Chapter 27: Emergency Psychiatry

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Introduction

Psychiatric emergencies are acute disturbances in thought, behaviour, mood, or social relationship that require immediate intervention to save the patient and/or others from imminent danger (Baker, 2022). Emergency psychiatry is the clinical assessment and management of these events.

Psychiatric emergencies can arise in any setting, including the person's home or a public place. Increasingly, and for a number of reasons, people experiencing psychiatric emergencies are brought to the Emergency Departments of our hospitals. This chapter describes these psychiatric emergencies and their management.

A doctor's approach and style of thinking and acting in a psychiatric emergency is quite different to a psychiatrist's behaviour in a quiet consulting room with a cooperative patient who is a good historian. Frequently, there is an imperative to make a rapid assessment on imperfect information. A sound knowledge of psychiatric conditions and treatments is essential, but not sufficient. In the emergency situation, the psychiatrist needs to be assessing the patient and the situation on a number of levels. What is the nature of the patient's distress? What are the likely diagnostic and aetiological hypotheses? What information can family/ambulance officers/police/Emergency Department staff provide? What are

the immediate risks (aggression, self-harm, absconding, misadventure, medical emergency)? What is going to be the safest setting to manage the patient? Does the patient require involuntary detention under mental health legislation? Who needs to be involved in the care of the patient? What advice and direction do they require? All the while, psychiatrists dealing with a psychiatric emergency must contain their own anxieties in order to bring calm and authority to the situation and to provide explanation, direction and reassurance to the patient, the family and colleagues. The urgent clinical situations seen in psychiatry can be divided into behavioural and medical emergencies.

Behavioural Emergencies

Acute Severe Behavioural Disturbance

Acute Severe Behavioural Disturbance (ASBD) can come in many forms, from agitation, pacing, shouting, nonsensical speech and bizarre posturing to withdrawal, mutism and torpor. Assessment follows the principles of general medicine and includes (i) obtaining as full a history as possible; (ii) corroborating or clarifying that history by speaking to the patient's family and friends and to witnesses and health care staff; (iii) performing as complete an examination as possible, with specific emphasis on the neurological and endocrine systems; and (iv) ordering appropriate investigations. An early priority is assessing your own safety as well as that of the patient, other patients, visitors and staff. A life-threatening medical emergency has usually, but not always, been identified at triage.

Once this has been done, the diagnostic schema usually known as Fould's hierarchy (see Figure 27.1) can be helpful. This framework used in emergency assessment grossly oversimplifies Fould's and Bedford's complex and interesting work on relationships between classes of mental illness (Foulds and Bedford, 1975) but is nonetheless clinically valuable. The hierarchical pyramid reinforces three helpful concepts. Firstly, each item on the pyramid is a more urgent diagnostic consideration than those below; secondly, each can mimic the symptoms of those below; and thirdly, items lower down the pyramid are encountered more frequently than those above.

The first diagnostic consideration, the tip of the pyramid, is 'organic', in other words, a physiological cause of acute brain disturbance. It is critical to consider this as these are the disorders that can kill patients rapidly. No great harm is done when a psychiatric disorder such as mania or schizophrenia is misdiagnosed as an organic condition, but the reverse error can be life-threatening.

