How to use psychotropics in behavioural emergencies

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The vernacular use of “psychotic” is quite different from the medical or psychiatric use. It conjures up the image of the raving, agitated person who is in danger of harming themselves and probably those around them as well. This is the group of patients that are being referred to by the term “behavioural emergencies”. They can be brought into the emergency department or perhaps “go crazy” on the ward; often in the psychiatric unit.

The principle under the NSW Mental Health Act is “treatment in the least restrictive environment”.

Where it is safe to do so, aim for the top of the list:

- verbal de-escalation techniques
- “show of force” with de-escalation
- voluntary oral sedative +/- antipsychotic
- “takedown” with involuntary intramuscular sedative +/- antipsychotic

**Principles of treatment**

- safety (yourself, staff and the patient) is of utmost importance;
- agitated patients can often tolerate larger than expected doses;
- “least restrictive therapy” – the goal is **not** to turn the patient into a drooling vegetable (antipsychotics cause both hypersalivation and sedation);
- oral is preferable to parental;
- liquid formations (or dissolvable wafers) are better tolerated than tablets in these patients;
- a benzodiazepine is best for sedation but in the severely agitated patient, it may not be enough;
- an antipsychotic can be used in conjunction to provide additional effect (though remember, you are using the **sedative effect** of the antipsychotic; the antipsychotic effect occurs slowly over days to weeks);
- aim for monotherapy with regards to antipsychotics where possible (e.g., starting someone on regular risperidone tablets, using olanzapine as an intramuscular “PRN” and chlorpromazine syrup an oral “PRN” is far from optimal practice);
- remember the legal dimension and your obligations under the Mental Health Act.

**Oral therapy**

**diazepam** 5-20 mg every 2-6 hours up to 120 mg in 24 hours (titrate to response)
- really crazy person: diazepam 20 mg every 2 hours until settled
- agitated elderly person: start with 5 mg (perhaps even 2.5 mg)

**Consider adding an antipsychotic**

**Risperidone**
(dissolving tablets preferable) 2 mg every 2-4 hours up to 6 mg in 24 hours (titrate to response)

- **usual dose:** start with 2 mg for most people
- **small person:** consider starting at 1 mg
- **agitated elderly person:** start with 1 mg (perhaps even 0.5 mg)

*or*

**Olanzapine**
(wafers preferable) 5-10 mg every 2-4 hours up to 30 mg in 24 hours (titrate to response)

- really crazy person: 10 mg
- smaller sized person: 5 mg
- agitated elderly person: start with 2.5 mg

**If benzodiazepines are contraindicated**

**Chlorpromazine** (liquid preferable) 50-200 mg every 2 hours up to 400 mg in 24 hours (titrate to response)

- usual dose: 100 mg
- smaller person: 50 mg
- elderly: avoid

**Intramuscular therapy**

**Midazolam** 2.5-10 mg IM every 20 minutes up to 20 mg per “sedation event” (titrate to response)

- really crazy person: 10 mg
- not so crazy person: 5 mg
- small person or unsure about tolerance: 2.5 mg
- elderly person: start low – 1 mg initially
  - resuscitation equipment with airway support must be available before use of midazolam
  - monitoring of oximetry and blood pressure for 4 hours is recommended

*and/or*

**Olanzapine**

5-10 mg IM every 2-4 hours up to 30 mg in 24 hours (titrate to response)

- really crazy person: 10 mg
- agitated elderly person: start with 2.5 mg
or if sedation for 2-3 days desired

**zuclopenthixol acetate**

(Clopixol-Acuphase) 50-150 mg every 2-3 days

- *usually*: 100 mg per dose
- *small / elderly person*: avoid if possible

Source material: Dr May Su Resources: [Therapeutic Guidelines: Psychotropic 5, 2003](#)

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