WEAVE SPRINT . PAPER III

# Perinatal and women's mental health, and emergency psychiatry

*Two kinds of patient the textbooks keep apart and the ward does not: the woman whose treatment has to answer for two people at once, and the patient whose first hour decides everything. Prescribing in pregnancy and in lactation, and the withdrawn letter categories that still turn up in question banks. Then the postpartum period, and women's mental health across the rest of the lifespan. Then the emergencies, taught as acts rather than as names: who you call, what you give, what you watch, and where the patient goes next. The syndromes themselves are taught elsewhere in this series and are named, not repeated.*

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Dr. Wilfred D'souza . Dr. Niharika Reddy

WEAVE . CENTRE FOR INTEGRATIVE PSYCHIATRY

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|---|---|---|---|
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01
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02
### The fit

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03
### The setting

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04
### The coordination

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**About this insert.** Weave Sprint is educational outreach from Weave, the psychiatry vertical of Trijog. Therapy is provided through Trijog.

# Contents

PAPER III

# Perinatal and women's mental health, and emergency psychiatry

Eight bands . one complete notes document

## Orientation: two doors, one patient

### 1 · Orientation: two doors, one patient

**This chapter has two doors, and one patient walks through both.** The first is the door of the antenatal clinic, the labour room and the postnatal ward, where the question is rarely whether a woman is unwell and almost always what may safely be done about it while she is carrying or feeding a child. The second is the casualty door at two in the morning, through which a patient arrives rigid, or confused, or fighting the people holding him, and through which no diagnosis has yet arrived. The chapter is built on the fact that the same woman can come through the second door weeks after leaving the first, and that nothing about the first door's caution is suspended when she does.

What follows is an **advance organizer** rather than a summary. It asserts no figure of its own, because every figure in this chapter belongs to the section that owns it, and it describes no syndrome, because not describing syndromes is the whole design. What it owns is the shape: the decision the chapter is organised around, the two seams that run through its halves, the order in which it runs, and the map of what it deliberately does not carry. The accompanying figure sets out the same architecture visually.

| The act | The setting | The first hour | Two patients |
| --- | --- | --- | --- |
| WHAT EVERY SECTION HERE TEACHES, FROM THE FIRST MINUTE TO THE HANDOVER | WHERE IT IS DONE, ON WHOSE AUTHORITY, AND WHERE THE PATIENT GOES NEXT | THE SEAM RUNNING THE LENGTH OF THE EMERGENCY HALF OF THIS CHAPTER | THE SEAM RUNNING THE LENGTH OF THE PERINATAL HALF OF THIS CHAPTER |

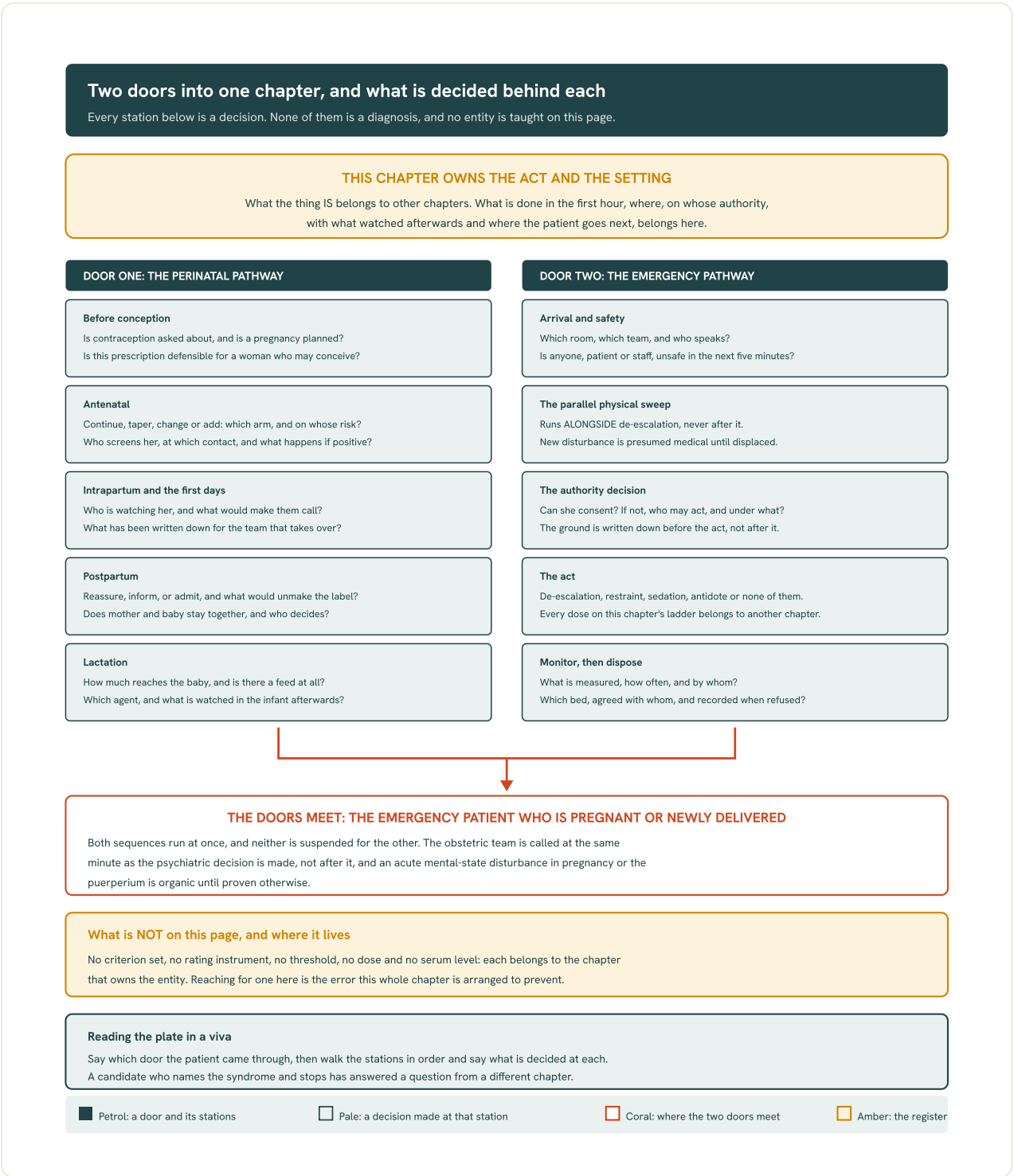


Fig 28.1. The chapter drawn as two doors the same patient may come through, the perinatal pathway from before conception to lactation set against the emergency pathway from arrival to disposition, with every station stated as a decision rather than as an entity, the point at which the two sequences run together in the pregnant or newly delivered emergency patient marked, and the criteria, instruments, thresholds and doses that belong to other chapters named as absent.

## 1.1 The decision this chapter is organised around

Almost everything named in this chapter has already been taught elsewhere, and taught properly: with its clinical features, its differential, its pathophysiology, its drug treatments and their doses. That body of work is the **entity**. What a syndrome is, what it looks like at the bedside, how it is told

apart from the things it resembles, and which agent shifts it, all of that belongs to the chapters that own each disorder, and none of it is repeated here.

This chapter owns the other half, which nothing has yet carried. It is the **act** and the **setting**: what is done in the first hour, where it is done, on whose authority it is done when the patient cannot agree or will not, and where the patient goes afterwards. Reduced to a single contrast, the other chapters answer the question *what is this?* and this one answers *what do I do about it, here, tonight, and who allows me to?*

That division is not a compromise and it is not a shortage of material. It is the harder half of the question, and it is the half that is examined badly and practised badly. A registrar who names a hyperthermic drug reaction correctly and then leaves the patient on an open psychiatric ward has the entity right and the setting wrong, and it is the second error the patient carries. A woman whose antidepressant is stopped for exactly the right reason and in exactly the wrong manner is harmed by the manner. The **disposition** decision, the monitoring cadence, the authority question and the handover are where emergency and perinatal psychiatry are actually won or lost, and they are the content of this chapter.

RULE **Every section here answers what is done, where, on whose authority and where the patient goes next. None of them answers what the thing is.** Hold that while you read, because it decides what counts as a complete answer in this material. A section that says little about a disorder you already know is not thin; it has been written on the assumption that you know it, and everything it does say is content its owning chapter does not carry. The corollary is the one that costs marks. If you can describe a syndrome in this chapter but cannot say who you would call, what you would check before sedating, how often it would be checked afterwards and which bed the patient would be in at dawn, you have read the wrong half of the material.

### 1.2 The first hour, and how the emergency half is held together

**Every emergency in this chapter is entered through one sequence.** Recognise that something is wrong, make the patient and the room safe, establish who has the authority to act on someone who cannot consent, act, monitor what the act has done, and decide where the patient goes. That sequence is **the first hour**, and it is the seam that runs the length of the emergency half.

It is set out in full by the section on the assessment and management of the acutely agitated and aggressive patient, which owns it. Every other emergency section names it and enters it at a different point rather than restating it, and knowing where your section enters is most of what makes this half quick to read. The rigid, hyperthermic and toxidromic sections enter at the act, because recognition has happened elsewhere and their question is what the recognition selects. The sections on observation, monitoring and restraint occupy the stretch after the act, which is the stretch most often skipped. Triage and disposition own the two ends.

Two properties of the seam are worth carrying from the start. The first is that it is not a checklist to be worked through and ticked; the sections that own its steps will show you where two of them are meant to be running at the same time. The second is that establishing authority is a clinical step and

not paperwork appended afterwards. It has a statutory frame, that frame is Indian, and it is taught in full by the Mental health legislation and forensic psychiatry notes and by the Forensic ethics, consent and legal procedure notes. What this chapter teaches is the decision itself: who is asked, what is recorded, and what is done when there is nobody available to ask.

### 1.3 The two-patient problem, and how the perinatal half is held together

The perinatal half has a seam of its own, and it is easier to state than to apply. Every decision in it is made for two people at once. That is **the two-patient problem**, and the framework for reasoning through it is set out by the section on prescribing psychotropics in pregnancy, which owns it; the remaining perinatal sections state which two patients their own decision is for and then get on with the decision.

Two things about the frame are worth fixing before you meet it. The first is that the second patient changes identity as the chapter moves: a fetus while she is pregnant, an infant at the breast while she is feeding, a relationship while that relationship is still forming, and, on the night she is acutely unwell, a baby who needs a named adult holding him. The second is that doing nothing is not the neutral option against which the others are scored. Untreated illness is itself one of the exposures being weighed, and the section that owns the framework builds that in from the first line rather than adding it as a caveat at the end.

> **GOOD TO REMEMBER**
>
> The four questions above are the ones this chapter answers, and they are worth carrying as questions rather than as an acronym: what is done now, where it is done, on whose authority, and where the patient goes next. A fifth runs the length of the perinatal half and is asked of every one of the other four, which is who else is the patient. The chapter's own memorable spine is cashed in at the close, built from what the sections actually taught, and it is not seeded here.

That is also why the sections ahead spend their space on sequence, cadence, authority and destination: those are the things rarely written down anywhere, and asked for every time. Four habits make the chapter read as one argument rather than as thirty-one:

- read every section for what it INSTRUCTS, and take the entity it names on trust from the chapter that owns it;
- where a section names another account by description, go and read that account before answering on the point it hands over;
- treat a declared gap as a finding rather than as an omission, because a stated absence is what stops a remembered number being written in;
- and hold the fifth question, who else is the patient, open across the whole perinatal half rather than asking it once.

Every section in this chapter answers four questions and leaves the fifth to the chapter that owns the disorder: what is done now, where it is done, on whose authority, and where the patient goes next. In the perinatal half all four are answered twice over, because two patients are in front of you; in the emergency half they are answered as one sequence, from the door to the handover.

# Prescribing and treating in pregnancy and lactation

## 2 · Prescribing psychotropics in pregnancy (risk categories, teratogenicity)

**Every prescription written in pregnancy is written for two patients, and only one of them can be asked what she wants.** That asymmetry is the whole of the difficulty, and it is why this decision behaves unlike any other prescribing decision in psychiatry. Candidates prepare the topic as a list of safe and unsafe drugs and then answer the wrong question, because what is actually being examined is not a list. It is a method for reasoning about an exposure whose harm is uncommon, delayed, hard to attribute to any one cause, and measured against a background that was never zero. Get the method right and the agent-level figures become usable. Get it wrong and no quantity of memorised percentages will rescue you, because you will not know what any of them are percentages of.

The topic also carries a piece of currency that Indian teaching has been slow to absorb. The pregnancy risk categories that a generation of candidates learned as a five-rung ladder are no longer the labelling scheme they were drawn from, and a chapter written now has to say so with a date attached rather than quietly reprint the grid. Presenting the withdrawn system as current practice is the commonest way this topic is got wrong in print, and it is worth understanding why the regulator abandoned it, because the reasons are themselves the teaching.

Owned here in full: the two-patient frame that governs every perinatal decision in these notes; the withdrawn letter system and the labelling rule that replaced it; the general teratogenicity framework, meaning critical periods, background risk, and absolute against relative risk; kinetic change across the trimesters and its postpartum reversal; the pre-conception conversation; and the record a shared decision leaves behind. Named once and not re-derived: the agent-level malformation figures for individual mood stabilisers and antiepileptics, which belong with the agents in the Mood disorders: pharmacotherapy notes; electroconvulsive therapy in pregnancy, which belongs to the ECT and neurostimulation notes; and the milk-side exposure metric, defined in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes and applied in the breastfeeding topic of these notes.

**2 to 4 per cent**
BACKGROUND MAJOR BIRTH DEFECT RATE THE REGULATOR CALLS A REASONABLE REPRESENTATION, IN DRAFT GUIDANCE

**15 to 20 per cent**
BACKGROUND MISCARRIAGE RATE REPORTED IN CLINICALLY RECOGNISED PREGNANCIES, SAME DRAFT GUIDANCE

**3 to 16 weeks**
POST-CONCEPTION, THE MOST CRITICAL PERIOD FOR BRAIN DEVELOPMENT, LONGER THAN ANY OTHER ORGAN

**up to 330 per cent**
RISE IN LAMOTRIGINE CLEARANCE IN PREGNANCY, THE CLEAREST WORKED EXAMPLE OF TRIMESTER KINETICS

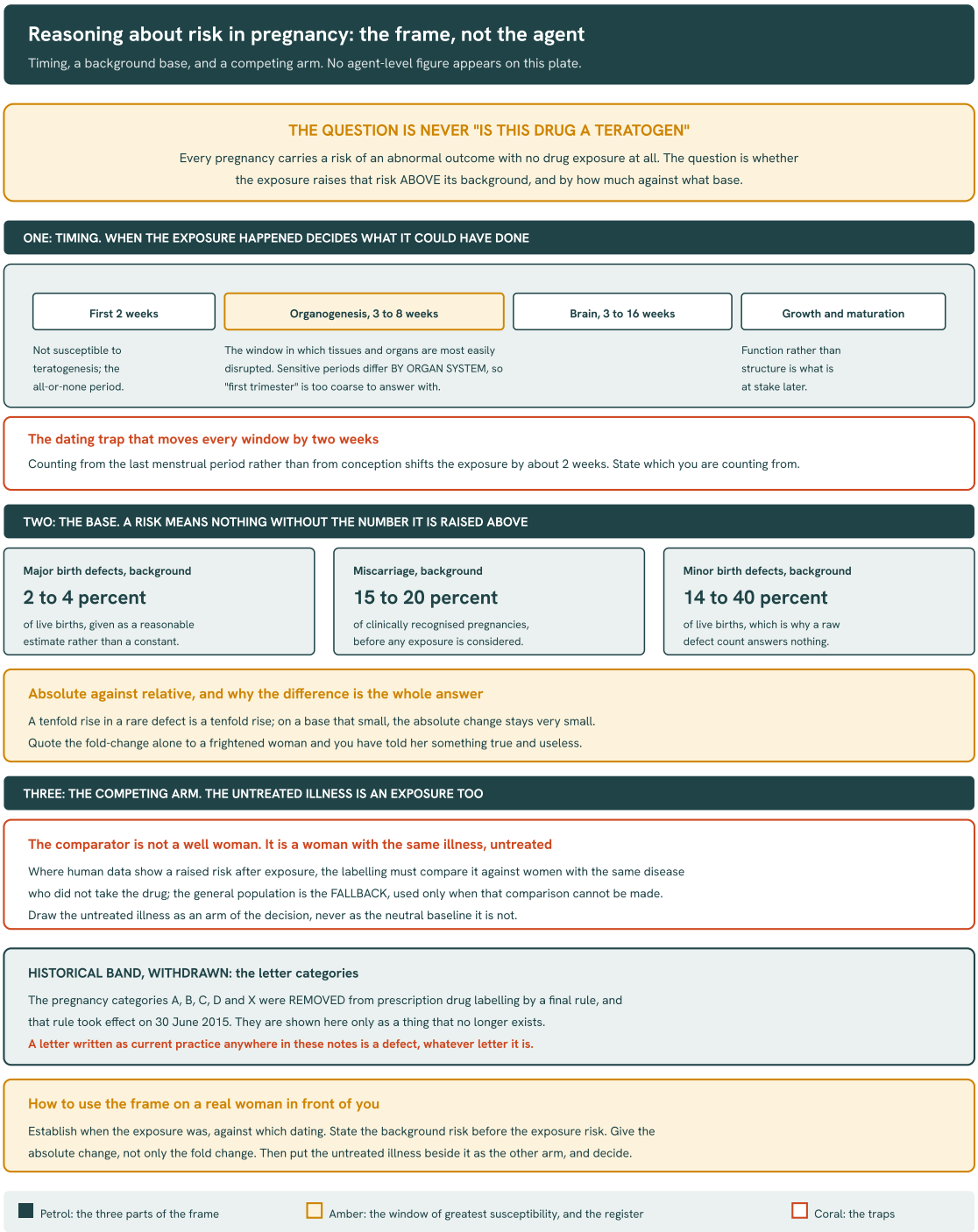


Fig 28.2. The general frame for reasoning about drug risk in pregnancy, drawn in three parts: the critical periods set against gestational age with the dating offset that moves all of them, the background rates of major and minor birth defects and of miscarriage that any exposure risk must be read against, and the untreated illness drawn as a competing arm rather than as a neutral baseline, with the withdrawn letter categories shown only in a dated historical band and labelled as removed.

### 2.1 Two patients, and the arm that has no drug in it

Start where the arithmetic starts. A woman with a serious mental illness who stops her medication has not moved into an unexposed condition. She has moved from one exposure to a different one, and the second is no better characterised than the first. The American College of Obstetricians and Gynecologists states this as a recommendation rather than a sentiment in its clinical practice guideline on the treatment and management of mental health conditions during pregnancy and postpartum, issued in 2023: consider untreated or inadequately treated mental health disorders **an exposure**, and recognise the risks associated with inadequate treatment alongside the perinatal risks of any psychopharmacologic agent. Read that twice, because it inverts the way the question is usually asked in an outpatient department. The default framing puts the drug on trial and treats no-drug as the neutral condition. The guideline puts both arms on trial.

**This is not a soft principle, and that surprises people.** It is written into the labelling regulation itself. Where human data indicate an increased risk of a specific adverse developmental outcome after exposure in pregnancy, the United States regulation on labelling for use in specific populations requires that risk to be quantitatively compared with the risk of the same outcome in infants born to women who were not exposed to the drug but who have the disease or condition the drug is indicated to treat. The comparator the regulator mandates is the untreated ill woman, not the healthy population. Only when risk information for women with that condition is unavailable does the regulation permit the fallback of comparing with the rate at which the outcome occurs in the general population, and that fallback is explicitly second best, used because the better data are missing rather than because the healthy population is the right yardstick.

The same regulation carries the untreated illness onto the label as a required element rather than leaving it to the prescriber's conscience. Under clinical considerations, labelling must describe **any serious known or potential risk to the pregnant woman or to the embryo or fetus associated with the disease or condition for which the drug is indicated**. So when you open a current label to answer a woman's question about her medication, the document is built to tell you two things, not one: what the drug may do, and what her illness may do if it is left to run. Most clinicians read only the first half, which is precisely how a counselling conversation ends up numerically lopsided while feeling scrupulously cautious.

RULE **There is no unexposed arm in this decision, only two exposures.** The woman in front of you will carry either drug exposure or illness exposure, and usually some of each. Any counselling that quantifies one arm and leaves the other qualitative is not balanced counselling, however carefully the drug numbers are quoted. When you cannot quantify the illness arm, say so out loud rather than letting silence stand in for safety, because a number beside a blank always wins the argument.

### 2.2 The pregnancy risk categories, dated at both ends

Now the historical instrument, taught as history and dated on the page. The United States Food and Drug Administration adopted a pregnancy category system in **1979** to convey risk and benefit information about potential or documented human teratogenic risk and the potential maternal and

fetal benefits of drug treatment in pregnancy. Under those regulations each drug product was identified with a pregnancy category: A, B, C, D or X. That is the grid Indian question banks still test, and it is the grid that no longer exists in current labelling.

It was dismantled deliberately. A final rule on the content and format of labelling for human prescription drug and biological products, referred to by the agency as the **Pregnancy and Lactation Labeling Rule**, requires the removal of the pregnancy categories A, B, C, D and X from all human prescription drug and biological product labelling. Removal is mandatory and it reaches all such labelling rather than only newly submitted products. The rule is effective **30 June 2015**, and that is the date from which the letter system ceased to be the applicable labelling scheme going forward. A system born in 1979 and struck out with effect from 2015 is a historical object, and it should appear in your answer with both of those dates attached or not at all.

**What replaced it is a change of form, not a change of stringency.** The agency's stated position is that **a narrative structure** for pregnancy labelling, rather than a category system, is best able to capture and convey the potential risks of drug exposure based on animal or human data or both. Concretely, the rule replaces the old subsections on pregnancy, nursing mothers, and labor and delivery with three subsections entitled Pregnancy, Lactation, and Females and Males of Reproductive Potential. A letter has become a description of the evidence, which is harder to memorise and far harder to misuse.

Two boundaries are worth holding, because both are commonly misstated. First, the letters never covered breastfeeding: the agency records plainly that the categories were not used to characterise the risks and benefits of drug treatment by lactating women. Anyone who quotes a lactation letter category is quoting something that never existed. Second, the instrument governs prescription products only. Labelling for over-the-counter medicines does not change, and over-the-counter drug products are not affected by the final rule, which matters in a country where a great deal of what a pregnant woman actually swallows was never prescribed to her.

The disappearance was staggered rather than instant, and this is where a confident single date would be an invention. Products submitted after the effective date use the new format immediately, while labelling for prescription drugs approved on or after 30 June 2001 is phased in gradually. For an application not subject to the earlier physician labelling rule, and therefore not required to adopt the new narrative content at all, the holder must still remove the pregnancy category from its labelling within 3 years after the rule's effective date. For an application that is subject to that earlier rule, the category is not removed until the product's labelling is revised into the new format, which may fall more than 3 years after the effective date. The letters therefore left product by product on a staggered schedule. No single calendar day on which every letter vanished can be quoted from the rule, and this account does not supply one.

TRAP **Answering a pregnancy prescribing question by reciting a letter.** Candidates do it because the grid is compact, memorable and still printed in old question banks, and because a single character feels like an answer. It is not an answer now and it was not a good one then. If a question asks for the category of an agent, the mark is in naming the system, dating its withdrawal, naming the narrative labelling rule that replaced it, and then reasoning about the actual evidence. A bare letter offered as current practice is a factual error, not a shortcut.

### 2.3 Why a letter could not carry the information

The reasons the regulator gave are the most efficient teaching in this whole topic, because each one is a general lesson about risk communication wearing regulatory clothes. The agency records that the system had long been criticised as confusing and overly simplistic, and then sets out what went wrong in specific terms.

- It was read as a grade. Through experience and stakeholder feedback the agency learned that the categories were heavily relied upon by clinicians but misinterpreted, misunderstood and erroneously used as a grading system in which fetal risk increased from A to X. The letters looked ordinal, so they were read as ordinal, and the underlying data never supported a single ranked axis of harm.
- It implied equivalence that did not exist. The categories gave the incorrect impression that drugs in the same category carried the same risk or potential for human adverse developmental outcomes. Two agents sharing a letter were never thereby comparable.
- It collapsed incommensurable evidence. The categories did not discriminate between risk information from non-clinical animal studies and from post-marketing human studies, and did not discriminate between drugs associated with adverse outcomes of differing severity or incidence. One character concealed both what kind of evidence existed and how bad the outcome was.
- It saw only structural harm. Stakeholders pointed out that the categories focused on structural abnormalities and so did not adequately address the full range of potential developmental toxicities. For psychotropics this is the decisive objection, since the harms that most concern a psychiatrist are functional and neurodevelopmental and a letter had no way to express them.
- No category system worked, including the alternatives. The agency explored a range of models to see whether the former system or a different one could communicate differences in degrees of fetal risk, and reports that when the criteria were applied to actual animal and human findings for drugs with known risk profiles, none of the models produced clinically informative and reliable differentiations of risk.

That last point is the one to carry into an answer, because it is the strongest and the least quoted. The failure was not that the wrong five letters were chosen. It was that the categorical form itself cannot hold the information, since a single ordered label has to compress evidence type, outcome

severity, outcome frequency and gestational timing into one dimension, and those four dimensions do not lie on one line. Every subsequent element of a current label is an attempt to keep them apart.

### 2.4 What a current label must state, and how to read one in clinic

If the answer is no longer a letter, you have to know what the answer now looks like, otherwise the replacement is an abstraction. The regulation specifies required content, and reading a label for this decision means going after those elements deliberately rather than skimming the pregnancy paragraph for a reassuring adjective.

The single most useful requirement is the mandated comparator statement. The labelling must state the percentage range of live births in the United States with a major birth defect and the percentage range of pregnancies in the United States that end in miscarriage, regardless of drug exposure. Absolute against relative risk, which most clinicians treat as a matter of good communication style, is here a legal requirement of the document: the background sits on the page beside the drug figure so that the reader cannot see one without the other. The second is the required anatomy of the risk statement itself. Where human data establish the presence or absence of an adverse developmental outcome, the risk summary must summarise the specific outcome, its incidence, and the effects of dose, duration of exposure and gestational timing of exposure. Gestational timing is a required dimension, which is the critical-period principle written into law.

| WHAT THE LABEL MUST CARRY | THE QUESTION IT ANSWERS BEFORE YOU PRESCRIBE |
|---|---|
| BACKGROUND RATES, STATED REGARDLESS OF EXPOSURE | The percentage range of live births with a major birth defect and of pregnancies ending in miscarriage, so the drug figure has a denominator on the same page |
| COMPARATOR FOR A HUMAN-DATA RISK | Unexposed women who have the same disease, with the general population only when data for diseased women are unavailable |
| DIMENSIONS OF THE RISK STATEMENT | Which outcome, how often, and how it varies with dose, duration and gestational timing |
| DISEASE-ASSOCIATED RISK, UNDER CLINICAL CONSIDERATIONS | Serious known or potential risk of the untreated condition to the woman or the embryo or fetus |
| DOSE ADJUSTMENT, UNDER CLINICAL CONSIDERATIONS | A summary of pharmacokinetic data supporting dose adjustment during pregnancy and the postpartum period |
| THE THREE NARRATIVE SUBSECTIONS | Pregnancy, Lactation, and Females and Males of Reproductive Potential, so pregnancy, feeding and contraception are answered from separate text rather than one letter |

**The practical consequence is a change in what you extract.** The old act was to find a character and act on it, which took seconds and told you almost nothing. The new act takes minutes and gives you material for the actual conversation: the background rate you will quote first, the comparator

the evidence used, whether the human data are informative or absent, the timing dependence, and whether the kinetics oblige you to plan a dose change. That is also why a label is no longer a substitute for judgement. It furnishes the arguments; it does not close them.

### 2.5 The denominator, before any drug is involved

Nothing in this topic can be interpreted without a background rate, and the first thing to establish with a frightened woman is that the alternative to her tablet is not a guaranteed normal baby. The framework begins from the premise that every pregnancy has a risk of an abnormal outcome regardless of drug exposure, and that reproductive toxicologists treat the major manifestations of abnormal fetal development as growth alteration, functional deficit, structural malformation and death. Malformation is one member of that set and not the whole of teratogenicity, which is why a drug with a clean malformation record is not thereby a drug with a clean developmental record.

The regulator's own draft guidance on pregnancy, lactation and reproductive potential labelling, issued for comment in 2020 and non-binding, states that because various factors may affect the overall rate, a range of 2 to 4 per cent is a reasonable representation of the background major birth defect rate, and that miscarriage has been reported to occur in 15 to 20 per cent of clinically recognised pregnancies. Note the status carefully, because it is examinable in its own right: the requirement to print a background range is binding regulation, while these particular figures are a draft recommendation and must be quoted as such.

A rate means nothing until the numerator is defined. Most case reports and studies concern **major birth defects**, meaning those incompatible with life or requiring medical or surgical intervention, as against **minor birth defects**, the minor physical anomalies of less clinical importance that deviate from normal without obvious medical or surgical consequence. The minor category is enormous and elastic: minor defects occur in 14 to 40 per cent of live births, and the width of that range is itself the lesson, since what counts as a minor defect is substantially subjective. A study that widens its numerator definition can manufacture an apparent excess without a single extra child being harmed.

Two cautions travel with any background figure, and both come from the regulator rather than from commentary. All-inclusive background rates of major birth defects may include infants with genetic syndromes and chromosomal abnormalities not caused by a medication or other toxic exposure, so at best such rates constitute very crude comparisons. And population estimates can vary considerably by maternal age, race, geographic region, socioeconomic status and time period, including because the availability of diagnostic tools changes across eras. A background rate is a property of a named population, so carrying one across populations is a substantive assumption, not a neutral convenience.

**IN INDIA**

Three service realities change how this is used here. The letter categories were a United States labelling instrument and were never Indian law, yet they persist in Indian teaching, in older printed inserts and in question banks, which is why dating them matters more in an Indian answer than in an American one; no Indian labelling instrument governing pregnancy risk communication was available for this account, so nothing here should be read as a statement of Indian regulatory requirement. The background figures quoted above are United States estimates, and no Indian background malformation or miscarriage rate was retrievable for this account, so the denominator you quote to a woman in a district clinic is imported into a population with a different maternal age structure, different consanguinity, different nutrition and different ascertainment. Say that it is imported. Third, most women here present already pregnant rather than planning, and serum monitoring for the agents where it would help is often not obtainable outside a teaching hospital, so the follow-up plan has to be built out of clinical review at intervals a family can actually attend rather than out of assays.

### 2.6 Absolute against relative, and the study that reassures nobody

Here is the inferential target, stated by the regulator in one sentence: the purpose of collecting and evaluating data on drug exposure during pregnancy is to address whether a particular exposure increases the risk of abnormal fetal development above the background rate. The question is never whether a bad outcome occurred in exposed pregnancies. Bad outcomes occur in unexposed pregnancies at a rate that is not small. The question is whether they occurred more often than they would have anyway.

The worked illustration is the most useful arithmetic in the topic. A population experiencing a tenfold increase in a specific rare birth defect, **from 0.04 per cent to 0.4 per cent**, may still have a total birth defect rate across all malformations that is not measurably different from a reference population. Two conclusions follow and they point in opposite directions, which is why this example earns its place. A large relative increase on a tiny absolute base can be real and still invisible in aggregate data, so a reassuring study of total malformation rates does not exclude it. Equally, a tenfold relative risk quoted to a woman without its base sounds like a catastrophe when the absolute change may be a fraction of one per cent. The number that belongs in the consultation is the absolute one, with the background beside it; the relative figure belongs in the appraisal of the study.

**Negative studies need reading with the same suspicion as positive ones.** The regulator's appraisal rule is blunt: any study reporting no increase in the background rate of birth defects in exposed pregnancies can be viewed with scepticism unless the power of the study to detect or rule out a stated level of risk is also included. Pregnancy exposure cohorts are small, outcomes are rare, and a study with a hundred exposed pregnancies can exclude almost nothing while reading, in an abstract, as clean. When a colleague tells you an agent has been shown to be safe in pregnancy, the

follow-up question is not which study, it is safe against what level of risk, with what power to exclude it.

**GOOD TO REMEMBER**

Write the background figures down before the consultation starts, not during it. The moment you are working out arithmetic in front of a frightened woman, you will quote whichever number you can retrieve, and the retrievable number is almost always the relative one. Two numbers spoken in the same breath, the background rate and the exposed rate, in the same units, do more counselling work than any amount of reassurance, and they are also what you will be able to defend later if the outcome is poor.

### 2.7 Timing: which clock, which window, which harm

The first thing to fix is the clock, because getting it wrong silently moves a drug into or out of the window that matters. The regulator warns that determining the gestational week of exposure from the date of the last menstrual period rather than the date of conception can produce a 2 week time difference that can be critical when evaluating an association between a birth defect and drug exposure, and states that in its own guidance gestational age means time since conception. Every window quoted below is post-conception. Obstetric practice in the clinic next door usually dates from the last menstrual period. If you carry a figure across without converting, you will be systematically out by a fortnight in the direction that makes exposure look earlier and safer than it was.

The organising principle is that sensitivity belongs to the organ rather than to the drug. Agents producing adverse fetal effects typically do so during discrete sensitive periods that vary with the particular teratogenic process and the target organ, and each part, tissue and organ of an embryo has a **critical period** during which its development may be disrupted. There is therefore no such thing as a safe trimester in general; there is only a window that is or is not critical for the structure you are worried about.

| WINDOW, COUNTED FROM CONCEPTION | WHAT IS HAPPENING | WHAT EXPOSURE CAN PRODUCE THERE |
|---|---|---|
| FIRST 2 WEEKS | Cleavage of the zygote and implantation of the blastocyst, before differentiation | Not susceptible to teratogenesis, and exposures are not known to cause congenital anomalies in human embryos; interference with cleavage or implantation, or early death and spontaneous abortion |
| 3 TO 8 WEEKS | Organogenesis, when the tissues and organs are forming, and when the embryo is most easily disrupted | Gross structural abnormalities readily seen at birth |
| 3 TO 16 WEEKS | The most critical period for brain development, with susceptibility continuing beyond it as the brain differentiates and grows rapidly | Disruption of the organ with the longest window of any, which is why a first-trimester rule alone cannot govern psychotropic exposure |
| LATER GESTATION | Rapid fetal growth and maturation, with active cell growth, differentiation and migration, particularly in the central nervous system | A different class of harm rather than a smaller quantity of the same harm: growth and function rather than gross structure |

Two clinical consequences follow, and both are commonly missed. The first is that the pre-differentiation window is also the window in which a woman is least likely to know she is pregnant, so an exposure that ENDED inside it is incapable of causing a malformation, though it is not incapable of causing a loss. That is a genuinely reassuring thing to be able to say, and it is worth saying precisely rather than vaguely, because the precision is what makes it true. Establish first which case you are in. A woman who stopped when the test turned positive has usually gone on dosing past this window and into organogenesis, since the window closes around the missed period, and the reassurance does not reach her exposure. Naming the clock is how you tell the two apart, and telling them apart is the whole point of naming it. The second is that the psychiatric agents we worry about act on a developing central nervous system whose critical period is the longest in the table and does not close when organogenesis does. A woman told she is past the dangerous phase at the end of the first trimester has been told something that is true of the palate and false of the brain.