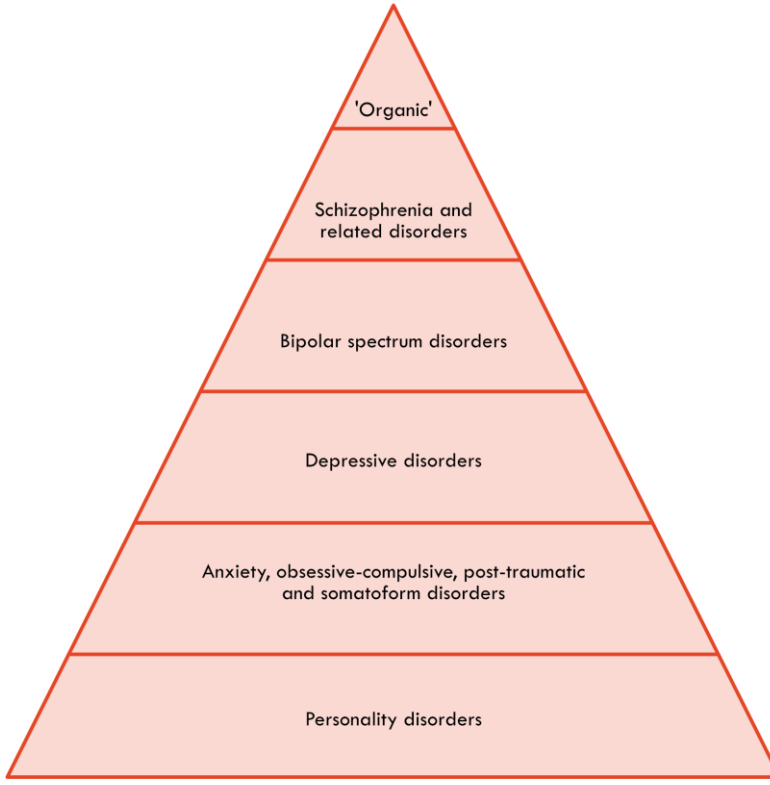

Figure 27.1. A Primer of clinical psychiatry, adapted from ClinicalGate (clinicalgate.com)

When considering an organic diagnosis, think of three broad categories: (i) exogenous (in other words intoxication or withdrawal states involving recreational drugs or prescribed medications); (ii) intracranial (such as bleeding, space-occupying lesions, cerebrovascular events or viral or autoimmune encephalitis); and (iii) systemic (any end organ failure or marked metabolic disturbance can cause a confusional state, most commonly hypoxia, sepsis, hypo- or hyper-glycaemia, acute renal failure, acute hepatic failure, profound hypo- or hyper-thyroidism and silent myocardial ischaemia). Context is important, and you are likely to have different diagnostic priorities for a young man seen in ED at 2am on a Sunday morning than for an elderly woman assessed twelve hours post-operatively on a surgical ward.

If you are satisfied that the disturbance is unlikely to be organic, actively consider psychosis. It is quite easy to spend an hour with a patient and not uncover psychotic symptoms unless they are specifically pursued. Ask about auditory

hallucinations, hallucinations in other modalities, unusual (persecutory, grandiose, bizarre) thoughts, ideas of reference, thought interference and passivity phenomena.

Next specifically enquire about symptoms of mania and major depressive disorder. Then consider anxiety disorders, post-traumatic states and OCD. Finally think about an acute stressor in a person with personality vulnerabilities.

If an 'organic' diagnosis is made, definitive medical management is indicated, with liaison psychiatry involvement to assist in psychological, environmental and (where indicated) pharmacological management of the condition. For others, reassurance, a low stimulus environment, presence of a staff member if indicated, active involvement of family or friends, judicious pharmacological management of agitation (usually with benzodiazepines) and specific treatment of the underlying psychiatric disorder are priorities.

Aggression

Approaching the patient with Acute Severe Behavioural Disturbance (ASBD) who is loud, pacing, agitated, or threatening requires as much clear thought as possible, in a very tense situation ("First take your own pulse…"). If you are asked to see a person who is agitated, aggressive or escalating in behaviour, try to ensure that it is done in a clearly visible area, where you can be seen by other staff, and can readily leave. Ensure that the patient can't get between you and the door. Find out as much as you can about the patient ahead of time by reading the notes, looking at the ambulance or police report and talking to anyone who might have accompanied the patient.

Approach the patient slowly, in a calm and low-key manner, and with an open stance (arms by your sides, palms forward). Pay close attention to your own subliminal cues; your body is trying to tell you something. If the patient's manner is very threatening, ensure that a sufficient number of staff members are very close by (at least five, including security). Carry out the history and examination as fully as possible in the circumstances. Do whatever eases a charged atmosphere, for example offer the patient a drink of water. Don't react, don't be aggressive and don't make promises you can't keep. If the person is highly agitated, offer an anxiolytic medication (usually a benzodiazepine, or a sedating antipsychotic medication). The most likely diagnoses to consider include:

1. Alcohol or stimulant (methamphetamine, cocaine) intoxication
2. Organic brain syndrome (developmental disorder, acquired brain injury, dementia)
3. Acute psychosis and/or mania (see Chapters 15 and 17)

