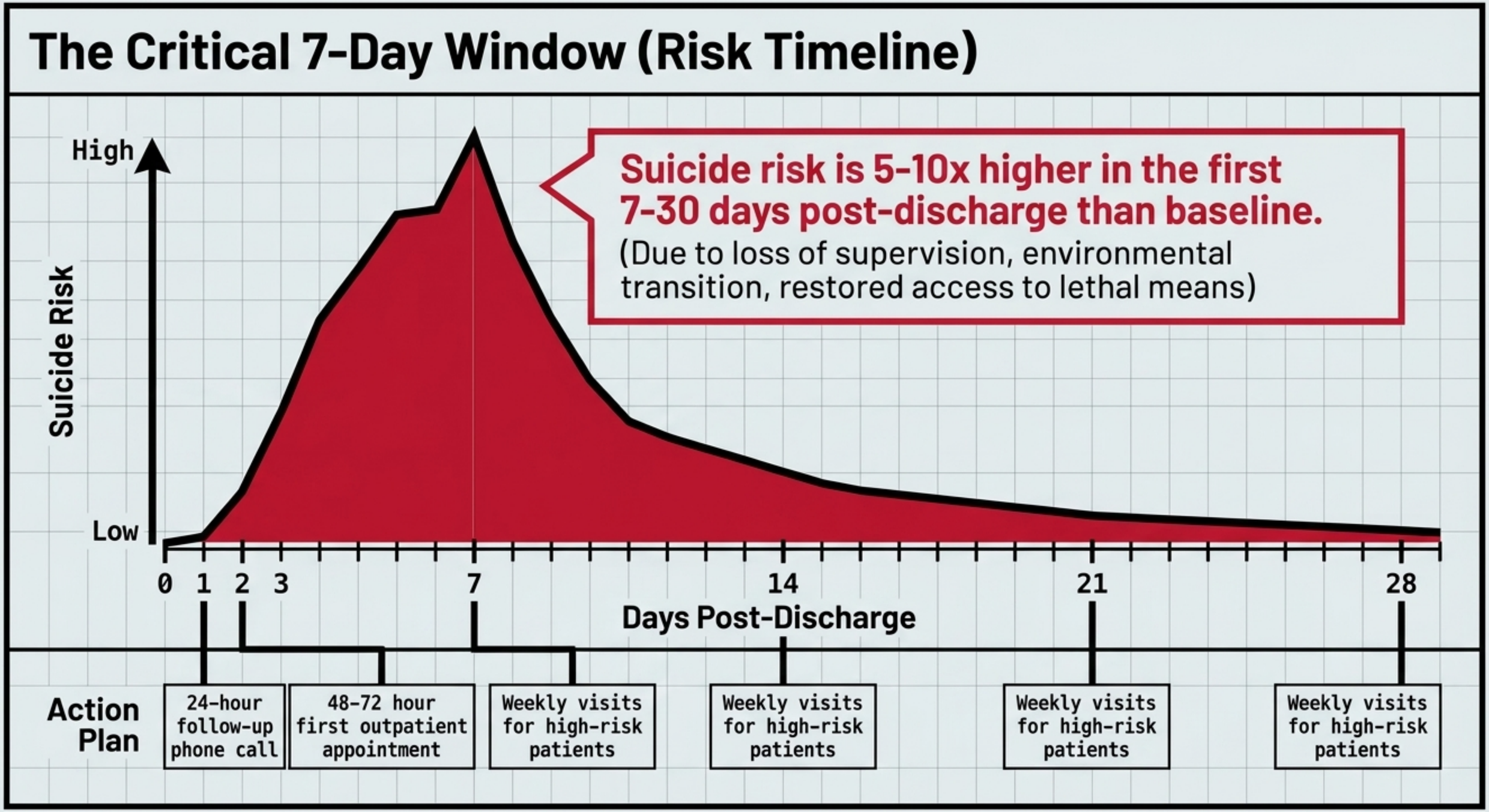
OUTPATIENT DISCHARGE

- ☐ Robust safety plan established
- ☐ Zero access to lethal means
- ☐ Intact support system
- ☐ Reliable follow-up scheduled

Bridge Interventions

- → 10-minute motivational conversation
- → Provide 988 crisis number
- → Warm handoff to outpatient care

The Critical 7-Day Window (Risk Timeline)



Synthesis

The 5 Golden Rules of ER Psychiatry

1	**De-escalate First:** 70-80% respond to verbal intervention. Use the staircase.
2	**Rule Out Mimics:** Hypoglycemia, toxidromes, and CNS infections hide behind psychiatric symptoms.
3	**Know the Lethal Traps:** Never combine IM Olanzapine + IM Benzos. Never give antipsychotics in untested Catatonia.
4	**Document Imminent Danger:** Legal holds require specific, actionable behavioral quotes, not just diagnoses.
5	**Guard the 7-Day Window:** Discharge is not the end; it is the most dangerous transition. Mandate 48-72h follow-up.