MNEMONIC

### Clock, window, harm

Three questions of any exposure, in order. **Clock:** is this week count measured from conception or from the last menstrual period, and have I converted. **Window:** which structures were in their critical period during the exposure, remembering that the brain's runs longest. **Harm:** which class of outcome that window can produce, since the same drug at a different point buys loss, malformation, or growth and functional harm rather than more or less of one thing.

## 2.8 Dose across the trimesters, and the reversal nobody owns

Once the decision to treat is made, the prescribing task changes character. The dose that was right at booking will frequently not be right at term, and this is a pharmacokinetic fact rather than a matter of the illness worsening. The obstetric guideline states that up-titration in pregnancy may be required with advancing gestation secondary to expected physiologic changes such as increased renal clearance and distribution volume, as well as changes in the activity of drug-metabolising enzymes. A woman whose symptoms creep back in the second half of pregnancy on a dose that held her for a year is not necessarily relapsing in the ordinary sense; she may simply be underdosed by her own physiology.

The direction of the change is broadly predictable from the elimination route, which is what makes this teachable rather than merely cautionary. A mechanistic pharmacokinetic review published in 2005 reports that renal excretion of unchanged drug is increased in pregnancy, and that metabolism catalysed by CYP3A4, CYP2D6, CYP2C9, UGT1A4 and UGT2B7 is increased, so that doses of drugs handled by those routes may need to rise to avoid loss of efficacy, whereas CYP1A2 and CYP2C19 activity is decreased, suggesting that reductions may be needed for their substrates. It is a narrative review rather than a primary study and no magnitude for an individual psychotropic should be taken from it, but the direction of travel is a usable heuristic when you are deciding which agents to watch hardest.

The magnitude, where it has been measured, can be startling. Lamotrigine is metabolised by **UGT1A4**, which is upregulated in pregnancy, increasing clearance of the drug by up to 330 per cent. That is the mechanism-to-magnitude chain the general principle needs in order to become real, and it is quoted here purely as kinetics. The malformation figures for this and every other agent, and the antiepileptic prescribing route, belong to their own chapters and are not extended here; the mood stabiliser numbers sit in the Mood disorders: pharmacotherapy notes.

**Where there is no level to chase, the monitoring has to be clinical.** Some psychiatric medications have therapeutic drug ranges requiring monitoring, whereas others such as the selective serotonin reuptake inhibitors have no established therapeutic concentration but do have **concentration-to-dose ratios** known to be dynamic across pregnancy and the postpartum. So the absence of an assay does not mean the absence of kinetic change; it means the change is invisible unless somebody is looking at the patient at planned intervals. No monitoring interval is asserted here, because none of

the sources consulted for this account gives one, and an invented review cadence would be worse than an honest blank.

The step that gets forgotten is the reversal. The guideline is explicit that the dose needs to be carefully down-titrated again postpartum to avoid toxicity, with close clinical monitoring of the patient. Pregnancy kinetics unwind quickly after delivery, so a dose raised across gestation becomes a toxic dose within days of birth if nobody owns the review. This is a systems failure waiting to happen, because the antenatal dose rise is made by whoever is following the pregnancy and the postnatal fall belongs to nobody in particular. Name the person and the date before the woman delivers, and write it where the postnatal team will see it, not only in the psychiatric notes.

### 2.9 The pre-conception conversation, and the record a shared decision leaves

Almost everything above is more useful before conception than after it, which is why the conversation is owed early and broadly rather than at the first positive test. The United Kingdom guideline on antenatal and postnatal mental health directs that all women of childbearing potential with a new, existing or past mental health problem be asked about contraception and any plans for a pregnancy, and told how pregnancy and childbirth might affect the mental health problem including the risk of relapse, and how the problem and its treatment might affect the woman, the fetus and baby, and parenting.

- Contraception and any plans for a pregnancy, asked about rather than waited for, which is what converts this from a perinatal topic into a general adult prescribing habit.
- How pregnancy and childbirth might affect the mental health problem, including the risk of relapse, which is the illness arm of the two-exposure comparison made concrete for this woman.
- How the problem and its treatment might affect the woman, the fetus and the baby, kept as three separate questions because the answers differ.
- How the problem and its treatment might affect parenting, which is the element most often dropped and the one families ask about most.

The timing argument for holding this conversation early is the pre-differentiation window discussed above. By the time a woman with an unplanned pregnancy reaches you, organogenesis has usually begun, the exposure has already happened, and the only decisions left are downstream ones. Nothing about the framework changes, but the menu shrinks. A conversation at the point of prescribing, repeated when contraception or plans change, is the only version of this that is genuinely preventive.

**The record is part of the clinical act, not an administrative afterthought.** Shared decisions in this area are revisited, sometimes years later and sometimes by people who were not in the room, and the woman herself will not retain the arithmetic. What protects the decision is a note showing the reasoning rather than the conclusion. No documentation proforma from a professional body was available for this account, so what follows is derived from what the labelling regulation itself obliges a label to contain, and should be read as a structure rather than as a standard.

- Both arms named: the risks discussed for the agent, and the risks discussed for the untreated or inadequately treated illness in this particular woman, including her own relapse history.
- The comparator used, and whether it was other women with the same condition or the general population, since the two support different conclusions.
- The absolute figures actually quoted, with the background rate beside them, and the population those figures come from.
- The dating frame used for any gestational window discussed, since a note that says nine weeks without saying from what is not interpretable later.
- The kinetic plan: which direction the dose is expected to move with advancing gestation, who reviews it, and who is responsible for the postpartum down-titration and by when.
- What the woman decided, in her words, and what would change the decision, so that a future clinician can tell a settled choice from an unresolved one.

One boundary before leaving the topic. This framework tells you how to reason about an agent; it does not tell you which agent. The individual malformation and adverse-outcome figures for particular mood stabilisers are in live disagreement across published sources, and they are taught with their agents in the Mood disorders: pharmacotherapy notes rather than restated here. What travels from this topic to every other perinatal decision, including the feeding decision in the breastfeeding topic of these notes and the emergency decisions later on, is the frame: two patients, two exposures, an absolute number with its background beside it, and a clock you have named out loud.

> Every figure you quote in this conversation is an increase above a background that is not zero, on a clock you must name, for a woman whose untreated illness is itself an exposure.

### 3 · Drugs safe in breastfeeding (relative infant dose, agent selection)

**Two people receive this prescription and only one of them is dosed.** The mother's milligrams are chosen, titrated and written down. The infant's are inferred from a milk assay and a body weight, arrive at intervals nobody controls, and appear on no chart at all. That asymmetry is what this topic is about, and why the question asked is never "which drug is safe" but "which drug, for which infant, watched how, and what would make you stop".

The temptation is to memorise a ranked list of agents, and a ranked list is precisely what the published figures do not support. Several of the agents a candidate is most likely to name have no published figure at all. In two of the four classes the headline figure means something quite different from what it appears to mean, because it omits an active metabolite carrying most of the exposure. And the highest figure in the table belongs to a drug women take through lactation, under monitoring, every day. What is examined is whether a candidate can read a percentage, see what it excludes, and make a decision the percentage was never capable of making. The two-patient frame

that governs this band, mother and infant weighed together, is developed in the pregnancy-prescribing topic of these notes.

## Choosing an agent in lactation: the number, and what the number hides

Every figure below is a relative infant dose, expressed as a percentage of the maternal weight-adjusted dosage.

**THE LINE IS NOTIONAL, AND IT IS A SCREEN, NOT A VERDICT**

A relative infant dose below 10 per cent of the maternal weight-adjusted dosage is the working rule of thumb.
Above it, ask harder questions. Below it, the agent is still chosen on the infant in front of you.

| AGENT | RELATIVE INFANT DOSE | WHAT THE NUMBER DOES NOT SAY |
|---|---|---|
| **ANTIDEPRESSANTS** | | |
| Sertraline | **0.5 per cent of the maternal weight-adjusted dosage; sertraline** | Smallest pooled figure; it heads the column arithmetically |
| Paroxetine | **1.2 per cent of the maternal weight-adjusted dosage; paroxetine** | Low in milk; its pregnancy profile is a separate question |
| Fluoxetine | **7 per cent counting norfluoxetine too; fluoxetine** | **The parent-only figure describes a different molecule** |
| Citalopram | **7.9 per cent of the maternal weight-adjusted dosage; citalopram** | Highest of the pooled antidepressant figures |
| Escitalopram | **3.9 per cent of the maternal weight-adjusted dosage; escitalopram** | **Maternal metaboliser status shifts it; not a constant** |
| Venlafaxine | **7.6 per cent counting desvenlafaxine too; venlafaxine** | Again a combined figure, again two molecules |
| Mirtazapine | **1.5 per cent of the maternal weight-adjusted dosage; mirtazapine** | The study that produced the working rule of thumb |
| **ANTIPSYCHOTICS** | | |
| Quetiapine | **0.09 per cent of the maternal weight-adjusted dosage; quetiapine** | Lowest in its column |
| Olanzapine | **1.6 per cent of the maternal weight-adjusted dosage; olanzapine** | Best evidenced antipsychotic on this metric |
| Risperidone | **4.3 per cent in total with its metabolite; risperidone** | **Most of the total is an active metabolite** |
| Haloperidol, clozapine | **No relative infant dose published** | Read the monitoring row instead; absence is not safety |
| **MOOD STABILISERS AND BENZODIAZEPINES** | | |
| Lamotrigine | **9.2 per cent of the maternal weight-adjusted dosage; lamotrigine** | **Series disagree; it has no single figure** |
| Lithium | **12.2 per cent of the maternal weight-adjusted dosage; lithium** | **Above the line; intake assumes the infant clears it** |
| Lorazepam | **8.5 per cent of the maternal weight-adjusted dosage; lorazepam** | **Highest of its class, and NOT the worst choice** |
| Alprazolam | **3 per cent of the maternal weight-adjusted dosage; alprazolam** | Low figure, and the selection rule points away from it |
| Valproate, carbamazepine | **No relative infant dose published** | **Valproate: settle the prescribing bar first** |

**Three ways this column is misread, and all three change the answer**

Parent drug against parent plus active metabolite: fluoxetine, venlafaxine and risperidone each have two figures.
A ranked list read as a ranking of safety: the metric describes intake, not what the infant does with it.
A figure read as a constant: maternal metaboliser status and infant clearance both move it.

**The infant shifts the line; the line does not shift the infant**

Prematurity, the first days of life and any condition that slows clearance all make the same percentage mean more.
So the threshold is drawn here as a band that moves with the baby, and never as a fixed line on the page.

Pale: a published figure · White: no figure published · Coral: where the number misleads · Amber: the register

Fig 28.3. Agent selection in lactation, with the relative infant dose for each antidepressant, antipsychotic, mood stabiliser and benzodiazepine that has one, each figure naming in the same line what it is a dose of, set against the notional ten per cent working threshold, the agents for which no figure is published shown as such rather than omitted, and the three misreadings that change the answer named alongside the infant factors that move the threshold rather than the number.

### 3.1 The number you quote, and the half of the exposure it leaves out

The **relative infant dose** expresses what the breastfed infant takes in as a percentage of the mother's own weight-adjusted dose, and a value **below 10 per cent** of that maternal weight-adjusted dose is conventionally taken as the notional level of acceptability. The derivation, the arithmetic and the worked exemplars are printed in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes and are not repeated here. What belongs here is what the metric cannot do, and the primary sentence supplying the threshold supplies the caveat alongside it: the feeding decision remains an individual risk and benefit analysis rather than a threshold test.

Read literally, the metric is a statement about intake, and says nothing about what happens after the milk is swallowed. Two infants taking identical relative infant doses of the same agent can reach entirely different serum concentrations, because absorption, hepatic conjugation and renal clearance are all maturational and all slower in the first weeks of life than the adult pharmacokinetics behind the calculation assume. The exposure that matters clinically is intake set against clearance, and only the first of those is inside the number.

RULE **A relative infant dose is an intake figure, not an exposure figure.** It is calculated from what enters the infant and it assumes he can clear it. Every caveat in this topic, prematurity, the first postnatal days, dehydration, intercurrent illness and maternal genotype, is a statement about a clearance term the metric does not carry. A figure comfortably acceptable in a thriving infant of a few months can be the wrong figure in a jaundiced newborn on the same milk, and nothing on the page changes to tell you so.

### 3.2 The agent table, and how to read a blank cell

The figures that follow come from the Drugs and Lactation Database, a compilation of maternal serum and milk assays, together with the primary pharmacokinetic study of mirtazapine that supplies the working threshold. They are laboratory calculations on small samples of healthy, term, exclusively breastfed infants, not outcome data. A blank in the percentage column is neither reassurance nor warning: it means the calculation was not made, and the reason differs by agent. For the anticonvulsant mood stabilisers the database gives its own reason and it is methodological, which is worth teaching in itself.

**0.09%**
QUETIAPINE, LOWEST PUBLISHED RELATIVE INFANT DOSE HERE

**0.5%**
SERTRALINE, LOWEST ANTIDEPRESSANT FIGURE

**12.2%**
LITHIUM, ONLY CENTRAL ESTIMATE ABOVE THE NOTIONAL LEVEL

**17.85%**
INFANT SIDE EFFECTS ON ATYPICALS, INDIAN MOTHER AND BABY UNIT

| AGENT | RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE | WHAT THE FIGURE DOES NOT CONTAIN |
|---|---|---|
| SERTRALINE | 0.5%, pooled dataset | Nothing material; this is the arithmetic reason it sits where it does |

| AGENT | RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE | WHAT THE FIGURE DOES NOT CONTAIN |
|---|---|---|
| PAROXETINE | 1.2%, pooled dataset | Discontinuation effects in the mother if it is stopped abruptly to permit feeding |
| FLUOXETINE | 2.4% for the parent drug alone | The active metabolite; measured with it, about 7%, range 3 to 12% |
| CITALOPRAM | 7.9%, pooled dataset | Individual studies in the same record running both below and above this |
| ESCITALOPRAM | 3.9%, with 1.7% more as desmethylcitalopram | Maternal genotype; modelled median 3.3%, range 0.8% to 11.3% |
| VENLAFAXINE | 7.6% for drug plus metabolite, range 4.7 to 9.2% | Nothing; but it must be quoted as the combined figure, never as the parent alone |
| MIRTAZAPINE | 1.5%, range 0.6 to 2.8%, plus 0.4% as the desmethyl metabolite | Maternal sedation, which is a feeding-safety issue in its own right |
| QUETIAPINE | 0.09% on average; modelled worst case 0.43% | Nothing; the worst case already assumes every feed at the peak milk level |
| OLANZAPINE | 1.6% on average, range 0 to 2.66% | Nothing material; the best-evidenced antipsychotic on this metric |
| RISPERIDONE | 4.3% in total | Four fifths of it is 9-hydroxyrisperidone, itself a marketed antipsychotic |
| HALOPERIDOL | No figure published | A maternal oral ceiling statement instead: up to 10 mg daily gives low milk levels |
| CLOZAPINE | No figure published | The only agent here for which an infant blood count is the named action |
| LITHIUM | 12.2%, range 0 to 30%, in the better-technique series | Infant clearance, which is the variable that actually decides the case |
| LAMOTRIGINE | 9.2%, range 3.1 to 21.1%, in one series | A second series averaging 11.6%, range 5 to 31% |
| VALPROATE | No figure published | The calculation is held to be less meaningful for this class. |

| AGENT | RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE | WHAT THE FIGURE DOES NOT CONTAIN |
|---|---|---|
| VALPROATE, BEFORE THE LACTATION QUESTION ARISES AT ALL | Not a relative infant dose question | A woman who is breastfeeding is by definition of childbearing potential, so the bar on offering valproate to this group absent the conditions set out with contraception counselling in these notes applies to her before any milk calculation is reached. Settle that question first; it is not answered by this table. |
| CARBAMAZEPINE | No figure published | The same methodological reason as valproate |
| LORAZEPAM | About 8.5%, counting conjugated as well as free drug | Nothing; the conjugate is why this figure is the highest of its class, and the figure is not a verdict on the agent. It is short-acting and free of active metabolites, which is precisely what the selection rule in the row below asks for |
| ALPRAZOLAM | About 3% | Reported infant sedation, which drives the caution against repeated use in nursing and points instead to a shorter-acting benzodiazepine without active metabolites, especially with a neonate or a preterm infant |
| CLONAZEPAM | Maximum 2.5%, from a single mother and infant pair | Any population estimate; this is one report, not a mean |
| DIAZEPAM | No figure published | Accumulation of drug and metabolite in infant serum on repeated dosing |

### 3.3 Antidepressants: the metabolite is the decision

Sertraline heads the antidepressant column for an arithmetic reason rather than a pharmacological one: its pooled figure is simply the smallest, and it carries no long-lived active metabolite to be added to it. Paroxetine follows closely, and mirtazapine is comparably low where sleep and appetite dominate the presentation.

Fluoxetine is where a single number misleads most reliably. The parent compound's pooled figure looks unremarkable, and the database flags in the same breath that the figure omits **norfluoxetine**, an active metabolite of equivalent antidepressant activity. Where both were measured together, in 14 mothers, the combined figure rose to about **7 per cent** of the maternal weight-adjusted dose, with the upper end of the range crossing the notional level. Long half-lives also mean the infant has

no trough to be fed in. That is the whole clinical argument for choosing a shorter-acting agent when treatment is started fresh in a breastfeeding mother, and emphatically not an argument for switching a woman already well on fluoxetine.

Citalopram gives the highest single-agent figure among the plain serotonin reuptake inhibitors, close enough to the notional level to matter when the infant is young or unwell. Escitalopram demonstrates why the column cannot be read as a table of constants at all. In a modelled analysis the median figure came with a range spanning more than an order of magnitude, and it split by maternal genotype: a **CYP2C19 poor metaboliser** mother produced a modelled relative infant dose of 5.5 per cent of her weight-adjusted dose against 3 per cent in other phenotypes. One agent therefore spans much of the column on its own, which should permanently discourage comparing two drugs on the second decimal place. Venlafaxine must always be quoted as drug plus **desvenlafaxine**, because the active metabolite carries most of it.

### 3.4 Antipsychotics: what is actually prescribed, and what is actually watched

Quetiapine gives the lowest published relative infant dose of any agent here, and the figure survives its own worst case: a model assuming that every single feed occurred at the peak milk concentration still returned a figure far below the notional level. That is a useful shape to recognise, because most published figures are averages across a dosing interval and a worst case is rarely offered. Olanzapine is the best-evidenced of the class and its published range extends down to zero. Risperidone is the trap.

TRAP **Quoting risperidone by its parent drug alone.** The parent contributes 0.84 per cent of the maternal weight-adjusted dose and **9-hydroxyrisperidone** a further 3.46 per cent, giving **4.3 per cent** in total. Candidates quote the first of those because it is the figure attached to the drug name they recognise, and thereby understate the infant's exposure roughly fivefold. A small series gives a mean of 3.3 per cent, range 2.2 to 4.7 per cent, which is consistent with the combined total and not with the parent figure. The general form of the error is the one that also catches fluoxetine and venlafaxine: where an agent has an active metabolite, the drug name and the number in front of you are describing different molecules.

Haloperidol has no relative infant dose in the database at all. What exists instead is a statement about the mother: doses of up to 10 mg daily by mouth during lactation produce low levels in milk and usually do not affect the breastfed infant, with very limited long-term follow-up showing no adverse developmental effect where haloperidol is used alone. That is a ceiling on the mother's oral daily dose offered in place of a figure for the infant, and it must be taught as exactly that. Clozapine likewise has no published figure, and the same database records that other agents are preferred and that some sources advise a woman taking it should not breastfeed at all.

**IN INDIA**

The most usable cadence available comes from an Indian tertiary-centre mother and baby inpatient psychiatry unit, published in the Indian Journal of Psychiatry in 2021, in which infants of 28 postpartum women taking atypical antipsychotics had medication side effects checked every alternate day for 1 to 2 weeks against a prepared checklist. Side effects including sedation and constipation attributable to the antipsychotic occurred in 17.85 per cent of that single-centre, uncontrolled, short-window sample. The exposure profile is Indian too: 15 of the 28 infants were exposed to olanzapine at maternal oral doses of 2.5 to 30 mg daily, 11 to risperidone at maternal oral doses of 4 to 8 mg daily, and 2 to quetiapine. The service point matters more than the percentage. An alternate-day check by the nurse at the cot is deliverable in a district hospital anywhere in the country. Serial infant serum levels and repeat white cell counts are not, and where the blood test cannot realistically be obtained, the agent choice itself must carry the safety the monitoring was supposed to provide.

### 3.5 Mood stabilisers: where the metric runs out

Lithium carries the highest central relative infant dose of any agent here, and the only central estimate sitting above the notional level. It also carries the widest disagreement between datasets. The better-technique series gives one figure; an older estimate from 6 infants, in reports published up to the start of the nineteen-nineties, gives about **26 per cent** of the maternal weight-adjusted dose, range 11 to 42 per cent, with the database noting that many of those case reports were of poor quality and that the reason for the gap between the two estimates is not apparent. Both have to be stated. Quietly choosing the lower because it supports a decision already made is the error, and so is quoting the higher to close a conversation down. Whether lithium prohibits feeding outright or permits it under monitoring is a separate argument with a substantial cohort literature behind it, and it is developed in the Mood disorders: pharmacotherapy notes rather than restated here.

Lamotrigine straddles the line rather than sitting on one side of it. One series gives a central figure just under the notional level with an upper bound at twice it; a second series averages above the line entirely. The honest teaching is that lamotrigine has no single relative infant dose, and that a mother asking for one is asking for a certainty the published data does not contain.

Valproate and carbamazepine have no figure at all, and here the database states its own reason rather than leaving the cell mysteriously empty. In the published lactation reports most women were taking **combination anticonvulsant therapy**, and because some of these agents induce and others inhibit the metabolism of the rest, the relationship between the mother's dose and the concentration in her milk becomes variable enough that the weight-adjusted percentage is less meaningful for this class than for other drugs in that database. That is a statement about the method rather than the drug, and it is why those two cells must stay blank rather than be filled from memory in a viva.

### 3.6 Anxiolytics: the agent for which timing the feed is useless

The benzodiazepine column contains the topic's most counter-intuitive result. Lorazepam has the practice reputation of being the most benign of the group and carries the highest published relative infant dose of them, **about 8.5 per cent** of the maternal weight-adjusted dose. The reason is both methodological and clinically real: the figure counts **conjugated as well as free drug**, because infants can deconjugate and absorb glucuronides, so a metabolite an adult would have safely inactivated becomes available to the baby again. Alprazolam and clonazepam give lower figures, the clonazepam one from a single mother and infant pair rather than a population, which is the kind of provenance difference that disappears once figures are tabulated side by side.

Diazepam is the exception that governs the practical advice given later in this topic. Diazepam and nordiazepam accumulate in the serum of breastfed infants with repeated doses, and because both half-lives are long, timing breastfeeding with respect to the maternal dose is of little or no benefit in reducing infant exposure. Every timing manoeuvre a mother might be offered assumes a peak and a trough she can feed between. Diazepam on repeated dosing does not provide one.

Two further rules attach to this class, both population rules rather than agent rules. Because of reported infant effects including sedation, alprazolam is probably not the best benzodiazepine for repeated use during nursing, particularly with a neonate or premature infant, and a **shorter-acting benzodiazepine without active metabolites** is preferred. And the class as a whole has to be read against guidance that would rather it were not being prescribed to this population at all: the National Institute for Health and Care Excellence guidance on antenatal and postnatal mental health, which applies in England and Wales, advises considering gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding.

### 3.7 The infant who is not in the data

Every figure in the table was derived in a healthy, term, exclusively breastfed baby. The Indian cohort states this explicitly by way of its exclusions: preterm delivery, birth weight below 2 kilograms, major neonatal complications needing intensive care, major congenital anomaly and major medical or surgical illness were all excluded before a single infant was observed. Whatever reassurance that study offers, therefore, it does not offer it about the preterm infant, the small infant or the sick infant, and those are precisely the infants in whom clearance is worst. The reassurance and the risk have been separated by the study design, and a reader who does not check the exclusions will carry the reassurance across the gap.

The database makes the mechanism explicit for lithium and the shape generalises. Lithium in milk can harm the infant acutely where **elimination is impaired**, as in dehydration or in the newborn or premature infant, and a neonate may in addition be carrying transplacentally acquired serum lithium from before delivery. Consider what that does to the arithmetic. A baby with gastroenteritis and reduced feeding has an unchanged relative infant dose on paper and a rising serum concentration in reality, because the number describes what goes in and the illness has changed

what comes out. The clinical habit follows directly: treat acute illness in the infant of a mother on a narrow-margin agent as a reason to reassess feeding that day, not at the next appointment.

MNEMONIC

**Metabolite, Maturity, Malady, Mother**

The four things a relative infant dose does not contain. **M**etabolite: the active metabolite frequently excluded from the headline figure. **M**aturity: prematurity and the first postnatal weeks, when clearance is immature. **M**alady: intercurrent infant illness or dehydration, which changes elimination without changing the number. **M**other: her metaboliser phenotype, which can move the figure several-fold on the same prescription.

### 3.8 What is watched in the infant, and who does the watching

Monitoring here is overwhelmingly clinical rather than laboratory, and where a blood test is named it is named for a reason a candidate should be able to give. The residual duty, covering every agent for which no panel and no figure exists, is a single line from the same English and Welsh guidance: where a woman is taking psychotropic medication while breastfeeding, the baby is monitored for adverse effects. No panel, no interval and no duration is specified there, so none should be invented to fill the silence.

| AGENT | INFANT CLINICAL WATCH | INFANT BLOOD TEST NAMED BY THE SOURCE |
|---|---|---|
| LITHIUM | Dehydration, feeding, any acute illness | Serum lithium, creatinine, blood urea nitrogen and thyroid stimulating hormone, at intervals variously recommended from periodic to every 4 to 12 weeks, attributed to some investigators rather than to a guideline |
| LAMOTRIGINE | Apnoea, rash, drowsiness, poor sucking; stop feeding if a rash appears, until the cause is established | Infant serum level where there is concern; platelet count and liver function; levels before and after any increase in the maternal dose. Less extensive monitoring where the mother takes 150 mg daily or less |
| CARBAMAZEPINE | Jaundice, drowsiness, adequate weight gain, milestones; more closely in younger exclusively breastfed infants and on polytherapy | Serum carbamazepine, liver enzymes and a complete blood count, attributed by the source to one author rather than a guideline; no interval given |
| VALPROATE | Jaundice, unusual bruising or bleeding; sedation or withdrawal reactions where sedating agents are combined | None specified |
| CLOZAPINE | Close monitoring for excessive sedation | Periodic infant white blood cell count; the source gives no interval |
| HALOPERIDOL | Drowsiness and developmental milestones, more closely with concurrent antipsychotics; on the decanoate also excessive sedation, irritability, poor feeding and extrapyramidal signs | None specified |
| ANY OTHER PSYCHOTROPIC | Adverse effects, unspecified | None; the residual duty carries no panel |

Three things are worth drawing out. Clozapine is the only agent for which a blood count on the infant is the named action, for the reason the reader already knows from the mother's own monitoring. Lamotrigine carries the most specific panel and the only monitoring-intensity threshold expressed as a maternal dose, on the stated logic that beneath it the infant is unlikely to have measurable serum drug at all. And the lithium panel is the only one with a named interval, attributed by the source to investigators rather than to a guideline and arriving with no target value and no action threshold: the reader is told what to send, not what to do with the result. An interval with no owner reads as universal, and none of these are.

### 3.9 Timing, expressing, and the decision the table cannot make

**Mothers do not ask about relative infant dose.** They ask whether to feed before the tablet or after it, whether expressing and discarding the milk helps, and whether to stop feeding altogether. The first two have arithmetic answers; the third does not. For sertraline the manoeuvre has actually been quantified: in one series the relative infant dose was 0.54 per cent of the maternal weight-adjusted dose, and **pumping and discarding** milk 8 to 9 hours after the mother's dose was calculated to reduce the infant's daily dosage by 17 per cent. A proportional reduction of that size, applied to an intake already among the smallest in the table, buys almost nothing at the cost of a discarded feed, a pump the family may not own, and a mother's sleep. Timing is not useless; its value must be computed against the figure it is applied to.

Timing is worth more where the peak is sharp and the baseline higher, nothing at all for diazepam on repeated dosing, and something quite specific after a single dose. After one dose of diazepam, for sedation before a procedure or for a seizure, there is usually no need to wait before resuming breastfeeding; with a newborn or preterm infant a cautious approach is to wait 6 to 8 hours before resuming nursing, and for that population other agents are preferred in the first place. That is one of the few genuinely timed acts here and it is worth carrying precisely.

The last question is the one no percentage answers. The English and Welsh guidance sets a default of encouraging breastfeeding in women with a mental health problem, and names its exceptions: carbamazepine, clozapine and lithium. Notice what that list is and is not. It is a service-level decision rule rather than a pharmacokinetic ranking, and most of the named agents have no published relative infant dose at all, so they appear on it because of the absence of a number rather than because of a high one. The same recommendation closes by requiring that each woman be supported in the choice of feeding method that best suits her and her family, which is what stops an exception list becoming a prohibition. It constrains what is encouraged; it does not decide for the woman.

The genuinely hard case is the woman already well on the agent with the worst milk data. The guidance names both sides without resolving them: the limited safety data on these drugs in milk, and the risk associated with switching from a previously effective medication, with specialist perinatal advice sought for specific drugs. Nothing in the percentage column tells you the second of those. A relapse in the early postnatal weeks costs the infant his mother's availability, frequently costs the feeding relationship anyway, and sometimes costs an admission, none of which appears in a milk assay. That is why the agent table is a set of inputs rather than a ranking of answers. One caution on jurisdiction: that guidance is English and Welsh, Indian guidance controls for Indian practice where it exists, and no Indian equivalent of the exception list was retrievable, so it structures the conversation rather than governing an Indian unit.

**GOOD TO REMEMBER**

Before the first dose, write down which infant this is: gestation at birth, current weight, age in weeks, whether feeding is exclusive, and whether the baby is well today. Then write down what will be watched and who will watch it. Every figure here assumes a term, healthy, exclusively breastfed baby, and the moment yours is not one, the number has stopped describing him and the plan is built from the infant instead.

- Name the metabolite before quoting the number: fluoxetine, venlafaxine and risperidone are each understated by their parent-drug figures.
- Read a blank cell as an absent calculation, never as reassurance, and be able to say why it is missing.
- Reassess feeding on the day an infant becomes acutely unwell, not at the next review, wherever the mother is on a narrow-margin agent.
- State whose an interval is. Where a source attributes a schedule to investigators rather than a guideline, say so out loud.

Quote no relative infant dose without naming the metabolite it excludes and the infant it assumes: a term, healthy, exclusively breastfed baby who can clear what he takes in.

## 4 · Mood and anxiety disorders in pregnancy

**The commonest question about mood and anxiety disorders in pregnancy is not which drug is safe but what to do about the drug she is already taking.** A woman maintained on treatment for depression, bipolar disorder or an anxiety disorder arrives either pregnant or planning to be, and something has to be decided in that consultation, on that afternoon, by whoever is sitting opposite her. Candidates prepare this as a teratogenicity table and then find that no table answers it, because the question on the table is not what an agent does to a fetus. It is what to do about a person who is currently well because of it. The two-patient frame is set out where these notes deal with prescribing psychotropics in pregnancy; what is added here is that the exposure being weighed on one side has a competitor on the other, and the competitor is her illness.

Owned here in full: the antenatal decision itself and the four arms it actually has, which are to continue, to switch, to reduce or to stop, each priced with what it costs; the relapse and recurrence evidence that turns stopping from a neutral act into a decision with a bill attached; the manner of stopping, where stopping is what she chooses; the detection of perinatal anxiety and perinatal obsessive-compulsive disorder, both of which are systematically under-recognised; and the narrow set of situations in which a non-pharmacological route is genuinely first-line rather than a way of postponing the decision. Named once and not re-taught here: the depressive, bipolar and anxiety syndromes themselves, which belong to the Mood disorders: classification, depressive and bipolar

syndromes, neurobiology notes; and agent selection, comparative teratogenicity and dosing, which belong to the Mood disorders: pharmacotherapy notes.

**68 per cent**
RELAPSED IN PREGNANCY AFTER STOPPING THE ANTIDEPRESSANT

**26 per cent**
RELAPSED IN PREGNANCY ON THE ANTIDEPRESSANT MAINTAINED

**71 per cent**
HAD AT LEAST ONE RECURRENCE IN PREGNANCY IN A BIPOLAR COHORT

**22.2 per cent**
PERINATAL GENERALISED ANXIETY DISORDER, POOLED ACROSS LOW- AND MIDDLE-INCOME COUNTRIES

### 4.1 Who is in front of you, and what is actually being decided

Three consultations hide behind this heading and they are not the same problem. The first is the woman who is planning a pregnancy and has come to ask about it: the only version of this decision made with time in hand, where every arm is still open and nothing has been done that cannot be undone. The second, and by a distance the commonest, is the woman who is already several weeks pregnant when she finds out, whose exposure decision was made for her by biology before anyone was consulted. The third is the woman with no psychiatric history who becomes unwell during the antenatal period, where the question is whether to start rather than whether to continue, and where the reference point is a woman who has never been treated at all.

The decision itself has four arms, not two. She can continue what she is on; she can be switched to a different agent; the dose can be reduced; or the drug can be stopped. Examination answers and, more damagingly, real consultations collapse this into a binary of drug or no drug, and every collapse of that kind moves the conversation to the arm that feels safest rather than the arm that is safest. Each of the four is a positive act with a specific price, and a candidate who can name the price of each has understood the topic. The prices are not symmetrical and they are not all pharmacological: two of them are paid by the fetus, one is paid by the woman's mental state, and one is paid by both at once.

| THE ARM | WHAT IT IS MEANT TO BUY | WHAT IT ACTUALLY COSTS |
|---|---|---|
| CONTINUE | Maintained control of an illness that is currently in remission on this agent | Steady exposure of the fetus to one drug for the whole of the antenatal period, and the review burden that goes with it |
| SWITCH | Exchange of an agent with worse evidence for one with better evidence | Exposure to two drugs across the changeover instead of one, plus destabilisation of a woman who was well |
| REDUCE | Less exposure while keeping some treatment | Possible loss of efficacy without a matching loss of exposure, which is the worst ratio of the four |
| STOP | Zero further drug exposure from the day it is stopped | Relapse or recurrence risk that is quantified, large, and largely borne in the antenatal period itself |

MNEMONIC

**Continue, Switch, Reduce, Stop - and name the bill for each**

Four arms, four bills. Say all four aloud in the consultation, price each one in her hearing, and the conversation stops being a request for permission to stop and becomes a choice between four named positions.