4. Cluster B (antisocial, borderline, narcissistic) personality organization in crisis (see Chapter 22)

The initial approach to the irritable, agitated, or aggressive patient is one of verbal de-escalation. The aim is to restore a workable clinician-patient dialogue. The Mental Health clinician is often the leader and 'culture bearer' in these challenging situations. The most important issue is attitude. Fundamental to successful interventions with an agitated patient are: positive regard for the patient, the capacity for empathy and patience. De-escalation frequently takes the form of a verbal loop in which the clinician listens to the patient, finds a way to respond that agrees with or validates the patient's position, and then states what he wants the patient to do, for example, accept medication, sit down, etc. (Accinni et al., 2021).

In rare situations, physical restraint and parenteral sedation may need to be considered. This should not be used unless there is no other possible way of ensuring the safety of your patient, other patients, visitors and staff (and of course yourself) from harm. The principles in this situation are to ensure sufficient preparation (medications drawn up, space cleared of potential implements), sufficient numbers of staff (five-point restraint: one person for each limb, and the head)), prompt action and a paramount consideration for the safety, welfare and dignity of the patient. Recall that many patients presenting with severe behavioural disorders will have a history of trauma and may find restraint especially distressing. Before working in this area, ensure you are familiar with a detailed and up-to-date protocol for the use of restraint of the agitated patient.

Acute Psychosis

The patient with an acute psychosis may not be aware that they are unwell. The hospital, and especially the Emergency Department, can be a strange and frightening environment. While many feel reassured that they are in a medical facility, the hospital setting exacerbates the condition of some patients. The person with acute psychosis may find the world a threatening place and may not trust people, or even believe they are not who they purport to be. It is important to understand that the patient's agitation may arise from persecutory or referential ideas. The patient requires careful assessment, explanation and reassurance. If the person is presenting with their first episode of psychosis, they and their family are entering a strange and intimidating world of mental health services and often the psychiatric inpatient unit. How the clinician interacts with the person and their family and manages the situation can leave a lasting impression. Again, as with the aggressive or agitated patient, the mental health clinician has an important role as leader and culture bearer. Positive regard, empathy and patience are required.

Investigations are done on patients presenting with a first episode of psychosis to exclude organic causes and contributory factors, and may include: FBC, EUC, LFTs, TFTs, Brain MRI or CT, EEG, B12, Folate, antineuronal antibodies to exclude autoimmune encephalitis, urine drug screen and ECG (as many medications have potential cardiac side effects). Further investigations may be required depending on the history obtained.

If the patient is known to have schizophrenia or a similar diagnosis, an antipsychotic may be initiated in emergency. However, if a drug-induced psychosis is a possible diagnosis, it may be worth holding off on commencing an antipsychotic with a view that a drug-induced psychosis will usually resolve without antipsychotics over a few days to a week. In either circumstance the patient's distress may be assisted by the short-term use of benzodiazepines.

Acute Mania

The manic patient presents as elevated, loud, expansive and overactive or irritable, argumentative and hostile. Usually they are distractible and this can often be used to advantage to avoid confrontation. Often the manic patient will not have slept for a number of days and may not have attended to their hydration and self-care. One severe case was a man in his 40s who was brought by police having been found half-naked, bare foot and hollering in a national park. He had been out there for 4 days in the burning sun by day and low temperatures at night, eating and drinking only what he could find in the bush. He was hoarse from shouting "God's Word", severely sunburned and his feet lacerated from walking on sharp stones. Here the disruptive behaviour is an interaction between his mania, dehydration, sunburn and his injuries. All require management.

The principles that apply to the care of the acutely psychotic patient apply with the manic patient. The investigations required are the same as for other psychotic illnesses such as schizophrenia. One important point of emphasis is that the manic patient requires containment and sleep. Sedation in the first 48 hours is frequently required. Antidepressant medication should be discontinued. If the patient is known to suffer bipolar disorder an antimanic agent (lithium, valproate) or a second generation antipsychotic (or a combination of the two) may be commenced in the emergency department. However, as is the case with acute psychosis, if a drug-induced psychosis is a possible diagnosis, it may be worth providing benzodiazepines alone initially.

