

[HOSPITAL / HEALTH AUTHORITY NAME]

MENTAL HEALTH CRISIS, SELF-HARM, AGITATION, AND BEHAVIOURAL EMERGENCY PATHWAY

Protocol 42: Parallel Medical and Mental-Health Assessment, Suicide and Self-Harm Care, De-escalation, Acute Behavioural Disturbance, Restrictive Intervention Safeguards, Capacity, Observation, Transfer, and Safe Disposition

DRAFT FOR EMERGENCY MEDICINE, PSYCHIATRY / MENTAL HEALTH, NURSING, PAEDIATRICS, ANAESTHESIA / CRITICAL CARE, PHARMACY, TOXICOLOGY, SOCIAL WORK, SAFEGUARDING, SECURITY, EMS, POLICE LIAISON, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be adapted to local mental-health legislation, consent and capacity law, safeguarding duties, observation policy, search policy, restrictive-intervention policy, approved rapid-tranquillisation chart, medication formulary, staffing, psychiatric response times, transfer resources, police agreements, and community crisis services before implementation.

MENTAL-HEALTH EMERGENCY SAFETY RULE: Behaviour is a presentation, not a diagnosis. Hypoxia, hypoglycaemia, head injury, seizure, infection, delirium, intoxication, withdrawal, medication toxicity, pregnancy-related illness, pain and other medical causes must be sought and treated in parallel with compassionate mental-health care. No person who self-harms should be dismissed, punished, discharged on the basis of a risk score, or left without a documented safety and follow-up plan.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Mental Health Service / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Psychiatry / Mental Health; Nursing; Paediatrics; Anaesthesia / Critical Care; Pharmacy; Toxicology; Social Work; Safeguarding; Security; EMS; Police Liaison
Applies to	Children, adolescents and adults presenting with acute psychological distress, suicidal thoughts or behaviour, self-harm, psychosis, mania, severe depression, agitation, behavioural disturbance, impaired decision-making, or a mental-health concern accompanying a physical emergency.
Interfaces	Protocol 1 Patient Journey; Protocol 2 Triage; Protocol 3 Resuscitation / Sepsis / Shock; Protocol 17 Altered Mental Status; Protocol 19 Seizures; Protocol 27 Glycaemic Emergencies; Protocol 29 Poisoning / Intoxication / Withdrawal; Protocol 31 Trauma; Protocol 32 Head Injury; Protocol 38 Obstetric / Postpartum Emergencies; Protocol 40 Seriously Ill Child; Protocol 43 Safeguarding; Protocol 48 Airway; Protocol 50 Procedural Sedation; Protocol 51 Capacity / Refusal; Protocol 58 Security and Staff Safety.
Version / status	Draft 1.0 for local multidisciplinary validation
Review cycle	After any suicide or serious self-harm event linked to ED care, death or collapse during restraint or sedation, unplanned intubation, absconding with serious harm, unlawful restriction, medication event, assault, delayed psychiatric review, major law or guideline update, or at least every 2 years.
Required approval	Emergency Department; Mental Health Service; Nursing; Paediatrics; Anaesthesia / ICU; Pharmacy; Toxicology; Social Work; Safeguarding; Security; EMS; Legal / Risk; Clinical Governance.

1. Purpose

To provide a standardized emergency-department pathway for rapid recognition, humane assessment, immediate stabilization, suicide and self-harm care, de-escalation, management of acute behavioural disturbance, lawful and least-restrictive intervention, mental-health consultation, transfer and safe disposition. The protocol integrates physical healthcare and psychosocial care rather than treating them as sequential or competing tasks.

The aims are to reduce avoidable harm from missed medical illness, stigma, delayed analgesia or antidotes, inadequate observation, environmental hazards, prolonged struggle, unsafe restraint, unmonitored sedation, over-reliance on prediction scores, unlawful detention, fragmented transfer and discharge without collaborative safety planning.

2. Scope

This protocol begins at pre-alert or first ED contact and continues through triage, emergency medical treatment, mental-health assessment, observation, admission, interfacility transfer, discharge, departure before completion or death. It applies whether the mental-health problem is the primary reason for attendance or becomes apparent during care for another condition.

The protocol does not replace diagnosis-specific treatment, toxicology pathways, child-protection procedures, mental-health legislation, capacity law, police powers or a locally approved rapid-tranquillisation order set. It must be used with the linked protocols and local legal advice.

3. Core policy statements

- Physical and mental-health assessment occur in parallel. A psychiatric history does not make new abnormal physiology psychiatric, and a normal initial examination does not exclude overdose, intoxication, evolving head injury, delirium or other medical disease.
- Every person is approached with dignity, privacy, cultural safety and trauma-informed care. Use calm language, explain actions, preserve clothing and personal items when safe, and avoid punitive, humiliating or criminalizing responses to distress or repeated self-harm.
- Ask directly and respectfully about suicidal thoughts, intent, plans, access to means, recent acts and reasons for living. Direct inquiry is a clinical assessment and must lead to action when immediate danger is identified.

- Do not use a risk scale or a global label such as low, medium or high risk to predict suicide, decide treatment or determine discharge. Use a documented individualized formulation of needs, vulnerabilities, strengths, foreseeable changes and immediate safety requirements.
- A person who has self-harmed should receive age-appropriate psychosocial assessment at every attendance unless a current jointly agreed specialist plan explicitly states a different evidence-based approach. Do not delay assessment until all medical treatment is complete or until an alcohol level reaches a numerical threshold.
- Observation is active clinical care, not passive watching. It must be performed by trained healthcare staff, have a stated purpose and interval, support engagement, be handed over explicitly and be reviewed after any change.
- De-escalation and voluntary care are first-line. Restrictive intervention is a last resort, lawful, necessary, proportionate, time-limited and the least restrictive option capable of preventing serious harm or enabling essential treatment.
- Rapid tranquillisation is a high-risk emergency intervention. It requires a named senior clinician, a safety brief when possible, immediate airway and resuscitation capability, a locally approved drug pathway, cumulative-dose tracking and continuous post-administration monitoring.
- Mental illness, intoxication, unusual beliefs, refusal or an unwise decision do not by themselves prove lack of capacity. Capacity is decision-specific and time-specific, and staff must maximize the person's ability to decide before concluding that capacity is absent.
- Children, adolescents, pregnant or postpartum people, older adults, people with cognitive impairment, neurodevelopmental conditions, communication needs, learning disability, homelessness, custody status or exposure to abuse require adapted assessment and safeguarding.