### 4.2 Building the conversation the guidance actually requires

Before any arm is chosen there is a discussion, and the guidance specifies its contents rather than leaving them to the clinician's instinct. The National Institute for Health and Care Excellence, in guidance published in 2014 and last updated in 2020, requires that detailed advice about the risks of mental health problems and the benefits and harms of treatment in the antenatal and postnatal periods cover three things that clinicians routinely leave out.

- The **background risk of harm** to the woman and to the fetus or baby that comes from the mental health problem itself, and the risk to her mental health and to her parenting if she is not treated at all.
- The risks and harms attached to stopping or changing a treatment, which is a separate question from the risks attached to being on it.
- The need for prompt treatment, because of what an untreated mental health problem can do to the fetus or baby.

**Notice what that list does to the arithmetic.** The framework behind it, that the untreated illness is itself an exposure and that a relative risk must be read against its base rate, is set out where these notes deal with prescribing psychotropics in pregnancy, and is not re-derived here. What belongs to this decision is the direction it points. The American College of Obstetricians and Gynecologists, in its clinical practice guideline of 2023, directs that the **absolute risk** of adverse obstetric, perinatal and infant developmental outcomes, which for almost all psychiatric medications appears to be low, be set against the high risk of illness recurrence, and states that in general this balance favours continuing pharmacotherapy.

RULE **The default is not neutrality, and the burden of argument sits on stopping.** The same American guideline states that although pharmacotherapy is an exposure, for most individuals and most medications the risk of that exposure is lower than the risk of symptom exacerbation or relapse. Continuation is therefore the position that stands unless a case is made against it, and a clinician who stops a psychotropic in pregnancy is the one who owes the argument, not the one who keeps it going.

### 4.3 Pricing the stop option in unipolar depression

The counterweight to teratogenic risk is relapse risk, and unless it is quantified in the consultation it does not weigh anything at all. The best-known evidence comes from a prospective multicentre cohort of women with a history of major depression who were euthymic at conception and followed

across the antenatal period. Of 201 women, 86, or 43 per cent, relapsed during pregnancy. That headline figure conceals the finding that matters. Among the 82 women who maintained medication throughout, 21, or 26 per cent, relapsed, against 44 of the 65 who discontinued, which is **68 per cent**. Expressed as an effect size across the whole of pregnancy, discontinuation carried a hazard ratio for relapse of **5.0**, with a 95 per cent confidence interval of 2.8 to 9.1.

The authors' conclusion is the sentence to carry into the consultation: pregnancy is not **protective** against relapse of major depression, and a woman with a depressive history who is euthymic on an antidepressant should be told that stopping it in pregnancy is associated with relapse. Many women and a fair number of clinicians hold the opposite belief, usually without ever having examined it, and the belief does real work: it makes stopping feel like a return to a natural, safer state rather than the removal of an active treatment from a person who has an illness.

Two honest qualifications travel with these numbers and a good candidate offers them before being asked. The design is naturalistic rather than randomised, so the women who discontinued were not allocated to do so; they chose, and the reasons a woman chooses to stop may themselves predict how she will fare. The direction of that bias is not obvious, because a woman with milder illness may feel safer stopping while a woman with more severe illness may be the one most frightened by exposure. What survives the qualification is the size of the gap and the fact that both arms were followed prospectively by the same investigators to the same endpoint.

### 4.4 Pricing the stop option in bipolar disorder

The bipolar figures are larger and the decision is correspondingly less balanced. In a prospective cohort of women with bipolar disorder who were euthymic at conception, the overall risk of at least one recurrence during pregnancy was **71 per cent**. Comparing those who discontinued a mood stabiliser with those who continued it, the discontinuers carried twofold the recurrence risk, a median time to first recurrence more than fourfold shorter, and a proportion of weeks spent ill during pregnancy that was five times greater. That last measure is the one to quote to a woman who is thinking in terms of a single feared event, because it describes not whether she becomes unwell but how much of her pregnancy she spends unwell.

An independent guideline summary of two cohort studies reaches the same place by a different route. Compared with continued use, discontinuing a mood-stabilising medication in pregnancy was associated with an increased risk of recurrence at an adjusted hazard ratio of 2.2 with a 95 per cent interval of 1.2 to 4.2, and with a reduced time to recurrence of 2 weeks against 28 weeks, at an adjusted hazard ratio of 12.1 with an interval of 1.6 to 91. Print the second interval whenever the point estimate is printed. An interval that wide says the direction is secure and the magnitude is not, and a candidate who quotes the point estimate alone has misrepresented the evidence in the direction of confidence.

Two further features of that cohort change what you do rather than what you think. Most recurrences were depressive or mixed, at 74 per cent, so the surveillance a clinician sets up should

not be built around watching for mania; and 47 per cent of recurrences fell in the first trimester, which is exactly the window in which a woman who has just stopped is least likely to be under psychiatric review and most likely to be attributing her symptoms to being pregnant. The investigators' own framing closes the argument: treatment planning here has to consider not only the relative risk of fetal exposure to a mood stabiliser but also the high risk of recurrence and morbidity that comes from stopping maintenance treatment.

### 4.5 Continue: the default, and the clock that governs any later stop

The American guideline sets two defaults that are worth memorising as a pair, because they are not the same default. In severe mental health conditions such as bipolar disorder and the psychotic disorders, pregnant and postpartum individuals should in general continue medication management. In depression or an anxiety disorder diagnosed in the antenatal or postnatal period, continued pharmacotherapy should be recommended for at least **6 to 12 months** of symptom remission before discontinuation is even considered. Note what that second default is a clock on. It runs from remission, not from delivery, not from the end of breastfeeding, and not from any gestational milestone. A woman who becomes well at some point in the antenatal period and delivers three months later has not finished the clock, and the postnatal request to come off is therefore usually a request made early rather than a request made at a natural end point.

The same guideline states plainly that discontinuing effective pharmacotherapy in pregnancy or the postpartum period increases relapse risk and is not recommended, and that where discontinuation is being considered it requires careful consideration of the risk of recurrence. For major depressive disorder it names two predictors of recurrence that a clinician can check in the room: **discontinuation before remission**, meaning before symptoms have completely resolved rather than merely improved, and an increasing number of lifetime depressive episodes. Both are answerable from the history in under a minute, and both convert an abstract worry into a statement about this woman.

Continuing is itself an act and not the absence of one. It commits the clinician to review, to a plan for what happens if she becomes unwell anyway, and to a decision about whether the dose that is right in the first trimester is still the right dose later, since the handling of a drug changes across pregnancy for reasons that belong to the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. No review interval is asserted here, because none is carried in the sources used for this topic; what is asserted is that a decision to continue with no review date written next to it has not been fully made.

### 4.6 Switch: paying for one exposure with two

Switching is the arm that most often gets proposed by a clinician rather than requested by a woman, usually with the intention of moving her from an agent with worse reproductive evidence to one with better. Its cost is structural and easy to miss. A switch is executed as a **cross-taper**, the initial medication down-titrated while the newer agent is started and up-titrated, and the American guideline notes that this results in increased exposure, which is best avoided if a therapeutic effect

can be reached with a single agent. For a period that may run into weeks the fetus sees two drugs where it previously saw one, and the woman spends that period on a subtherapeutic amount of the drug that was working and a not-yet-effective amount of the drug that might.

Two sequencing rules follow from that, and both are stated in the guideline rather than inferred. First, because a switch is expensive, careful assessment of what medication has actually been effective for this woman in the past is of particular importance; the agent with the best published reproductive data is of no use to a woman it has never worked for, and switching away from the one agent that has ever produced remission in her is the most consequential version of this error. Second, assuming that side effects are not prohibitive, dose optimisation should be considered before switching. Optimising is cheap in exposure terms and reversible; switching is neither.

### 4.7 Reduce: buying the exposure without buying the benefit

Reduction is the arm that feels like a compromise and has the worst ratio of the four. The British guidance directs use of the lowest effective dose, and adds in the same breath that this matters particularly where the risks of adverse effects to the woman, fetus and baby may be dose related. But it then states the cost explicitly: a **sub-therapeutic dose** may also expose the fetus to risks and not treat the mental health problem effectively.

The word carrying the weight in that recommendation is effective. Lowest effective dose is not the same instruction as lowest dose, and the two get conflated whenever a clinician halves a dose in the first trimester as a gesture towards caution. Exposure does not fall to nothing when a dose is halved; the drug is still crossing, still being metabolised, still detectable in the pregnancy. What may fall to nothing is the therapeutic effect that justified the exposure in the first place. A woman on a reduced dose who then relapses has ended up with both costs and neither benefit, and she has also lost the argument that the drug does not work for her, since it was never given a fair test at the dose that worked.

### 4.8 Stop: the taper is the instruction, not the decision

Stopping is two decisions wearing one word, and only the second is fully inside the clinician's control. The first is whether to stop, which is largely hers. The second is how, which is a technical act with evidence behind it. In the bipolar cohort described above, the median recurrence latency was 11 times shorter after abrupt or rapid discontinuation of a mood stabiliser than after gradual discontinuation. Same decision to stop, same drug, and an order-of-magnitude difference in how long she stayed well, determined by a variable the prescriber sets.

For the antidepressants the American guideline names the method directly: to avoid the discontinuation syndrome, a person who has been on a serotonin reuptake inhibitor or a serotonin and noradrenaline reuptake inhibitor should undergo a **progressive taper** over **2 to 4 weeks**. Two clinical consequences follow. An entry in the notes that reads only that the drug was stopped, with no taper written beside it, is half an instruction, and the missing half is the half that predicts the outcome. And because a discontinuation syndrome in a pregnant woman produces sleep

disturbance, agitation, nausea and dysphoria, it is routinely misread as either an early relapse or as the pregnancy itself, which sends the consultation in the wrong direction at the worst moment.

> Stopping is never the cautious option and never one decision: whether to stop belongs largely to her, how to stop belongs entirely to you, and the manner of stopping changes the outcome as much as the choice to stop.

### 4.9 When she has already decided to stop

Some women will decide to come off medication whatever is said, and the clinical task then changes from persuasion to damage limitation. The British guidance sets out what the conversation should contain when a woman with a severe mental illness decides to stop a psychotropic in the antenatal or postnatal period: discuss her reasons, and discuss the possibility of each of the following, then make sure she knows the risks to herself and to the fetus or baby of stopping.

- Restarting the medication, offered here without any precondition attached.
- Switching to a different medication, if the objection is to this agent rather than to treatment.
- A psychological intervention, which is a treatment and not a placeholder.
- Increasing the level of monitoring and support, which is the arm that stays available when every other one has been refused.

The parallel recommendation for a woman with depression or an anxiety disorder is worth putting side by side with that one, because it differs in exactly one place and the difference is examinable. There, the restarting option is conditioned: it applies if the depression or anxiety disorder is or has been severe and there has been a **previous good response to treatment**. No such condition appears in the severe mental illness recommendation. The threshold for pressing a restart is therefore explicitly higher in depression and anxiety than in severe mental illness, which is a proportionality judgement written into the guidance rather than a clinical preference, and it tells you where the guidance thinks the greater danger of undertreatment lies.

**GOOD TO REMEMBER**

Write the four arms and their costs into the notes, name which one was chosen, name who chose it, and write a date next to it. A decision recorded as "patient wishes to stop, medication stopped" cannot be defended, cannot be reviewed and cannot be handed over. A decision recorded as four options offered, relapse risk quantified in her hearing, her choice, taper plan, review date, is the same clinical act with the evidence of care attached to it.

### 4.10 When the pregnancy is already confirmed

This is the presentation that walks into most clinics, and it carries a correction that changes the first thing a clinician says. Where a pregnant woman has taken a psychotropic with a known teratogenic risk at any point in the first trimester, the British guidance directs that the pregnancy be confirmed

as quickly as possible and that she be told, explicitly, that stopping or switching the medication after the pregnancy is confirmed may not remove the risk of fetal malformations.

The logic is uncomfortable and it is the point. By the time a routine test is positive, the exposure that would have mattered has usually already happened. Stopping today therefore buys much less than it appears to on the risk that is being feared, while buying, in full and immediately, the relapse risk quantified earlier in this topic. That does not make stopping wrong; it makes stopping a decision that has to be justified on its own forward-looking terms rather than as a retrospective repair. The practical acts that follow are to confirm and date the pregnancy rather than assume it, to record what she actually took and when rather than what she was prescribed, and to route the exposure question to the people who can actually assess it obstetrically, instead of resolving it by withdrawing the treatment.

TRAP **Stopping the drug the day the test comes back positive, in the belief that this undoes the exposure.** It is made in good faith and it feels like the responsible act, which is why it is so durable. It usually cannot reverse a first-trimester exposure that has already occurred, and it adds a discontinuation to a woman in the very trimester in which recurrences cluster. The reflex substitutes an act that is visible for one that is useful.

### 4.11 Asking about antenatal anxiety, and why the number depends on how you ask

Perinatal services are built around depression, and the arithmetic does not support that design. In a Canadian cohort assessed by structured diagnostic interview, the prevalence of anxiety and related disorders was 15.8 per cent during pregnancy and 17.1 per cent in the early postpartum, against depression at 3.9 per cent and 4.8 per cent in the same sample. That is a single regional cohort, and only participants who screened positive went on to interview, so the authors describe their own estimates as conservative. Even discounted for both, a service whose only routine perinatal enquiry is about low mood is aimed at the smaller of the two problems.

The second thing to understand about these figures is that the number you find is partly a property of the method you used. Within one meta-analysis, generalised anxiety prevalence came out at 24.4 per cent when estimated from screening tools and 11.5 per cent when estimated from **diagnostic interview**, for the same construct in the same review. Roughly half the apparent prevalence of perinatal anxiety is instrument. That is not an argument against screening, which is doing what a screen is meant to do; it is an argument for never quoting a prevalence figure in an answer without saying how it was ascertained, and for never treating a positive screen as a diagnosis in the clinic.

| WHAT WAS COUNTED | HOW IT WAS ASCERTAINED | STUDY BASE | THE FIGURE |
|---|---|---|---|
| ANTENATAL ANXIETY SYMPTOMS | Self-report | 102 studies, 221 974 women, 34 countries | Self-reported anxiety symptoms in 18.2 per cent in the first trimester, 19.1 per cent in the second and 24.6 per cent in the third |
| ANY ANTENATAL ANXIETY DISORDER | Clinical diagnosis | The same global review | Any anxiety disorder in 15.2 per cent |
| ANTENATAL GENERALISED ANXIETY DISORDER | Clinical diagnosis | The same global review | Generalised anxiety disorder in 4.1 per cent |
| PERINATAL GENERALISED ANXIETY DISORDER | Pooled across all ascertainment methods | 203 studies, 212 318 women, 33 low- and middle-income countries | Generalised anxiety disorder in 22.2 per cent, the most prevalent disorder in that review |
| THE SAME, SPLIT BY COUNTRY INCOME BAND | Pooled, subgrouped | The same low- and middle-income review | Generalised anxiety in 27.6 per cent in lower-middle-income countries, 24.0 per cent in low-income countries and 19.1 per cent in upper-middle-income countries |

For an Indian answer, the pooled low- and middle-income figure is the more defensible comparator than a global pooled figure, because the studies behind it were done in economies that resemble the one the reader works in. One caution belongs with it and is stated rather than glossed: that review reports prevalence by World Bank income band, but it does not itself state which band India falls into, so no Indian figure is being asserted here by implication.

### 4.12 Asking about perinatal obsessive-compulsive disorder

Obsessive-compulsive disorder in the perinatal period is the clearest example in this topic of a diagnosis whose apparent frequency is determined by whether anyone asked. The older pooled estimates, drawn from studies using structured interviews, put prevalence at 1.08 per cent in the general female population, 2.07 per cent in pregnancy and 2.43 per cent postpartum, with regionally matched risk ratios of 1.45 in pregnancy and 2.38 postpartum and an aggregate risk ratio of 1.79. That much was established years ago: the perinatal period raises the risk, and it raises it more after delivery than before.

A later province-wide cohort of unselected women, interviewed directly and asked about perinatal-specific content, returned figures several times higher. Weighted **period prevalence** was 7.8 per cent prenatally and 16.9 per cent postpartum, with average point prevalence of 2.9 per cent prenatally and 7.0 per cent postpartum. Keep the two quantities apart when quoting them, since a

period prevalence spanning months and a point prevalence at a single assessment are different measurements and the higher pair is not the more alarming version of the lower pair. The two estimates disagree substantially and the disagreement is unresolved; the honest position for a candidate is to quote both and to name the methodological reason they differ rather than to pick the more striking one.

**The timing tells you when to ask.** Point prevalence rose across pregnancy and the early postpartum to a peak of close to 9 per cent at approximately 8 weeks postpartum before declining, and the cumulative incidence of new diagnoses was estimated at 9 per cent by 6 months postpartum. Two things follow for the clinic. The peak sits in the early postnatal weeks, when most contact is obstetric or paediatric rather than psychiatric, so the enquiry has to be built into whatever contact exists rather than into a psychiatric follow-up that has not been arranged. And a large share of it is new onset rather than pre-existing illness carried into the pregnancy, which means a negative psychiatric history is not a reason to skip the question.

The authors state the mechanism of under-recognition as a measurement fact rather than a clinical impression: when women are encouraged to report their **perinatal-specific symptoms** and current diagnostic criteria are applied, estimates come out higher than previously believed. Under-recognition here is a failure to ask about content, not a failure of the disorder to occur. The general enquiries most clinicians make do not reach obsessions whose content is about the infant, and a woman rarely volunteers them, for reasons that are obvious the moment you consider what she believes will happen if she says them aloud in an antenatal clinic.

PITFALL

Acting on the content of an intrusive thought about harm to the infant instead of on its form. The reflex is an emergency referral, a safeguarding entry, or a decision to keep mother and baby apart, and it punishes a woman for disclosing. What you ask about is the form. The discrimination itself, and the risk formulation that follows from it, are made in the section of these notes on mother-infant bonding and infanticide risk; the urgent-risk pathway belongs to the section on psychiatric emergencies in the perinatal period.

### 4.13 Choosing a non-pharmacological route where it is genuinely first-line

A psychological intervention appears in the guidance as one of the named options when a woman decides to stop medication, alongside restarting, switching and increased monitoring. It is a treatment arm in its own right, and there are three situations in which it is genuinely first-line rather than a way of deferring the decision.

- The woman not currently on medication whose symptoms are of low or moderate severity with no history of severe illness, where the comparison is between a psychological treatment and starting a drug rather than between a psychological treatment and continuing one.
- The woman who has firmly declined medication, where the real comparison is between a psychological intervention and nothing at all, and where the arm that is available beats the arm

that is optimal.

- The woman who has stopped and accepted increased monitoring, where a psychological intervention is what turns a surveillance plan into an active one.

What makes any of these real is availability inside a clinically useful interval. A referral to a service that will assess her after delivery is not first-line treatment for antenatal illness; it is a deferral wearing a treatment's name, and the pregnancy will be over before the intervention begins. The honest test to apply before writing it in the plan is whether she will actually be seen while the problem is still the problem. Where the answer is no, saying so and choosing among the remaining arms is better practice than recording an intervention that will not arrive, because the record then reflects the decision that was actually made. No severity threshold, no named therapy and no efficacy estimate for psychological treatment in the antenatal period is asserted here; none is carried in the sources used for this topic, and the principle is offered without a number rather than with an invented one. Where the illness is severe enough that no pharmacological arm is acceptable to her and psychological treatment is not sufficient, electroconvulsive therapy becomes the next question, and it belongs in full to the ECT and neurostimulation notes.

**IN INDIA**

A peer-reviewed analysis of Indian maternal mental health policy records that the National Mental Health Policy launched in 2014, directed at vulnerable populations and at de-stigmatisation, does not include women in the perinatal period among the populations it names as susceptible to psychiatric problems. That is a policy analysis rather than a government instrument, and it is cited as analysis. Its practical consequence is the one every reader will recognise: there is no funded pathway that puts a psychiatrist inside the antenatal clinic, so almost every contact this woman has during pregnancy is obstetric, and almost every opportunity to ask about anxiety or intrusive thoughts belongs to someone who has not been asked to ask. The arms of the decision above are all deliverable in that setting except one. Continuing, tapering properly, optimising a dose and increasing the frequency of review can all be done in a district clinic with a telephone number that works. A timely psychological intervention usually cannot. Where that is the local reality, it should change which arm is chosen, not be recorded as though it had been offered.

A closing note on jurisdiction, because it governs how the material above should be used. The four-arm structure, the required contents of the risk-and-benefit discussion, the remission clock, the taper interval and the option sets are British and American guidance. No Indian national guideline on the antenatal psychotropic decision was retrievable for this topic, and where an Indian instrument exists it controls for Indian practice. The relapse and recurrence figures come from North American cohorts of women who were in specialist follow-up and euthymic at conception, which is a more closely observed population than most Indian services can offer; the direction of that difference is that relapse in a less closely followed population is likely to be detected later rather than to occur less often. Use the structure as a way of organising the consultation, and the

figures as the order of magnitude of what stopping costs, which is the part a woman needs in her hearing before she decides.

# The postpartum period

## 5 · Postpartum blues (features, course)

**Why the marks sit in the act and not in the description.** **Postpartum blues** is judged quickly, usually by somebody who is not a psychiatrist, and then rarely revisited. What the state is, how it runs, and how it stands against a postnatal depressive episode and against a puerperal psychosis belong to the three-way treatment carried by the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and none of it is restated here. What belongs at the front door is different: the act performed in the room, the person into whose hands the judgment is given, and the condition under which it must be reopened.

The label is the easy part; the harm sits in how it is closed. A woman correctly judged to have blues may be depressed some weeks later: the first judgment was not wrong, the way it was ended can be. Every decision in this band is taken for **two patients** at once, the mother and the infant who depends on her, a frame belonging with prescribing in pregnancy and holding even though nothing is prescribed.

| Reassure, inform, return | Reassurance and a named threshold | Mother and infant |
|---|---|---|
| THE THREE THINGS DONE WITH HER, AND ALL THAT IS DONE | THE TWO LIMBS OF THE TRIGGER, EACH INERT WITHOUT THE OTHER | WHO EVERY DECISION IN THIS BAND IS TAKEN FOR |

### 5.1 The discrimination the front door actually makes

There are not three descriptions to choose between at the door so much as three **dispositions**, and the choice turns on what is safe to do next rather than on which picture fits best.

- **Reassure and review.** She is coping with the support she has, nothing needs treating tonight, and she can safely be seen again. That is the blues judgment: a disposition, not a description.
- **Treat now.** The state is deepening, or simply failing to lift, and function is going rather than holding. It has become a treatment question and enters the screening and referral pathway taught where postnatal depression is handled in this chapter.
- **Do not discharge.** Disorganisation, fluctuating awareness, perceptual disturbance, or any thought of harm to herself or to the infant takes her out of this category altogether and calls for same-day assessment and an admission decision. The branches then separate by destination, and getting them the wrong way round is the error. Fluctuating awareness or disorganisation is an organic question first, and goes to the emergency triage of the confused patient in these notes. A thought of harm goes to the risk assessment taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The presentation as a whole goes to this chapter's account of postpartum psychosis, which owns the same-day assessment and the admission decision it triggers.

Blues is therefore a **provisional judgment** by construction: it says treatment is not needed now, not that it never will be. And because the third branch is settled at the moment of contact rather than by watching, the examination that excludes it belongs to the first visit, not to the review.

### 5.2 The act in the room, and why each part fails alone

The response to blues has been set out as an act rather than as a description by the **IGEDEPP** prospective multicentre cohort, the cleanest available statement of the front-door task. **Three** things are done with the woman: her awareness of what she is living through is raised, so it has a name she recognises; she is reassured; and she is given information about postpartum depression and the symptoms by which it declares itself.

Take one away and the other two stop working. Awareness without reassurance medicalises an experience that does not need treating. Reassurance without information is heard as an instruction to disregard whatever comes next, so a woman whose state deepens reads that as her own failure. The information is what actually gets dropped, out of kindness: a woman never told a postpartum depressive episode exists cannot recognise she has crossed into one.

MNEMONIC

**Reassure, Inform, Return**

**R**eassure, with her awareness raised rather than her experience dismissed; **I**nform, about postpartum depression and the symptoms that announce it; **R**eturn, on a stated trigger held by a named person.

### 5.3 The trigger that reopens the judgment

RULE **Blues is managed by reassurance plus a named return threshold, and it ceases to be blues the moment the threshold is crossed.** Each half is inert without the other. Reassurance alone closes the encounter; a threshold alone, handed over flat, converts a settling experience into vigilance. Together they turn a judgment nobody can check today into one that checks itself later.

The condition attached is that the blues **worsens or is prolonged**, either of which requires management, so the trigger has **two** limbs and no third. That is what spares the clinician from having to predict: you have to be right about the trigger, not about the future. It stays coarse because it will be applied by an exhausted woman and by relatives with no clinical training.

How long counts as prolonged is fixed by no figure this section can assert, and inventing one would hand the family a false permission to wait. What the clinician can do instead is fix the review and let that date carry the meaning of prolonged: if the state has not lifted by the contact already arranged, the judgment is reopened there.

### 5.4 Handing the threshold to somebody who will still be there

**Safety-netting is an allocation, not a sentence.** A threshold given to the woman alone lands on the person least placed to act on it: the judgment about whether a state is worsening is being asked of

the person whose state it is. **Safety-netting** means deciding, before she leaves the room, who else holds the trigger, and fixing a contact rather than issuing an invitation to return.

| WHO HOLDS THE THRESHOLD | WHAT THEY ARE ASKED TO NOTICE | WHAT THEY DO WITH IT |
|---|---|---|
| **The woman herself** | That the state is deepening, or has not lifted | Present again, without waiting for the review |
| **The relative in the room** | The same change, which she may minimise | Bring her, having been told where and to whom |
| **Whoever sees her at the next routine contact** | Whether the judgment still holds | Escalate rather than reassure a second time |

**IN INDIA**

The threshold assumes a clinician who stays reachable, and that is where this pathway breaks. The postnatal contact is commonly obstetric, or the frontline home visit by the auxiliary nurse midwife or the accredited social health activist, rather than anything psychiatric. Many women move to the natal home after delivery, often in another district, so whoever set the threshold is not whoever sees her next. Two adjustments cost nothing: give the trigger to the relative travelling with her, and name a destination where she is going.

TRAP **Writing postpartum blues into the record as a diagnosis instead of as a judgment with a trigger attached.** The label is correct when written, and correctness feels like a finished act, so it travels forward as a conclusion and the next clinician reassures a second time without ever seeing the condition the first reassurance depended on. In a viva the discriminating answer is what was said, to whom, and what was arranged.

**GOOD TO REMEMBER**

If the consultation is cut short, protect the trigger and the review before the reassurance. Warmth is remembered but not inherited; a threshold never stated is the part nobody downstream can reconstruct.

You are entitled to record postpartum blues only if you also state, out loud and in the notes, what would make you unmake it.

## 6 · Postpartum depression (assessment, EPDS, management)

**Why the marks are here.** Depression after childbirth is one of the few psychiatric conditions in which the diagnostic work is easy and the detection work is hard. A woman has more scheduled contact with health services in the perinatal year than at almost any other time in adult life, and she is still routinely missed, because being seen is not being asked. What this section teaches is not the illness but the machinery around it: who asks, at which contacts, with what, and what happens to

the woman who answers yes. The entity itself, its specifier, epidemiology, recurrence risk and first-line treatment, belongs to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

Two features make this a service question rather than a bedside one. Every decision in the perinatal band is taken for two patients at once, the mother and the fetus or infant, which is the frame these notes set out for prescribing in pregnancy: a missed diagnosis here is transmitted rather than contained. And screening is itself an intervention with a cost. It manufactures positives, and a positive that goes nowhere is worse than no screen, because it teaches a woman that disclosure achieves nothing.


Fig 28.4. The perinatal screening and service pathway on a timeline from before conception to one year after birth, showing who asks at each contact, the timed reviews and the intervals a positive screen sets running, with the Indian route drawn as the alternative it has to be, through the antenatal, delivery and immunisation contacts that already exist and the workforce already in the room, and with the referral limb marked as the place the pathway fails first.

## 6.1 A screen is not a service

The governing principle comes from the American College of Obstetricians and Gynecologists, in its 2023 clinical practice guideline: screening is valuable but by itself insufficient, and earns its

place only inside a system that carries a woman through the whole mental health pathway. That guideline names the stages in order: detection, assessment, triage and referral, treatment access and initiation, symptom monitoring, and **measurement-guided treatment adjustments** continued until symptoms remit.

Read that as a chain of joins, not a list of activities, because the weakest join is almost never detection. Detection is cheap and easy to audit, which is why services install it first and why the unaccompanied screening programme is so common. Assessment costs clinician time; triage needs a destination with capacity; initiation needs it to accept and start; monitoring needs somebody to own the case after the referral letter leaves. Naming the stage at which a described service breaks answers the question; naming an instrument does not.

MNEMONIC

### Who, When, With what, What next

The four questions a perinatal screening pathway must answer before it is worth running. **Who** is screened, and by which worker. **When** in the perinatal timeline the contacts fall. **With what** enquiry or instrument. **What next** when the answer is positive. Services specify the first three and improvise the fourth at the point of need, which is where the pathway fails.

RULE **Do not put a screening instrument into a service until the destination of a positive result has been named, and named as a person or a clinic rather than a category.** It is the easiest part of the pathway to install and the least useful alone. Where a service cannot say who assesses the positives, within what interval, and who follows the woman if treatment starts, a questionnaire increases documented distress without increasing treated distress.

## 6.2 Who is screened: a population defined by the care episode, not by risk

The first design decision is whom to ask, and the guidelines that have thought hardest about it define the population by the care a person is receiving rather than by risk stratification. ACOG makes screening for depression and anxiety universal across well-woman, prepregnancy, prenatal and postpartum care, using standardised and validated instruments. That is the difference between a programme and case-finding: a programme asks everyone inside a defined care episode.

The reasoning matters more than the rule. Risk-based screening sounds efficient and fails structurally: risk factors are unevenly documented, so the woman with the thinnest record is least likely to be flagged and often most exposed, and risk assessment inserts a judgement between the woman and the question, at which point bias and social distance select who is asked. A universal rule keeps judgement for the assessment rather than the front door.

The Australian clinical practice guideline of 2023 widens the population further than any other, offering screening to **non-birthing parents** early in pregnancy and again from 3 to 6 months after the birth, repeated when clinically indicated. That limb is missing from most teaching and almost

every service, yet a depressed partner is both a risk to the infant and a determinant of whether the mother's treatment succeeds.

### 6.3 Which contacts carry the enquiry

The second decision is when, and every serious guideline answers with named contacts rather than a frequency, because a contact already exists in a schedule and a frequency has to be remembered. The NICE guideline on antenatal and postnatal mental health, published in 2014 and last updated in 2020, places the first enquiry at the woman's first contact with primary care or her booking visit, and again in the early postnatal period. Its form matters: the **depression identification questions** are asked inside a general discussion about mental health and wellbeing, not bolted on as a separate screening event, because an enquiry that arrives as a form feels like an audit.

NICE postnatal care guidance, issued in 2021 and updated in 2026, makes assessment of psychological and emotional wellbeing a standing item at every postnatal contact, routes the clinician to the mental health guidance for recognition and referral, and requires concerns to be followed by further assessment and follow-up. Screening thereby becomes part of routine postnatal care, the only form in which it survives a busy service.

| ISSUER AND YEAR | WHO ASKS | ANTENATAL CONTACTS | POSTNATAL CONTACTS |
|---|---|---|---|
| **NICE, antenatal and postnatal mental health, 2014, updated 2020** | Primary care first; then the health visitor and any professional in regular contact | First contact with primary care or the booking visit, then later contacts | The early postnatal period, and contacts through the first year after birth |
| **NICE, postnatal care, 2021, updated 2026** | The postnatal care provider; the GP at the timed review | Outside scope | Wellbeing assessed at each postnatal contact; GP assessment 6 to 8 weeks after the birth |
| **ACOG, 2023** | The obstetric or well-woman provider | Initial prenatal visit, and again later in pregnancy | Postpartum visits |
| **Australian clinical practice guideline, 2023** | The perinatal care provider | As early as practical in pregnancy, repeated at least once later in pregnancy | First postnatal screen 6 to 12 weeks after birth, repeated at least once in the first postnatal year |
| **American Academy of Pediatrics, 2019** | The paediatric medical home | Coordination with prenatal providers where depression was diagnosed before birth | The 1-, 2-, 4- and 6-month well-child visits |
| **India** | No national requirement to screen; community health workers hold the contacts | Four incentivised antenatal care visits | Two incentivised postnatal care visits, plus institutional delivery |

One point in the accompanying comparison is easily missed. These postnatal schedules are timed rather than merely repeated: the Australian schedule sets its first postnatal screen beyond the

earliest weeks after delivery, when transient emotional change is expected and a screen would largely detect that instead, so the timetable itself carries a discrimination the front door would otherwise make unaided.

### 6.4 Who does the screening, and for how long

The third decision is whose job this is, and the answer is uncomfortable for psychiatry: mostly not ours. NICE names the **health visitor**, with every other professional in regular contact during pregnancy and the postnatal period, defined as the first year after birth, as those who should ask the depression identification questions and the GAD-2 at contacts after the first, and use a rating instrument as part of monitoring. Screening is a repeated act distributed across a workforce, and the psychiatrist sits downstream of it.

The American Academy of Pediatrics gives the answer residents almost never do. Its 2019 policy statement puts postpartum depression screening inside the **paediatric medical home** at the early well-child visits, with three duties attached: coordinating with the prenatal provider where depression was diagnosed before birth, using community resources for the mother's treatment and referral, and supporting the mother-infant relationship including breastfeeding. The logic is attendance: after delivery the appointment reliably kept is the baby's, so the clinician who reliably sees the mother is the baby's doctor.

> **GOOD TO REMEMBER**
>
> A positive screen must be owned by a named person until it is closed, and the guidance builds that in rather than leaving it to goodwill: NICE requires the woman's GP to be told about a referral, and makes wellbeing a standing item at every postnatal contact so the finding is revisited by whoever sees her next. Your equivalent act is to record which contact the enquiry happened at, what the answer was, and who owns the next step.