Catatonia

Catatonia is a rare presentation of acute psychosis, most often seen in organic disorders, schizophrenia-spectrum disorders, acute mania and amphetamine-associated psychosis. The clinical hallmarks are marked psychomotor slowing often to the point of immobility, mutism, resistance to passive movement ("gegenhalten") and so-called "waxy flexibility" (limbs remain as positioned by the examiner) although incomplete forms are more commonly seen. In fact some studies suggest that in an attenuated form catatonia can be seen in up to 10% of psychiatric inpatients (Heckers and Walther, 2023). The initial clinical priority is prompt exclusion of neurological, metabolic and other causes of sudden onset rigidity and unresponsiveness. Immaculate medical and nursing care of the immobile patient is essential, including adequate hydration (intravenous fluids if needed), regular turns, monitoring of pressure areas and where indicated DVT prophylaxis. Up to three quarters of patients will respond to parenteral lorazepam 1-2mg 6th hourly as needed, up to 6mg/day. For patients who are unresponsive or deteriorating clinically, electroconvulsive therapy is the treatment of choice. Antipsychotic medication is generally held to be ineffective and should in any case be withheld until neuroleptic malignant syndrome is excluded, but may be needed during recovery for residual psychotic symptoms.

Suicidality and Self-Harm

Assessing a patient for suicidality might occur after a suicide attempt or act of self-harm, after a patient has presented with suicidal thoughts or after concerns have been raised during an unrelated presentation. Previously guidelines to suicide risk assessment have tended to focus on risk factors and encouraged stratification into 'high', 'moderate' and 'low' risk groups. However, the evidence now makes plain that a risk-stratification approach cannot guide management and should not be undertaken (Heckers and Walther, 2023). A careful, unhurried history, augmented by any corroborative sources you can find, is of paramount importance, for at least five reasons.

Firstly, it helps to allow a diagnosis to be made, and use of Fould's hierarchy can let us determine whether organic factors, psychosis or severe mood disturbance are present, each of which require a specific response. Although diagnosis is not a strong prognostic factor for suicide overall, some symptoms seen in particular mental disorders (persecutory delusions in schizophrenia, severe major depression with agitation and/or psychotic features) indicate a need for a particularly careful assessment. Secondly, elements in the history should influence your formulation and management plan: these include past suicide attempts, a family history of completed suicide, impulsiveness, poor physical health, chronic pain and substance abuse. Thirdly, it allows an assessment of capacity, which is vital if consideration is to be

given to involuntary treatment. Fourthly, it allows for engagement with the patient; there is nothing like taking the time to really hear someone's story to lessen resistance and build trust.

Fifthly, with empathy and understanding it can lead to a formulation, to try to answer the question "Why is this person presenting with this problem at this time"? If uncertain, come back and see the patient a second time. This will give you important information about the level of engagement and the variability of their clinical presentation.

A decision to discharge a patient who has expressed or elicited suicidal concerns should not be made without a thorough discussion with a senior mental health clinician. Factors that will influence this decision include:

- severity of the attempt or intensity of the ideation,
- the quality of engagement,
- the patient's current expressed attitudes,
- the availability of a responsible adult who is aware of the situation to be with the patient and
- the availability of after-hours mental health services.

The Patient with Borderline Personality Disorder in Crisis

People living with borderline personality disorder (see Chapter 22) have usually had the unlucky combination of an exquisitely sensitive and over-emotional temperament and an invalidating or abusive developmental background. They are prone to discontinuities of affect, cohesion and sense of self. The most common emergency presentations are with overdose, self-cutting and suicide attempts. Many self-harm presentations are attempts to cope with unbearable and overwhelming emotions or complete lack of feeling in a numbed and often depersonalized state. With patients who present repeatedly there can be a temptation to discount the importance of an individual act of self-harm, but it is important to remember that members of this group have a 10% lifetime risk of suicide.

The key to assessing and managing the patients with borderline personality disorder who present in crisis is the ability to connect and engage (Meares, 2012). In addition to the positive regard, empathy and patience required in most psychiatric emergencies, how the clinician handles transference and countertransference is vital. There are some particular points additional to those of the standard emergency psychiatric assessment principles that apply to the patient.