4. Definitions and severity framework

Term	Operational definition / response
Mental-health crisis	Acute distress, symptoms or social circumstances that overwhelm usual coping and require urgent assessment, support or treatment. Crisis severity is determined by current needs and danger, not diagnosis alone.
Self-harm	Intentional self-poisoning or self-injury, irrespective of apparent purpose. Assess every episode in its own context, including suicidal intent, function, medical severity and safeguarding.
Suicidal crisis	Current or recent suicidal thoughts, intent, planning, preparatory behaviour, attempt, interrupted attempt or inability to maintain safety. Treat immediate danger and establish a collaborative safety plan.
Agitation	Increased psychomotor activity, distress, fear, irritability or restlessness that may impair safe assessment. Agitation is a symptom with medical, toxicological, neurological, psychiatric and environmental causes.
Acute behavioural disturbance (ABD)	A severe clinical presentation that may include extreme agitation, continuous activity, fear, abnormal strength, hyperthermia, tachypnoea or tachycardia and may be associated with life-threatening physiology. It is not a diagnosis and must not be used to obscure the underlying cause.
Delirium	Acute disturbance of attention and awareness with fluctuating cognition, usually caused by medical illness, medication, intoxication or withdrawal. Treat as an organic emergency.
Psychosis	Hallucinations, delusions, thought disorder or marked loss of reality testing. Consider medical, neurological and substance causes, especially in first presentation, atypical age or abnormal physiology.
Psychosocial assessment	A collaborative specialist assessment of the episode, its functions and context, mental state, needs, strengths, vulnerabilities, safeguarding, supports, treatment preferences and safety planning.
Risk formulation	An individualized synthesis of historical, current, foreseeable and protective factors used to guide care. It is not a numerical prediction or low / medium / high label.
Rapid tranquillisation	Parenteral medication used when oral medication is not possible or appropriate and urgent reduction of dangerous agitation is needed. The aim is calm and safe assessment, not unconsciousness.
Restrictive intervention	Manual restraint, environmental restriction or medication used primarily to restrict movement or behaviour. It requires legal authority, clinical justification, monitoring and post-incident review.
Capacity	The ability, for the specific decision at the specific time, to understand, retain, use or weigh relevant information and communicate a choice, after practicable support has been provided.
Safety plan	A collaboratively written plan describing warning signs, coping steps, supportive people and places, professional contacts, emergency actions and restriction of access to lethal means.

5. Roles and accountability

Role	Minimum responsibility
Triage / receiving nurse	Simultaneous physical and mental-health triage; identify immediate medical danger, self-harm / suicide concern, agitation, vulnerability and risk of leaving; select and document observation level; remove hazards according to policy; escalate without delay.

Role	Minimum responsibility
ED clinician	Lead parallel medical assessment, treat injury / poisoning, assess mental state and immediate safety, determine capacity for urgent decisions, initiate de-escalation or emergency intervention, consult mental health and coordinate disposition.
Mental-health clinician	Provide timely age-appropriate psychosocial assessment, risk formulation, diagnosis and treatment advice, legal-status review, safety / care planning, admission decision and follow-up arrangements.
Senior ED clinician	Review high-acuity, diagnostic uncertainty, first-episode psychosis, significant self-harm, possible delirium, restrictive intervention, rapid tranquillisation, refusal with serious danger, prolonged boarding and all departures before completion with unresolved safety concerns.
Nursing team	Provide therapeutic observation, environmental safety, repeated physical observations, medication administration, family communication, personal care, nutrition and hydration, handover and escalation.
Anaesthesia / critical care	Support severe ABD, airway risk, hyperthermia, severe acidosis, cardiorespiratory compromise, difficult sedation, intubation, post-sedation deterioration and critical transfer.
Paediatrics / obstetrics	Provide age- or pregnancy-specific medical care, adapted consent and safeguarding support, and joint management with child / adolescent or perinatal mental-health services.
Pharmacy / toxicology	Support overdose management, medication reconciliation, interaction / QT risk, cumulative sedative dosing, antidotes, approved rapid-tranquillisation concentrations and safer discharge quantities.
Security	Support scene safety under the direction of the clinical lead and local policy. Security staff do not replace trained clinical observation, capacity assessment, restraint leadership or post-sedation monitoring.
Social work / safeguarding	Assess abuse, exploitation, housing, dependants, caregiver capacity, trafficking, domestic violence and safe placement; coordinate multi-agency response.
EMS / police liaison	Provide detailed handover of behaviour, physiology, force / restraint, controlled-energy device or irritant exposure, medicines, capacity concerns, legal status and property; support safe lawful transfer without obstructing clinical care.

6. Required readiness

Readiness domain	Minimum local requirement
Environment	A low-stimulus, ligature-reduced, observable interview area close to clinical staff, with outward-opening access where feasible, two exits or a safe staff escape route, panic alarm, minimal movable objects and rapid access to resuscitation.
Resuscitation	Oxygen, suction, bag-mask ventilation, airway equipment, defibrillator, capnography where available, monitoring, IV / IO access, fluids, temperature control and antidotes immediately available whenever restraint or parenteral sedation may occur.
Staffing	24-hour senior ED decision-maker; trained nursing observation; rapid access to mental-health expertise; paediatric, anaesthetic, toxicology, safeguarding and security escalation.
Policies	Mental-health triage, observation, environmental search, property handling, weapons, absconding, police custody, restrictive intervention, rapid tranquillisation, capacity / refusal, safeguarding, transfer and death.
Medication safety	Current approved oral and parenteral agitation chart with age, pregnancy, frailty, intoxication, QT and maximum cumulative dose safeguards; pharmacy-approved concentrations; reversal / rescue plan.
Communication	Interpreter, hearing / communication aids, trauma-informed information, family liaison, crisis numbers, written safety-plan template and accessible discharge instructions.
Transport	Agreed receiving hospitals and mental-health facilities, clinical and security escort standards, restraint safeguards, monitoring capability, weather / distance contingency and transfer-of-responsibility process.
Training	De-escalation, suicide inquiry, psychosocial support, delirium recognition, capacity, law, safeguarding, safe restraint, rapid tranquillisation, airway rescue and post-incident debrief.

7. Pre-alert, triage, and immediate danger recognition

Presentation / finding	Immediate response
Airway, breathing or circulation threat; collapse; severe bleeding; hanging / strangulation; major trauma; overdose; seizure	Move to resuscitation, activate linked protocol, treat first and maintain observation. Mental-health assessment proceeds when clinically possible.
Hypoxia, hypoglycaemia, hyperthermia, severe tachycardia, hypotension, severe hypertension with symptoms, chest pain, marked acidosis, rigidity or reduced consciousness	Treat as medical / toxicological emergency. Consider ABD, serotonin toxicity, neuroleptic malignant syndrome, heat illness, sepsis, withdrawal or occult trauma.
Current suicide attempt, active intent with available means, command hallucinations to harm, inability to maintain safety, violent threat with weapon	Place in the safest observable area, summon senior clinical and security support, remove access to means by policy, begin direct assessment and use the least restrictive intervention required.

Presentation / finding	Immediate response
Severe agitation, continuous exertion, extreme fear / paranoia, repeated escape attempts or inability to permit essential assessment	Activate behavioural emergency response. Reduce stimulation, assign one communicator, prepare resuscitation monitoring and senior-led de-escalation / sedation plan.
New confusion, fluctuating attention, disorientation, visual hallucinations, atypical first psychiatric presentation, older age	Assume delirium or medical cause until assessed. Obtain collateral history, glucose, temperature, oxygenation, medication review and targeted investigation.
Child / adolescent self-harm, unaccompanied minor, abuse / exploitation concern, postpartum psychosis, cognitive impairment or vulnerable dependant at home	Urgent senior and safeguarding assessment with age- or condition-appropriate specialist involvement.
Distress without immediate danger and stable physiology	Provide privacy, active support, symptom relief and timely mental-health triage. Reassess if waiting, behaviour or circumstances change.
TRIAGE RULE: Do not place a person in an isolated room and then reduce contact. The safer location is close enough for trained staff to observe, engage and respond, while protecting privacy and reducing stimulation.	