### 6.5 The enquiry that no instrument performs

Alongside the depression questions, and frequently omitted, runs a second enquiry that is historical rather than symptomatic. NICE directs that at a woman's first contact with services in pregnancy and the postnatal period the clinician asks about three things:

- any past or present severe mental illness;
- any past or present treatment by a specialist mental health service, including inpatient care;
- any severe perinatal mental illness in a first-degree relative, named as mother, sister or daughter.

Note the strength of the instruction: the depression enquiry is framed as something to consider, this one as something to do. Note also what it is for. A symptom questionnaire describes today, and the women at highest risk here are frequently well when asked. No rating instrument detects a lifetime course or a family history, so this is the only route by which the highest-risk group is identified, and it runs through history-taking rather than screening in the technical sense.

What follows from a positive history does not wait for symptoms. NICE directs referral to a secondary mental health service, preferably a **specialist perinatal mental health service**, for assessment and treatment of every woman who has or is suspected to have severe mental illness, and every woman with any history of one, whether from pregnancy, the postnatal period or any other time in her life. History alone triggers it, and the GP is told. This period compresses the interval between the first sign of relapse and a dangerous outcome, so the assessment must be in place before the sign appears.

### 6.6 What actually happens to a positive screen

The fourth decision is the one services skip, and NICE specifies it precisely. A positive answer to either depression identification question, a woman judged at risk, or clinical concern opens two branches, and the clinician chooses:

- use the **Edinburgh Postnatal Depression Scale** or the **Patient Health Questionnaire** as part of a full assessment; or
- refer to her GP, and to a mental health professional if a severe mental health problem is suspected.

Two structural points follow and they are the heart of this topic. The instrument is the second step of the pathway, not the first: the screening act is the conversational enquiry, and the rating scale enters afterwards, inside a full assessment, in a woman who has already said something. A service that inverts this hands the questionnaire out at a desk and scores it without a conversation. Referral is also an alternative to using the instrument rather than a consequence of it, which matters wherever the person who detects the problem is not the person who will assess it.

These notes name the instruments and stop there. What an examination can fairly ask is where an instrument sits in the pathway, who administers it, and what its result may decide.

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TRAP **Starting an antidepressant on the strength of a positive depression screen.** ACOG requires screening for **bipolar disorder** before pharmacotherapy for depression or anxiety is initiated, if it has not already been done. This is a sequencing rule inside the pathway rather than a fact about either illness, and it is the front door's most consequential ordering decision: a depression screen is cross-sectional and knows nothing of lifetime course, so a pathway beginning with a positive screen can end in a precipitated episode of a different kind.

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### 6.7 The intervals that make a positive screen mean something

A pathway with no clock is an aspiration. NICE attaches two intervals to a perinatal mental health referral: assessment for treatment within **2 weeks** of referral, and psychological interventions within **1 month** of the initial assessment. Both sit in the same guidance as the screening recommendations: the body that tells you to ask also tells you how fast you must answer for the reply.

They are short for a reason. The perinatal year is a moving target: the infant's developmental window does not pause while a waiting list clears, the mother's capacity to attend falls as the illness progresses, and the contact through which she was detected expires on its own schedule. A wait unremarkable in general adult practice is useless here, because by the time it is reached she is no longer attending the service that found her.

| 4 | 6 to 8 weeks | 0.05 | 1.2 |
|---|---|---|---|
| MINIMUM SCREENING EVENTS ACROSS THE PERINATAL YEAR, AUSTRALIAN GUIDELINE | AFTER THE BIRTH, THE GP POSTNATAL ASSESSMENT, NICE | PSYCHIATRISTS PER 100,000 POPULATION, MADHYA PRADESH, LOWEST REPORTED | PSYCHIATRISTS PER 100,000 POPULATION, KERALA, HIGHEST REPORTED |

### 6.8 The Indian position: the contacts exist, the instruction does not

Everything above describes systems that have decided to screen. India has not, and the absence is documented rather than assumed. A systematic review of Indian national maternity and mental health policies and programmes concludes that they appear not to consider perinatal mental health at all; its search yielded **11** relevant documents and no peer-reviewed publications, and identified no specific national policy or programme on maternal mental health. A policy analysis records that the **National Mental Health Policy**, launched in 2014 with a stated focus on vulnerable populations and de-stigmatisation, still fails to include perinatal women among the populations named as susceptible. Promising initiatives exist at state level; where they do not, need goes unrecognised and unmet.

**Why the referral limb is the harder problem.** Citing the national mental health survey of 2015 to 2016, the same analysis reports that every state except Kerala fell below the benchmark of **one psychiatrist per 100,000 population**, the reported figures spanning more than an order of magnitude between lowest and highest. Those figures are quoted in a policy analysis rather than read from the survey report, and are best taught as reported rather than settled. The conclusion does not turn on the decimal place: the referral limb every Western pathway assumes cannot exist at scale across most Indian states. That argues for a pathway built on task-shifted first-line management and brief psychological intervention by trained non-specialists, with specialist referral reserved for severe illness and for the history-based enquiry above. It is not an argument against screening; it is a decisive argument against installing an instrument and calling it a service.

**IN INDIA**

The contacts exist and are already funded. Cash benefits attached to four antenatal care visits, two postnatal care visits and institutional delivery create windows in which a woman is present, expected and identifiable, and the authors propose them as the natural sites at which healthcare workers could screen for perinatal mental illness. The workforce exists too: **accredited social health activists**, auxiliary nurse midwives and staff of primary and community health centres, credited by the same authors with the country's falling maternal and infant mortality. What is missing is the instruction to ask, and a named destination for the answer.

A perinatal screening pathway is judged by what happens in the fortnight after a positive answer, never by the instrument that produced it.

## 7 · Postpartum psychosis (presentation, emergency management)

**Why it matters clinically.** Nearly every other perinatal presentation is answered with an appointment. This one is answered with a clock, and the second patient in the room cannot report anything. What the service owes her is a same-day assessment by somebody with the authority to admit, a decision about where she sleeps tonight, and a written answer to who is holding the baby meanwhile. What postpartum psychosis is, how it declares itself and how its phenomenology separates from its neighbours belong to the Other psychotic disorders, delusional syndromes and catatonia notes, which own it as a psychotic disorder.

The examination question has the same shape: what you do, in what order, on whose authority, and where she and the baby go next. Candidates lose the marks by preparing it as a description and meeting it as a disposition. Every decision below is made for two patients at once, the frame set out where prescribing in pregnancy is taken up in these notes.

### 7.1 The classification that removes the discretion

The 2023 ACOG clinical practice guideline on mental health conditions during pregnancy and the postpartum classifies this presentation as an **obstetric and psychiatric emergency**, and as a severe mental health illness. The dual assignment is the operative part: it belongs to two services at once, so neither can hold it as a referral to the other and wait. It also sets a default for the time when you are still uncertain, since the trigger for everything that follows is a patient with possible or probable postpartum psychosis, not a confirmed one, which puts the threshold for acting below the threshold for diagnosing.

TRAP **Each service assumes the other owns her.** The obstetric team sees a psychiatric problem in an obstetric bed; the psychiatric team sees a recently delivered woman with a wound, a fundus and a feeding infant. The referral moves sideways while the clock runs, and both sets of notes honestly record that they referred on. Begin the act, then call the other team.

### 7.2 What "immediate" means once somebody writes it down

NICE guideline CG192 on antenatal and postnatal mental health, published in 2014 and last updated in 2020, is where the word acquires a number. A woman with sudden onset of symptoms suggesting postpartum psychosis is referred to a secondary mental health service, preferably a **specialist perinatal mental health service**, for immediate assessment **within 4 hours of referral**. No other perinatal presentation in that guideline carries a response time counted in hours. An emergency nobody has timed cannot be audited.

Three details are worth holding apart. The trigger is sudden onset of symptoms, so the referrer need not have made the diagnosis. The destination is a service, not a named individual, which puts the

problem of finding somebody free on the receiving end. And the interval is a time to assessment, not to admission: it promises a competent pair of eyes, not a bed.

| Assessed within 4 h | A psychiatric emergency | Staffed round the clock, all week |
|---|---|---|
| NICE CG192 STANDARD AFTER REFERRAL OF SYMPTOMS SUGGESTING THIS PRESENTATION | THE CLASSIFICATION THAT REMOVES THE DISCRETION, AND WITH IT THE OPTION OF A ROUTINE APPOINTMENT | DEDICATED MULTIDISCIPLINARY STAFF ABLE TO CARE FOR MOTHERS AND BABIES |

Two honesties belong with that number. It and the postnatal window below are English NHS guidance, quoted with their owner attached rather than as a domestic obligation; no Indian national counterpart was available for the four-hour standard, and none requiring that the destination be a specialist mother and baby unit. The joint-admission default itself is a different matter and is NOT a gap: it is Indian statute, restated in Indian guidance, and it is taught with psychiatric emergencies in pregnancy and the postpartum period in these notes. And no source here states an observation cadence for the stretch between referral and assessment, so that gap is left open rather than filled with a plausible frequency.

### 7.3 The act at the point of contact, and the two rules about the infant

ACOG sets out the immediate act in one passage, written for whoever is standing there. The clinician encountering possible or probable postpartum psychosis obtains an **emergent psychiatric consultation**, or otherwise connects the patient with emergency medical or emergency mental health services; the condition then requires immediate emergent evaluation, admission and treatment, to assure the safety of the patient and the infant together. **Intensive monitoring** is required, and the guideline names what it is for: the risk of suicide and the risk of infanticide. No source available here attaches an interval or content to that monitoring, so it is left unstated rather than invented. Risk assessment as a framework belongs to the Somatic-symptom, sexual, impulse-control disorders and suicide notes; infanticide is a risk to ask about here, its classification belonging to the Mental health legislation and forensic psychiatry notes.

Two supervision rules close the passage: the patient should not be left alone, and she should not be left unattended with the infant. They are separate rules, and the second is not a separation order. It says the pair are not to be by themselves together, which a third person in the room satisfies, and it is compatible with feeding, holding and ordinary contact.

MNEMONIC

**Never alone, never alone with the baby**

The first covers the mother's safety, the second the infant's, and the second is about who else is present rather than where the baby is. Both bite from the moment the presentation is suspected: before the assessment, before the bed, before anyone has agreed a diagnosis.

### 7.4 What the admission actually buys

An admission is justified by what it delivers, and here that is a medical evaluation which cannot be completed in a corridor. Read the list below as an EXCLUSION SET rather than as a benefit of the bed: the question it answers is whether this presentation is organic, and that question is opened at the door and merely finished on the ward. The bedside acts that come first, and the order they come in, are set out with psychiatric emergencies in pregnancy and the postpartum period in these notes. The **psychiatric inpatient evaluation** is described as one that may include:

- physical examination, and head imaging;
- complete blood count, and a complete metabolic panel;
- thyroid-stimulating hormone level, and ammonia level;
- lumbar puncture and electroencephalogram, which some clinicians add and others do not.

The strength is permissive: it may include these things, not must, and converting it into a compulsory battery invents a standard. No sequence, turnaround time or action threshold is given, and none is supplied here from memory. Each item needs a patient who stays put and a team that will chase the result, so an emergency department can start this work and only an admission finishes it. Treat the workup and the sedation decision as one plan with one owner: an evaluation abandoned because the patient was too disturbed, and never diarised again, has excluded nothing.

### 7.5 The risk formulation that has two subjects

At the first Indian mother and baby unit the admission decision is a formal step: every mother-infant dyad is assessed by the team for suitability, and that assessment has named limbs.

- a structured risk assessment covering self-harm and harm to the infant, carried out with a structured instrument, the **Formal Initial Risk Assessment for Mothers And Babies**, named here and not reproduced;
- infant health details;
- ruling out medical conditions in the mother;
- assessment of problems related to breastfeeding.

The shape of that list is the teaching: two limbs are about the baby and a third about the pair. A formulation that speaks only of the mother is not an abbreviated version of the right one but a different one, and it cannot answer what the team must close before admission, which is whether these two can safely be in a room together and on what conditions.

The 2023 Australian clinical practice guideline gives the test in usable form. Co-admission may not be appropriate for women who are severely unwell and incapable of caring for the infant, or where the safety of the infant may be compromised. Those are two independent gates, capability and danger, and they recover on different timescales, so collapsing them into one impression of how unwell she looks loses the decision. Against them sits the benefit the same guideline names, since

co-admission assists the development of **mothercraft skills** and of a positive relationship with the infant.

**GOOD TO REMEMBER**

A supervision plan that names nobody is not a plan. Record who is with the mother now, who is with the infant now, who takes over at the next handover, and what would change the arrangement. The rules being absolute, the only variable is which named adult discharges them at any hour, and that is what goes missing between shifts.

### 7.6 Where she goes, and where the burden of proof sits

**The destination is a decision, not a vacancy.** The default is that mother and infant are admitted together, and separation is the deviation that has to be argued for, authored, dated and reviewed rather than arrived at because no cot was free. That is the whole of what this topic needs from the destination question, and it is the part a candidate is examined on: not what a specialist unit contains, but who carries the burden when one is not available.

What such a unit is, what its presence changes, the service specification behind it, the Indian answer to who cares for the infant while its mother cannot, and the availability position in this country are all set out with lactation and mother-baby unit care in these notes. This topic does not restate them, because a destination described twice in one chapter drifts, and the two accounts then disagree about the thing a reader most needs to be sure of.

The Indian statutory position on rooming-in and on the review clock that governs any separation is a different matter again, and it is not guidance but law. It is taught with psychiatric emergencies in pregnancy and the postpartum period in these notes. A clinician who separates a mother from her infant in India is working inside a statutory framework with an interval and a ceiling that are not the team's to set.

**RULE** **Joint admission is the default and separation is the deviation.** The clinical question is never whether to justify keeping them together; it is whether the reasons for parting them are good enough to be written down and reviewed.

### 7.7 The handover, and what this section hands on

What the receiving team needs is not the mental state examination, which they will repeat, but what is hard to reconstruct: when the clock started, what the risk assessment covered on both sides, who has been supervising each of them and under what instruction, and the reason for the destination chosen. A handover carrying the diagnosis but not the supervision plan has passed on the label and dropped the safety.

Three boundaries are worth naming. What changes about every other emergency when the patient is pregnant or newly delivered is taken up in the section of these notes on psychiatric emergencies in pregnancy and the postpartum period, which is built around this presentation. What the unit

does across the rest of the admission sits with the section on lactation and mother-baby unit care, and agent selection in a breastfeeding woman with the section on drugs in breastfeeding, a decision that follows the destination rather than preceding it.

> Postpartum psychosis is acted on before it is confirmed: same-day assessment by a service that can admit, an admission that buys the medical evaluation, and a supervision plan naming an adult for the mother and an adult for the infant, written before either is left alone.

## 8 · Mother-infant bonding and infanticide risk

**Why the marks are here.** A woman can be profoundly depressed after childbirth and remain warmly, competently attached to her baby. Another can pass every mood enquiry you put to her and feel nothing at all for hers. Almost every clinical error made in this area comes from assuming that one of those two sentences is impossible. The depressive syndrome itself, its specifier, its epidemiology and its first-line treatment belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. What is owned here is the relationship: how the bond is elicited and observed at the bedside rather than inferred from the mood, how far along the rejection and hostility gradient a given mother has travelled, and what the resulting formulation obliges you to arrange for the infant before she leaves your care. Every decision here is made for two patients at once, as the sections on prescribing in pregnancy set out, and the infant is the patient who cannot be interviewed.

Infanticide enters this topic in one form only: as a risk to be asked about and acted on. The classification of filicide and neonaticide, and its forensic frame, belong to the Mental health legislation and forensic psychiatry notes, which also carry postpartum psychosis as the illness context in which infanticide is conventionally taught. That taxonomy is named here and not reproduced, for a clinical reason: a classification of completed acts is a retrospective instrument built for courts, and it does not tell you what to ask the woman in front of you on a postnatal ward.

### 8.1 Separate the bond from the mood before you ask anything else

The argument for treating a disturbed mother-infant relationship as an entity in its own right, rather than as a symptom of postnatal depression, opens with a claim about where the feeling points. A disturbed relationship is a distinct phenomenon whose **affective focus** differs from that of depression. That word carries the whole argument. Depressive affect is diffuse and self-referred: everything is grey, and the woman herself is the worthless object. The affect of a bonding disorder is aimed, and it is aimed at one specific person who is in the room.

The claim is then supported in both directions, which is what makes it a dissociation rather than a preference. In one direction, maternal aversion to the infant is often disproportionate to depression and can occur without it. That half obliges you to ask about the bond in a woman whose mood enquiry is entirely negative, and it is why a depression instrument can never serve as a bonding instrument: it is not measuring the thing. In the other direction, only a minority of depressed

mothers have a relationship problem with their infants, and what follows is both a clinical instruction and an ethical one. Select that minority for special treatment. Do not stigmatise the rest. Assuming that a depressed mother is a poorly bonded mother is wrong most of the time and harmful every time it is wrong, because the assumption reaches the woman, her family and often her notes.

The figure that makes the argument operational comes from women already diagnosed with postnatal depression, among whom a bonding disorder was present in **29%** of those depressed mothers. It sits in the right place to be useful: high enough that the bond must be asked about in every depressed mother, and low enough that it cannot be assumed in any of them. Two caveats travel with it: it is reported in a later paper citing an earlier study rather than generated by the paper that carries it, and it describes women referred for psychiatric help rather than a community.

RULE **Mood and bond are separate endpoints, so they are enquired about separately, recorded separately, and recovered from separately.** A mood enquiry that comes back negative has excluded a mood disorder and nothing else. A mood enquiry that comes back positive has raised the prior probability of a bonding disorder and settled nothing. In practice this means two passes at the same interview: one about how she feels in herself, one about how she feels towards this baby, in that order, because the second is harder to disclose and comes more readily once the first has shown that you are not there to judge her.

There is a genuine counter-position, and an examiner may know it. In the founding series, postnatal mental illness and recalled severe pain during labour were both significantly associated with these disorders, which in their severe forms did not occur in the absence of postnatal mental illness. Taken at face value that makes severe bonding disorder a complication of illness rather than an independent entity. The sampling caveat is load-bearing: the cohort was recruited among women who had suffered postnatal mental illness, so it was structurally incapable of demonstrating severe bonding disorder without it. The safe answer states both positions and says why they cannot be compared directly.

### 8.2 Establish that the disturbance belongs to one child

The clinical description that founded the field came from a series of self-selected women who reported absent affection, sometimes frank hate, rejection, neglect or impulses to harm, in relation to at least one of their children. Two features of it do the diagnostic work. The feelings often began immediately or very shortly after the birth, so this is not the slow erosion of a relationship across months of exhausted parenting. And, with a single exception in the whole series, they were **specific to one child**, which is what produced the term maternal bonding disorder rather than any language about parenting capacity or personality.

Child-specificity is the most useful discrimination available at the bedside and the one a candidate most often misses. A woman who is affectionate with her older child and cannot bear to hold her newborn does not have a parenting problem or a failure of character. She has a disorder of one relationship, and the intact relationship sitting beside the disordered one is the evidence. It also

reframes the conversation, because a mother who believes she is being assessed as a mother will conceal, while a mother who understands that you are asking about one particular bond will often tell you. So ask it plainly: whether she felt like this with her other children, and what is different about this one.

What the disorder contains has been described consistently across the literature: a distressing lack of maternal feeling, irritability, hostility and aggressive impulses, pathological ideas, and outright rejection. The list runs from an absence to an action. The absence, that flat and frightening nothing where the mother expected to find love, is the least likely to be volunteered without a direct question, because it carries more shame than any symptom in perinatal psychiatry. Its distressing quality matters diagnostically: these women are not indifferent to their indifference, and a mother who reports the absence with no distress about it is describing something else.

### 8.3 Place it in the classification, and know why it is missing from yours

A construct with a substantial clinical literature, a structured interview and inpatient admissions attached to it is nonetheless absent from most residents' differentials, and the reason given by the field's own originator generalises. Writing in 2004, he attributed the neglect of these disorders principally to their absence from ICD-10 and DSM-IV. That is a dated statement, since both classifications named in it have since been superseded. The mechanism it describes is not dated at all: a phenomenon with no code is not counted, so it is not audited, so it is not commissioned for, so it is not taught, so it is not looked for.

The current classificatory position is a partial answer at best. The nearest available category is **caregiver-child relationship problem**, defined as substantial and sustained dissatisfaction within a caregiver-child relationship, including a parental relationship, associated with significant disturbance in functioning. Read that against the clinical picture and the gap is obvious. Dissatisfaction and functional disturbance are captured; rejection of the infant is not, and pathological anger directed at the infant is not. The old complaint has been answered in form rather than in substance, and a candidate who says so, having quoted the definition accurately, is showing the judgement these questions are set to find. One limit is declared rather than hidden: that definition came from a coding reference mirroring the classification rather than from the classification's own browser, so the alphanumeric code is not printed here and should be verified at source.

The practical consequence is that nothing in the record will prompt you: no box to tick, no code that triggers a review. The enquiry has to be made deliberately, in free text, and a unit that wants it done reliably must build the prompt into its own postnatal proforma.

### 8.4 Ask about rejection and about anger, in the words the literature uses

The gradient is useful only if it is expressed as behaviour a clinician can ask about by name, and it is. At the severe level of rejection the mother may try to escape; may seek permanent transfer of infant care within or outside the family; may express the wish that the baby be stolen, or succumb

to cot death. Those last two are what candidates most often fail to ask about, because they sound too extreme to raise, and they are exactly what a woman will confirm if asked plainly and never volunteer. The question is not whether she wants to harm the baby. It is whether she has found herself wishing the baby were simply gone, by any route, including one that would not be her doing.

Presented separately in the same account, and the separation matters, is **pathological anger**: shouting, cursing or screaming at the infant, accompanied by impulses to strike, shake or smother the child. It is tempting to read them as two points on one severity scale, with anger further along. They are not described that way. **Emotional rejection**, the core concept of a bonding disorder, and pathological anger, which may harm the baby, can coexist, but they have different clinical features and require different intervention strategies. They are elicited by different questions, and the inference each supports differs: rejection points towards neglect, deprivation and relinquishment of care, anger towards an assault that could happen tonight. That last reading is clinical inference from the two descriptions rather than a sourced finding, and should be offered as such.

The category ladder and its proportions come from over 200 mothers referred to services in Birmingham and Christchurch, all interviewed with a semi-structured interview. **Established rejection** was present in **10.6%** of those referred mothers and threatened rejection in a further **14.6%** of them, while pathological anger of some degree was present in **28.6%** of the same referred mothers and was severe in 8.3% of them. Quote these with their denominator attached every time: they describe women already referred to specialist perinatal services, and an answer offering them as population prevalences has misread the study rather than merely rounded it.

| CATEGORY ON THE GRADIENT | WHAT THE MOTHER DESCRIBES OR IS SEEN TO DO | WHAT IT SHOULD MAKE YOU ASK NEXT | WHAT IT CHANGES TODAY |
|---|---|---|---|
| **Threatened rejection** | Rejection voiced or approached rather than settled into. The source separates it from established rejection but does not describe its behaviours, and none are supplied here | What would have to happen for the threat to become a request, and whom she has already told | Frequency of contact, and whether the family have begun arranging a transfer of care |
| **Established rejection** | Attempts to escape; seeking permanent transfer of infant care within or outside the family; expressing the wish that the baby be stolen, or succumb to cot death | Who is physically caring for the baby now, and what happens when she is alone with the infant | Whether the infant's daily care can rest on her at all, and who else is named to provide it |
| **Pathological anger** | Shouting, cursing or screaming at the infant, accompanied by impulses to strike, shake or smother the child | Whether an impulse has ever come close to an act, what stopped it, and whether that brake still holds | Whether the infant can be unsupervised with her tonight, which is a disposition question rather than a formulation question |

**The two antenatal openings.** The same referred series found rejection strongly associated with unwanted pregnancy and lack of interaction with the foetus. Both are askable before delivery, in an ordinary antenatal consultation, in ordinary language: whether this pregnancy was wanted, and whether she talks to, thinks about or has any sense of the baby she is carrying. That converts a postnatal problem into an antenatal enquiry, which is the only point in the pathway where anything can be arranged before the relationship starts badly.

### 8.5 Assess the relationship at every postnatal contact, and decide who supplies the information

The guideline-level bedside method is short enough to memorise and worth memorising. NICE guidance on antenatal and postnatal mental health, published in 2014 and last updated in 2020, requires clinicians to recognise that some women with a mental health problem experience difficulties with the mother-baby relationship, and to assess the nature of that relationship at all postnatal contacts along three named axes: verbal interaction, **emotional sensitivity** and physical care. It further requires that the woman's own concerns about her relationship with her baby are discussed, and that information and treatment for the mental health problem are provided. Read those last two duties as concurrent rather than sequential: the relationship is not parked until the illness is treated.

Its economy is the point. Verbal interaction is whether she talks to the baby at all, and in what register. Emotional sensitivity is whether she reads and answers the infant's signals, or handles a

distressed baby as an object to be managed. Physical care is whether feeding, changing and holding are done, and how. None of it needs an instrument, a room or an appointment, and all of it can be recorded in a line.

MNEMONIC

### Ask her, watch them, ask them

The three sources of a bonding picture. **Ask her**: her own account of how she feels towards this baby, taken separately from the mood enquiry and after it. **Watch them**: the dyad observed directly, across the named axes, including what happens at separation. **Ask them**: the relatives and nursing staff who have watched the pair across a whole day and night. No single source is sufficient, and disagreement between them is data rather than noise.

Where a structured route is wanted, a semistructured interview containing a specific section for assessing perinatal bonding disorders exists in the form of **the Stafford Interview**, developed by the same author who advanced the construct. Where a self-report route is wanted, **the Postpartum Bonding Questionnaire** is the named instrument in this literature. Both are named here and nothing is reproduced from either: no item, no probe, no scoring rule, no threshold. An instrument reproduced piecemeal in a revision note gets used piecemeal in a clinic, and a bonding measure administered without its scoring yields a number that feels like a finding.

The important design question is not which instrument but who supplies the information. At the mother and baby unit at NIMHANS, Bengaluru, described in 2015, an objective bonding instrument was used to assess maternal infant safety, psychotic ideas about the baby, maternal care toward the baby and other aspects of maternal behaviour toward the infant, based on family and nurses observations rather than on what the mother said about herself. That is the only workable method in a woman too unwell to give an account, or too frightened of losing her baby to give an honest one, and those groups include most of the mothers about whom the question matters.

What that observation consists of was set out concretely by the same unit in a later outcome series, reported in 2021. Each mother-infant dyad was observed for:

- care for the baby's basic needs;
- affectionate behaviour;
- significant incidents;
- an overall assessment of safety;
- how the mother handles separation from the baby;
- whether the mother has been separated from the baby in recent days, and the reasons for it.

The last two are what a Western checklist usually omits and what carries most information in an Indian ward, where separation is often arranged informally by relatives long before a clinician has been asked. A mother relieved by separation, a mother distressed by it and a mother who does not

register it are not the same formulation, and eliciting the difference costs nothing beyond a nurse who writes down what she saw.

| ROUTE | WHO SUPPLIES THE INFORMATION | WHAT IT CAPTURES WELL | WHERE IT FAILS |
|---|---|---|---|
| **The woman's own concerns, raised at every postnatal contact** | The mother | The distressing absence of feeling, which nothing else detects, and her own reading of the relationship | Shame, and fear of losing the baby, both of which suppress disclosure |
| **Direct observation of the dyad along the named axes** | The clinician at the contact | Verbal interaction, emotional sensitivity and physical care, in minutes and with no equipment | A single brief window, and a mother who knows she is being watched |
| **Structured clinical interview with a bonding section** | The mother, with a trained interviewer | Category assignment on the rejection and anger gradient | Training and time; unavailable in most general settings |
| **Third-party observational rating** | Relatives and ward nurses across a whole day | Infant safety, care actually delivered, incidents, and behaviour at separation | Observer variability; needs a ward and a habit of recording |

PITFALL

A reassuring self-report bonding questionnaire in a floridly unwell or a frightened mother is not reassurance, and filing it as such is the commonest way this assessment passes on paper while failing the infant in fact. Self-report assumes a respondent who can introspect and who believes that answering honestly is safe. A woman with active psychotic illness may satisfy neither condition, and a woman who has worked out that her answers decide whether she keeps her baby will satisfy the second only if you have told her, credibly, what happens next. Where self-report and observation disagree, the observation is the safer document, and the disagreement itself belongs in the notes.

### 8.6 Formulate the risk, and make the intrusive-thought discrimination first

Guideline risk assessment in the perinatal period is carried out with the woman and, if she agrees, her partner, family or carer, and is focused on self-neglect, self-harm, suicidal thoughts and intent, risks to others including the baby, smoking, drug or alcohol misuse, and domestic violence and abuse. The baby is written inside the risks to others limb, in a parenthesis, rather than given a heading of its own. That drafting is exactly how an infant gets missed by a clinician working down a proforma at speed, and it is why a bonding formulation has to be conducted as its own act rather than trusted to appear inside a general risk assessment.

What the formulation must consider is set out probabilistically and should be repeated in that register. The risks are higher in mothers with a disorder of the mother-infant relationship, and emotional deprivation, impaired cognitive and personality development, child abuse, child neglect

and infanticide are probably commoner in this group. That is probability rather than established fact, and reproducing the hedge is what allows infanticide to sit among the outcomes to be asked about and acted on, rather than becoming the headline that turns every disclosure of maternal ambivalence into a child protection emergency. The slow outcomes on that list happen far more often, and a formulation attending only to the dramatic one will miss the ones already under way.

The discrimination on which the whole formulation turns is between an intrusive thought and a psychotic idea. In its clinical practice guideline on screening and diagnosis of mental health conditions during pregnancy and postpartum, issued in 2023, the American College of Obstetricians and Gynecologists states that **intrusive thoughts** not associated with psychosis are common, that they can indicate severe distress and severe illness associated with depression, anxiety and obsessive-compulsive disorder, and that they most often do not indicate risk of actual harm to the infant, although they do merit further inquiry and evaluation. The discriminator is whether the thought is ego dystonic and distressing to her: an unwanted image of the baby being dropped, which horrifies her and which she manages by avoiding the stairs, marks illness severity rather than danger. Note the clause that survives the reassurance: common and non-predictive is not the same as ignorable.

TRAP **Reading a disclosed ego-dystonic intrusive thought of harm as evidence that the baby is in danger, and separating them on it.** The error is costly in both directions. The mother who has just described the most frightening thing in her head, having been told it was safe to speak, watches her infant removed, and she will not disclose again. Meanwhile the presentation that genuinely warrants urgency, an idea about the baby held with conviction and without distress, is quieter, is not offered spontaneously, and is missed by a clinician whose alarm has already been spent. Distress about the thought is reassuring; conviction is not; the enquiry continues either way.

### 8.7 Convert the formulation into supervision, surrogate care and a discharge plan

A bonding assessment that does not alter a plan has not been done, and there is Indian inpatient evidence for both of the ways it alters one. First, the disorder can stand alone as a reason for admission. In the Indian mother and baby unit series, three mothers were admitted for a primary mother-infant bonding disorder that was independent of the psychiatric problem. That is a small absolute number, offered as a demonstration that the category exists in practice rather than as a frequency estimate. Its force is that the bonding disorder was severe enough to justify an inpatient bed in its own right, in an Indian setting, without a mood or psychotic illness driving it.

Second, and more useful for everyday work, the bonding rating generates the discharge plan. Among 98 dyads in that unit who needed mother-infant bonding interventions, bonding was rated as normal at discharge in 88 of those mothers, while ten of those dyads needed close supervision or **surrogate infant care** even at discharge. Most dyads who need bonding work respond to it, which is the reason to do the work rather than plan around the relationship failing. A minority do not, and for them the discharge summary must name a person: who is supervising, when, and what specifically they are supervising against. A plan that says the family will help is not a plan. What a

joint mother-and-baby admission is for, and how available such a facility is, is a separate question not taught here.

**IN INDIA**

Most of the assessment table assumes a service the average Indian unit does not have. A dedicated joint admission facility exists in very few centres, which leaves the method needing nothing but a ward, a nurse and the habit of writing down what was seen. In most Indian wards the person continuously with the mother and baby is a relative rather than a nurse, which makes third-party observation unusually available and unusually unreliable at once, since the relative may be the one who wants the baby transferred, or the one who will be blamed if anything goes wrong. Ask them separately, and record who said it. The same reality shapes the discharge decision: where close supervision or surrogate infant care is needed, the surrogate will almost always be a family member, so the plan names the individual, confirms that they have agreed, and sets a review date, rather than assuming a joint family absorbs the problem.

### 8.8 Re-examine the bond after the mood has recovered

The last act is the one most often skipped, and it is a timing rule rather than a technique. Where bonding difficulties are prominent, the instruction is to attend to the relationship problems in their own right and to assess whether they are still present beyond the recovery from depression. The timing is the whole of it: the re-assessment comes after mood recovery and not at the same sitting, because before recovery you cannot tell how much of the flatness towards the baby is the depression speaking. Treat the illness, look again at the bond, and treat what is left as a target in its own right. No interval is given in the source used here, so this is taught as a sequence and not as a number of weeks.

Indian prospective inpatient data make the same point as a null result. In dyads admitted to a mother and baby unit and assessed at admission, at discharge and again at follow-up, there was no correlation between maternal psychopathology and mother-infant bonding. The translation should be said plainly to teams: the woman whose psychosis has resolved is not thereby a woman whose bond has recovered. Symptomatic recovery and bonding recovery are separate endpoints, they move independently, and discharging on the first without measuring the second is a decision taken on the wrong variable.

**GOOD TO REMEMBER**

Book the second look before you need it. At the moment the mood is treated and discharge is being discussed, write two things into the plan: when the bond will be re-examined after recovery, and the named person who will do it. Both are trivial to record on the spot and impossible to reconstruct afterwards; without them the re-assessment becomes a good intention nobody owns. If the mother is going home to a district where nobody will see her again for months, make the re-assessment the stated reason for the follow-up appointment rather than bolting it onto a medication review.

| 29% | 10.6% | 14.6% | 28.6% |
|---|---|---|---|
| OF MOTHERS DIAGNOSED WITH POSTNATAL DEPRESSION HAVE A MOTHER-INFANT BONDING DISORDER | ESTABLISHED REJECTION, AMONG OVER 200 MOTHERS REFERRED TO SPECIALIST SERVICES | THREATENED REJECTION, AMONG THE SAME REFERRED MOTHERS | PATHOLOGICAL ANGER OF ANY DEGREE, AMONG THE SAME REFERRED MOTHERS |

A depression screen is not a bonding enquiry: ask about the mood and the bond separately, ask about the bond again after the mood has recovered, and let the answer to that second question, not the first, decide who is watching the baby at discharge.