Connecting with the patient with borderline personality disorder

1. Listen (put your agenda on hold)
2. Choose what is most alive (amplification)
3. Find and affirm that which is positive (validation)
4. Use the language of the patient
5. Attunement to the patient's feeling state (empathy)
6. Stay aware of your own feelings, thoughts,
7. Avoid using the personal pronoun 'you' (speak about things in a more general sense: "it seems…..")
8. Acknowledge disruptions and your own disjunctions

The Patient with an Eating Disorder in Crisis

Patients with severe eating disorders (see Chapter 21) have the highest mortality rate of any psychiatric disorder. Most often the acute crisis involves a patient with anorexia nervosa presenting after a period of food restriction and purging. Many of these patients also have depression or borderline personality disorder and so may present with an episode of self-harm when the more life-threatening aspect of their situation is their physiological state of starvation.

The key parameters that must be assessed to determine whether the anorexic patient requires a medical admission of re-feeding and restoration of their physical health are:

1. BP < 90/60mmHg or BP postural drop (> 20 mmHg).
2. BMI <14kg/m2 in women or 16kg/m2 in men plus acute medical issue (e.g. infection).
3. Significant electrolyte disturbance (i.e. serum potassium < 2.5mmol/L, hypophosphatemia).
4. Haematological abnormalities such as significant anaemia (Hb < 70) or severe neutropaenia < 1.0 x 10^9/L.
5. LFT dysfunction (3 upper limit of normal).
6. Hypothermia (temperature < 35.5°C).
7. Renal failure
8. Symptomatic hypoglycemia (< 2.7mmol/L).
9. Heart rate < 40 bpm or > 110 bpm or postural tachycardia of increase of > 10 bpm.

Refeeding syndrome is a potentially life-threatening complication of medical treatment for profoundly starved patients, in which an array of electrolyte and haematological imbalances including hypophosphataemia, hypokalaemia, low thiamine and white cell dysfunction can lead to multi-organ damage, neurological impairment and death. Recent studies suggest the risk may be less than previously considered, and that in most cases rapid re-feeding under close medical and nutritional supervision can safely take place (Staab et al., 2022).

Medical Emergencies

General Considerations

The following conditions are life-threatening medical conditions seen in patients with psychiatric disorders. There remains a stigmatising tendency to view unexpected clinical events in medically hospitalised psychiatric patents as "behavioural" until proven otherwise, sometimes with catastrophic results. Any acute deterioration in your patient needs prompt review, with active consideration of these life-threatening medical complications.

Delirium

The syndrome of delirium results from disruption of normal brain function due to biochemical, electrical, or mechanical disturbances. Delirium can be thought of as a 'brain fever'. As with fever in a respiratory infection, it is a reliable indicator that something serious is going on, and that investigation and intervention are required. Possible outcomes include death and dementia and as with any other acute organ failure, delirium should be considered a medical emergency. The patient requires hospitalisation and investigation unless the cause is known and imminently correctable.

While each patient's clinical presentation will vary, sometimes considerably, because of personality factors or the nature of the organic insult, certain features make the diagnosis of delirium relatively simple. The hallmark of delirium is acute onset of a state of *clouded consciousness*: a reduction in the clarity of awareness of the environment. This means the patient has difficulty shifting, focusing and sustaining attention, and is easily distracted by irrelevant stimuli. Impairment of consciousness ranges on a continuum from excited hypervigilance and overactivity - to barely discernible dulling - to coma. Characteristically this fluctuates, often worsening at night with fatigue and decreased environmental stimulation.

Often the patient is unable to accurately describe: the hour of the day, the day of the week, the month, the year. He is unable to find his way in the ward. He

does not know which ward he is in, or which hospital, nor indeed which city and sometimes which state or even country. He may indicate he does not know who the doctor is or not recognize family members. A corroborative history from family confirms these capacities were recently intact. Memory impairment occurs because of failure to register new information, disturbance of short term processing and distorted thinking.