8. The first 10 minutes

1. Ensure immediate safety. Identify weapons, ligatures, medicines, toxic substances, concealed injuries, active violence and unsafe environmental features. Call the appropriate response team early.
2. Introduce one lead communicator. State your name and role, acknowledge distress, explain that the team will address physical health and emotional safety together, and ask what would help the person feel safer.
3. Perform rapid ABCDE assessment, complete vital signs, capillary glucose, temperature, oxygen saturation and pain assessment. Expose only as needed and preserve dignity.
4. Treat time-critical injury, poisoning, hypoglycaemia, hypoxia, seizure, sepsis, hyperthermia, withdrawal, trauma or obstetric emergency without waiting for psychiatric review.
5. Ask directly about current suicidal thoughts, recent self-harm, intent, plan, access to means, thoughts of harming others and ability to remain safe in the department.
6. Obtain collateral information from EMS, police, family, carers, records, pharmacy and prior crisis plans while respecting confidentiality and immediate safety duties.
7. Select and document the observation level, staff member responsible, environmental precautions, search / property actions and review time. Observation must continue during tests, toileting and transfer.
8. Begin verbal and environmental de-escalation. Offer water, food, analgesia, nicotine replacement or sensory adjustments when clinically appropriate; do not crowd, argue or make sudden contact.
9. Call mental-health services early and begin parallel assessment. Activate paediatrics, obstetrics, toxicology, safeguarding, anaesthesia or critical care according to the presentation.
10. Document the timeline, working formulation, capacity for urgent decisions, interventions, response, unresolved threats and named ownership of the next review.

9. Parallel medical assessment and exclusion of organic causes

A focused but complete medical assessment is required. The extent of investigation is guided by history, examination, age, first or atypical presentation, abnormal physiology, trauma, pregnancy, substance exposure, medication, comorbidity and the ability to obtain reliable collateral information. Avoid both blanket testing and premature psychiatric attribution.

Domain	Assessment priorities
Airway / breathing	Airway obstruction, aspiration, hypoxia, hyperventilation, opioid or sedative effect, chest injury, asthma, pulmonary embolism and respiratory fatigue.
Circulation	Pulse, blood pressure, perfusion, ECG rhythm, chest pain, dehydration, occult bleeding, stimulant toxicity, QT prolongation, myocarditis or cardiotoxic overdose.
Disability	Glucose, GCS / AVPU, attention, orientation, pupils, focal deficit, seizure, head injury, meningism, intoxication, withdrawal, delirium and postictal state.
Exposure	Temperature, rash, rigidity, clonus, sweating, track marks, hidden wounds, ligature marks, pressure injury, pregnancy, infection, dehydration and evidence of restraint-related injury.
Medication / substances	Prescribed, over-the-counter and traditional medicines; recent changes; adherence; alcohol; stimulants; cannabis; opioids; sedatives; unknown tablets; toxins; withdrawal risk.
Context	Recent loss, trauma, abuse, conflict, housing, finances, legal stress, sleep deprivation, access to care, social isolation, caregiving duties and prior crisis plans.

DELIRIUM RULE: Fluctuating attention, disorientation, altered consciousness, new visual hallucinations or abrupt behavioural change is delirium until proven otherwise. A psychiatric diagnosis should not be made until urgent medical causes have been considered and treated.

10. Engagement, trauma-informed care, and de-escalation

Do	Avoid
Use one calm lead speaker, simple sentences and the person's preferred name.	Multiple staff talking, shouting, rapid questions or contradictory commands.
Maintain personal space, non-threatening posture and clear access to exits for patient and staff.	Cornering, blocking the exit without legal need, sudden touch or standing over the person.

Do	Avoid
Acknowledge emotion and perceived threat without endorsing delusions: "I can see this feels frightening."	Arguing about beliefs, ridicule, confrontation, moral judgment or demanding insight.
Offer realistic choices and small steps: room, chair, support person, oral medication, food, drink or a short pause.	False promises, threats of restraint, punitive consequences or impossible choices.
Set respectful limits around violence while describing what staff can do to help.	Humiliating language, coercive bargaining or using police presence as intimidation.
Reduce noise, heat, light and crowding; address pain, nicotine withdrawal, hunger, sensory overload and communication needs.	Leaving modifiable discomfort untreated or interpreting all behaviour as deliberate non-compliance.
Use trusted family, carer, peer or interpreter when the person agrees or immediate safety requires collateral information.	Using children as interpreters or disclosing unnecessary confidential information.
Reassess and acknowledge cooperation. Explain each intervention before it occurs whenever possible.	Continuing a restrictive response after the danger has resolved.

- Allow time. Silence, reduced demands and a single clear question may be more effective than repeated persuasion.
- For autism, learning disability, dementia or communication impairment, ask carers about baseline, triggers, sensory needs, communication method, pain behaviours and effective calming strategies.
- Offer oral medication voluntarily when appropriate and explain expected benefit and adverse effects. Oral medication is part of de-escalation, not a substitute for assessment.
- If de-escalation fails and serious harm or essential treatment cannot otherwise be prevented, conduct a team safety brief and move to the least restrictive lawful intervention.

11. Mental state examination and focused ED safety assessment

Component	Minimum documentation
Appearance / behaviour	Self-care, eye contact, psychomotor activity, cooperation, distress, agitation, abnormal movements, intoxication signs and response to engagement.
Speech / thought	Rate, volume, coherence, thought form, hopelessness, guilt, grandiosity, paranoia, obsessional content and preoccupation.
Perception	Hallucinations, command content, dissociation, flashbacks and whether experiences are linked to substance use, sleep deprivation or delirium.
Mood / affect	Subjective mood, observed affect, anxiety, irritability, emotional reactivity, anhedonia and congruence.
Cognition	Attention, orientation, memory, fluctuation, understanding and ability to participate.
Insight / judgement	Understanding of difficulties, treatment preferences, ability to anticipate consequences and willingness to collaborate with care.
Self-harm / suicide	Recent act, medical severity, intent at the time, current thoughts, plan, preparation, access to means, rehearsal, regret / relief, ambivalence, prior attempts and reasons for living.
Harm to others	Specific person or group, intent, plan, access to weapons, escalating threats, command hallucinations, domestic context and duty to protect / share information under local law.
Supports / vulnerabilities	Family, friends, treatment team, housing, children / dependants, caregiving, abuse, exploitation, legal stress, treatment interruption and barriers to follow-up.
Formulation / plan	Predisposing, precipitating, perpetuating and protective factors; foreseeable changes; immediate needs; observation; legal status; treatment; destination and contingency.

ASSESSMENT RULE: A checklist supports completeness but does not replace compassionate conversation, collateral information, clinical judgement or psychosocial assessment. Document what the person needs to be safe now and what must change before discharge.