## 9 · Lactation and mother-baby unit care

**Why the marks are here.** Ask a candidate what to do for a severely ill woman three weeks after her delivery and the answer arrives as a drug. Ask where she is to be nursed, who holds the baby while she is sedated, who decides whether the baby stays with her, and who picks up the telephone six weeks after she goes home, and the answer usually stops. That second set of questions is what this section owns: what a mother-baby unit is, what it is asked to do, how the joint admission and separation decisions are made and remade, what is physically done for a feed during acute treatment, and what an Indian team assembles when no such unit is within reach. Which drug to choose for a lactating woman is a different question with its own metric, and it belongs to the topic on drugs safe in breastfeeding in these notes.

Carry one idea through the section. A mother-baby unit is not a psychiatric ward that tolerates an infant on the premises. It is a service with a written specification, and every clause of it exists because something predictable goes wrong when it is missing.

### 9.1 The specification, and why each clause earns its place

The structural definition used by the Indian group that built the country's first such service is deliberately spare, and it teaches better than any description of the atmosphere on the unit. A mother-baby unit is an inpatient psychiatry service with at least **four** beds, physically separate from the other wards, configured for **joint admission** of the mother along with her baby, and staffed round the clock, every day of the week, by dedicated multidisciplinary staff who look after both of them.

Each clause earns its place. A minimum bed number exists because a smaller service cannot hold a rota, and one or two cots on an acute open ward is a gesture that collapses the first time the ward is full. Round-the-clock staffing matters because the hours in which an acutely unwell newly delivered mother is least able to care for her baby are the night hours, exactly when a general ward runs thinnest. And staff who care for both is what separates the model from every imitation of it: without someone competent and rostered to notice the baby is unwell, the service has an infant on the premises and nobody accountable for that infant.

What the unit is *for* is a separate specification from what it *is*, and the functional one is what candidates omit. Such a unit is expected to encourage breastfeeding, deliver specific interventions for parenting, provide psychotherapy, work on the mother's relationship with her infant, and educate her about the current illness and about preventing the next one; it must also support the spouse and caregivers and involve social services where the infant is at risk. Treating the mother's illness does not appear on that list, because treatment is the assumption rather than the purpose. The purpose is that a functioning dyad leaves the hospital, and a unit discharging a well mother and a relationship nobody has worked on has done the ward's job and not the unit's.

The English service guidance adds the limbs that make the specification auditable rather than aspirational. Specialist perinatal inpatient services should provide facilities designed specifically for mothers and babies, be staffed by specialist perinatal mental health staff and staffed to care appropriately for the babies, liaise effectively with general medical and mental health services, have the full range of therapeutic services available, and be closely integrated with community services so that continuity is preserved and the stay kept short. The last two limbs are what a new service forgets: without a therapeutic programme a unit is an admission ward with cots, and without community integration it produces long stays because there is nowhere safe to discharge into.

RULE **Joint admission is the default and separation is the deviation that has to be justified, recorded and reviewed.** Almost every ward runs the opposite assumption without ever having decided to, because the infant is not the ward's patient. The English guidance inverts it explicitly: a woman needing inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a **specialist mother and baby unit**, unless there are specific reasons for not doing so. Read that for its grammar: the burden of argument sits on whoever proposes to separate the pair, and that direction is worth more in an answer than the recommendation itself.

### 9.2 The arithmetic that decides whether such a unit can exist near you

Residents in India are routinely taught that mother-baby units are scarce here, in a tone implying the scarcity is a national failing. The service-planning parameter behind the model explains most of it. The same English guidance specifies that each **managed perinatal mental health network** should have designated specialist inpatient services covering a population in which there are between **25,000 and 50,000** live births a year, varying with the local rate of psychiatric morbidity.

The catchment for one unit is therefore defined by births rather than headcount or distance, and it is a large number of births. A service with that denominator is by construction regional or tertiary, never a district service, and it will sit in a handful of centres in any health system that builds it at all. So most severely ill postnatal women anywhere, and the overwhelming majority in India, will be treated by clinicians who have no mother-baby unit and never will. The model is therefore taught not as an ideal but as a specification you can partially reproduce, and the defensible answer to a district planning question names the unit as the regional referral destination and spends its words on what the district builds instead.

### 9.3 Who comes through the door, and what the case-mix demands of the design

The published series from India's first unit gives the denominator a resident actually needs. There were 237 admissions across a little over four years from July 2009; the mothers had a mean age of 24.25 years and a mean of 6.50 years of education, and most came from lower socio-economic status and rural backgrounds. Most of them, 80 per cent, stayed for three to four weeks, and the mean length of stay was 17.23 days.

That profile should change how the unit is run rather than merely being recited. Women admitted for weeks from rural homes with minimal schooling cannot be handed written psychoeducation and a follow-up card and be expected to return: the family that travelled with them is part of the treatment and of the discharge plan. A stay of weeks is also long enough for a feed to be established or lost, which is why lactation here is an active programme and not a courtesy.

The risk case-mix dictates the physical design. In the same service, suicide risk was present in 36 mothers, 17 per cent of the series, and risk to the infant from the mother in 32 mothers, 16 per cent; problems in the mother's relationship with her infant affected 98 mothers, 41 per cent. Two of those percentages are the series' own and do not recompute against the series' own denominator: the first two work out nearer fifteen and thirteen and a half per cent. They are reproduced as printed rather than silently corrected, and the design argument is made from the counts, which are not in doubt. A unit admitting mothers together with their babies is therefore admitting, at any time, roughly one mother in seven who poses some risk to the baby sleeping beside her, and it must be built and staffed on that assumption rather than on the hope of filtering such women out at the door. Everything downstream follows: the sightlines, the observation arrangements, who may take the infant out of the bay, and the requirement that a member of staff rather than a relative is accountable overnight. The taxonomy of harm to infants by parents belongs to the Mental health legislation and forensic psychiatry notes; the design consequence belongs here.

The feed is in trouble at the door as often as the relationship is. Breastfeeding had stopped completely because of the maternal illness in 87 mothers, 36 per cent of that series, while 150 were still feeding at least partially on arrival. More than a third of the lactation work is therefore restoration, not maintenance, and a service that can only support a continuing feed will fail the sicker half of its intake.

| 237 | 17.23 days | 11 weeks | 86% |
|---|---|---|---|
| ADMISSIONS IN THE INDIAN MOTHER-BABY UNIT SERIES | MEAN STAY, INDIAN MOTHER-BABY UNIT SERIES | MEAN STAY, FRENCH AND BELGIAN MOTHER-BABY UNITS | LACTATION RESTORED AMONG INDIAN MOTHERS WHO HAD STOPPED |

### 9.4 How the unit is staffed, and the two posts an Indian service borrows

The first mother-baby unit in India opened in July 2009 at the National Institute of Mental Health and Neurosciences in Bengaluru, as a five bedded facility for mother-infant dyads. Naming the place and the date teaches better than a vague statement that such units are rare: it says where the Indian evidence comes from and gives the referral a destination.

Its staffing model is the transferable part. The unit is run by a multidisciplinary team of psychiatrists, psychiatric social workers and nurses; one psychiatry trainee is posted to it round the clock, and social work and psychology trainees provide part-time input. Two posts are not resident but available: a **lactation expert** is on call to respond to breastfeeding difficulties, and paediatric support is obtained from a neighbouring paediatric hospital rather than from an in-house paediatrician.

**The design lesson in that sentence.** An Indian unit does not solve the two-patient problem by employing two full establishments. It borrows the two competencies it cannot generate and makes the borrowing formal rather than ad hoc. Telephoning the paediatric registrar when somebody happens to worry about the baby is not the same arrangement, because it depends on a psychiatric nurse recognising an unwell neonate. A named service, a route of referral and an expectation that the infant is reviewed as part of the admission converts a hope into a pathway.

**IN INDIA**

Those two on-call posts are exactly the two an ordinary Indian psychiatric ward lacks. Most district and many teaching hospitals have no identified lactation counsellor, and where one exists she is attached to the obstetric service and never comes to the psychiatry ward because nobody has asked her to. That is administrative rather than financial: one written arrangement with the obstetric or paediatric department buys the most useful non-psychiatric competency on the ward. If you cannot build a unit, build the two referral routes it borrows, because they are the cheap half of the specification.

### 9.5 The separation decision: safety, not diagnosis, and never final

This is the hard call in perinatal inpatient practice, because it is made about someone who is not your patient, on incomplete evidence, with consequences outlasting the admission. Two things must be held together: joint admission is the default, and a proportion of dyads cannot safely be admitted together on arrival.

The Indian series shows the decision being made and then unmade, which is the shape to reproduce. Ten mothers were refused admission to the unit initially because there was **serious risk to the infant** from the mother, and were cared for on a different ward away from the baby; they were moved into the unit with their infants once the high-risk status had improved. Three features of that practice are what to take. The criterion is the infant's safety as it stands now, not the mother's diagnostic label. The separation is an interim arrangement with an expected end rather than a disposal. And somebody must own the review, because a separation nobody is scheduled to reconsider becomes permanent by default.

Joint admission is not, however, a promise that the pair goes home together, and teaching it as one is dishonest. In a French mother-baby unit series, separation at discharge occurred in **23 per cent** of joint admissions; women admitted with acute postpartum psychoses and with major depressive disorders had better outcomes than those with chronic psychoses, and the latter were more often

separated from their children at discharge. The authors make the point any good answer should: where separation occurred, the admission had bought the time in which to arrange the best available placement for the child. An admission ending in separation is therefore not a failed admission but one in which a considered decision replaced an emergency one.

The gradient replicates in a multi-unit national dataset from France and Belgium: women with schizophrenia or chronic delusional disorders, and women with personality disorders or intellectual disability, stayed longer, improved less, and were more often separated from their babies or discharged with supervision than women with other diagnoses. It is a robust finding and the most misused one in this topic.

TRAP **Converting the diagnostic gradient into a decision rule.** Candidates read that chronic psychosis predicts separation and then write that a mother with chronic schizophrenia should be separated from her infant. That inverts an observed association into a policy, and it fails both ways: it separates dyads that were manageable, and it reassures the team about a benign-sounding diagnosis attached to a frankly unsafe home. Diagnosis is not the criterion. What it legitimately does is tell you where to look hardest, how long to plan for, and when to open the placement conversation early, so the option is prepared and not forced.

When separation happens the infant goes somewhere, and the routes differ by jurisdiction. In the French series the separated children fell into two groups: those removed by judicial order into foster care, and those placed in the **unofficial custody of another family member**, an arrangement the children's court judge usually confirmed afterwards. The second route is the one that matters for Indian practice, where family placement is the norm and a court order the exception. That machinery is French, however, and the Indian legal route for a child in need of care and protection belongs to the Mental health legislation and forensic psychiatry notes rather than being asserted from a European series.

| AXIS | SEPARATION DECIDED AT ADMISSION | SEPARATION DECIDED AT DISCHARGE |
|---|---|---|
| **What triggers it** | Serious risk to the infant from the mother, assessed on arrival | Persistent inability to care safely for the infant once the acute episode is treated |
| **Expected course** | Interim and reversible; the Indian series moved such mothers in once the risk state improved | May be durable; in a French series it occurred in 23 per cent of joint admissions |
| **What the admission buys** | A safe place to treat while the risk is reassessed | Time to arrange the best placement rather than an emergency one |
| **Commonest error** | Making it once and never scheduling the review | Reading it off the diagnosis instead of the observed caregiving |

### 9.6 Managing lactation during acute treatment: the package, not the principle

Everyone agrees breastfeeding should be supported during psychiatric treatment. Almost nobody can say what supporting it consists of, which is why the itemised package from an Indian unit is the most useful content here. The interventions delivered were: dispelling myths about feeding during treatment; helping with positioning at the feed; educating the mother on timing the feed against the peak level of the psychotropic in her milk; encouraging electric breast pumps and **expressed breast milk** where sedation, agitation or a treatment session stopped her feeding; and seeking a lactation expert's advice for severe difficulties. Of the 87 mothers who had stopped breastfeeding because of mental illness, lactation was restored in 75, **86 per cent**.

Read that outcome twice. A feed stopped by maternal mental illness is in the great majority of cases recoverable, and it is recovered by unglamorous physical and educational work rather than by any decision about the drug. So "has stopped breastfeeding" at admission is a problem to be worked on, not a fact to be recorded and left. The pump keeps the option open while she is too unwell to feed, and its absence in the first days makes the loss permanent.

MNEMONIC

**Myths, Position, Timing, Pump, Expert**

The five moves of the lactation package, in the order usually needed: dispel the **myths** that treatment forbids feeding; correct the **position** at the breast; teach the **timing** of the feed against the peak drug level in milk; use the **pump** and expressed milk when sedation, agitation or a treatment session stops her feeding; call the lactation **expert** for severe difficulties. The first two need no equipment and no prescription, and are the two most often skipped.

| THE OBSTACLE AT THE BEDSIDE | WHAT IS ACTUALLY DONE | WHO DOES IT |
|---|---|---|
| **The family believes any psychotropic makes the milk unsafe and has stopped the feed** | The myth is addressed directly, with the family present, before anything else | Treating team, at admission |
| **She is willing but the infant is not latching and the feed is failing mechanically** | Hands-on correction of positioning and attachment at the feed | Nursing staff, repeatedly, not once |
| **She is feeding but anxious about drug in the milk at every feed** | Education on timing the feed against the peak psychotropic level in milk | Treating team, with agent-specific information |
| **She is too sedated or agitated to feed, or is off the ward for a treatment session** | Electric pump and expressed breast milk, preserving supply and option | Nursing staff, on a schedule not on request |
| **Severe or persistent difficulty that ward measures have not solved** | Formal referral for specialist lactation advice | Lactation expert, on call |
| **Nobody has decided whether her drug is compatible with the feed at all** | An explicit agent-level decision, written down rather than assumed | Treating psychiatrist; the agent table sits outside this section |

Two boundaries around that last row keep the answer clean. Which drug is acceptable in lactation, judged by how much of the maternal dose reaches the infant, belongs to the topic on drugs safe in breastfeeding in these notes, and the metric behind that judgement is defined in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. And where the reason she is off the ward is a course of electroconvulsive treatment, that licenses no teaching here about the treatment in the perinatal period, which sits in the ECT and neurostimulation notes.

### 9.7 The milk supply question the ward actually asks

A second lactation question, quite separate from infant exposure, is the one asked out loud on ward rounds: will this antipsychotic wreck her supply? It is about the mother's prolactin axis rather than the baby's blood, and confusing the two is the commonest muddle here.

The mechanism is straightforward. The rise in prolactin on haloperidol follows from blockade of dopamine in the **tuberoinfundibular pathway**, dopamine being the tonic inhibitor of prolactin release. The answer, stated plainly by the lactation database, is that a raised maternal prolactin level in a mother whose lactation is already established may not affect her ability to breastfeed. That is narrower than it first appears, and the narrowness is the teaching point: the source says it of established lactation and does not extend it further. In a woman admitted in the first days after delivery, before the feed is running, the same reassurance is not available and the question is unsettled.

The axis is also not loaded equally by every agent, which gives the ward a real selection axis when the feed itself is under threat. **Olanzapine**, unlike the phenothiazines, has a minimal effect on serum prolactin levels. That is a group tendency and not an absolute, since the same record notes hyperprolactinaemia and galactorrhoea have been reported with it. Note what this axis does not do: it says nothing about how much drug the infant receives, and an agent chosen on it must still clear the exposure question in the topic on drugs safe in breastfeeding in these notes.

> The two lactation questions are separate and both must be answered explicitly: how much drug reaches the baby, which decides whether the feed is safe, and what the drug does to the mother's prolactin axis, which affects whether there is a feed at all.

### 9.8 What joint admission changes, and how strong the evidence actually is

The argument usually offered for the model is a chain of consequences following from separation of a mother from her infant: mothers refuse admission, the feed fails, the diagnostic picture is harder to read, dyadic psychotherapy becomes impossible, stays run longer, relapse after discharge rises, and infant care falls on the husband and extended family. Its own source states that chain as what the absence of a unit *may* produce. It is a mechanism argument, not a measured effect, and presenting it as measured is overclaiming.

The measured evidence is narrower than the enthusiasm around it. In an Australian cohort assessed at admission and at discharge, joint admission was highly beneficial in the short term across clinical, functional and parenting outcomes, with the authors noting that follow-up studies are needed before longer-term benefit to the dyad can be claimed. Within that cohort 73.3 per cent recovered symptomatically, and recovery was associated with increasing maternal age and with lower psychosocial risk at admission. Both are observational, and the second is the interesting one: psychosocial risk, not diagnosis, does the predictive work, which is the lesson the separation literature teaches from the other end.

Length of stay is where the international and Indian pictures diverge most sharply. Across the French and Belgian units the mean duration of hospitalisation was 11 weeks, and units also offering day-care admission in the same or a nearby unit had shorter mean admissions. The Indian mean quoted earlier is measured in days rather than months. Some of that gap is case-mix and some is what the receiving community can hold; the reproducible lever is the day-care arm.

Finally, the honest statement about the evidence base, which a good answer includes rather than avoids. A systematic review of research in psychiatric mother-baby units found that most studies of the impact of admission showed favourable results, but that few follow-up studies had been done and few had compared outcomes on such units against other clinical settings; it also reports a shortage of research on infant outcomes. The model rests on before-and-after data and a strong mechanism argument, not on comparative data, and saying so defends it better than implying a trial that does not exist.

### 9.9 Where there is no unit: the alternate model, and the variants that scale down

The plainest statement of the Indian position comes from the group that runs the country's first unit: in many low-resource settings the absence of specialised mother-baby units necessitates **alternate models of care**. The unit is the standard; the alternate model is the norm, and teaching only the standard teaches most Indian readers about a facility they will never work in.

The components named in its place by the same group are:

- family engagement, which in Indian practice means an admitted attendant rather than a visiting relative;
- telepsychosocial support and caregiver education, which are how expertise reaches a district where none is resident;
- safety planning, and community-based care that continues after the ward has finished.

The same source names multidisciplinary team working and a medication plan compatible with breastfeeding as further elements. Two of these are notably cheap and notably omitted: caregiver education and safety planning need time and a written record and nothing else.

There is also a documented intermediate between a full unit and nothing. The French unit had capacity for four families day and night through the week, and additionally treated a limited number of mother-baby pairs in day or even **half-day hospitalisation** from Monday through Friday. Partial admission of a dyad is therefore an established configuration rather than an improvisation; it maps onto Indian day-care infrastructure far better than a residential unit does, and it needs no night establishment, the most expensive part of the specification.

One indication for joint admission is worth knowing precisely because nobody expects it. The French unit's fourth category of situation in which mother-baby hospitalisation may be proposed is child-led: children with functional symptoms such as sleeping or eating disorders, or with developmental delay, admitted for short-term inpatient treatment in a mother-child setting, where the parents are normally not mentally ill and it is the child who has the disorder. Held alongside the maternal indications, that makes the point that what is admitted and treated here is a relationship, which is why the unit needs staff competent in both halves of it.

### 9.10 Where the patient goes next: discharge is not the end of the episode

A service model is only as good as its disposition, and this one is demanding: two people go home, one of them cannot report her own condition, and the mother's illness carries a relapse risk in the months ahead. The community integration clause exists for exactly this, and where it is absent the gains of the admission are lost within weeks.

An Indian unit's answer is instructive because it is affordable. Mothers discharged were given a mobile telephone helpline number answered by a social worker. Of 113 mothers, 51, 45 per cent, made 248 calls between them. What they called about lists everything a discharge plan should have anticipated and usually has not:

- medication, sleep problems and symptom exacerbation;
- appointments, and planning future pregnancies;
- suicidal ideation, with separate calls about domestic violence and about infant health and breastfeeding.

Three things follow. Nearly half of discharged mothers used a channel costing one social worker's time, so this tail is real and cheap to catch. The content spans psychiatry, obstetrics, paediatrics and safeguarding, so whoever answers must be able to route and not merely reassure. And the reported limitation is what an Indian service must design around: some women could not use it for want of a telephone, so a helpline supplements a follow-up appointment and never replaces it.

**GOOD TO REMEMBER**

Four things to put in the notes of any acutely ill postnatal woman you admit, unit or no unit. Write the separation decision as a decision, with the reason, the person who made it and the date it will be reviewed, because an unreviewed separation becomes permanent. Write the feeding status as a plan and not a fact, since more than a third arrive having already stopped and most of those feeds can be brought back. Book the infant's paediatric review at admission, not when somebody becomes worried. And name, before she leaves, whom she or her family will telephone and what will happen when they do.

# Women's mental health across the lifespan

## 10 · Premenstrual dysphoric disorder (criteria, management)

**The disorder the classification hides.** A woman describes a week of irritability, hopelessness and conflict at home that lifts within a day or two of her period starting. The first question is not which drug. It is which clinic she belongs to, what must be documented before anyone commits to a label, and who holds her meanwhile. **Premenstrual dysphoric disorder** earns its place here for reasons unrelated to its symptom list: the classification does not file it where a psychiatrist would look, most of these women are already in another specialty's clinic when the question is asked, and the step that settles it is a service step, not a bedside one.

### 10.1 Filed under gynaecology: what the code tree does to your pathway

In the World Health Organization's current international classification the disorder carries the code **GA34.41**. It sits under a parent grouping of **premenstrual disturbances**, coded **GA34.4**, and its immediate neighbour there is **premenstrual tension syndrome**, coded **GA34.40**. That grouping resides in the **genitourinary chapter**, among the diseases of the female genital system, in the same company as endometriosis and the menopausal disorders. It is not filed there and forgotten. The classification's own clinical manual for the mental, behavioural and neurodevelopmental disorders cross-lists the disorder into its depressive disorders grouping as a secondary-parented category, and prints the reason: the prominence of mood symptoms in its clinical presentation, and to assist in differential diagnosis. One code, two homes, and the two do different work.

| GA34.41 | GA34.4 | GA34.40 |
|---|---|---|
| PREMENSTRUAL DYSPHORIC DISORDER | PARENT GROUPING | SIBLING CODE |

Where a disorder is coded decides who meets it, who counts it and who is expected to treat it, and each consequence lands on the psychiatric service rather than on the coder:

- the record leaves the hospital tagged to a gynaecological chapter, so an audit or a registry built from the mental disorders codes never retrieves these women;
- the specialty that sees her first is the one the code sits with, so the psychiatric opinion arrives as a referral, not as a first contact;
- a service planning clinics from mental-chapter workload data cannot see the demand, and will not staff for it.

TRAP **Finding the disorder in the mental-disorders manual and assuming the coded record will therefore be found among the mental disorders.** The manual does carry it, deliberately, with its reason printed. The code does not move. What leaves the hospital is a genitourinary code, so a registry, an audit or a workload return assembled from mental-disorder code ranges retrieves none of these women however the manual is arranged. Read the manual for the diagnosis and the code for the count, and never let one stand in for the other.

### 10.2 The front door: which clinic she is in when the question reaches you

**The referral route changes the first act.** These complaints reach psychiatry along four paths, and running the same interview on each produces a treatment discussion in a patient whose complaint has not been shown to be cycle-bound at all.

| WHERE THE QUESTION REACHES YOU | THE FIRST ACT | WHERE SHE GOES NEXT |
|---|---|---|
| **Obstetrics and gynaecology outpatient, referred for mood symptoms before menses** | Establish whether the complaint is confined to the premenstrual window; issue the record and fix the review | Joint review with the referring clinic once the record exists |
| **Primary care or general outpatient, presenting as irritability and conflict at home** | Ask directly whether the complaint tracks the cycle | Full psychiatric assessment if symptoms cross the whole cycle; forward-looking record if not |
| **Already under psychiatric follow-up, worse premenstrually** | Do not relabel on the timing alone; record where in the cycle each review falls | Stays with the treating team; the discrimination from **premenstrual exacerbation** is taught by the Endocrine and metabolic psychiatry notes |
| **Crisis contact with distress the family attributes to the cycle** | Risk assessment first and on its own terms, timing question second | Disposition on the risk, never on the presumed cycle attribution |

RULE **A premenstrual complaint is a routing decision before it is a diagnosis, and a diagnosis before it is a prescription.** What decides the routing is information about time, which cannot be had in the consultation where the question is first asked. The service must build around that: a record collected across cycles, a named reviewer, a plan for the interval. Compressing those steps into one sitting substitutes recall for observation.

### 10.3 The act this section owns: documenting the timing forward, not backwards

Confirmation rests on **prospective charting**: the patient records symptoms as the cycle runs rather than reconstructing them at the clinic. The instrument, the number of cycles it must cover and the rules for reading it belong to the Endocrine and metabolic psychiatry notes. What a service chapter owns is what that requirement costs and how a clinic delivers it. Before she leaves the room:

- the review appointment is fixed and written down, its date chosen against her cycle rather than clinic convenience;

- she is told what she is bringing back and what will be decided when she does, so the second visit has a purpose she can weigh against its cost;
- a named plan covers deterioration before review, including whom she contacts if the worst part of the cycle brings a safety concern, assessed on the principles set out in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

**IN INDIA**

The prospective record assumes a second visit, and that is where this pathway breaks. She is often attending a district or teaching hospital far from home, with a relative whose permission and lost wages the trip costs, for a complaint the family has already filed as a normal period problem rather than illness. The visit for charting alone is the one that gets dropped. Two adjustments cost nothing: fix the review to a date she can keep, and give the record in a form she can carry, in her own language. Where psychiatric opinion sits inside the obstetrics and gynaecology clinic rather than behind a referral, charting is likelier to be completed.

### 10.4 Handing on: who holds this patient, and where the rest is taught

Two chapters carry premenstrual dysphoric disorder in full between them, and this section adds no third account. Its nosological position, meaning how it stands in relation to the depressive disorders, belongs to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. The working clinical material, meaning the criteria set, the rating record and how it is read, the discrimination from premenstrual worsening of an existing disorder, the epidemiology and the treatment ladder with its starting doses, belongs to the Endocrine and metabolic psychiatry notes. No criterion and no dose is printed here.

What remains is the **disposition** decision, and it is usually shared rather than transferred. Once the diagnosis is established most of these women are managed in the clinic that first saw them, with psychiatric input reserved for comorbid mood or anxiety disorder, for failure of first-line treatment, or where risk rather than distress leads. Psychiatry retains her outright when the cycle-linked worsening proves to sit on a disorder running through the month.

**GOOD TO REMEMBER**

Write the cycle position into the note at every review, for any woman of reproductive age under follow-up for a mood or anxiety disorder, whether or not premenstrual symptoms have been raised. Without it, a year of notes cannot answer the timing question later.

Premenstrual dysphoric disorder is coded in the genitourinary chapter and cross-listed into the depressive disorders: the manual will hand it to a psychiatrist and the code will not, so the service has to go and collect it, and the diagnosis is settled by a record kept forward across cycles.

## 11 · Menopause and perimenopausal mental health

**Why a transition filed outside psychiatry gets a psychiatric section.** A woman in midlife presents with low mood, broken nights and flushing, and the explanation is agreed before she arrives: it is the change. Almost none of the work that follows is endocrinology. Staging, the endocrine markers, the size of any risk the transition carries, the oestradiol evidence and endometrial protection belong to the Endocrine and metabolic psychiatry notes, and the hypothalamic-pituitary-gonadal axis beneath them to the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. What is left over is a consultation, and that is what gets examined.

### 11.1 Where the transition sits, and what its placement instructs you to do

The World Health Organization's current international classification carries the transition as one grouping, **GA30 Menopausal or perimenopausal disorders**, filed among the diseases of the female genital system in the genitourinary chapter rather than among the mental disorders. What that placement does to a psychiatric pathway is worked out with premenstrual dysphoric disorder elsewhere in these notes and is not re-derived here. Its neighbours are the other reproductive events of adult life: **GA31** female infertility, **GA32** complications associated with medically assisted reproduction and **GA33** recurrent pregnancy loss, whose psychiatric side is taken up in the section of these notes on infertility, abortion and contraception. The transition has a nosological home, and it is not psychiatry's.

Read that as a clinical instruction, not a filing detail. There is no label called menopausal depression to reach for: you identify the mental disorder that is present, diagnose it on its own terms, and record the **menopausal transition** as the setting in which it appeared. Where the complaint genuinely is a symptom of the transition, the clinician who treats it sits outside psychiatry and the correct act is a referral, not a prescription.

RULE **The perimenopause is a context, not a diagnosis.** A context tells you what else to ask about and whom to involve, not what to treat. Collapse it into the diagnosis and two opposite errors open at once: a depressive episode goes untreated because it has been explained away, and a transition needing a gynaecological opinion is absorbed into a psychiatric formulation.

### 11.2 Establishing the episode before attributing it

**Identification is the whole of the psychiatric task here.** An expert panel convened by the North American Menopause Society and the National Network of Depression Centers Women and Mood Disorders Task Group framed the perimenopause as a **window of vulnerability** for depressive symptoms and for major depressive episodes, and recorded that clinical recommendations on identifying and treating depression in that window were lacking. Both halves are usable: raise the index of suspicion where nobody screens, and do not wait for a bespoke pathway, because what you have is the ordinary assessment done early.

The difficulty the panel names is **overlap**. Symptoms of the transition complicate the presentation of depression, run alongside it and overlap it, so the same broken sleep and fatigue read either way.

Establish the episode on its own core features and course, not on the symptoms the two conditions share, since a shared symptom cannot arbitrate between them. How far the risk of depression rises across the transition is a question this section does not answer; it sits with the entity in the Endocrine and metabolic psychiatry notes. The framing above is North American expert-panel guidance, not Indian practice.

TRAP **Waiting for the transition to finish.** It is the most comfortable error available, because the patient offers it herself: review is set a long way out, and a woman with recurrent depressive illness goes untreated on an explanation her history does not support. An episode diagnosed in the perimenopause is treated on the same terms as one diagnosed at any other point: the timing changes what else you look for and whom you involve, never whether you treat.

### 11.3 The history that decides the formulation

The decisive fact about this window is historical rather than endocrine. The same panel concluded that most midlife women who have a major depressive episode during the perimenopause have had a **prior episode of depression**, and that they present with a classic depressive picture combined with menopause symptoms, **vasomotor symptoms** and sleep disturbance among them, plus the psychosocial pressures of midlife. The lay picture, of a fresh illness with a purely hormonal cause, is what the family arrives holding; correcting it is this section's work. So the **lifetime mood history** comes before the flushes. What the answer changes:

- if there were earlier episodes, this one is a recurrence, and her own record is the most useful thing in the room: what she was given, whether it worked, why it stopped;
- if there were none, a first episode in later life earns a physical review and a look at what she already takes before anything is attributed to the transition;
- ask separately about mood at earlier reproductive events, because many women do not file those episodes under depression and answer no to the general question, yes to the specific one.

### 11.4 Dividing the decision, and working where there is nobody to divide it with

This is a two-clinic presentation, and saying which decision belongs where is most of what a psychiatric opinion adds; the handoff fails quietly when each clinician assumes the other is deciding.

| THE QUESTION | WHOSE DECISION | WHERE IT IS TAUGHT |
|---|---|---|
| **Is she in the transition, and does a hormonal measurement help?** | Gynaecology or the physician | the Endocrine and metabolic psychiatry notes |
| **Is hormonal treatment indicated, and what protects the endometrium?** | Gynaecology | the Endocrine and metabolic psychiatry notes |
| **Is a depressive episode present, and is it a recurrence?** | Yours, in this consultation | the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes |
| **Which antidepressant, and for how long?** | Yours | the Mood disorders: pharmacotherapy notes |

Notice what the table does not contain: a second patient. Every other decision in this band is made for a mother and a fetus or infant at once, a calculus set out with prescribing in pregnancy earlier in these notes; here the risk is hers alone. Three things must be explicit when you write:

- which symptoms you have assigned to the mood episode and which you have left with the transition, so two clinicians do not treat one complaint;
- whether an episode is established, suspected or excluded, in those words, because menopausal symptoms with low mood commits nobody to anything;
- the single decision you want made, and who reviews her next, so that a woman who improves on hormonal treatment alone is not discharged by both clinics.

IN INDIA

Plan the consultation on the assumption that you cannot refer. The perinatal period has scheduled contacts and this transition has none, so no appointment obliges anyone to ask about her mood: these episodes are missed for structural rather than clinical reasons. Dedicated menopause services are gynaecology-led where they exist and cannot be assumed at district or taluk level, so outside a teaching hospital, whoever sees her first asks the mood questions.

| GA30 | Genitourinary | Overlap | Prior episode |
|---|---|---|---|
| GROUPING FOR THE TRANSITION | CHAPTER IT IS FILED IN | WHY IDENTIFICATION IS ACTIVE | THE USUAL HISTORY |

Most depressive episodes in the perimenopause occur in women who have been depressed before: the transition is where the episode happened, not what it is.

## 12 · Gender and mental health, intimate partner violence

**Why this earns a section of its own.** Two facts about who becomes unwell, and who is reached, are stable enough to plan a service around: common mental disorders are commoner in women, and a

substantial minority of those women are being hurt at home by the person they live with. Neither is a diagnosis; both change what is done in the room. Whom you ask, what has to be in place before you are entitled to ask, what you say in the first minutes after the answer is yes, and who in the Indian system is legally supposed to do the rest: that is this section. The syndromes themselves are taught in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes and in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

It is examined because an epidemiological finding, a guideline recommendation with a stated strength and an Indian statute bear on the same five minutes of consultation. A candidate who can quote a prevalence but cannot say who may be asked, on what trigger and with what arranged beforehand, has learned the wrong half.

### 12.1 The size of the sex difference, and the shape that constrains its explanation

The reference estimate comes from meta-analyses restricted to nationally representative samples, which matters because clinic samples are shaped by who reaches a clinic. Pooled, the female-to-male odds ratio for depression is **1.95**, with a confidence interval of 1.88 to 2.03, and the standardised mean difference for depressive symptoms is 0.27. Hold both. The odds ratio says a woman is roughly twice as likely to carry the diagnosis; the standardised mean difference says the symptom-score distributions overlap heavily. Those are compatible, and quoting only the first teaches a difference between two kinds of person rather than a shift in one population.

The shape across the lifespan is where the teaching sits, and it is not a constant. It is detectable in late childhood, with an odds ratio of 2.37 at age 12, reaches its maximum in adolescence at 3.02 for ages 13 to 15, then falls back and stays broadly stable through adult life. A difference that switches on around puberty, peaks and partially resolves fits neither a fixed constitutional account nor a pure ascertainment account. The pooled base spans over 90 nations, which is why it is carried in preference to any single survey.