Perceptual disturbances are characteristically a hypersensitivity to stimuli, illusions, misinterpretations and hallucinations. Illusions are distorted perceptions: the folds of bedclothes become a geography of mountain ranges. Misinterpretations are correct perceptions given a wrong meaning: a door slamming is thought to be a pistol shot. Hallucinations are false perceptions in the absence of sensory stimuli. Visual hallucinations commit the physician to *excluding* the diagnosis of delirium.

Thinking is disturbed, usually slowed, and characteristically the patient's utterances are no longer goal-directed. Reasoning is defective, complex ideas cannot be formulated, and there is difficulty grasping and understanding. The thought disorder of delirium is most commonly manifest in fragmented and rambling speech. Delusions may be reported, often secondary to perceptual anomalies but these are disorganised rather than systematised.

Psychomotor activity is also disturbed. The patient with hyperactive delirium is restless and hyperactive and this activity is purposeless. He gropes and picks at his bedding or attempts to stand in or get out of bed. Alternatively, and more commonly, the patient with hypoactive delirium may be slowed, sluggish and apathetic. The sleep-wakefulness cycle is usually disturbed, the patient somnolent and drowsy during the day, aroused and overactive at night.

Delirium is often missed in medical settings, especially hypoactive rather than hyperactive forms. As delirium indicates a very significant risk of morbidity and mortality, and a risk of progression to dementia, screening of vulnerable populations (especially elderly medical inpatients, older patients post-surgery, those with multiple medical co-morbidities and those on multiple medications) with well-validated brief instruments such as the Confusion Assessment Method (CAM) or Delirium Rating Scale (DRS) is vital (Helfand et al., 2021).

The patient with delirium requires medical investigation and management. The patient should be nursed in an easily observable bed, with a quiet environment. Attendance of a family or a one-to-one nursing special can provide orientation, reassurance and mitigate the risk of falls, wandering or absconding. The patient may require sedation if they are agitated, paranoid, or hyperactive. Care should be taken to not prescribe benzodiazepines where an intracranial cause is suspected.

There is no evidence that antipsychotics speed the resolution of delirium, and they should generally be avoided. If unavoidable, antipsychotics must be used very judiciously and in low doses with older patients as these medications are associated with increased cardiac and cerebrovascular morbidity.

Delirium in summary:

- Acute onset (hours–days)
- Clouding of consciousness
- Disorientation
- Memory impairment
- Perceptual disturbance
- Disrupted cognition
- Decreased or increased motor activity
- Disturbed sleep-wake cycle
- Fluctuating course

Acute Alcohol Withdrawal (Delirium Tremens) or Benzodiazepine Withdrawal

Delirium Tremens (the DTs) occurs in acute severe alcohol withdrawal. The clinical picture is of a patient with a history of substantial, prolonged alcohol intake who becomes agitated, tremulous and confused on day 2 or 3 of abstinence from alcohol. A very similar picture can occur with acute benzodiazepine withdrawal. Typically, the patient has a raised temperature, pulse and blood pressure, is shaking, sweating, confused, agitated, paranoid and reports visual hallucinations and illusions.

The patient is first given at least 300 mg parenteral thiamine – and substantially more if Wernicke encephalopathy (WE) is suspected. An oral multi-vitamin is commenced daily. At the same time, the severity of the withdrawal is assessed with an alcohol withdrawal scale (AWS). Sedation with 10-20 mg diazepam oral or IV every one to two hours is continued while the AWS score is greater than 4 and until the patient is lightly sedated. Small doses of haloperidol are sometimes required in the early stages (Schuckit, 2014). Signs of Wernicke encephalopathy include altered mental state, oculomotor abnormalities such as nystagmus, gait ataxia and evidence of nutritional deficiencies (Cantu-Weinstein et al., 2024).

Neuroleptic Malignant Syndrome

Four acute extrapyramidal syndromes can occur after starting or increasing an antipsychotic medication: neuroleptic malignant syndrome, acute dystonia, pseudoparkinsonism (slowing, shuffling gait, reduced arm swing) and akathisia (subjective motor restlessness). While all are distressing, the first two are also potentially dangerous and require immediate treatment.