12. Self-harm and suicidal crisis

- Treat wounds, poisoning, strangulation, burns, trauma, pregnancy complications and infection promptly. Record the method, timing, quantity, source and possibility of repeated or concealed exposure.
- Ask about intent at the time and now, planning, preparation, access to means, interrupted attempts, farewell messages, online activity, substance use, escalating frequency, recent discharge, loss, shame, abuse and reasons for living.
- Offer age-appropriate specialist psychosocial assessment as early as possible and at every attendance. Medical treatment and psychosocial assessment should proceed concurrently when the person can participate.
- Do not delay solely because the person is intoxicated or because a numerical alcohol level is elevated. If participation is limited, provide regular clinical review and complete assessment as soon as possible.
- Use a needs-based risk formulation, not a score or global risk category. Reassess after sobriety, sleep, treatment, collateral information, change in social circumstances or any expressed wish to leave.
- Ask permission to involve family or carers. Even without consent, they may provide information. Share information without consent only as permitted or required for serious safety, safeguarding or legal duties.
- Assess access to medicines, pesticides, firearms, ropes / ligatures, heights, vehicles, water and other locally relevant lethal means. Collaboratively arrange secure storage, removal or restricted access.
- For frequent self-harm, follow an agreed multidisciplinary care plan where available. Repeated attendance is not grounds for reduced compassion, punishment, refusal of care or automatic discharge.
- Before discharge after self-harm, ensure psychosocial assessment, collaborative safety plan, follow-up, communication with relevant services, safer prescribing and clear return instructions.

Immediate safety question	Action if present
Current intent, plan or preparation with accessible means	Continuous or close observation according to need; remove access to means; urgent mental-health assessment; legal review if refusing care.
Unable or unwilling to maintain safety in the ED	Increase observation and engagement; review environment; senior clinician and mental-health response; consider least-restrictive legal intervention.
Medical instability or uncertain ingestion	Resuscitation / medical admission with mental-health input; do not transfer to a non-medical facility.
Safeguarding, violence, exploitation or unsafe home	Activate Protocol 43 and multi-agency planning; do not discharge to the unsafe setting.
Unable to participate because of distress, intoxication, delirium or sedation	Continue medical care and therapeutic observation; repeat assessment when participation improves; consider admission.
Protective supports and collaborative plan appear reliable	Verify contacts, access and transport; provide written safety plan and timely follow-up; explain how to return immediately.

13. Acute agitation and acute behavioural disturbance

ABD is a severe presentation that may have toxicological, medical, neurological, psychiatric or mixed causes. The immediate objectives are to prevent injury, stop harmful exertion and sympathetic over-stimulation, treat reversible physiology and obtain safe control sufficient for assessment. Avoid prolonged physical struggle, chasing or crowding.

Action	Operational standard
Activate	Call senior ED clinician, resuscitation-capable nursing team, security, anaesthesia / critical care and mental-health support according to severity.
Obtain prehospital history	Observed behaviour, substances, trauma, exertion, temperature, restraint type / duration, force or device used, medicines administered, adverse events, legal status and collateral information.
Create environment	Low stimulus, safe exits, minimal equipment, no ligature hazards, ready resuscitation bay and route. Keep the team out of the person's immediate space until roles are clear.
Brief team	Name leader and communicator; define de-escalation plan, thresholds for restraint / medication, roles, airway plan, monitoring, IV access, movement to resuscitation and who will order release of restraint.
Treat physiology	Oxygen as needed, glucose, temperature, ECG, trauma survey, cooling, fluids, electrolyte / acid-base management, antidote and linked toxicology or sepsis care.
Control dangerous agitation	Offer oral medication if feasible. If essential assessment or treatment cannot occur and serious harm is imminent, use the approved parenteral pathway with trained restraint and immediate monitoring.
Reassess cause	Once calmer, repeat history, full examination and investigations. Do not stop after sedation; identify the underlying diagnosis and injuries.

COLLAPSE WARNING: A suddenly quiet or collapsed person after extreme agitation, exertion, restraint or sedation may be exhausted, hypoxic, hyperthermic, acidotic, intoxicated or peri-arrest. Release pressure, assess airway and breathing immediately, move to resuscitation and treat as a medical emergency.

14. Restrictive interventions and rapid tranquillisation

Restrictive intervention is not routine behavioural management. It is justified only when voluntary measures have failed or cannot be attempted and there is an immediate, serious and otherwise unmanageable threat, or essential emergency treatment cannot be delivered. The clinical leader must state the legal and clinical basis, intended goal and stopping condition.

- Use only trained staff working as a coordinated team with one clearly identified leader. Continue verbal reassurance throughout and explain what the person must do for restriction to end.
- Avoid taking the person to the floor. If unavoidable, prefer a position that permits free breathing and direct observation. Prone restraint should be avoided; if it occurs, it must be as brief as possible with immediate repositioning.
- Never apply pressure to the neck, chest, back or abdomen; obstruct the mouth or nose; impair communication; use pain compliance; or leave a restrained person unobserved.
- Use extra caution in pregnancy, obesity, frailty, respiratory or cardiac disease, intoxication, hyperthermia, recent struggle, children and people with physical disability.
- Do not use mechanical restraint merely to prevent self-harm or stop a person leaving the ED. Do not improvise seclusion. A calm observable room with staff engagement is not seclusion when the person is free to leave.
- Searching and removal of property must follow local policy, preserve dignity, use the least intrusive method and be documented. Clinical staff remain responsible for health assessment and observation.
- End restriction as soon as the immediate purpose is achieved. Examine for injury, monitor, restore the therapeutic relationship and conduct patient and staff debrief.

Clinical situation	Medication principle - use only the locally approved order set
Cooperative or partially cooperative agitation	Offer oral medication appropriate to the likely cause, previous response and patient preference. Reassess before any repeat dose.
Psychiatric agitation requiring parenteral treatment	A local pathway may use IM lorazepam or an IM antipsychotic-based regimen. Consider intoxication, respiratory disease, pregnancy, frailty, QT interval, prior antipsychotic exposure and interactions.

Clinical situation	Medication principle - use only the locally approved order set
Severe ABD with dangerous continuous activity	A resuscitation-level pathway may include IM ketamine or droperidol where locally approved and staff are trained. Early anaesthetic / critical-care support and airway readiness are mandatory.
Alcohol or sedative intoxication	Avoid compounding respiratory depression. Seek senior toxicology / anaesthetic advice and use continuous respiratory monitoring.
Stimulant toxicity or withdrawal	Treat hyperthermia, cardiovascular complications, seizures and severe agitation under Protocol 29 and the local toxicology pathway.
Child / adolescent, pregnancy, older or frail adult	Do not extrapolate an adult standard regimen. Use age- and condition-specific specialist advice and dosing.
MEDICATION RULE: Prescribe one initial dose, record all prehospital and ED sedatives, and reassess effect before repeating. The target is safe calmness, not deep unconsciousness. Exact doses, concentrations, repeat intervals, maximum cumulative doses and drug combinations must be maintained in a separately controlled rapid-tranquillisation chart approved by emergency medicine, psychiatry, anaesthesia and pharmacy.	

15. Post-sedation monitoring and adverse-event rescue

Requirement	Minimum standard
Location	Resuscitation-capable area with suction, oxygen, bag-mask ventilation, airway equipment, defibrillator, IV / IO equipment and reversal / rescue medicines immediately available.
Monitoring	Continuous direct clinical observation, pulse oximetry and cardiac monitoring; capnography when available or when ventilation may be impaired; repeated blood pressure, respiratory rate, temperature and consciousness.
Frequency	Document observations at least every 15 minutes while sedated, restrained, intoxicated or physiologically abnormal, and more frequently or continuously according to clinical state and the local medication pathway. Step down only after senior review.
Position	Maintain a position that permits free airway and chest movement. Never leave the person prone or with pressure on the torso. Use lateral positioning if vomiting risk and clinically safe.
Investigations	Glucose, ECG, temperature, gas / lactate, electrolytes, CK, renal function, toxicology and trauma assessment as indicated. Obtain tests after control if they could not be obtained safely before.
Rescue	Treat obstruction, hypoventilation, hypoxia, hypotension, arrhythmia, dystonia, seizure, hyperthermia, laryngospasm or emergence reaction immediately; call anaesthesia / critical care early.
Release / recovery	Release restraint progressively when safe; continue observation until physiology and mental state are stable, the person can protect the airway and the underlying cause and destination are addressed.
Debrief	Explain why intervention occurred, listen to the person's account, assess injuries and emotional impact, review alternatives, update the care plan and support involved staff / witnesses.