### 12.2 Testing the explanations, and the mirror error that follows them

**Dispose of the reporting-artefact account first.** Its logic is familiar: women consult, disclose and are labelled more readily, so the excess is partly manufactured at measurement. That makes a checkable prediction: if the excess were mainly men under-reporting, it should shrink where disclosure is least constrained. The cross-national moderator analysis in the same meta-analytic programme found the opposite: larger female-to-male differences in major depression in nations with greater gender equity, though not for depression symptoms. Measurement bias is not abolished by that, but the simplest artefact story runs the wrong way, and a candidate who offers it as the whole explanation can be asked why the difference is largest where women are freest to speak.

The social-role account has been tested directly. Across cohorts and countries in the World Health Organization's World Mental Health Survey Initiative, the directions were consistent: women carried more anxiety and mood disorders, men more externalizing and substance use disorders.

What moved was the size: in more recent cohorts the difference narrowed for major depressive disorder and for substance use disorders, tracking variation in **gender role traditionality**, indexed by aggregate patterns of female education, employment, marital timing and use of birth control. A difference that moves when social roles move is, to that extent, made rather than found.

Then the mirror error, which those authors named themselves: the magnitude of the difference does not license overlooking depression in men. The male excess of externalizing and substance presentations is how a male depressive episode gets rerouted away from a mood assessment, so the difference becomes partly self-fulfilling at the clinic door.

### 12.3 The Indian figures, and the half of the disparity that is about who is reached

An Indian chapter cannot run on cross-national odds ratios. National survey data give a weighted current prevalence of common mental disorders in adults of 5.1 per cent, and a higher prevalence in women at 5.79 per cent. Check what the label covers first: common mental disorders here means depressive and anxiety disorders, the anxiety group including generalized anxiety disorder, social phobia, agoraphobia, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder, ascertained by structured interview. On multiple logistic regression, with age, education, occupation, marital status and residence in the model, the risk in women was **1.53** times that in men.

Set a second adjusted figure from the same model beside it: people in metro urban cities carried 1.86 times the risk of those in rural areas. Sex is one structural driver among several, and treating it as the only one misses the urban, displaced, low-income patient in front of you.

The service half is left out of most answers. The **treatment gap** for common mental disorders in the same data was about 80.4 per cent overall and slightly greater in women, at **81.5 per cent**. Teach the female excess in prevalence and stop, and you have taught half a disparity: it sits inside a population that is overwhelmingly untreated. That is the argument for asking well when contact happens, because for many of these women it will not be repeated.

### 12.4 Reading a violence prevalence figure: the denominator is part of the number

Global estimates from the World Health Organization put lifetime exposure to physical or sexual intimate partner violence, or non-partner sexual violence, at about one in three women worldwide. It is also the most misquoted, because a second sits beside it on a different denominator: among women ever in a relationship, 25.8 per cent of those aged 15 to 49 years and 24.7 per cent of those aged 15 years and older have been subjected to physical or sexual violence by a current or former husband or male intimate partner. The first denominator is all women and includes non-partner violence; the second is ever-partnered women only.

The highest lifetime prevalence of intimate partner violence is reported in Oceania at 37 per cent, Sub-Saharan Africa at 32 per cent and Southern Asia at 31 per cent. Southern Asia is a regional aggregate, not an Indian figure. Over twenty years the average annual decline has been 0.2 per cent, and the one-in-three figure has stayed effectively stagnant.

| 22.3% | 2.7% | 31.6% | 0.2% |
|---|---|---|---|
| EVER-MARRIED INDIAN WOMEN 18 TO 49 WHO HAVE EVER EXPERIENCED SPOUSAL VIOLENCE | THE SAME WOMEN, PHYSICAL VIOLENCE DURING ANY PREGNANCY | WOMEN WORLDWIDE, LIFETIME PHYSICAL OR SEXUAL PARTNER VIOLENCE, OR NON-PARTNER SEXUAL VIOLENCE | AVERAGE ANNUAL FALL IN PARTNER VIOLENCE OVER TWENTY YEARS |

The Indian figure comes from the key-indicator table of the National Family Health Survey, whose latest round has fieldwork in 2023-24 and gives urban, rural and total columns beside a single total for the previous round, 2019-21. Ever-married women aged 18 to 49 ever experiencing spousal violence run at 22.3 per cent nationally, against 29.2 per cent nationally in the previous round; the same women reported physical violence during any pregnancy at 2.7 per cent nationally, against 3.1 per cent nationally in the previous round. Both comparisons are national against national, which is what makes them comparisons; the disaggregation is a separate reading, and the rural column runs higher than the urban on both indicators, at 24.4 per cent against 17.5 per cent for spousal violence ever. Two cautions travel with the fall: the issuing institute states these fact-sheet results to be provisional, and a fall in a disclosure-dependent indicator is not by itself a fall in the behaviour.

**PITFALL**

Quoting the Indian national figure as a measure of domestic abuse in general. The survey's own footnote defines **spousal violence** as physical and sexual violence, so emotional abuse, economic abuse and controlling behaviour sit outside the headline number. A woman who is not hit, not sexually coerced and comprehensively controlled therefore falls outside the indicator altogether, and a resident who learned the number as a measure of abuse will hear her account as something lesser than what the statistics describe.

### 12.5 Intimate partner violence as a risk factor, and as the presentation itself

The World Health Organization's statement of consequences is the bridge from a social fact to a psychiatric one. Violence against women is listed as leading to depression, post-traumatic stress and anxiety disorders, sleep difficulties, alcohol use disorders and suicide attempts, and to increased smoking, substance use and risky sexual behaviours. In women subjected to intimate partner violence during pregnancy it is listed as increasing the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight, which ties this material to the antenatal and postnatal decisions taken elsewhere.

Two quantitative anchors answer different questions. The first is direction. A systematic review of longitudinal studies found, in women, a pooled odds ratio of **1.97** for intimate partner violence predicting incident depressive symptoms, with a confidence interval of 1.56 to 2.48 across six studies, and 12 of 13 studies pointing the same way. It found the reverse path too, depressive symptoms predicting incident violence, at 1.93 across four studies, and violence was also associated with incident suicide attempts. The relationship is bidirectional, so a depressive episode in a woman being abused is neither purely reactive nor safely treated as though the exposure had stopped.

The second anchor justifies enquiry in a psychiatric clinic specifically. Compared with women without mental disorders, the odds of adult lifetime partner violence were 2.77 in women with depressive disorders, 4.08 in women with anxiety disorders and **7.34** in women with post-traumatic stress disorder, with individual studies reporting raised odds across all diagnostic categories including the psychoses. Those authors could not investigate causal direction, having too few longitudinal studies to pool. The operational point survives that, because it is about base rates: a psychiatric outpatient population is enriched for exposure, so asking only when it is volunteered misses most of it.

### 12.6 The enquiry decision: not everyone, and not by accident

Instinct gets this backwards. The World Health Organization's clinical and policy guidelines recommend that **universal screening**, also called routine enquiry and meaning asking women in all health-care encounters, should not be implemented; the quality of evidence was graded low to moderate and the recommendation is conditional. The reasoning is examinable. Screening increases identification but has not been shown to reduce violence or improve health outcomes; where referral options are limited the burden is real, women find repeated asking difficult when nothing follows, and the question degrades into a tick-box.

The positive half is stronger. The same guidelines make a strong recommendation, on indirect evidence, that providers undertake **clinical enquiry** about exposure to intimate partner violence when assessing conditions that violence may cause or complicate, to improve identification and subsequent care. The example conditions listed are psychiatric: symptoms of depression, anxiety, post-traumatic stress disorder and sleep disorders, and suicidality or self-harm. Read the two together and the rule for a psychiatrist is not conditional. Routine, for us, means routine within the presentations that trigger it.

| THE SITUATION | WHAT THE GUIDELINE SAYS TO DO | HOW STRONGLY |
|---|---|---|
| **Every woman attending any health-care encounter** | Do not implement universal screening or routine enquiry | Conditional; evidence low to moderate |
| **A woman assessed for a condition violence may cause or complicate** | Ask about exposure, to improve identification and subsequent care | Strong, on indirect evidence |
| **A woman presenting with depression, anxiety, post-traumatic stress disorder, self-harm or a suicide attempt** | She could be asked as good clinical practice, since exposure may change her care | A remark, not a graded recommendation |
| **Antenatal care** | An opportunity to enquire routinely, given the vulnerability of pregnancy and the possibility of follow-up | A remark, conditional on minimum requirements; evidence limited and from high-income settings |

The antenatal exception is the seam to every perinatal decision. Routine enquiry is permitted there because pregnancy creates a **dual vulnerability**, because interventions following identification

may improve outcomes, and because the antenatal schedule uniquely offers repeated contact. It is conditional on the guideline's minimum requirements for a health sector response, and a clinic that asks without them takes the risk of asking and none of the benefit.

TRAP **Answering "screen every woman" because it sounds like the caring answer.** It is the answer the guideline explicitly rejects, and rejecting it is not a counsel of neglect. The distinction tested is between asking everybody once and asking the right patients properly: enquiry is targeted by presentation, unconditional inside those presentations, and routine in antenatal care alone. A candidate who cannot state the negative recommendation cannot explain why the positive one is graded strong while the negative one is only conditional.

### 12.7 The preconditions, and the manner of asking

Before the question is asked at all, conditions have to hold. The guideline states them as a minimum, not as good form:

- it is safe to ask, which the guideline operationalises as the partner not being present;
- the provider is trained in the correct way to ask, and in how to respond to a woman who discloses, at least to first-line support;
- the provider is aware of and knowledgeable about the resources she can be referred to, before the question is put.

The companion clinical handbook sharpens the first into an absolute: never raise the issue of partner violence unless a woman is alone, and note the reason: even if she is with another woman, that woman could be the mother or sister of an abuser. This is the rule most often broken in an Indian outpatient department, where the accompanying relative is a fixture and separating a patient from her attendant reads as rude. Build it into clinic routine, because improvising it in front of the family announces the question you were trying to ask privately.

The manner is specified too. Ask in an empathic, non-judgmental way, in language appropriate to the culture and community you work in, and use the words the woman herself uses rather than the words violence and abuse, which many women do not accept for what is happening to them. The question is therefore built out of her own account: what happens at home when he is angry, whether she is ever frightened, whether anyone stops her going out. The construct is coercion and injury; the vocabulary is hers.

MNEMONIC

**Alone, trained, and somewhere to send her**

**Alone**: no partner present, and no accompanying person at all before the topic is raised. **Trained**: to ask, and to respond to a disclosure at least to the level of first-line support. **Somewhere to send her**: referral resources known before the question, not after the answer.

RULE **Asking is a commitment, not a question.** Every element of the minimum condition is about the capacity to answer the answer, which is why a service can be criticised for asking as readily as for not asking. Enquiry with nowhere to refer, no privacy and no trained response converts a disclosure into new risk the woman carries home, and that is the mechanism behind the guideline's objection to universal screening where referral options are limited.

### 12.8 First-line support, and what changes when the room is an emergency department

What follows a disclosure has a name and a fixed content. The guideline makes a strong recommendation, on indirect evidence, that women who disclose any form of violence by an intimate partner or other family member, or sexual assault by any perpetrator, are offered immediate support, and that providers offer **first-line support** as a minimum. Learn the components as acts rather than attitudes.

| COMPONENT OF FIRST-LINE SUPPORT | WHAT IT REQUIRES OF YOU |
|---|---|
| **Consultation conducted in private** | Arranged before the topic is raised, not once she has started |
| **Confidentiality ensured, and its limits stated** | She is told what would have to be passed on, for example where reporting is mandatory, before deciding how much to say |
| **Non-judgmental, supportive, validating** | Her account is treated as an account of events, not a symptom to interpret |
| **Practical care responding to her concerns without intruding** | Her stated priority sets the agenda, not the one you would choose |
| **Asking about her history of violence, listening without pressure** | Silence is allowed; with an interpreter, care over sensitive material |
| **Helping her access information about resources** | Named legal and other services, not an assurance that help exists |
| **Assisting her to increase safety for herself and her children** | The children sit inside the safety question, not a separate referral |
| **Providing or mobilising social support** | Someone in her own network, identified with her |

Two structural points sit around that table. First, a fallback: a provider who cannot give first-line support must ensure someone else, in that setting or an easily accessible one, is immediately available. It is not permission to defer. Second, the setting rule that makes this an emergency topic. In settings such as emergency care departments, as much as possible is done at first contact because the woman may not return, and safe, accessible means of follow-up are negotiated with her. Three principles run underneath: do no harm, the safety of the woman and her children is uppermost, and the woman always decides.

### 12.9 The safety assessment as a repeated act

**It is a process, not a form.** The clinical handbook frames safety assessment as ongoing rather than a single conversation, revisited each time she is seen because her situation changes, and instructs the clinician to say plainly that partner violence is not likely to stop on its own. That sentence does work: a woman who expects the violence to resolve will decline planning she would otherwise accept, and the family urging her to be patient shares the expectation.

The judgement is narrow, and should be stated narrowly: whether there is an immediate and likely risk of serious injury. If she is worried about her safety she is taken seriously, her appraisal being evidence rather than anxiety to be reassured away. Where immediate high risk is apparent, the handbook names the concern to her in plain words and puts concrete options on the table:

- contacting the police;
- arranging for her to stay that night away from home;
- where it is not safe to return home at all, referral for shelter or safe housing, or identifying a safe place with her.

One omission is declared rather than left silent. The handbook's job aid for assessing immediate risk carries a fixed list of questions and a numeric answer threshold, adapted from a published violence-risk instrument. Neither items nor threshold is reproduced here, and no violence-risk instrument appears in item or score form anywhere in these notes. What transfers is the judgement, the options and the revisiting.

> **GOOD TO REMEMBER**
>
> Four things should exist before she leaves that did not exist when she arrived: a record of what she disclosed, kept where her partner cannot request it; a named person or service she can contact, written somewhere she can safely carry; a plan for tonight if tonight is the risk; and a next appointment she has agreed is safe to attend. In an emergency department all four are done at that contact.

### 12.10 The Indian legal and service frame, named and not renumbered

The governing instrument is the Protection of Women from Domestic Violence Act, 2005, whose long title describes it as an Act to provide for more effective protection of the rights of women guaranteed under the Constitution who are victims of violence of any kind occurring within the family. Two features matter clinically. It is a civil protective statute, so its purpose is protection and relief rather than conviction, and a woman can want the first without the second. And it builds a service architecture: it creates the **Protection Officer**, recognises registered service providers, provides for notified shelter homes and places duties on medical facilities. Its reliefs are a **protection order**, monetary relief, a custody order, a residence order and a compensation order.

The provision a psychiatrist is personally bound by is short. If an **aggrieved person**, or a Protection Officer or service provider on her behalf, requests the person in charge of a medical facility to

provide medical aid, that person shall provide it in the facility. The duty is triggered by a request. It is not conditional on a police complaint, and a refusal on the ground that the police are not involved has no basis in the Act.

The information duty sits on a police officer, Protection Officer, service provider or Magistrate who receives a complaint of domestic violence, is present at the place of an incident, or has an incident reported to them. They are to inform her of her right to apply for those reliefs, of the availability of service providers and Protection Officers, and of her right to free legal services. Note that a treating clinician is not among the named duty holders unless the facility is registered as a service provider. It is still the referral information a psychiatrist should be able to give from memory, but an answer saying a doctor must inform her under the statute is an over-claim.

**IN INDIA**

The statute creates the roles; it does not staff them for you. Three local facts have to be known by name before this material is usable in your department, and none is in any book: who your district's Protection Officer is and how they are actually reached, which organisations near you are registered service providers rather than merely helpful, and where the nearest notified shelter is and whether it admits at night. The guideline precondition that a provider know the referral resources before asking is, in an Indian district hospital, an administrative task somebody does once for the whole unit. A service that has not done it cannot yet run enquiry, however willing its residents are.

### 12.11 Obligations on disclosure, and where the settled ground ends

The reporting question is most often answered from memory and answered wrongly, so state exactly what is sourced. Government of India guidance for medical practitioners on medico-legal care in cases of sexual violence, issued through the Ministry of Home Affairs, records that the examining registered medical practitioner or hospital is required to inform the police about a sexual offence. It records in the same breath that if the survivor does not wish to lodge a first information report or take part in a police investigation, the practitioner is bound to provide medical treatment, and that **informed refusal** is documented in such cases. It further records that every hospital and doctor is bound to provide free first aid or medical treatment to victims of rape and to intimate the police, and that the victim, or the person in whom she reposes trust, may refuse medico-legal examination or evidence collection or both, with that refusal never taken as denial of treatment.

Two limits travel with that paragraph. The first is scope: the guidance addresses sexual offences. It does not settle what a clinician must report when an adult woman discloses non-sexual intimate partner violence and asks that nothing be done, which is the commoner situation by a wide margin. That position is not sourced here and is not asserted. The practical course is to state the limits of confidentiality to her before she decides how much to say, as first-line support requires, and to take the doctrine of confidentiality and its exceptions from the Forensic ethics, consent and legal procedure notes. The second limit is currency: the guidance cites a code of criminal procedure and a

penal code since replaced, and the successor provisions are not carried here. Name the duty, and do not translate an old section number into a new one from memory.

### 12.12 Sexual and gender minority patients at the same doors

The same logic extends to a group the epidemiology reaches less reliably. Pooling population-based studies, lesbian and gay people carried odds ratios for common mental disorders between 1.97 and 2.89 compared with heterosexual people, across every diagnostic category investigated, and bisexual people higher odds still, between 2.70 and 4.81, their excess over lesbian and gay people concentrated in depression and suicidality. Exploratory analysis found no narrowing in recent years except for alcohol use disorders. One limitation governs Indian use of these figures: the evidence base is predominantly Western, so the direction transfers more safely than the magnitude.

In India the obligation is statutory as well as clinical. The Transgender Persons (Protection of Rights) Act provides that no person or establishment shall discriminate against a transgender person on grounds that include the denial or discontinuation of, or unfair treatment in, healthcare services, and bars the same in access to any facility available to the general public. Read that against what an emergency department does. A refusal of registration, a refusal to admit, a ward placement made on documents rather than the patient's stated gender, or unequal treatment at triage is a statutory matter in India, not only an ethical one. The Act also requires the appropriate Government to provide medical care including sex reassignment surgery and hormonal therapy, counselling before and after both, a health manual in accordance with the **World Professional Association for Transgender Health** guidelines, review of the medical curriculum, and access in hospitals. The counselling obligation is directly psychiatry's.

The Indian professional position has a date, and dating it teaches better than presenting it as timeless. A peer-reviewed account records that in 2018, a day before the Supreme Court of India began hearing the curative petition on the penal provision then criminalising carnal intercourse against the order of nature, the Indian Psychiatric Society issued an official statement that homosexuality is not a mental pathology, and that in 2014 the then President had termed it a pathology requiring treatment. That is a secondary account rather than the Society's own instrument and should be quoted as such, and the penal provision it refers to has itself been replaced, with no successor number given here. The profession's position in India was therefore contested within living professional memory, which is why a patient may arrive expecting to be pathologised and will read your first questions as a test of whether she is safe with you.

> Do not raise intimate partner violence unless she is alone, you are trained to respond and you already know where she can be referred; and in an emergency department, do everything at that contact, because there may not be another.

## 13 · Psychiatric aspects of infertility, abortion and contraception

**Why the marks are here.** Reproductive medicine hands psychiatry three separate tasks, and candidates lose marks treating them as one. In infertility the psychiatrist is asked to keep two people functioning through a long, expensive, invasive treatment that may not work. In abortion the psychiatrist may be asked for an opinion a statute names as a precondition of a lawful procedure. In contraception the psychiatrist is the prescriber whose own drug is why the conversation cannot be left to the gynaecologist. Three acts, three sources of authority, three destinations.

The characteristic error is to arrive with a view about whether fertility treatment, or termination, or a contraceptive decision is psychologically good or bad for women. None of the three settings asks that. Each asks a procedural question with a defined answer: what must be discussed and by whom, what opinion the law requires and on what ground, and what must be in place before a prescription is defensible. Get it wrong and a careful formulation answers a question nobody asked, while the real question goes back unanswered to a clinic working against a clock. The disorders that present inside these settings are taught in the chapters that own them and are named here rather than restated.

### 13.1 Taking the referral: what infertility is, whose it is, and who is asking

**Infertility** is defined by the World Health Organization as a disease of the male or female reproductive system, established by failure to achieve a pregnancy after **twelve months or more** of regular unprotected sexual intercourse, and it may arise from male, female or unexplained factors. Two things in that definition matter at the point of referral: it is framed as a disease of a reproductive system rather than as a failure of a person, and it is explicitly not assumed to be the woman's. Estimates on the same authority suggest approximately **one in every six** people of reproductive age worldwide experience infertility in their lifetime. This is not a niche referral.

The classification reinforces this. The international classification of diseases carries female infertility at GA31 and, as a separate entry, **complications associated with medically assisted reproduction** at **GA32**, both filed among the diseases of the female genital system in the genitourinary chapter alongside recurrent pregnancy loss. A treatment given its own morbidity entry, distinct from the condition it treats, is one whose burden the classification has already conceded. Much of what you are asked to manage is generated by the treatment, not by the infertility.

The first act on receiving the referral is therefore to establish which question is being asked, because the letter will rarely say. Is this couple in a state to start or continue a cycle. Is a mental disorder present that needs treatment in its own right, irrespective of the fertility work. Does an existing illness or its medication change what the service can safely offer. Each has a different output and destination, and answering the wrong one is how this consultation is wasted. Note too that the

referral will almost always name the woman even where the factor is the man's or unexplained, and correcting that framing is part of the first consultation.

**IN INDIA**

The World Health Organization records in the same fact sheet that equal and equitable access to fertility care remains a challenge in most countries, particularly in low and middle-income countries, and that fertility care is rarely prioritized in national universal health coverage benefit packages. Read that as a clinical fact, not a policy one. Where treatment is paid for privately and cycle by cycle, continuing is also a household financial decision, often with in-laws holding the money, and the distress you are asked to treat is partly a debt and partly a loss of standing. Who is paying, and what happens in the family if the next cycle fails, is material the formulation is built from, and the question most reliably omitted.

### 13.2 Mapping the cycle: what to ask before, during and after treatment

The most useful structure for this work is not a psychiatric one. **Routine psychosocial care**, as the European Society of Human Reproduction and Embryology guideline for fertility staff sets it out, organises the emotional course of treatment as needs experienced across the treatment pathway, before, during and after treatment, and sorts those needs into four kinds: behavioural, relational, emotional and cognitive. The table below carries what the guideline places in each.

Learn it as a grid rather than a list, because the grid turns a vague enquiry about coping into a structured interview. The same four domains carry different content at each phase. Before treatment the cognitive domain is dominated by what the couple has understood about their chances; during treatment by what each injection, scan and result means; afterwards by whether to go again. The relational domain moves the same way, from disclosure and whom to tell, through the erosion of a sexual relationship that has become scheduled, to the anniversary of a failed cycle.

**MNEMONIC**

**Be Real Every Cycle**

**B**ehavioural, **R**elational, **E**motional, **C**ognitive: the four psychosocial need domains, asked at each of the three phases of the pathway. Four questions, three times, and the interview is covered.

| NEED DOMAIN | WHAT THE GUIDELINE PLACES IN IT | WHAT THAT TURNS INTO AT THE BEDSIDE |
|---|---|---|
| **Behavioural** | Lifestyle, exercise, nutrition, compliance | Whether the regimen is actually being taken as prescribed, and what has been given up to take it |
| **Relational** | The relationship with the partner where there is one, family, friends and the wider network, and work | Who knows, who is asking, who is paying, what leave has been used |
| **Emotional** | Wellbeing, including anxiety, depression and quality of life | The screen for a treatable disorder, and whether this is distress or illness |
| **Cognitive** | Treatment concerns and knowledge | What the couple believes the odds are, and whether that matches what the clinic has told them |

The guideline's other structural instruction is about who does this. It directs that fertility clinic staff detect and address these needs, making routine psychosocial care a responsibility distributed across the team rather than a referral generated when someone cries in the waiting area. The durable act is therefore to teach the four domains to the nursing and embryology staff who see the couple far more often than you do, and to keep the psychiatric consultation for the questions that need one.

### 13.3 Why the burden is a treatment outcome and not a side issue

The argument that psychological care in a fertility unit is a luxury collapses against the discontinuation data. A systematic review of why patients stop fertility treatment, pooling studies across several countries, found that **discontinuation** is not driven mainly by treatment failure or by cost alone. The reasons selected most often were postponement of treatment, then physical and psychological burden, then relational and personal problems, then rejection of the treatment itself, with organizational and clinic problems behind.

| 39.18% | 19.07% | 16.67% | 13.23% |
|---|---|---|---|
| STOPPING FERTILITY TREATMENT: POSTPONEMENT | STOPPING FERTILITY TREATMENT: BURDEN | STOPPING FERTILITY TREATMENT: RELATIONAL | STOPPING FERTILITY TREATMENT: REJECTION |

The split within that burden category is instructive: the psychological component accounted for 14 per cent of reasons selected for discontinuing fertility treatment and the physical component for 6.32 per cent. The mind is carrying more than twice the load of the body in the decision to stop, and adding the relational and personal figures makes the psychosocial share the largest identifiable block after simple postponement. The same authors report that none of the predictors they examined was consistently associated with discontinuation, and that finding has the sharpest operational consequence: you cannot select in advance who will drop out and support only them. Support has to be routine, which is exactly what the guideline above calls it.

**GOOD TO REMEMBER**

Ask directly, at every review, whether the couple has considered stopping, and treat the answer as clinical data rather than as a failure of morale. People who stop treatment that might still have worked usually stop after a period in which nobody asked. The question does not push them towards stopping; it converts an unspoken drift into a decision made deliberately, with the psychological burden named as one of the things being weighed.

### 13.4 The counselling duty Indian law places on the fertility clinic

India answers the European guideline with a statute rather than guidance. The Assisted Reproductive Technology (Regulation) Act places on assisted reproductive technology clinics a duty to counsel, and specifies its content. The clinics must:

- provide **professional counselling** to the commissioning couple and woman about all the implications and chances of success of assisted reproductive technology procedures in the clinic;
- inform them of the advantages, disadvantages and cost of the procedures, their medical side effects and risks including the risk of multiple pregnancy;
- help them arrive at an informed decision on the matters most likely to be best for them.

The Act further requires that they be made aware of the rights of a child born through assisted reproductive technology, and a companion provision requires the written informed consent of all the parties seeking it before treatment. Counselling in Indian assisted reproduction is therefore an obligation with a statutory duty holder, and the duty holder is the clinic. It is not an extra a busy unit may drop, and it is not, by default, the psychiatrist's.

Hold that distinction: the two get conflated in practice and the conflation harms both. The clinic's statutory counselling is informational and decisional, covering implications, success rates, costs, side effects, risks and support to a decision. A psychiatric consultation is diagnostic and therapeutic, triggered by a question about mental state, capacity, medication or risk. When a unit sends a couple to you and calls it counselling, clarify in writing which is being requested, because the record must show whether the clinic has discharged its statutory duty and, separately, what psychiatric opinion was given. A note that blurs them leaves the clinic exposed and leaves you carrying a duty that is not yours.

### 13.5 Saying honestly what psychosocial care can and cannot deliver

Residents oversell this work in vivas, and the guideline itself does not. Its own summary is that the evidence presented shows that providing routine psychosocial care is associated with, or has the potential to, reduce stress and concerns about medical procedures and to improve lifestyle outcomes, fertility-related knowledge, patient wellbeing and compliance with treatment. Read the verbs: association, or potential, is not demonstrated causation. It then quantifies its own foundations: only 45 of the 125 recommendations in that guideline, 36.0 per cent of them, were

based on high-quality evidence, and the guideline group wrote recommendations aimed at generating the research the rest of them need.

Two consequences follow. First, the outcomes on that list are stress, procedural concern, lifestyle, knowledge, wellbeing and compliance. A pregnancy outcome is not among them, and you should not imply one. A couple told that counselling improves their chance of a baby has been given a false reason to attend, and will read the next failed cycle as a failure of their own psychological effort, which is the attribution this work exists to prevent. Second, compliance and treatment concerns are on the list, and compliance is what the discontinuation data says is at stake. The defensible claim is that psychosocial care makes an arduous treatment tolerable enough to complete, and that distress is worth treating in its own right, not that it is fertility treatment by another route.

### 13.6 The termination request: which statutory question you are being asked

The Indian frame is the Medical Termination of Pregnancy Act, 1971, as amended by the Medical Termination of Pregnancy (Amendment) Act, 2021, which defines termination of pregnancy as a procedure to terminate a pregnancy by medical or surgical methods and introduces the Medical Board as a statutory body. Name the Acts; do not carry their section numbers into an answer, because a wrong number reads worse than none.

Under the statute as amended, a pregnancy may be terminated by a registered medical practitioner on the opinion, formed in good faith, that continuance would involve a risk to the life of the pregnant woman or of **grave injury to her physical or mental health**, or that there is a substantial risk that the child, if born, would suffer from any serious physical or mental abnormality. How many practitioners must hold that opinion depends on the length of the pregnancy, and that two-tier structure is the part most often mangled in written answers.

| LENGTH OF PREGNANCY | OPINION THE STATUTE REQUIRES | WHERE THE PSYCHIATRIST ENTERS |
|---|---|---|
| **Not exceeding twenty weeks of pregnancy** | The opinion of one registered medical practitioner, formed in good faith | As the practitioner forming that opinion where the ground is mental health, or as the source of the evidence the treating practitioner relies on |
| **Exceeding twenty weeks but not exceeding twenty-four weeks of pregnancy, for a prescribed category of woman** | The opinion of not less than two registered medical practitioners, formed in good faith | Commonly as one of the two, since one of the prescribed categories is itself psychiatric |
| **Where termination is necessitated by substantial foetal abnormalities** | Diagnosis by a Medical Board, on which the length-of-pregnancy limits do not apply | Not the psychiatric route; recognise it so a case is not misrouted through a psychiatric opinion |

RULE **The statutory question is prospective, and it is about continuance.** The Act asks whether continuance of the pregnancy would involve grave injury to mental health. It does not ask whether termination will damage mental health, and it does not ask you to predict outcome after the procedure. An opinion that discusses post-abortion regret, or weighs whether she will cope afterwards, answers a question the statute does not pose and can defeat a lawful request while appearing thorough. Write about continuance.

### 13.7 The two presumptions, and the categories that open the extended window

The statute does not leave grave injury to mental health entirely to case-by-case judgment. Two explanations attach to it, and the difference between them is the most examinable psychiatric content in the Indian abortion frame. Where a pregnancy results from failure of any device or method used by any woman or her partner to limit the number of children or prevent pregnancy, the anguish caused by such pregnancy may be presumed to constitute grave injury to the mental health of the pregnant woman. Where a pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute grave injury to her mental health.

Three things follow. The verbs differ, and permissive is not mandatory. The reach differs: the contraceptive-failure explanation is expressed for the first gestational clause, the rape explanation for both. And the trigger for the second is the woman's own allegation, not a police finding, corroboration or a conviction; requiring proof first is a misreading with real consequences for a woman against a deadline. Note also that the amendment replaced the older married-woman-and-her-husband framing of the device-failure explanation with any woman or her partner, removing marital status from that route entirely.

> Grave injury to mental health is a statutory ground for termination in India, and where the woman alleges the pregnancy was caused by rape the anguish shall be presumed to constitute it.

The extended window depends on being within a **prescribed category of vulnerable women**. Answering in Parliament, the Government of India stated that the amendment rules define these categories, eligible for termination beyond twenty weeks till twenty-four weeks of gestation with the permission of two doctors, as survivors of sexual assault or rape or incest; minors; change of marital status during the ongoing pregnancy, namely widowhood and divorce; women with physical disabilities meeting the major disability criteria laid down under the Rights of Persons with Disabilities Act, 2016; mentally ill women, the Government's own wording adding the phrase including mental retardation; foetal malformation carrying a substantial risk of being incompatible with life or of the child being seriously handicapped; and women with pregnancy in humanitarian settings or disaster or emergency situations as declared by the Government. Two caveats belong with that list. The wording quoted for the fifth category is the Government's and reflects superseded terminology. And the categories come from an official parliamentary answer restating

the rules rather than from the rules as separately retrieved, so name the categories and the rules and do not cite a rule number.

Mentally ill women being a named category is what most often brings an Indian psychiatrist into this decision, and it carries a trap. Membership of the category opens the extended window; it does not establish the ground, and it does not answer whether this woman can consent. Capacity and consent are set out in the Forensic ethics, consent and legal procedure notes, and where the woman is a minor, or a reporting obligation may bite, protective legislation belongs with the Mental health legislation and forensic psychiatry notes. Establish category, ground and capacity as three separate findings and record them separately.

### 13.8 Answering on the evidence, not on the politics

Whether abortion damages mental health is treated in public debate as an open scientific controversy. It is better understood as a methodological artefact, which is the most useful thing to carry out of this topic. A systematic review of studies of abortion and long-term mental health outcomes rated each study on the methodological features needed to answer the question, and found **a clear quality gradient**: the highest quality studies had findings that were mostly neutral, suggesting few if any differences between women who had abortions and their comparison groups in terms of mental health sequelae, while the studies with the most flawed methodology were the ones that found negative mental health sequelae of abortion. No study in that review reached the top rating.

TRAP **Reading the abortion literature as a genuine disagreement between equally good studies.** Candidates write that the evidence is conflicting and leave it there, which sounds balanced and is wrong. The direction of a finding in this literature tracks methodological quality, and the weakest designs generate the strongest claims of harm. The comparison group is where most fail: women who have an abortion are compared with women never pregnant, or who carried to term by choice, leaving the unwanted pregnancy itself, the exposure that predicts distress, uncontrolled.

The design that solves the comparison-group problem compares women who obtained an abortion just under a facility's gestational limit with women turned away because they had passed it. In that prospective longitudinal cohort, being denied an abortion was associated with greater risk of initially experiencing adverse psychological outcomes compared with having one: at the first assessment after seeking the abortion the women who had been denied it reported more anxiety symptoms, lower self-esteem and lower life satisfaction, with similar levels of depression in the two groups. Over the follow-up, psychological wellbeing improved and the two groups eventually converged. The authors state that their findings do not support policies restricting access to abortion on the basis that abortion harms women's mental health.

Handle the transfer honestly. That cohort was recruited in a jurisdiction whose statutory and service model is not India's, so the psychiatric finding transfers and the service model does not. What it gives an Indian psychiatrist is a defensible answer to the question a family, a colleague or an examiner will put: the mental-health case against access is not supported by the strongest available

design, and the acute psychological cost in these data sits with denial rather than with the procedure. It is not licence to promise any woman a particular emotional outcome. Where a woman denied a termination presents with active suicidal ideation, assessment and disposition are those in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; a legal refusal as the stressor changes the urgency, not the method.