Neuroleptic malignant syndrome has four cardinal features in a patient who has recently been treated with antipsychotic medication (Schönfeldt-Lecuona et al., 2020):

1. increased muscle tone
2. fever
3. elevated creatinine kinase (CK)
4. altered sensorium

Prevalence estimates vary widely, from one in six thousand to one in thirty neuroleptic-treated patients, although the most comprehensive review points to an occurrence of less than one in a thousand (Gurrera et al., 2007). Once the possibility of NMS has been raised, it should be rigorously evaluated, as a discharge comment of "*? NMS*" can greatly complicate future treatment. The diagnosis is unlikely without at least three of the features above, and the CK will usually be significantly elevated, typically > 1000 mU/mL. Remember that some degree of CK elevation is likely in a psychiatrically unwell patient who has walked long distances, lain for long periods of time, been involved in physical altercations or received intramuscular medication. Treatment involves supportive medical care, withdrawal of the causative agent and in severe cases consideration of specific pharmacological therapies (dantrolene, bromocriptine, and biperiden), lorazepam or ECT.

Laryngeal Dystonia

Acute dystonias occurring with antipsychotic medication typically affect the head and neck and can cause such distressing experiences as oculogyric crisis (forced involuntary upward gaze) and lockjaw. They are more commonly seen with potent D2 receptor blocking agents, such as haloperidol or risperidone. Laryngeal dystonia is a rare but unforgettable presentation, with hoarse voice, stridor and difficulty breathing. It can easily be mistaken for an anaphylactic reaction but should be distinguishable on history and lack of skin or mucosal changes (Ilchef, 1997). Treatment is with an intravenous anticholinergic agent such as benzatropine.

Serotonin Syndrome

Serotonin syndrome arises from the use of substances that increase serotonin levels in the central nervous system, especially when these are taken at high doses or in combination (Scotton et al., 2019). The features of serotonin toxicity are neuromuscular excitation (hyperreflexia, clonus), autonomic changes (tachycardia, hypothermia) and altered mental state (agitation, confusion). Table 27.1 shows some agents associated with serotonin syndrome.

The principles of treatment are discontinuation of all serotonergic agents, cooling and fluid resuscitation where appropriate, benzodiazepines to reduce muscular rigidity and the risk of lactic acidosis and rhabdomyolysis, and consideration of a serotonin antagonist such as cyproheptadine, although this last measure has not been conclusively demonstrated to be of benefit (Nordstrom et al., 2016).

Conclusion

A variety of emergency presentations are seen in psychiatry, both behavioural and medical. Compared to the more predictable course of end-organ failure seen in other clinical disciplines, crises in psychiatry can be dramatic, dynamic and unpredictable, and require not only close attention to the person and their clinical state but also a rapid assessment of context, environment and safety, including of course your own.

Attending closely, anticipating and responding quickly to escalating distress, agitation or behavioural disturbance in a calm, non-threatening but authoritative manner can rapidly transform a fraught environment and improve outcomes. Intervene early in a deteriorating situation, prioritize the safety of everyone present, exclude an organic cause to the extent possible, be kind and always be mindful of your patient's dignity.

Table 27.1. Medications contributing to the Serotonin Syndrome. Adapted from Spadaro et al. (2022).

Class of Medications	Medications
Psychotropic	SSRIs: citalopram, fluoxetine, sertraline, escitalopram, paroxetine, fluvoxamine SNRIs: venlafaxine, desvenlafaxine, duloxetine TCAs: dosulepin, clomipramine, impramine, amitriptyline MAOIs: phenelzine, tranylcypromine RIMA: moclobemide NaSSA: Mirtazapine
Anticonvulsants	Lamotrigine, carbamazepine, valproate
Antiemetics	Ondansetron, granisetron, metoclopramide
Anti-migraine	Triptans, ergotamine, methylergonovine
Opioids	Fentanyl, methadone, dextromethorphan, tramadol
Illicit Drugs	Methamphetamine, amphetamine, ecstasy (MDMA), psilocybin, LSD
Miscellaneous	Methylene blue, St. John's Wort, chlorpheniramine

Further Reading

Mental Health and Drug and Alcohol Office. Mental Health for Emergency Departments – A reference Guide. NSW Ministry of Health March 2015. www.health.nsw.gov.au/mentalhealth/resources/Publications/mental-health-ed-guide.pdf

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