16. Common psychiatric syndromes and high-risk presentations

Presentation	ED priorities
First-episode psychosis	Full medical / neurological / substance assessment; collateral history; pregnancy test when relevant; assess command hallucinations, self-neglect, exploitation and ability to care for dependants; urgent specialist review.
Mania	Assess sleep loss, impulsivity, spending / sexual risk, aggression, psychosis, substance use, dehydration and capacity; consider thyroid, medication and neurological causes.
Severe depression	Assess psychosis, catatonia, nutrition, self-neglect, guilt / hopelessness, recent loss, suicide planning and ability to care for self / dependants.
Panic / severe anxiety	Exclude cardiopulmonary, endocrine, toxicological and withdrawal causes. Provide calm explanation and avoid attributing abnormal physiology to anxiety without assessment.
Catatonia	Reduced movement or speech, posturing, negativism, excitement or autonomic instability is a medical and psychiatric emergency. Exclude delirium, encephalitis, seizures, NMS and toxicity; obtain urgent senior and specialist input.
Eating disorder crisis	Assess bradycardia, hypotension, temperature, glucose, electrolytes, ECG / QT, dehydration, purging, suicidality and refeeding risk; use medical admission criteria and specialist advice.
Postpartum psychosis / severe perinatal illness	Urgent obstetric and psychiatric review; assess infant and other children, sleep deprivation, mania, psychosis, self-harm and harm-to-infant thoughts; do not leave parent and infant unsupported.
Trauma-related / dissociative crisis	Provide a quiet, choice-based approach; assess current abuse, injury, sexual assault, trafficking and self-harm; avoid unnecessary touch and repeated retelling.

17. Substance-related presentations, delirium, and cognitive impairment

- Use Protocol 29 for intoxication, overdose and withdrawal. Do not assume behaviour is purely psychiatric when substance use is present; trauma, hypoxia, hypoglycaemia, infection, co-ingestion and withdrawal frequently coexist.
- Review prescribed and non-prescribed drugs, including anticholinergic medicines, steroids, dopaminergic drugs, antidepressants, antipsychotics, sedatives, stimulants and herbal preparations.
- Delirium requires identification and treatment of the cause, repeated cognition and physiology, pain relief, hydration, sleep support, sensory aids and avoidance of unnecessary psychoactive medication.
- In dementia or learning disability, compare with baseline using carers and records. New agitation may signal pain, urinary retention, constipation, infection, medication effect, fracture, sensory loss or environmental distress.
- When sedating a person with possible intoxication, use the lowest effective locally approved regimen, avoid unsafe combinations and provide continuous respiratory monitoring.

18. Children, adolescents, and neurodevelopmental needs

- Children and adolescents require simultaneous paediatric, mental-health and safeguarding assessment. Use age-appropriate language and involve a clinician experienced in child and adolescent mental health whenever possible.
- Speak with the young person alone for part of the assessment when safe and developmentally appropriate, while explaining confidentiality and its limits. Also obtain caregiver, school and service information.
- Ask about home, school, peers, bullying, abuse, exploitation, caring responsibilities, social media, online contacts, identity-related stress, pregnancy, substance use and access to medicines or other lethal means.
- Assess parental / caregiver capacity, the effect on siblings and whether the home is safe. A caregiver request for discharge does not override emergency treatment, safeguarding or legal duties when serious harm is foreseeable.
- For autism, ADHD, learning disability or sensory processing needs, use the person's communication profile, minimize sensory overload, preserve routines and avoid interpreting distress behaviour as deliberate aggression.
- Any medication, restraint or transfer plan must be age-, weight- and development-specific with paediatric and mental-health oversight. Adult rapid-tranquillisation doses must not be used.
- If admission is needed, use an age-appropriate environment with joint paediatric and mental-health review, family access and education / safeguarding coordination.

19. Older adults, frailty, and other vulnerable groups

- New mental or behavioural change in an older adult is delirium, medication toxicity, pain or neurological disease until assessed. Suicide risk may be concealed by somatic complaints, withdrawal or refusal of food / treatment.
- Assess cognition, frailty, falls, sensory impairment, polypharmacy, bereavement, loneliness, elder abuse, caregiver stress, access to medication and ability to manage at home.
- For people experiencing homelessness, migration, custody, disability, discrimination or language barriers, address practical safety, medication access, transport, documentation and continuity rather than assuming non-adherence.
- For patients in police custody, healthcare decisions remain clinical. Restraints, questioning and officer presence must not obstruct examination, confidentiality, treatment or legal safeguards.
- Identify children, dependent adults and animals who may be affected by the crisis and activate safeguarding or welfare support where required.

20. Capacity, consent, refusal, and mental-health law

Principle	Operational application
Presume capacity	Do not infer incapacity from diagnosis, intoxication, disagreement, communication difficulty or an unwise decision.
Support decision-making	Treat pain, hypoxia, hypoglycaemia and distress; use interpreters and aids; provide simple information, time, privacy, trusted support and repeated explanation.
Assess the specific decision	Document whether the person can understand, retain, use or weigh relevant information and communicate a choice for the decision required now.
Fluctuation	Repeat assessment after treatment, sobriety, sleep or de-escalation. A previous finding does not automatically apply to a new decision or later time.
Emergency treatment	If capacity is absent and delay risks death or serious deterioration, provide necessary proportionate treatment under the applicable legal framework and best-interest / necessity principles.
Mental-health legislation	Use only the locally applicable law and authorized personnel. Clarify what the law permits: assessment, detention, transport and treatment may have different requirements.
Wish to leave	Assess immediate medical danger, mental state, self-harm / suicide safety, capacity, safeguarding and available legal authority. Attempt to resolve needs and barriers. Do not rely on security or unlawful restraint.
Documentation	Record information given, supports used, the person's reasoning, capacity elements, legal basis, alternatives, senior advice and plan for reassessment.

LEGAL SAFETY RULE: A clinician cannot create legal authority by writing that a patient is "not allowed to leave." Use the applicable capacity, emergency-treatment, mental-health and safeguarding framework, obtain senior / legal advice when uncertain, and document the exact basis and limits of any restriction.

21. Safeguarding, abuse, exploitation, and violence

- Ask about domestic violence, sexual assault, coercive control, child or elder abuse, trafficking, exploitation, bullying, discrimination and unsafe caregiving at the earliest safe opportunity, preferably when the person is alone.
- Assess injuries and preserve forensic evidence under Protocol 43 and relevant sexual-assault pathways. Do not require a police report before providing healthcare.
- Consider risk to children, dependent adults, partners and identifiable third parties. Share relevant information according to local law and duty-to-protect / safeguarding procedures.
- When family or carers are involved, assess whether their presence is supportive or coercive. Do not disclose the person's location, history or plan to an unsafe individual.
- Discharge or transfer must not return a person to an unsafe environment merely because no psychiatric bed is available. Escalate to social work, safeguarding and senior management.