### 13.9 Writing the opinion, and protecting it

The output of this consultation is a document, and its quality is what gets examined and, occasionally, litigated. Four features distinguish a usable opinion from an essay. It states the ground in the statute's own terms rather than in diagnostic shorthand, because a diagnosis is evidence for the ground and is not the ground itself. It addresses continuance rather than outcome after the procedure. It records capacity and voluntariness as separate findings with reasons for each, since coercion runs both ways and a woman pressed towards termination and one prevented from it both present as ambivalence. And it is dated against the gestational age at the time of writing, because the window it opens is closing while the note is being typed.

Speed is therefore part of the standard of care here in a way it is not in most psychiatric opinions. A request left in an outpatient queue for a fortnight can convert a first-tier decision requiring one practitioner into a second-tier decision requiring two, or take the case outside the window entirely; where the service cannot see the woman quickly, saying so in writing and escalating is itself the clinical act.

The last element is confidentiality, and here the statute is unusually direct. **The confidentiality provision** of the Act as amended states that no registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under the Act except to a person authorised by any law for the time being in force, and that contravention is punishable with imprisonment which may extend to **one year**, or with fine, or with both. Note what that means for a consulting psychiatrist: the duty is on the registered medical practitioner, not only on the operating gynaecologist, and it attaches to the woman's identity rather than to the clinical detail.

> **PITFALL**
>
> The breach in this area is almost never a deliberate disclosure. It is a case discussed by name in an open ward round, a shared register carrying the woman's name against the indication, a case sheet photographed and sent to a colleague for advice, or a relative told at the door what the appointment was for. Each discloses name and particulars, and the sanction here runs to imprisonment. Decide how a termination case will be recorded, presented and handed over in your unit before the first such case, not after.

### 13.10 Contraception counselling as a psychiatric responsibility

**Why it matters clinically.** The commonest way psychiatry harms a pregnancy is not by mismanaging one. It is by never having the conversation that would have made the pregnancy a planned event. The four-limb pre-conception recommendation itself, its wording and the record it

leaves behind, is set out with prescribing psychotropics in pregnancy elsewhere in these notes and is not restated here. What this topic owns is the contraceptive limb of it, which is the one a general psychiatric clinic acts on every week and the one that has a prescribing bar attached.

Read the population before the content, because it is not the population the topic's name suggests. Not pregnant women. Not women already on a teratogen. All **women of childbearing potential** with a new, existing or past mental health problem, which in a general psychiatric clinic is most of the women on the list. Contraception is placed first of the four limbs, ahead of relapse risk and parenting, making it the entry point to the conversation rather than an afterthought once a pregnancy is announced. That conversation is a decision made for two patients at once, one of whom does not yet exist; the framework for weighing treatment risk against the risk of the untreated illness belongs with prescribing in pregnancy and is not re-derived here.

The prescribing rule that pairs with it is deliberately not a number. The same guideline recommends that, when prescribing psychotropic medication or anti-epileptics for women or girls of childbearing potential, including young girls likely to need treatment into their childbearing years, the prescriber takes account of the latest data on the risks to the fetus and baby and follows **the medicines regulator's current safety advice** on anti-epileptic drugs in pregnancy. That is an instruction to consult the live regulatory position rather than a remembered figure, which is the right discipline: agent-level teratogenicity figures move, disagree between sources, and belong with the chapters that own each agent.

One prescribing bar makes contraception a formal precondition rather than advice. The same guideline recommends not offering valproate for acute or long-term treatment of a mental health problem in women or girls of childbearing potential, including young girls likely to need treatment into their childbearing years, unless other options are ineffective or not tolerated and the **pregnancy prevention programme** is in place. Both limbs are required, not either. Contraception here is not a conversation the prescriber ought to have; it is a condition of the prescription being defensible at all, whatever the indication. The regulator's current requirements under such a programme were not retrievable for this section and are not stated; check the live position.

Finally, name the pharmacology and do not re-derive it. Enzyme-inducing psychotropics can reduce the effectiveness of hormonal contraception; the mechanism, the agents involved and the hormonal thresholds at stake are taught in the Mood disorders: pharmacotherapy notes and in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. What belongs here is the act the mechanism obliges: when you start or change such a drug in a woman of childbearing potential, the contraceptive method is reviewed in the same consultation and the review is documented. The failure in practice is never ignorance of the interaction. It is that the psychiatrist knew it and treated contraception as somebody else's department.

No Indian recommendation equivalent to that discussion duty was located for this section, so it is cited as United Kingdom guidance and the Indian reader substitutes the current advice of the

national medicines regulator on the anti-epileptic limb. The practical Indian gap is not knowledge but access: the conversation names a method the woman must then obtain, often from a different service, sometimes without her family knowing, and usually at her own cost. A referral that ends at the door of a clinic she cannot reach unaccompanied has discharged nothing. Ask how she will get the method, and where follow-up will happen, before the consultation ends.

# The behavioural emergency

## 14 · Assessment and management of the acutely agitated and aggressive patient

**Why the marks are here.** Asked how to manage an acutely agitated and aggressive patient, most candidates produce a ladder: talk to the patient, offer oral medication, tranquillise, restrain. The ladder is correct, it is taught in full by the Mental health legislation and forensic psychiatry notes and by the Schizophrenia: management, antipsychotics and adverse effects notes, and it is not restated here. The trouble is that it answers only the second half of the question. It begins once the clinician has decided this is an agitated psychiatric patient who needs calming, and says nothing about the minutes before that decision: which room the patient is in, how many people are in it, who may speak, how far away they stand, what is measured while the talking happens, and which physical causes are excluded at the same moment. That is the assessment half, and where the examinable difficulty sits.

What follows is act and setting rather than entity. The sequence it belongs to is the one every other emergency invokes: recognise, make safe, decide who has authority to act, act, monitor, dispose. This section owns the front of that sequence, from arrival to the moment a treatment decision is taken, and owns it for the undifferentiated patient, whose diagnosis is not yet known and may never turn out to be psychiatric. The organising commitment is that assessment and calming are not consecutive. They run at the same time, in the same room, performed by different members of the same team, and a candidate who describes them sequentially has described something that does not happen.

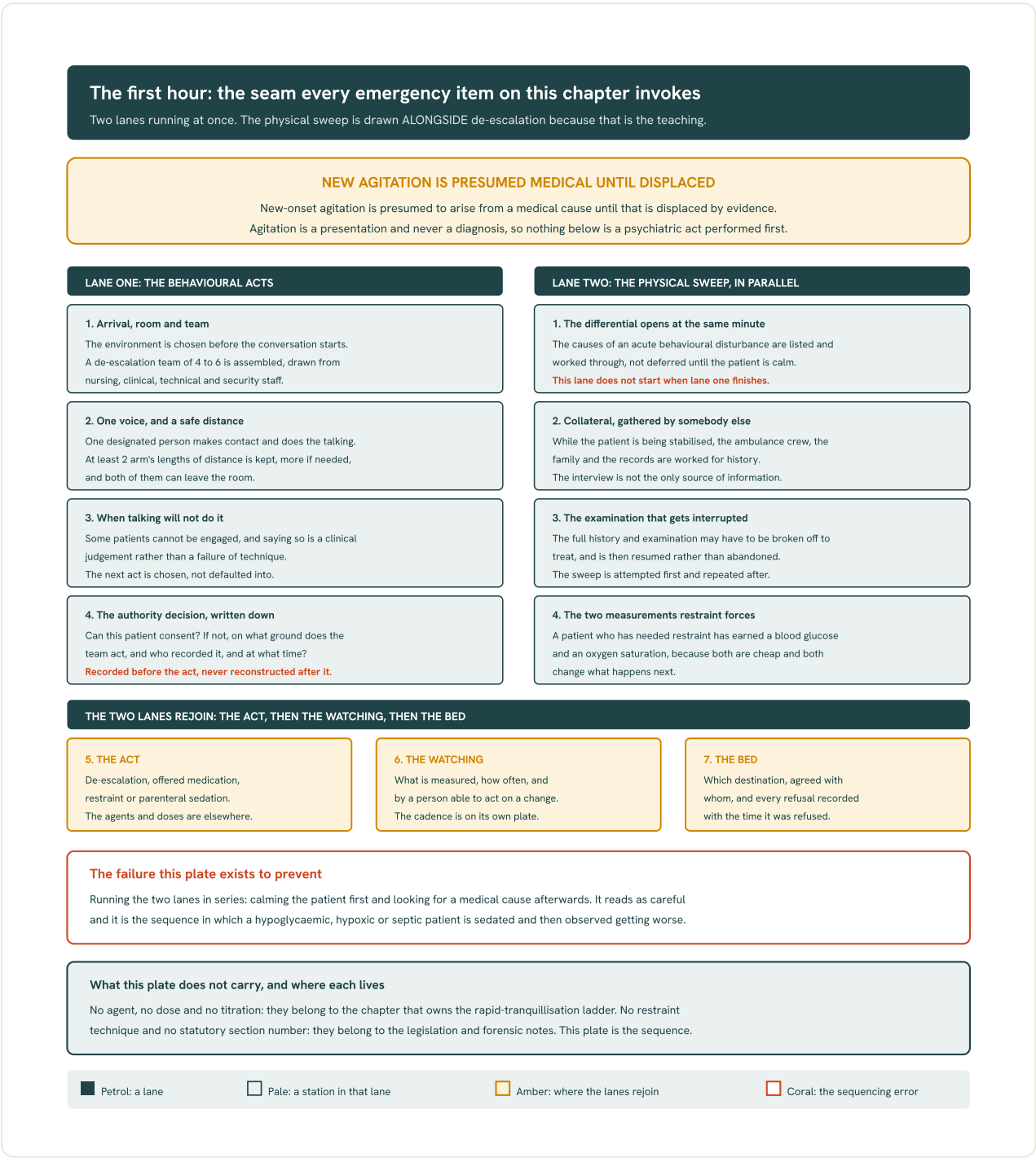


Fig 28.5. The first hour drawn as two lanes running at once, the behavioural acts of environment, one designated voice, safe distance and the authority decision set beside the physical sweep of differential, collateral, the interrupted examination and the two measurements that restraint compels, with the lanes rejoining at the act, the watching and the bed, and the sequencing error of running them one after the other named as the failure the arrangement exists to prevent.

## 14.1 Agitation is a presentation, and never a diagnosis

The most consequential error in this area is to treat agitation as though it were itself the thing to be treated. It is a final common pathway. The consensus statement of the American Association for Emergency Psychiatry, produced by its **Project BETA** medical evaluation workgroup, puts this as a formal consensus position rather than as advice: agitation that is **new in onset** is to be presumed to

arise from a general medical condition. The presumption runs that way deliberately, and it does not wait for a positive finding to activate it. The clinician who wants to conclude that this is psychiatric carries the burden of excluding the medical cause first.

Two riders come with it. The first is about testing: the same consensus states that routine laboratory testing is not indicated, and that **directed testing** chosen from the most likely diagnosis is what is indicated instead. The reflex in a busy casualty runs the other way, and a standard panel sent from the trolley is expensive, slow, frequently uninterpretable, and above all a substitute for thinking. A directed test follows a hypothesis; a routine panel replaces one.

The second rider names when to hold the presumption most tightly. Suspicion rises where the past medical history is concerning, with immunosuppression given as the example, and where onset falls outside the normal age ranges of psychiatric disease. The second is the more useful at the bedside, because it is available before any test result and often before any history: first-onset agitation in a man in his seventies, or in a child, is a medical presentation until proved otherwise, whatever the referral letter says.

TRAP **Reading a known psychiatric history as the explanation for new agitation.** The patient with an established diagnosis is the exact patient in whom the medical cause is missed, because the history supplies a ready-made account that closes the question before it is asked, and the presumption rule carries no exemption for people already known to services. Candidates make this error because the vignette gives the diagnosis in its first line and they read it as the answer rather than the distractor. The discipline is to notice that the history explains why this patient might become agitated, which is a different question from why they are agitated today.

### 14.2 Reading risk at the door, with what the first minutes actually give you

Prediction at the front door is where the honest answer is uncomfortable and should be given anyway. The available evidence-based recommendation is not about the emergency room. The National Institute for Health and Care Excellence guideline on the short-term management of violence and aggression recommends considering an **actuarial prediction instrument** rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan, and it names two: the **Broset Violence Checklist** and the **Dynamic Appraisal of Situational Aggression, Inpatient Version**. Neither is reproduced here, and no item, anchor or threshold from either belongs in an answer; they are named, and naming them is the whole of what a candidate should do with them.

The recommendation carries a scope restriction that is routinely dropped when it is quoted, and dropping it is a real error. It is written for inpatient psychiatric settings, where a known patient is observed continuously by staff who saw them yesterday and can score a change. The emergency door is a different problem: a stranger, no baseline, no serial observation, minutes rather than shifts. No instrument validated for that position is quoted here because none was available to quote, and the correct answer says so rather than transplanting an inpatient tool to the door and calling the transplant evidence.

What remains is what the first minutes genuinely supply: behaviour observed in real time, and an account from whoever brought the patient. What makes a prediction from that defensible is not a score but a stated basis. What specifically is being predicted, over what period, from which observed features, and what would change the answer. That formulation is transferable at handover and survives the question an incident review actually asks, which is never what the risk level was but always what it rested on. The framework for assessing risk to self, and the instruments used for it, belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

### 14.3 The room: exits, doors, stimulus and ligature points

The environment is the only part of this problem that can be fixed before the patient arrives, and the part candidates never mention. The Royal College of Emergency Medicine best practice guideline on **acute behavioural disturbance** in emergency departments specifies the ideal space for verbal and environmental de-escalation. It is a United Kingdom emergency department specification and should be attributed as one; no equivalent Indian specification is quoted here because none was found. Read its features as events they are designed to prevent, because each removes something that has actually gone wrong somewhere.

| WHAT THE SPECIFICATION ASKS FOR | WHAT ITS ABSENCE PRODUCES |
|---|---|
| **Adequate and appropriately located exits, so staff can leave without being trapped by the patient** | A clinician cornered between the patient and the curtain, whose attention is on their own escape and who is read accurately as afraid |
| **Doors which open outwards** | A door wedged shut from inside, so that entry becomes forced entry with no intermediate step |
| **A quiet, low-stimulus space that is not too warm** | De-escalation attempted against a continuing provocation, so its failure is misattributed to the patient |
| **No equipment, furniture or moveable object usable as a weapon or to barricade an exit** | Injury and a barricaded room, and a threshold for restraint that falls because waiting has been made costlier |
| **No potential ligature points** | Self-harm in the interval when nobody is in the room, so staffing rather than fabric becomes rate-limiting |
| **Constant observability, and staff able to signal for additional support easily** | An incident found late, and help that arrives after the event rather than in time |

Where the department cannot supply the room, the specification becomes a checklist for choosing the least bad space and stating what has been accepted. Observability and the ability to signal are the two that must be met somehow, because both are about the arrival of help, and both can be met with people when they cannot be met with architecture.

### 14.4 Where you stand: distance, positioning and your own way out

Personal safety at this stage is a matter of geometry, and the geometry is specified. The Project BETA de-escalation consensus directs the clinician approaching an agitated patient to keep a minimum of **2 arm's lengths** between themselves and that patient. The unit is deliberate and should not be converted into metres: an arm's length scales with the two people in the room, and what is specified is the distance at which a strike cannot land. The stated reasoning is double: it gives the patient the space they need, and gives the clinician room to move out of the way if the patient kicks out or otherwise strikes.

Three refinements follow, each examinable. The clinician may take more distance in order to feel safe, which makes the parameter a floor rather than a prescription and legitimises the clinician's own discomfort as data. If the patient tells the clinician to get out of the way, the clinician does so immediately, because complying with a request that costs nothing is itself de-escalation, and refusing converts the clinician into the obstacle. And both people must be able to leave the room without feeling that the other is blocking the way, which is the sentence that decides where everybody stands: neither party is between the other and the door. In a cubicle with one exit this cannot be perfectly satisfied, and the practical resolution is to stand off the direct line to the door rather than on it, so neither has to move the other to leave.

MNEMONIC

**Room, Team, Voice, Sweep**

**Room**: the space and its exits, settled before the patient is in it. **Team**: enough people, and the right ones, present before the approach. **Voice**: one designated person makes and keeps verbal contact. **Sweep**: the physical differential runs in parallel with the talking, not after it. Everything the escalation ladder teaches begins only once these four are settled, which is why an answer that starts at the ladder has skipped the examinable half.

### 14.5 The team: how many, who, and who is allowed to speak

Working with an agitated patient is a team activity, and the Project BETA de-escalation consensus is specific about size: in a busy emergency service the **de-escalation team** should consist of **4 to 6 team members**, made up of nurses, clinicians, technicians, and police and security officers if available. The stated purpose explains why the figure is not arbitrary: enough people to provide verbal de-escalation, to offer the possibility of voluntary medication, and to maintain safety if agitation escalates to violence. Sufficient numbers also communicate non-verbally that violence will not be acceptable, and this is easy to get wrong in both directions. Too few, and the patient correctly perceives that the room can be dominated. Too many, or too close, and the same presence reads as a threat and drives the escalation it was assembled to prevent.

The rule about who speaks is one sentence and it is the most useful sentence here. The **first person to make contact** should be the person designated to de-escalate the patient, and if that person is not trained or is otherwise unable to take the role, another should be designated immediately. Two

things are fixed at once. Only one person interacts verbally, because an agitated person receiving instructions from several directions has been given a task they cannot perform and will experience the room as an assault. And the designation is a live decision rather than an accident of who reached the trolley first: if the nearest person cannot do it, the role moves, at once and out loud, so everyone else knows to stop talking.

The rest of the team therefore have jobs which are not talking. Someone obtains the bedside physiology, someone interviews the people who brought the patient, someone is positioned so help can be signalled and reached. In a well-run department this is choreographed and almost silent, and the loudest failure mode is a room full of staff all reasoning with the patient at once.

**IN INDIA**

None of the numbers above describes a district hospital casualty at two in the morning, where the available team may be one postgraduate resident, one nursing officer with a whole department to run, and one security guard whose training is in guarding rather than de-escalation. The honest position is not to pretend the specification is met but to state what is substituted and what that costs. The designated-de-escalator rule becomes easier rather than harder to keep when there are only two staff: one talks, one does everything else. But the missing team members are exactly the people who would have run the parallel physical sweep, so where numbers are short the sweep is the first thing silently dropped and the last thing that should be. Accompanying relatives are almost always present, and they are at once the collateral source, a calming influence in some cases and an inflaming one in others, and people whose own safety the team is responsible for. Which relative stays in the room is a clinical decision taken by the person leading.

### 14.6 The parallel sweep: what is measured while somebody else is talking

**The rule that organises the whole hour.** The Project BETA medical evaluation consensus states that the complete history and physical examination may have to be interrupted to treat the patient's agitation, and resumed once the patient is less agitated. Two clauses make this coherent: the patient may need treatment to reduce agitation without a definitive diagnosis, and the goal of medication is to calm the patient enough to allow a thorough evaluation. Read the last one carefully, because it inverts the usual framing. Sedation is not the end of the assessment; it is an instrument of it. A patient who has been calmed and then left alone has received half a treatment, and the half omitted is the reason the other half was given.

What is swept is set out most usefully for a resource-realistic setting by the World Health Organization mhGAP Intervention Guide, written for non-specialised health settings, whose table on the person with agitated or aggressive behaviour directs the clinician to attempt to communicate with the person and, in the same breath, to evaluate for an underlying cause:

- check blood glucose, and give glucose if it is low;
- check vital signs including temperature and oxygen saturation, and give oxygen if needed;
- rule out delirium and medical causes including poisoning;

- rule out drug and alcohol use, considering stimulant intoxication and alcohol or sedative withdrawal specifically;
- rule out agitation due to psychosis or a manic episode.

The order of that list is the teaching. The psychiatric attribution comes last, reached by exclusion rather than by recognition. Note also how little equipment the sequence needs: a glucometer, a thermometer, a saturation probe and a pair of hands. This is a protocol a district hospital can actually run, which is why it is the one worth memorising.

The Royal College of Emergency Medicine guideline supplies the same idea as causes to exclude rather than acts to perform, naming substance intoxication and mental health conditions as the most common factors, alongside substance withdrawal, head injury, hypoglycaemia, seizures, heat stroke and hypoxia. Serotonin syndrome and anticholinergic syndrome appear on the same list and are named here only; their recognition, discriminating features and treatment belong to the Schizophrenia: management, antipsychotics and adverse effects notes, and nothing resembling a grid comparing them belongs here. Taken as acts, the five this section owns are quick. Hypoglycaemia is excluded by a bedside stick, which takes less time than the argument about whether to do it. Hypoxia is excluded by a probe, which also detects the deteriorating patient nobody is watching because everybody is watching the behaviour. Head injury is excluded by looking, feeling the scalp, and asking whoever brought the patient about a fall or a blow, a question that stops being answerable once those people leave. Intoxication and withdrawal are excluded by history and examination, their entities belonging to the Substance use disorders notes, and delirium by cognitive assessment as far as the patient permits, the syndrome belonging to the Stroke, TBI, delirium and focal brain syndromes notes.

RULE **Assessment and calming are interleaved, not sequential.** The examination may be interrupted by treatment and then resumed, and treatment may precede the diagnosis, because the alternative is a patient who is neither evaluated nor calmed while the team waits for one to permit the other. The corollary is what makes this examinable: because the assessment is interrupted rather than abandoned, somebody must own resuming it. The commonest real failure is not that the sweep is refused but that it is deferred to a moment nobody owns, and the patient is found hours later, calm, undiagnosed, hypoglycaemic and still in the corridor.

| LANE RUNNING IN THE FIRST MINUTES | WHAT IS DONE | WHAT IT MAY NOT WAIT FOR |
|---|---|---|
| **Verbal contact** | One designated person makes contact and holds it; if that person is untrained or unable, another is designated immediately | A diagnosis, or a more senior clinician arriving |
| **Team and space** | 4 to 6 team members in a busy emergency service, drawn from nurses, clinicians, technicians and police and security officers if available | The patient becoming more disturbed before help is called |
| **Bedside physiology** | Blood glucose checked and glucose given if low; vital signs including temperature and oxygen saturation checked and oxygen given if needed | The patient becoming cooperative |
| **Physical differential** | Delirium and medical causes including poisoning excluded, and drug and alcohol use excluded | Laboratory results, which are directed rather than routine |
| **Collateral** | Ambulance crew, police, family, friends, relatives and nursing home personnel interviewed during behavioural stabilisation | The patient becoming interviewable |
| **If restraint occurs** | Oxygenation level and finger stick blood glucose done immediately, where they could not previously be obtained | The post-restraint review, or the next shift |
| **History and examination** | Interrupted to treat the agitation, then resumed once the patient is less agitated | A definitive diagnosis before any treatment |

**GOOD TO REMEMBER**

Restraint is the moment the two easiest measurements finally become obtainable, and the moment they are most often forgotten. If a patient must be restrained because de-escalation was impractical or ineffective, then oxygenation level and finger stick blood glucose are done immediately where they could not previously be obtained. Build it in as a fixed pairing: hands on, probe on, stick done, before anybody leaves the bedside to write. Restraint converts two impossible tests into two immediate ones, and a team that does not take them has thrown away the one benefit it conferred.

| | | | |
|---|---|---|---|
| **2 arm's lengths** MINIMUM DISTANCE ON APPROACHING AN AGITATED PATIENT | **4 to 6** DE-ESCALATION TEAM MEMBERS IN A BUSY EMERGENCY SERVICE | **1** PERSON DESIGNATED TO HOLD VERBAL CONTACT | **Immediate** OXYGENATION AND FINGER STICK GLUCOSE ONCE A PATIENT IS RESTRAINED |

### 14.7 Collateral is taken now, while the patient is being stabilised

Collateral history here is not a step that follows assessment. The Project BETA medical evaluation consensus places it inside the stabilisation itself: during the time the patient is being behaviourally stabilised, the **ambulance crew, police, family, friends, relatives and nursing home personnel** should be interviewed to obtain a history or collateral information. Learn that as a list, because it is a list of people physically present at that moment and at no other.

This is the most perishable resource in the encounter. The ambulance crew has another call; the police stop being responsible once they have handed over. Each holds information nobody else has and the patient, by definition, cannot supply: what the person was like yesterday, when the change began and how fast, whether there was a fall, what was taken and how much, whether the tablets in the house have gone. An hour later, when the patient is calm and the clinician is free to take a history, all of them have gone and the information with them.

The operational answer is to assign it. The team member not holding verbal contact interviews the accompanying people while de-escalation is still running, and before releasing anyone. Two questions justify the exercise even when time is shortest: what is different about this person compared with yesterday, and what could they have taken or been given. In Indian practice the accompanying group is large and its members frequently disagree, and that disagreement is itself information about the timeline. The task is not to arbitrate but to record who said what, because a discrepancy about time of onset is often the first sign that the story offered is not the story that happened.

### 14.8 When de-escalation has not worked yet, and when it cannot be attempted at all

Two situations look identical from the doorway and demand opposite responses, and telling them apart is the discrimination this section exists to teach. The Project BETA de-escalation consensus states both. There are patients who cannot be effectively engaged and verbally de-escalated, and the example given is the **delirious patient**. Against that, training should emphasise that a patient may not respond to initial efforts at engagement and that **persistence** is indicated, especially where the patient is not showing signs of further escalation towards violence.

The distinction turns on capacity to engage rather than degree of disturbance. The delirious patient is the exemplar because the medium itself has failed: attention cannot be held, so a sentence does not arrive intact, and repeating it more calmly does not repair the channel. Verbal de-escalation there is not merely ineffective, it consumes the time in which the reversible cause should have been found. The syndrome and its assessment belong to the Stroke, TBI, delirium and focal brain syndromes notes, and the front-door management of the confused patient is dealt with elsewhere in this chapter.

The opposite error is commoner and more damaging. A patient who has not answered the first two attempts is frequently written off as unresponsive, when the guidance is explicit that failure of initial efforts is not the end point. The condition attached to persistence is behavioural rather than

temporal, which makes it usable without a clock. If the patient is disturbed but not escalating, keep going, because that is time in which the physical sweep and the collateral are being completed by everyone else in the room. If the patient is escalating despite engagement, or cannot engage at all, the situation has changed category and the response moves to the staged escalation that the Mental health legislation and forensic psychiatry notes and the Schizophrenia: management, antipsychotics and adverse effects notes set out in full, with every agent and dose. The authority under which that is done for a patient who cannot consent is a separate question, addressed with the rapid tranquillisation and legislation material.

One further point, because it is where good answers lose marks. Deciding that de-escalation cannot be attempted is a clinical judgement that must be recorded with its reason, like any other move to a more restrictive intervention. The reason is not that the patient was agitated. It is that this patient could not sustain attention on a sentence, or that a designated person attempted engagement and the behaviour escalated during it. That separates a considered escalation from an impatient one.

### 14.9 What must be true before the first hour ends

The end of this section is the beginning of everything else, and the handover is best stated as conditions rather than narrative. Before the patient leaves the resuscitation area or assessment room, the following should be true and recordable.

- A glucose and a saturation exist, with a time against each, and if the patient was restrained they were taken at that moment.
- Somebody has been interviewed who saw the patient before this episode, and their name is written down.
- A named person led the verbal contact, and a named person is responsible for resuming the interrupted examination.
- The medical presumption has been tested rather than assumed away, and if set aside, the reason is written.
- The level of care, the level of observation and the disposition have been decided by somebody rather than defaulted to by nobody.

The last of those is where this section hands over. Observation levels and the admission decision, the rapid tranquillisation protocol with its authority question and its monitoring, and the physical safety of a person in restraint each have their own place in this chapter. What has been established here is the material all three depend on: the room was chosen, the team assembled and one voice designated, physical causes excluded while the talking was happening, the people who knew the patient spoken to before they left, and the presumption of a medical cause carried until actively displaced. An answer that reaches the escalation ladder without any of that has described the treatment of a diagnosis nobody has yet made.

Agitation is a presentation and never a diagnosis: the physical sweep runs alongside the talking rather than after it, and the psychiatric attribution is the last one made, not the first.

## 15 · Rapid tranquillization protocols

**Why the marks are here.** Rapid tranquillisation is examined as though it were a pharmacology question, and answered as one: which agent, in what order, at what dose. Those belong to the Schizophrenia: management, antipsychotics and adverse effects notes, which print the sequence and every first dose in it, and they are not repeated here. Take the drug chart away and what remains is the part that actually goes wrong on a ward. Rapid tranquillisation is a procedure. Like any procedure it has an indication statable in one sentence, an authority that must exist before it begins, a practitioner competent to manage what it may cause, a brief that fixes who does what, a written order whose form determines who thinks next, and a monitoring plan that outlives the drug by hours. Not one of those is a milligram.

The front of the emergency sequence, including the environment, the team, verbal de-escalation and the physical differential that runs in parallel with it, is set out with the assessment of the acutely agitated and aggressive patient elsewhere in these notes and is assumed rather than restated. What follows begins once the decision to sedate has been taken. The organising commitment is that the drug is the smallest and least dangerous component of the act, and that the avoidable deaths in this area happen in the hour after the injection rather than at the moment of it.

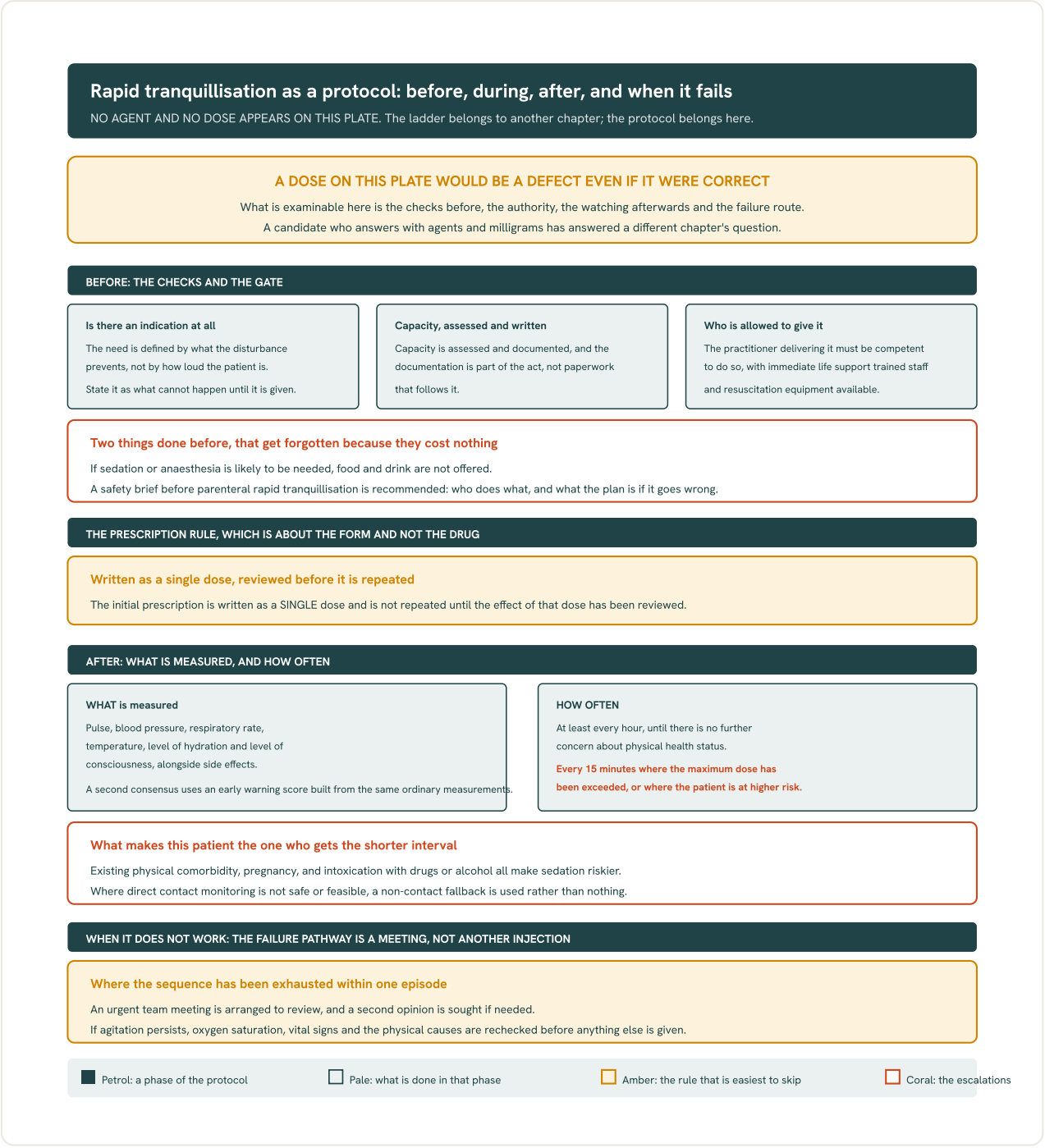


Fig 28.6. Rapid tranquillisation drawn as a protocol rather than as a drug ladder, with the indication test, the capacity assessment and the competence and resuscitation requirements before it, the single-dose prescription rule, the parameters measured afterwards and the two cadences that govern them, the patient factors that shorten the interval, and the failure pathway stated as an urgent team review rather than as a further injection. No agent and no dose appears anywhere on the plate.

## 15.1 The indication is what the disturbance prevents, not how disturbed the patient looks

The most useful answer to when this is indicated is a definition rather than a threshold. The Royal College of Emergency Medicine, in its best practice guideline on acute behavioural disturbance in emergency departments (version 2, October 2023), defines the need for rapid tranquillisation as the **inability to provide safe assessment or essential treatment**. That deserves a slow reading for what it declines to do. It does not define the indication by the patient's behaviour, by a level of

arousal, by how frightened the staff are, or by a score on any instrument. It defines it by what the clinician cannot do while the disturbance continues.

The definition cuts both ways, and both cuts are examinable. A patient who is loud, threatening and frightening to be near, but who can be examined and whose essential treatment can be given, does not meet it. Noise is not the indication, and a department that sedates noise will sedate distress, grief and cultural difference along with illness. Conversely a patient who is barely raising his voice, but who will not permit the examination his physical presentation demands or is pulling out the line that is treating him, does meet it. The quiet obstructive patient is the one this definition catches and intuition misses.

It also imposes a discipline of statement. If the indication is an inability, the clinician must say what it is an inability to do: this assessment, this investigation, this treatment. That sentence belongs in the record before the drug is drawn up, and it does a second job at review, because the question afterwards is not whether the patient is calmer but whether the thing that could not be done can now be done. Where nobody can complete the sentence, what is being treated is the department's distress.

RULE **Rapid tranquillisation is indicated by what the disturbance prevents, never by how disturbed the patient appears.** Everything else in the protocol follows. The indication states a purpose, the purpose sets the endpoint, the endpoint is what the post-dose review tests, and the monitoring exists to keep the patient alive until that review can be made. A protocol entered without a stated purpose has no endpoint, and sedation without an endpoint becomes sedation renewed by habit.