22. Investigations, imaging, and medication safety

Area	Guidance
Point-of-care	Glucose for altered behaviour, agitation, reduced intake, diabetes, intoxication or unexplained symptoms; pregnancy testing when relevant and consented or legally justified; urinalysis selectively.
Laboratory	Targeted FBC, electrolytes, renal / liver function, calcium / magnesium, CK, gas / lactate, toxicology levels, infection or endocrine tests based on presentation. Routine blanket testing is not a substitute for assessment.
ECG	Obtain for overdose, stimulant use, chest pain, syncope, significant electrolyte disorder, antipsychotic exposure, QT-risk drugs or before / after antipsychotic sedation when clinically feasible.
Imaging	Use trauma, focal neurology, seizure, headache, first atypical presentation, infection or altered-consciousness indications. Do not scan solely because a person is agitated.
Medication reconciliation	Record prescribed, PRN and administered medicines, depot injections, adherence, recent changes, allergies, adverse reactions and prehospital sedatives. Track cumulative doses and interactions.
Safer prescribing	Avoid unnecessary large take-home quantities of medicines that may be lethal in overdose. Coordinate limited supply, supervised administration or pharmacy / family storage when appropriate and lawful.
Long-term psychiatric treatment	Continue verified essential medicines when safe. Initiation or major change should involve mental-health expertise, physical-health review and follow-up rather than being used as a substitute for psychosocial assessment.

23. Observation, environmental safety, and prevention of absconding

Observation level	Minimum characteristics
General therapeutic observation	Patient located where staff are accessible; routine engagement and review; clear method to summon help; environmental risks addressed.
Enhanced intermittent observation	Named trained staff member checks and actively engages at a specified interval based on current needs. The interval, purpose, location and review trigger are documented.
Continuous within-sight observation	Named trained healthcare observer maintains uninterrupted visual contact and active engagement. Handover, breaks, toileting, imaging and transfer are explicitly covered.
Continuous within-reach observation	For immediate risk requiring rapid physical intervention, such as active self-harm or repeated removal of life-sustaining treatment. Must be reviewed frequently and reduced as soon as safe.
Post-sedation / restraint observation	Continuous clinical observation with physiological monitoring in a resuscitation-capable area until recovery and senior step-down decision.

- Observation level is a care intervention, not a prediction label. Record the reason, what staff are expected to do, the review time and what would trigger escalation or reduction.
- Observers must be trained healthcare staff. Security may support safety but must not be the sole observer for a person at risk of self-harm or post-sedation deterioration.
- Assess the environment repeatedly. Remove or secure medications, sharps, cords, plastic bags, belts, glass, lighters and other hazards according to local policy while preserving dignity and necessary aids.
- If a person attempts to leave, use engagement first. Immediately review capacity, medical danger, suicide / self-harm concerns, legal status and safeguarding. Activate the local missing / absconding procedure if the person leaves.
- Document the exact time last seen, clothing, direction, current danger, legal status, contacts made and responsibility for follow-up. Inform family or police only within legal and safety requirements.

24. Consultation, psychiatric assessment, and transfer

- Refer early. Urgent face-to-face mental-health assessment should occur within the locally agreed target; a one-hour response is an appropriate service goal for acute ED psychiatric emergencies where resources permit.
- Use parallel assessment. A person need not be "medically cleared" by a blanket test panel before speaking with mental-health staff. The ED must identify and communicate active medical issues, treatment needs and monitoring requirements.

- Consult toxicology, paediatrics, obstetrics, neurology, medicine, surgery, social work and safeguarding according to the presentation. First-episode psychosis, catatonia, severe eating disorder and postpartum psychosis require senior specialist involvement.
- Before mental-health transfer, confirm airway and physiological stability, completed treatment of time-critical injury / overdose, medication and restraint history, legal status, observation need, transport monitoring, accepting clinician and contingency for deterioration.
- Transfer responsibility does not occur when a referral is sent. It occurs at the locally defined handover point and must be documented. The ED retains clinical responsibility while the patient remains in the department.
- Patients boarding while awaiting a bed require ongoing medical and mental-health review, medication reconciliation, nutrition, hydration, sleep, hygiene, observation review, safeguarding and repeated consideration of the least restrictive setting.

TRANSFER DELAY RULE: Bed, weather, transport or staffing delay does not suspend treatment. Continue active physical and mental-health care, review at defined intervals, update the receiving clinician after any change and escalate prolonged unsafe boarding through operational leadership.

25. Disposition criteria

Disposition	Minimum criteria / indications
Resuscitation / ICU	Airway or ventilation threat, severe poisoning, hyperthermia, shock, severe acidosis, recurrent seizure, cardiorespiratory compromise, deep sedation, intubation or severe restraint-related injury.
Medical / surgical admission	Ongoing injury, overdose monitoring, delirium, infection, metabolic disorder, withdrawal, eating-disorder instability, pregnancy-related illness, inability to engage because of intoxication / distress, or medical uncertainty. Mental-health input continues.
Psychiatric admission / secure mental-health care	Specialist assessment identifies need for inpatient treatment or containment that cannot be safely delivered in the community, with medical stability and lawful transfer arrangements.
Paediatric admission	Child or adolescent requiring medical monitoring, safeguarding completion, age-appropriate mental-health care or a safe setting unavailable elsewhere. Joint daily review is required.
ED / short-stay observation	Only with a defined purpose, responsible senior clinician, observation level, treatment / assessment milestones, repeated review and maximum duration. Not a substitute for unavailable psychiatric care.
Discharge	Physical treatment complete; specialist psychosocial assessment where indicated; individualized formulation; no unresolved immediate danger requiring hospital care; capacity / legal issues resolved; collaborative safety and follow-up plan; safe destination and feasible access to help.
Departure before completion	Immediate senior review, capacity and legal assessment, attempt to resolve barriers, safety / safeguarding actions, direct contact with services or family as lawful, written advice if possible and documented missing-person process when indicated.

26. Discharge, safety planning, and follow-up

- Create the safety plan with the person, not for the person. Include personal warning signs, internal coping steps, safe people and places, family / friend support, professional contacts, emergency actions and restriction of access to lethal means.
- Confirm the plan is understandable and accessible in crisis. Provide a copy to the person and, with consent or lawful safety justification, to carers and relevant professionals.
- Arrange specific follow-up: service, clinician, date / time, location, transport and contact route. For ongoing safety concerns after self-harm, initial aftercare should occur within 48 hours or sooner according to need.
- Communicate with primary care and existing mental-health teams. Name the owner of pending tests, referrals and welfare checks. Do not place responsibility on the patient to relay critical information.
- Review discharge medicines for overdose lethality, interactions and quantity. Arrange limited dispensing, supervised supply or secure storage when appropriate.
- Do not discharge solely because the person denies suicidal thoughts after waiting, sleep or sedation. Reassess the episode, collateral information, access to means, foreseeable stressors, supports and ability to use the plan.
- Provide clear return instructions for renewed suicidal intent, inability to stay safe, worsening agitation or psychosis, medication adverse effects, intoxication / withdrawal, confusion, fever, seizure, chest pain, collapse or caregiver concern.

27. Communication with the person, family, and carers

- Use respectful language and acknowledge that ED attendance may involve fear, shame, prior trauma or previous poor experiences. Avoid labels such as manipulative, attention-seeking or difficult.
- Explain what information can remain confidential and when serious safety or safeguarding concerns require sharing. Seek consent early and revisit as the person becomes calmer.
- Family and carers may provide valuable information even when the person does not consent to their involvement. Listen without promising disclosure of confidential clinical details.
- Use a professional interpreter for complex discussion. Adapt information for literacy, language, sensory impairment, neurodevelopmental condition and cognitive ability, and confirm understanding with teach-back.
- After restraint or sedation, provide a supportive explanation and opportunity for the person to describe what happened, what was frightening and what could help avoid recurrence.

28. Documentation and handover

- ☐ Arrival / pre-alert time, source, legal / custody status, accompanying persons, belongings, search and environmental precautions.
- ☐ Full initial and serial physiological observations, glucose, temperature, pain, injuries, intoxication / withdrawal signs and linked medical protocols.
- ☐ Patient account, collateral sources, prior psychiatric / self-harm history, medicines, allergies, substance use, recent stressors and current supports.
- ☐ Mental state examination; current and recent self-harm / suicidal thoughts, intent, plan, preparation, access to means; harm-to-others assessment.
- ☐ Individualized formulation of needs, vulnerabilities, strengths, foreseeable changes and immediate safety actions; no unsupported global risk label.
- ☐ Capacity assessment for each relevant decision, supports used, legal basis of treatment / restriction and senior / legal advice.
- ☐ Observation level, named observer, interval / purpose, environmental actions, review times, handovers and any attempted departure.
- ☐ De-escalation attempts, oral medication offered, team safety brief, restraint position / duration / staff / indication, release criteria and injuries.
- ☐ Every sedative: drug, dose, route, time, prescriber, cumulative dose including prehospital treatment, response, adverse effects and monitoring.
- ☐ Mental-health referral / response time, clinician, psychosocial assessment, legal decision, receiving service, acceptance and transfer arrangements.
- ☐ Safeguarding, family / carer communication, interpreter, dependants, weapons / lethal-means plan and information shared without consent with rationale.
- ☐ Disposition rationale, safety plan, medicines, follow-up date / time, pending results owner, written advice and teach-back.

29. Quality indicators and audit

Indicator	Suggested measure
Parallel assessment	Percentage with complete initial physiological observations, glucose when indicated, mental-health triage and observation decision within acuity target.
Self-harm care	Percentage receiving age-appropriate psychosocial assessment at each attendance; documentation of individualized formulation, safety plan and follow-up.
Response time	Time from ED referral to mental-health contact and face-to-face assessment; delays and prolonged boarding escalated.
Observation reliability	Indication, level, named observer, interval, review and handover documented; incidents during observation reviewed.
De-escalation	Evidence of environmental and verbal strategies before restrictive intervention when clinically possible.
Restrictive intervention	Rate, indication, duration, position, injury, legal basis, post-event debrief and reduction plan; all prolonged or prone events reviewed.
Rapid tranquillisation	Senior decision, approved regimen, cumulative-dose record, monitoring compliance, adverse events, airway intervention and unplanned intubation.
Capacity / law	Decision-specific capacity and legal authority documented for refusal, detention, restraint and departure before completion.
Safe discharge	Specific follow-up, safety plan, means restriction, medication quantity review, communication with primary / mental-health care and return advice.
Outcomes	Suicide or serious self-harm after ED contact, absconding with harm, assault, death / collapse in restraint, return within 72 hours, complaints and inequity reviewed through multidisciplinary learning.

30. Training and implementation

- All ED staff require induction and recurrent training in mental-health triage, suicide inquiry, compassionate self-harm care, delirium, capacity, safeguarding, trauma-informed communication, de-escalation, observation and the local legal framework.
- Only trained teams should perform manual restraint or administer parenteral rapid tranquillisation. Competency includes team roles, airway protection, monitoring, emergency rescue, documentation and debrief.
- Run multidisciplinary simulation for concealed overdose, self-harm with wish to leave, first-episode psychosis, severe ABD with hyperthermia, post-sedation apnoea, paediatric crisis, postpartum psychosis, police custody and prolonged transfer delay.
- Use standardized mental-health triage, observation, self-harm assessment, safety-plan, capacity, restraint and post-sedation records. Audit equity by age, sex, ethnicity, disability, custody and repeat attendance where lawful.
- Include people with lived experience and families in reviewing the environment, language, information, observation, restrictive practices and discharge pathways.

31. Local configuration checklist

Local element	Complete before approval
Mental-health, capacity, consent and safeguarding legislation	_____
24-hour psychiatry / mental-health contact and response target	_____
Child / adolescent and perinatal mental-health pathway	_____

Local element	Complete before approval
Low-stimulus interview room and ligature / weapon safety check	_____
Observation levels, staffing, handover and escalation policy	_____
Search, property, weapons and prohibited-items policy	_____
De-escalation / behavioural emergency activation process	_____
Manual restraint policy, trained team and approved techniques	_____
Rapid-tranquillisation chart and pharmacy-approved stock	_____
Post-sedation monitoring and airway rescue standard	_____
Police custody, legal detention and transport agreement	_____
Psychiatric admission destinations and medical exclusion criteria	_____
Inter-island / interfacility transport and weather contingency	_____
Crisis, social work, safeguarding, housing and domestic-violence contacts	_____
Safety-plan template, crisis numbers and follow-up within 48 hours	_____
Serious-incident, restraint, absconding and death review process	_____

32. References and source framework

Source	Use in local adaptation
National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence. NICE guideline NG225, 2022; reviewed 2024.	Self-harm definition, parallel care, psychosocial assessment, avoidance of predictive risk scales, safety planning, admission, discharge and aftercare.
National Institute for Health and Care Excellence. Violence and aggression: short-term management in mental health, health and community settings. NICE guideline NG10, 2015, current.	De-escalation, observation, manual restraint safeguards, rapid tranquillisation, post-incident review and ED environment.
Royal College of Emergency Medicine. Acute Behavioural Disturbance in Emergency Departments. Best Practice Guideline, May 2025.	Recognition of ABD as a presentation, medical differential, team safety brief, de-escalation, resuscitation readiness, sedation and post-control investigation.
Royal College of Emergency Medicine. Care of Patients with Mental Health Problems in the Emergency Department. Clinical Standards, 2025.	Mental-health triage, observation, capacity, parallel assessment, psychosocial assessment, documentation and service standards.
National Institute for Health and Care Excellence. Decision-making and mental capacity. NICE guideline NG108, 2018, current.	Supported decision-making, decision-specific capacity and best-interest / least-restrictive care.
World Health Organization. Mental Health Gap Action Programme guideline for mental, neurological and substance-use disorders, 2023.	Suicide and self-harm intervention, person-centred care and evidence-based mental-health treatment in non-specialist settings.
World Health Organization QualityRights resources.	Rights-based care, reduction of coercion, supported decision-making and alternatives to seclusion and restraint.
Local law, formulary, toxicology service, safeguarding policy, police agreements and mental-health service standards.	Legal authority, exact medication doses, observation, referral, transport, reporting and operational capability.

Evidence governance note

This protocol deliberately keeps exact rapid-tranquillisation doses, concentrations and repeat intervals in a separately controlled local order set because approved agents, available formulations, age groups, pregnancy precautions, monitoring resources and legal requirements differ. The clinical protocol and medicine chart must be reviewed together after any guideline, formulary or service change.

Annex A. One-page mental-health emergency workflow

Step	Action
1. Make safe	Identify immediate medical danger, weapons, active self-harm, violence and environmental hazards. Use the least restrictive setting and summon help.
2. Treat ABCDE	Vitals, glucose, temperature, oxygenation, pain, injury, overdose, intoxication, withdrawal, delirium and pregnancy-related emergencies.
3. Engage	One lead communicator, low stimulus, validation, choices, clear limits, interpreter / carer and voluntary oral treatment when appropriate.
4. Assess immediate safety	Ask directly about suicide, self-harm, access to means, harm to others, ability to stay safe, safeguarding and wish to leave.
5. Observe	Document level, named trained observer, purpose, interval, environment, handover and review. Security is not a substitute for clinical observation.
6. Refer early	Mental health in parallel; add toxicology, paediatrics, obstetrics, social work, safeguarding, anaesthesia or critical care as needed.
7. If severe agitation	Senior-led safety brief; minimize struggle; trained restraint only if necessary; approved medication pathway; immediate monitoring and airway rescue capability.
8. Reassess	Repeat physiology, mental state, capacity, formulation and legal basis after treatment, sobriety, sleep, new collateral information or any change.
9. Decide destination	Medical / ICU, psychiatric, paediatric, observation or discharge based on needs, safety, law and service capability.
10. Close the loop	Psychosocial assessment, collaborative safety plan, lethal-means restriction, medicines review, named follow-up, handover, written advice and teach-back.

Annex B. De-escalation and behavioural-emergency safety brief

- ☐ Immediate medical threats and reversible causes considered; glucose, oxygenation and temperature obtained when feasible.
- ☐ One clinical leader and one communicator named; roles, exits, alarm and staff safety agreed.
- ☐ Patient preferences, prior care plan, effective calming strategies, communication / sensory needs and trusted support identified.
- ☐ Noise, crowding, heat, pain, hunger, thirst, nicotine withdrawal and other triggers addressed.
- ☐ Voluntary options offered: quiet room, support person, time, food / drink, analgesia, oral medication and explanation.
- ☐ Threshold and legal basis for restraint / parenteral medication stated; least restrictive option selected.
- ☐ Airway / breathing plan, resuscitation area, monitoring, IV access and anaesthetic / critical-care support ready.
- ☐ Approved medicine, dose, route, cumulative dose and contraindications checked; one dose prescribed before reassessment.
- ☐ Person maintaining airway and chest observation during restraint named; release criteria and decision-maker stated.
- ☐ Post-event injury check, monitoring, debrief, care-plan update and incident reporting assigned.

Annex C. Self-harm, suicide, and collaborative safety-plan record

Assessment area	Record
Episode	Method, timing, medical severity, intent at the time, planning / preparation, interruption, concealment and current view of survival.
Current crisis	Thoughts, intent, plan, access to means, command hallucinations, intoxication, agitation, hopelessness, shame and ability to remain safe.
History / foreseeable change	Previous attempts / self-harm, recent discharge, losses, abuse, legal / financial / relationship stress, upcoming events and treatment interruption.
Strengths / protection	Reasons for living, relationships, beliefs, responsibilities, coping skills, treatment connection, willingness to accept help and future goals.
Safety plan 1	Personal warning signs and internal coping actions.
Safety plan 2	Safe people and places for distraction; family / friends who can help.
Safety plan 3	Mental-health, primary-care and crisis contacts; where to attend in an emergency.
Means safety	Medicines, firearms, pesticides, ropes / ligatures, heights, vehicles, water and other locally relevant means removed, secured or access restricted.
Follow-up	Named service / clinician, date / time, transport, communication to primary / mental-health care and pending-result owner.
Understanding	Patient / caregiver has a copy, interpreter used if needed, teach-back completed and clear return instructions provided.

Annex D. Rapid-tranquillisation and post-sedation record

- ☐ Clinical indication, alternatives attempted, capacity / consent, legal basis and senior decision documented.
- ☐ Likely cause, age / weight, pregnancy, frailty, intoxication, respiratory / cardiac disease, QT risk, allergies and previous response reviewed.
- ☐ All prehospital and ED medicines, route, time and cumulative dose verified.
- ☐ Approved local agent selected: _____ Dose: _____ Route: _____ Time: _____ Prescriber: _____
- ☐ Team safety brief complete; restraint leader, airway observer, monitor, medication administrator and scribe named.
- ☐ Oxygen, suction, bag-mask, airway equipment, capnography, defibrillator, IV / IO and rescue medicines ready.
- ☐ Continuous observation / SpO₂ / cardiac monitoring started; capnography when available; BP / RR / temperature / consciousness recorded at required interval.
- ☐ Effect and adverse events assessed before any repeat dose; repeat authorized by: _____ at: _____
- ☐ Restraint position and duration recorded; no neck / chest / abdominal pressure; prone position avoided or ended immediately.
- ☐ Underlying cause, trauma, glucose, ECG, temperature, gas / lactate, electrolytes, CK and toxicology assessed after control as indicated.
- ☐ Recovery / release criteria met; injuries assessed; patient and staff debrief completed; incident review initiated if required.

Annex E. Capacity, refusal, and wish-to-leave checklist

- ☐ The exact decision and immediate consequences are stated.
- ☐ Pain, hypoxia, hypoglycaemia, intoxication, delirium, communication and emotional distress addressed as far as practicable.
- ☐ Information explained in accessible form; interpreter / aid / trusted support used; time and repetition provided.
- ☐ Patient can understand relevant information.
- ☐ Patient can retain it long enough to decide.
- ☐ Patient can use or weigh benefits, risks and alternatives.
- ☐ Patient can communicate a stable choice.
- ☐ Medical danger, self-harm / suicide concerns, safeguarding and risk to others assessed separately from capacity.
- ☐ Applicable legal authority and its limits confirmed; senior / mental-health / legal advice obtained when uncertain.
- ☐ Alternatives and least restrictive plan attempted; reasons for any restriction documented.
- ☐ Plan for reassessment, follow-up, family / service contact and missing-person response documented.

Annex F. Mental-health transfer and safe-discharge checklist

- ☐ Physical injuries / overdose treated; airway and physiology stable for destination and transport; ongoing medical needs accepted.
- ☐ Mental state, self-harm / suicide formulation, harm-to-others concern, capacity, legal status and safeguarding documented.
- ☐ Observation / restraint / medication history and post-sedation monitoring needs handed over.
- ☐ Accepting clinician, facility, time, transport, escort, monitoring, property and responsibility transfer confirmed.
- ☐ For discharge: psychosocial assessment completed where indicated; collaborative safety plan and lethal-means plan provided.
- ☐ Medicines reconciled; take-home quantity and overdose risk reviewed; next doses and adverse effects explained.
- ☐ Named follow-up service, clinician, date / time, location, transport and crisis contact verified.
- ☐ Primary care / mental-health team / safeguarding communication sent; pending results have a named owner.
- ☐ Safe destination and support confirmed; dependants and caregiver needs addressed.
- ☐ Written information, interpreter and teach-back completed; immediate return signs understood.

END OF PROTOCOL 42 - DRAFT 1.0 FOR LOCAL MULTIDISCIPLINARY VALIDATION