### 15.2 Authority: capacity is assessed and written down, never assumed

The act contemplated is giving a drug to an adult who has not agreed to it, which requires an authority, and the authority has two halves that candidates collapse into one: legal permission to treat without consent, and clinical competence to carry the treatment out. The second is the next section. The first begins with capacity, and the guidance is blunt about how it is handled. The Royal College of Emergency Medicine states that patients presenting with severe acute behavioural disturbance are likely to lack capacity to make treatment decisions and may require emergency treatment, and that this should be **formally assessed and documented**.

The two clauses pull against each other deliberately, and that tension is the teaching. The first is an empirical expectation: in this population incapacity is the likely finding. The second forbids acting on the expectation without checking it, because a likelihood is not a finding. The error runs both ways. The commoner one treats the disturbance as self-evidently establishing incapacity, so no assessment is made and the record contains a drug and no reasoning. The rarer one accepts a fluent refusal as evidence of capacity, because the patient is talking in sentences, and withholds treatment from someone who cannot retain or weigh what he is being told.

Formal assessment here does not mean an unhurried capacity interview, which the situation does not permit and the guidance does not demand. It means an assessment was attempted and its result

recorded: what the patient was told, what he was able and unable to do with that information, and the conclusion. Two or three contemporaneous lines will do; nothing will not. The documentation is load-bearing rather than bureaucratic, because the record is the only later evidence that the injection was a treatment decision rather than a convenience, and every subsequent review or inquiry begins by reading it.

One jurisdictional caution must be stated rather than smoothed over. The rule above is a United Kingdom statement of the step. The statutory basis on which a patient may be treated without consent in an emergency in India, and the position of restraint within that law, are set out in the Mental health legislation and forensic psychiatry notes, with the consent doctrine itself in the Forensic ethics, consent and legal procedure notes. They are named here and not restated, and no Indian statutory provision is asserted in this section. What survives translation is the structure of the obligation: identify the ground you are acting on, satisfy yourself it applies to this patient now, and write down that you did.

TRAP **Treating the disturbance as though it were the capacity assessment.** Candidates write that the patient was agitated and therefore lacked capacity, which reverses the logic: severe disturbance makes incapacity likely, and likelihood is exactly what an assessment is for. The error is attractive because it saves time in a situation that has none, and because the conclusion is usually correct, which is what makes it dangerous. A correct conclusion reached without an assessment is indistinguishable in the record from no conclusion at all, and it is the record that is examined afterwards. State the assessment and its documentation as a discrete step with its own place in the sequence, before the drug rather than after it.

### 15.3 Competence: who may give it, and who must be within reach

The second half of the authority question is clinical, and no legal framework answers it. The same emergency medicine guideline states that the practitioner delivering rapid tranquillisation must be **capable of managing those complications** if they arise, that care of the patient presenting with acute behavioural disturbance should be provided by a senior emergency medicine practitioner, and that early critical care support should be considered. The complications in view are recorded in the same source as apnoea, airway obstruction and a subsequent requirement for intubation, associated with most of the sedative agents used in this situation.

Put plainly: whoever gives a drug that may stop the patient breathing must be able to manage a patient who has stopped breathing. This is not about hierarchy or prescribing rights. It is about which skills are physically present in the room when the plunger goes down, and it has an uncomfortable implication for the common arrangement in which the decision is taken by a senior over the telephone and executed by whoever is on the floor. The decision may be delegable. The airway is not.

The standard is stated again from a different direction by the National Institute for Health and Care Excellence in its guideline on the short-term management of violence and aggression, NG10, published in 2015: staff trained in **immediate life support**, and a doctor trained to use

resuscitation equipment, should be immediately available to attend an emergency wherever restrictive interventions might be used. Read the limbs together, because the standard is equipment plus a person competent to use it and neither discharges it alone. A resuscitation trolley behind a locked door, and a nurse trained in life support on a ward whose defibrillator is three floors away, both fail it while appearing on paper to meet it.

Note also that the standard attaches to the possibility of a restrictive intervention rather than to its occurrence. It is a rostering and geography requirement settled before any particular patient arrives, which is why it cannot be improvised at the moment of need. The same logic explains considering critical care support early: an early call is made while there is still time for someone to walk to you, whereas a call made once the saturation is falling has become an emergency referral.

### 15.4 Before the drug: who is less safe to sedate, and the check everyone forgets

Pre-sedation assessment here is compressed and often uncooperative, so it has to be selective. The joint consensus guideline of the British Association for Psychopharmacology and the National Association of Psychiatric Intensive Care and Low Secure Units, published in 2018, names the factors conferring additional risk on the act of sedation itself:

- pre-existing physical health comorbidity, which converts a transient respiratory or haemodynamic effect into a decompensation;
- pregnancy, where the decision is being made for two patients at once and restraint positioning changes as well, taken up with the perinatal emergencies elsewhere in these notes;
- intoxication with, or withdrawal from, drugs or alcohol, the commonest unknown at the front door and the one most likely to be additive with what you are about to give;
- the potential for medication interactions, which in a patient whose regular prescription is unknown is a risk accepted rather than assessed.

The same source adds a category easy to miss because it is not pharmacological at all: non-medication risks are also a factor, and they include **the process of restraint** itself. This changes how the decision is framed. Clinicians weigh sedation against restraint as though they were alternatives and only one risk were being taken; in practice parenteral rapid tranquillisation in a resisting patient is delivered under restraint, so the two risks are additive and arrive together. The physical hazards of holding a person, and the observation that person needs during and after the hold, are taken up separately in these notes.

One further instruction deserves separate billing as the most reliably forgotten line in the protocol. The emergency medicine guideline directs that where sedation or general anaesthesia is likely to be required, the patient should be offered **no food or drink**. It is a short rule with a large consequence, and its difficulty is that it runs against the instinct that de-escalation trains into a good clinician.

**PITFALL**

De-escalation works partly through ordinary kindness, and the commonest ordinary kindness in an Indian casualty is a cup of tea or a glass of water brought by a relative who has been waiting outside for hours. If the patient is on a path towards parenteral sedation, that kindness fills the stomach of a person who may shortly be obtunded, unable to protect the airway and supine under restraint. The instruction is not to be unkind. It is to decide early whether sedation is likely, say so to the team and to the family in the same breath as the explanation of what is happening, and substitute a kindness that does not enter the stomach. A team that has not made this decision explicitly makes it by default, and the default is the tea.

### 15.5 The safety brief, and the three elements that make it more than a formality

Parenteral rapid tranquillisation is a team procedure performed at speed on a resisting person, which is the exact configuration in which tasks get duplicated, tasks get dropped, and nobody notices either. The emergency medicine guideline answers this with an instrument borrowed from surgery and resuscitation: it recommends considering a **safety brief** before parenteral rapid tranquillisation where practicable, covering roles, the intended plan, anticipated problems, restraint considerations, the intravenous access plan, the plan for moving to a resuscitation environment, and responsibility for the decision to relax restraint.

Each element removes a specific failure. Roles removes duplication: who holds which limb, who protects the head and airway, who draws up and gives, who keeps time, who continues talking to the patient, and who is doing none of these because they are watching the whole room. The intended plan removes the situation in which two people execute different plans in good faith. Anticipated problems converts a foreseeable crisis into a contingency somebody has already been assigned. Restraint considerations settles position and duration before adrenaline rather than during it.

The last three separate a brief from a formality. The intravenous access plan is settled beforehand because access gets harder as the patient becomes more disturbed and then more sedated, so the moment you urgently need a line is the moment you are least able to get one. The plan for moving to a resuscitation environment is a route, a trolley, a door and a person, worked out while there is time to walk it; a team that has not settled it discovers the lift is on another floor while carrying a patient who is not breathing. Responsibility for the decision to relax restraint is the element most often left unassigned, at the moment it matters most, because releasing too early and holding too long are both harmful and a team with no named owner does neither deliberately.

The guidance qualifies the brief with the words where practicable, and that should be taught honestly rather than quietly dropped. Some situations do not permit a huddle. They do permit a compressed version delivered in the corridor: roles, plan, who calls the release. The brief is a distribution of attention rather than a document, and a shortened brief distributes far more of it than none.

MNEMONIC

### Who, What, What if, Hold, Access, Exit, Release

The seven elements of the brief in the order they are needed. **Who**: roles. **What**: the intended plan. **What if**: anticipated problems. **Hold**: restraint considerations. **Access**: the intravenous plan. **Exit**: the route to a resuscitation environment. **Release**: the named owner of the decision to relax restraint. Teams that skip one skip the last, and the last is the one whose absence is felt at the most dangerous moment.

## 15.6 The order is written as one dose, and the review is what makes it a protocol

How the prescription is written determines who makes the next decision, which makes the form of the order a clinical matter and not a clerical one. The national guideline on violence and aggression recommends that the initial prescription for rapid tranquillisation is written as **a single dose**, and is not repeated until the effect of that dose has been reviewed.

The rule is doing something precise. An order written open, in the familiar form permitting repetition as required, silently transfers the next decision to whoever holds the chart when the patient is next disturbed. In practice that is the most junior person on the floor, at night, under pressure from a ward that wants quiet, assessing a patient who by then is least able to object. A single-dose order makes repetition impossible without a clinician returning to the patient, which is the point: it forces a fresh act of judgement at the moment the risk of accumulation begins.

It is also what makes the monitoring meaningful, so the two are always taught together. Observations recorded with no decision attached are chart-filling, and wards produce a great deal of it. The review of effect is what the observations are for, and it has two limbs that must both be answered. The clinical limb returns to the stated indication: can the assessment now be made, can the essential treatment now be given. The physiological limb asks what the drug has done to breathing, circulation and conscious level. A review answering only the first is how a patient becomes calm, monitored and dead.

GOOD TO REMEMBER

Write four things into the same entry as the order and it becomes a protocol rather than a prescription: the indication in the inability form, the single dose given, the time the effect will be reviewed, and the name of the person who will review it. A team that writes only the drug has documented an event. A team that writes all four has documented a decision, and has left the only instruction that survives a shift change.

## 15.7 After the dose: what is measured, how often, and until when

This is the genuinely owned part of the topic and the part most often missing from an answer. After rapid tranquillisation, the national guideline on violence and aggression directs that side effects and the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness are monitored at least **every hour**, until there are no further concerns about the

patient's physical health status. The interval shortens to **every 15 minutes** where the maximum dose has been exceeded, or where the patient:

- appears to be asleep or sedated;
- has taken illicit drugs or alcohol;
- has a pre-existing physical health problem;
- has experienced any harm as a result of any restrictive intervention.

The first trigger is counter-intuitive and is the one wards get wrong: the more successful the sedation looks, the closer the monitoring gets. A sleeping patient reads to a busy team as a solved problem and to this protocol as an escalation, because sleep and over-sedation are indistinguishable from the end of the bed and the difference between them is the airway. The fourth trigger matters too, because harm sustained during restraint escalates the monitoring of the sedation, which is the protocol acknowledging that the two interventions have combined into one physiological insult.

| Every hour | Every 15 min | 4 | 97% |
|---|---|---|---|
| MINIMUM MONITORING INTERVAL AFTER RAPID TRANQUILLISATION, NICE NG10 | NICE INTERVAL WHEN ANY ESCALATION TRIGGER IS PRESENT | BAP AND NAPICU MONITORING LEVELS, LOW TO CRITICAL | OF 44 UK RAPID TRANQUILLISATION DOCUMENTS NAMED MONITORING PARAMETERS |

**Notice what is missing.** This cadence has no fixed end. It runs until there are no further concerns about physical health status, which is a clinical stopping rule and not a duration, and the omission is deliberate. A fixed period invites a team to stop at the end of it, and the risk from a sedative does not expire on a clock; it expires when the physiology says so. The corollary is that somebody must be nominated to decide the concern has ended, because a stopping rule with no owner does not stop, it lapses.

The parameter set is worth comparing with the one the other major consensus uses, because they differ instructively. The joint BAP and NAPICU guideline monitors using the **National Early Warning Score**, which it defines as comprising temperature, pulse, systolic blood pressure, respiratory rate, oxygen saturation and level of consciousness. The instrument is named and its constituents are ordinary clinical measurements; no scoring, weighting or trigger threshold from it belongs in an answer.

| PARAMETER | WHICH SET NAMES IT | WHAT IT IS WATCHING FOR |
|---|---|---|
| **Respiratory rate** | Both sets | Respiratory depression, and the earliest bedside warning of it |
| **Level of consciousness** | Both sets | Depth of sedation, and whether the airway is still protected |
| **Pulse** | Both sets | Rate and rhythm disturbance, and the cost of the preceding struggle |
| **Blood pressure** | Both sets, systolic specified in the early warning score | Hypotension, including the postural drop seen only on sitting up |
| **Temperature** | Both sets | Pyrexia, which after antipsychotic exposure changes the diagnostic frame |
| **Oxygen saturation** | Early warning score only | Hypoxaemia, and the measurement a resisting patient will usually tolerate |
| **Level of hydration** | NICE set only | Prolonged struggle, refused fluids and a period nil by mouth |
| **Side effects** | NICE set only | Drug effects no physiological number displays, found only by looking |

### 15.8 Stratifying the monitoring: level set by route and by state, not by drug

The joint BAP and NAPICU consensus goes beyond a single interval and stratifies direct contact monitoring into **four** levels, each pairing a physical cadence with an observation intensity. Only the physical cadence is taught here. The observation intensity is a sixth vocabulary for a construct that already has five in print, and both the levels and the fact that their names do not agree across documents belong with observation after self-harm elsewhere in these notes; naming an intensity in this consensus's words to a nurse working in another document's words communicates nothing. Its own statement of status travels with it: the source records that these levels rest on the consensus of experts, given the dearth of available evidence. That label is not a reason to discount them. It tells the reader what kind of authority an interval carries, and it is why a local protocol may legitimately differ from this one while a local protocol that differs from a physiological principle may not.

| LEVEL | WHICH PATIENTS | PHYSICAL MONITORING | OBSERVATION |
|---|---|---|---|
| **Low** | Following pre-tranquillisation medication | Early warning score or equivalent every hour, minimum one hour | Standard psychiatric observations every hour |
| **Medium** | After intramuscular rapid tranquillisation, no higher level required | Early warning score or equivalent every 15 minutes, minimum one hour | Intermittent psychiatric observations every 15 minutes |
| **High** | After intramuscular rapid tranquillisation, over-sedated, asleep or significantly physically unwell | Early warning score or equivalent every 15 minutes, minimum one hour, with pulse oximetry until ambulatory | Continuous, within line of sight |
| **Critical** | After intravenous rapid tranquillisation, or unconscious and not rousable, or severely physically unwell | Continuous monitoring, resuscitation facilities essential | Continuous, within arm's length |

Two design features are the transferable part. First, the level is set by the route of administration and by the patient's state, never by which agent was used: intravenous administration goes to the top level regardless of what was given, and unrousability does the same. A candidate reasoning from the drug to the monitoring has the logic inverted. Second, the recovery marker at the high level is that the patient is ambulatory rather than talking. Walking tests conscious level, coordination, standing blood pressure and postural airway control at once, which makes it a better endpoint than conversation and available on any ward without equipment.

The observation column belongs to a construct taught in full with the emergency management of suicide risk elsewhere in these notes, where the levels, who sets them, who reviews them and what the handover carries are set out. What this section owns is the pairing: after rapid tranquillisation a physical cadence and an observation intensity are prescribed together, and prescribing one without the other leaves a patient either watched but not measured, or measured but not watched.

### 15.9 When the monitoring the protocol assumes does not exist

**The honest problem.** Every cadence above assumes a working pulse oximeter, a cuff the patient will tolerate, a thermometer, a member of staff who can stay in the room, and a resuscitation capability within reach. That set is frequently incomplete, and pretending otherwise produces an answer that is correct and useless. The consensus guideline addresses incompleteness directly, though from a different starting point: for patients in whom direct contact physical monitoring is not safe or feasible, it directs that **non-contact physical monitoring** be conducted until direct contact monitoring can be established, comprising:

- respiratory rate;
- level of consciousness;

- pallor;
- signs of pyrexia;
- evidence of dystonia or akathisia;
- signs of dehydration.

Notice the design of that set. Every item is obtainable from the end of the bed by a clinician with no equipment and no cooperation, which makes it usable both in the situation the guideline describes, where touching the patient is unsafe, and in the situation an Indian ward more often faces, where the equipment is elsewhere. The extension from one to the other should be made explicitly rather than smuggled: the source frames the constraint as safety or feasibility, not as resource scarcity, and a candidate who cites it as guidance about under-resourced settings has overstated it. What transfers legitimately is the principle that when the measured set is unavailable the answer is a different observation set, not an absence of observation. Two further features matter. The fallback is temporary by construction, since it runs until direct contact monitoring can be established, so adopting it carries a standing obligation to keep trying. And it is not a diluted version of the full set but a differently chosen one, weighted towards what a human observer detects reliably without instruments.

Protocol variation in this area is real and has been measured, rather than being a complaint. In national surveys of United Kingdom mental health organisations reported by the same consensus guideline, nearly all of the rapid tranquillisation documents examined specified monitoring parameters, but **14** different parameters appeared across them. Those were United Kingdom documents and say nothing about Indian practice, so the figure establishes only that having a protocol is not the same as having a standard. The consequence for a case sheet is that the phrase as per protocol records nothing: name the parameters actually measured and the interval actually used.

**IN INDIA**

In a district hospital casualty at night the full monitoring set is often not assembled, and the honest response is neither to recite the guideline nor to abandon it, but to state what is being substituted and what that costs. Name the observer: a cadence assigned to the ward is assigned to nobody, and where staff are few the single most effective act is to write one person's name against the observation until relieved. Run the non-contact set from the bedside, since it needs nothing and can begin the moment the injection is given rather than when a trolley is found. Prioritise the pulse oximeter above every other instrument if only one can be brought, because it is continuous, tolerated by a resisting patient, and directly relevant to the complication that actually kills. And record what was not available, in plain terms. That record is both an honest account of the care given and the only thing that has ever changed what a ward is equipped with.

### 15.10 Failure: what is done when the patient is still disturbed

Sedation that does not work is a common examination scenario and a dangerous clinical moment, because the instinctive response is to give more of the same and the guidance says something else. Where the sequence of intramuscular options has been exhausted within an episode, the national guideline on violence and aggression directs that **an urgent team meeting** be arranged to carry out a review, and that a second opinion be sought if needed. The agents and their order belong to the Schizophrenia: management, antipsychotics and adverse effects notes and are not reproduced here; what is owned here is the terminal step, and the striking thing about it is that it is not pharmacological. At the end of the ladder the recommended intervention is more clinicians, not more drug.

The World Health Organization mhGAP Intervention Guide, version 2.0 (2016), written for non-specialised settings, reaches the same destination by a different road. If the person remains agitated it directs the clinician to recheck oxygen saturation, vital signs and glucose, to consider pain, and to refer to hospital; and once agitation subsides, to move to the assessment that identifies what is actually wrong. Failure is treated as a reason to repeat the physical sweep, not to escalate the dose.

Held together, the two pathways teach one thing: failure of sedation is a diagnostic event. One response escalates the number of people making the decision, the other escalates the examination, and neither escalates the syringe. That is clinically right as well as procedurally safe, because the commonest reasons a correctly given sedative fails are that the cause of the disturbance is not the one assumed, that a physiological derangement is driving it, or that something is hurting.

Pain deserves its own sentence, since the instruction to consider it sits in a guideline written for clinicians with the fewest resources and is the cheapest thing on this page. The patient who cannot give a history is the patient whose pain is never asked about: retained urine after hours of restraint and immobility, an injury sustained in the struggle, a surgical abdomen underneath the agitation. An analgesic and a bladder scan have settled patients two rounds of sedation did not. The disposition follows from the same logic. Once the disturbance subsides the assessment begins rather than ends, and where the patient goes next is set by the monitoring level he currently needs rather than by which ward has a bed.

> Rapid tranquillisation is a procedure, not a prescription: an indication stated as something you cannot do, a capacity assessment written down, a practitioner who can manage the airway, one dose with a named reviewer, and a monitoring cadence that runs until someone decides the physical concern has ended.

## 16 · Suicide risk assessment and emergency management

**Why the marks are here.** The suicidal patient is examined as though suicide risk were an assessment problem alone, and it is half of one. Assessment produces a judgement; the judgement then has to become something a ward can deliver over the next several hours: a level of observation,

decisions about the room and what is in it, an admission decision, and conditions that must hold before the patient leaves. The framework for estimating risk, the disposition ladder and the counselling of patient and family about access to lethal means at home belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes and are not repeated here.

One warning governs everything below. The documents that create observation levels do not agree with each other: they use the same word for different things and different words for the same thing, and most decline to fix an interval at all.

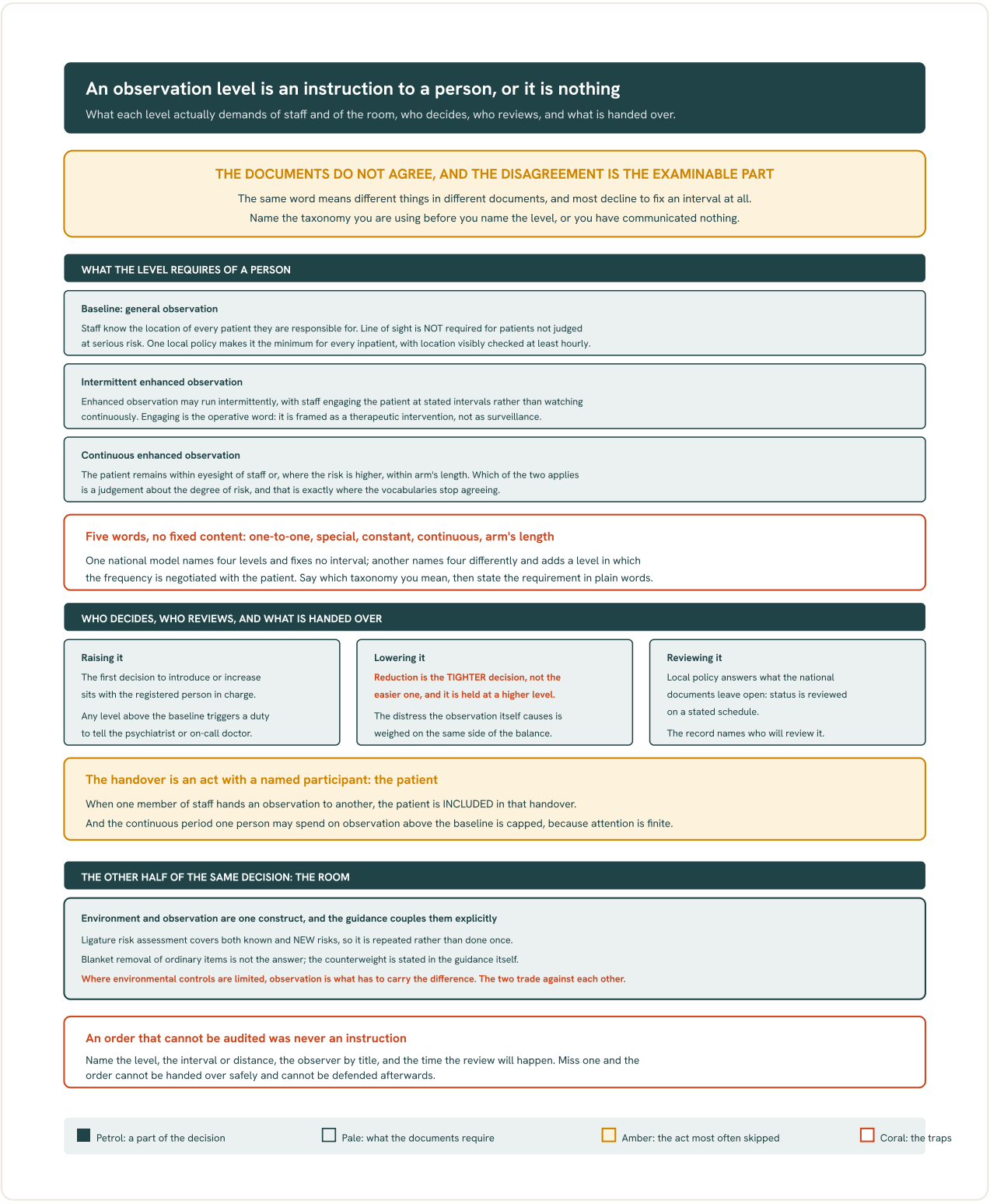


Fig 28.7. Observation as a decision rather than a label, with each level stated as what it requires of a person and of the room, the five interchangeable words that carry no fixed content across documents, the asymmetry by which raising a level is easier than lowering it, the review and the handover in which the patient is a named participant, and the environmental controls that observation has to compensate for when they are absent.

## 16.1 What an observation level is, and what it is for

**Clinical observation** is defined in the English self-harm guideline as a therapeutic intervention, used most commonly in hospital settings, that allows staff to monitor and assess the mental and

physical health of people who might harm themselves or others, and to be seen as an opportunity for active engagement as well as sensitive supervision. Physical health sits inside that definition, which is where psychiatric observation and medical monitoring stop being separable: the observer is the person most likely to notice a falling conscious level, or developing aspiration in a sedated patient.

The statutory Code of Practice is more explicit about purpose. It calls **enhanced observation** a therapeutic intervention aimed at reducing the factors that contribute to increased risk and promoting recovery, describes its content in deliberately ordinary language as sitting with the person, talking, and supporting participation in activities, and names its indication as the short-term management of behavioural disturbance, or a period of distress, to prevent suicide or serious self-harm.

So a member of staff on a chair at the door, completing a form at intervals and not speaking to the patient, is not delivering the intervention these documents describe. An observation that generates no information is a rota cost with no clinical yield.

### 16.2 The baseline, and the named levels above it

Every taxonomy begins from a baseline, and the baseline is itself a decision. The Code sets it in one sentence: staff should know the location of all patients for whom they are responsible, and it is not necessary routinely to keep within sight those not considered to present a serious risk of harm to themselves or others. **General observation** is defined by knowledge of location, not by line of sight. One English trust operationalises it as the minimum level for every inpatient, with location and safety visibly checked **at least once an hour**, and rules out closed-circuit television as a substitute: a camera shows that a corridor is empty, not that a patient in a bay is breathing.

Above the baseline the English violence-and-aggression guideline names four levels. **Low-level intermittent observation** is its baseline for a specified psychiatric setting, once every **30 to 60 minutes**; **high-level intermittent observation**, for the patient at risk of becoming violent or aggressive but not presenting an immediate risk, runs once every **15 to 30 minutes**; above these sit continuous observation, built around a designated one-to-one nurse, and **multiprofessional continuous observation** for the highest risk. All four are defeasible: they apply unless a locally agreed policy states otherwise.

The statutory Code covers the same ground differently. Its intermittent enhanced observation is delivered at irregular and unpredictable intervals, and the irregularity is specification rather than accident, because a patient who can time the door knows how long they have. The Code adds that high use of intermittent observation has been shown to be associated with low levels of self-harm and to be tolerated by most patients. Its own **continuous observation**, and the trust's separately named **within arm's length observation**, sit alongside the national scheme rather than mapping onto it.

A second jurisdiction shows how much of this is convention. An Australian state guideline offers what it calls one possible model and fixes no interval anywhere in it: frequency and pattern follow the identified risk factors and the purpose of the observation. Its fourth level, **negotiated observation**, has nurses negotiate the frequency of engagement with people who have no identified risk factors requiring intermittent or constant observation, and is the only level in any of these documents whose frequency is set with the patient rather than for them.

| DOCUMENT AND THE LEVEL AS IT NAMES IT | FREQUENCY OR PROXIMITY THAT DOCUMENT FIXES |
|---|---|
| **Code of Practice: general observation** | No interval; location known, those not a serious risk need not be in sight |
| **English trust policy: general observation** | Visible check of location and safety at least once an hour; cameras excluded |
| **Violence-and-aggression guideline: low-level intermittent** | Observation once every 30 to 60 minutes |
| **Violence-and-aggression guideline: high-level intermittent** | Observation once every 15 to 30 minutes |
| **Code of Practice: intermittent enhanced observation** | Intervals of between 15 and 30 minutes, deliberately irregular |
| **Violence-and-aggression guideline: continuous** | Within eyesight or arm's length of a designated one-to-one nurse |
| **Code of Practice: continuous enhanced observation** | Within eyesight, or arm's length for the most serious degrees of risk |
| **Violence-and-aggression guideline: multiprofessional continuous** | Within eyesight of 2 or 3 staff members and arm's length of at least 1 |
| **English trust policy: within arm's length** | Close proximity, held during lavatory and bathroom use; care plan states staff numbers and distances |
| **Australian state guideline: constant, arm's length and visual** | Continuous one-to-one nursing observation by an experienced nurse |
| **Australian state guideline: intermittent** | No interval fixed; risk factors and purpose set frequency and pattern |
| **Australian state guideline: negotiated** | No interval fixed; frequency of engagement agreed with the patient |

TRAP **Treating one-to-one, special, constant, continuous and arm's length as synonyms.** The confusion sits in the source documents, not in the reader. "Continuous" sometimes means eyesight and sometimes arm's length according to the degree of risk; "constant" is the Australian word for a similar idea and is itself split in two; "one-to-one" is a staffing ratio appearing inside several levels rather than a level of its own. Asked what one-to-one observation involves, say that the term has no fixed content, name the taxonomy you are using, then state the requirement. A level written in a vocabulary the receiving nurse does not use has communicated nothing.

Only four intervals are fixed anywhere in the English violence-and-aggression guideline; everything else is remitted to the provider's own policy. That division between what a national document fixes and what it delegates is the most useful single thing to carry into a question here.

| 30 to 60 min | 15 to 30 min | 2 hours | 1 week |
|---|---|---|---|
| LOW-LEVEL INTERMITTENT OBSERVATION | HIGH-LEVEL INTERMITTENT OBSERVATION | LONGEST UNBROKEN SPELL ONE OBSERVER MAY HOLD | OBSERVATION THIS LONG TRIGGERS MULTIDISCIPLINARY REVIEW |

### 16.3 Moving up: the trigger, the authority, and who must be told

The escalation rule in the Code is not a score: continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks. That is a question about the sufficiency of the lower level rather than about how high the risk is, and it is the better question, because it forces the clinician to say what the lower level would fail to prevent and therefore what would have to change for the level to come down. No sourced document makes an instrument score the trigger, and no suicide-risk instrument's items, anchors or cut-offs appear here; the instruments belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

The first decision is a nursing one. The trust policy places the decision to introduce or increase observation, in the first instance, with the registered person in charge, where possible with medical staff and in response to an assessed risk, while holding that wherever possible it is made jointly by the multidisciplinary team and the patient. Medical involvement follows immediately rather than first: the violence-and-aggression guideline requires that the patient's psychiatrist or the on-call doctor be told as soon as possible whenever observation above the general level is carried out, and requires the record to carry the names and titles of the staff responsible for reviewing observation levels and when that review will happen. A reviewer who is a role rather than a person does not, in practice, review.

The level is never set on its own. The trust policy pairs it with an environmental decision, requiring consideration at the same time of searching the patient and their room or property and removing potentially harmful objects. How much of one is needed depends on how much of the other is already in place.

RULE **An observation level is a prescription, not a mood.** It has a named person who set it, a stated frequency or distance, a named reviewer recorded with their title, and a stated time at which the review will happen. A level entered without those four elements cannot be audited, cannot be handed over safely, and cannot be defended afterwards.

MNEMONIC

### Level, interval, distance, observer, review

The five things an observation order must state before it is an instruction rather than an intention. **Level**: which named level, in the taxonomy this hospital's own policy uses. **Interval**: how often, if intermittent, and whether the spacing is deliberately irregular. **Distance**: eyesight or arm's length, and how many staff. **Observer**: who may hold it, and whether it may be delegated. **Review**: by whom, by name and title, and when.

## 16.4 Coming down, and the review that is supposed to bring it down

What the national guideline does not do is fix how often the routine review happens. Instead it requires every provider organisation to hold a policy on observation and positive engagement, and prescribes its contents:

- the definitions of the levels of observation the organisation will use;
- who can instigate, increase, decrease and review observation;
- when an observer should be male or female;
- how often reviews should take place;
- how patients' experience of being observed is taken into account;
- how observation is underpinned by continuous attempts to engage therapeutically;
- the levels of observation necessary during other restrictive interventions;
- the need for multidisciplinary review when observation continues for **1 week** or more.

The guideline fixes exactly one interval there and hands the routine interval to the local document. So the answer to "how often is an observation level reviewed" is not a number: the provider's own policy is required to state one. The trust policy supplies a worked example, requiring review a minimum of daily for any patient nursed above general observation level, with the care plan setting out in advance the conditions and observed behaviours that would allow a prompt reduction.

Reduction is deliberately the tighter decision. One registered person in charge may raise a level immediately; no one person may lower it. Because these patients are by definition those judged at highest risk, reduction follows a formal process producing a team decision founded on a current mental state and risk assessment and on the views of patient and carers, normally taken by registered nursing staff or a mental health practitioner with the team. One delegated route exists: where the responsible clinician and team have identified the circumstances in advance, 2 registered practitioners may implement the change in their absence.

Without a counterweight the level accumulates, rising on one clinician's judgement in seconds and falling only through a meeting. The Code supplies that counterweight as a duty: staff must weigh the distress that increased observation itself causes, particularly over many hours or days, against

the identified risk of self-injury or behavioural disturbance, and must record every decision to increase or decrease.

**GOOD TO REMEMBER**

Write the exit criterion in the same entry that raises the level, in observable terms: what the patient would have to be doing, and over what period, before the level comes down. A team that has not pre-agreed this keeps patients at enhanced levels long after the clinical reason has gone, because at every review the safest decision for the individual reviewer is to change nothing.

### 16.5 The observer, the staffing cap and the handover

An enhanced level is a staffing decision before it is a clinical one, and the guideline concedes the point with a number. An individual staff member should not undertake a continuous period of observation above the general level for longer than **2 hours**, and where it is needed for longer, that staff member must be given regular breaks. The rationale is attentional rather than industrial: sustained vigilance directed at one person degrades with time on task. So every hour of enhanced observation must be filled by a named person on a rota, and the cap manufactures handovers inside every shift, which the documents specify:

- when one staff member hands an observation to another during a period of observation, the patient is included in the discussion where possible, so the handover is an event the patient is party to rather than a staff transaction about them;
- the staff member ending a period of additional observation gives a verbal handover, mindful of confidentiality, to the staff member taking over, involving the patient and their family or carer wherever possible;
- at the change of shift, the persons in charge of the outgoing and incoming shift are together responsible for reviewing and signing the observation record, confirming the documentation, and physically seeing the patients.

"Physically see the patients" is the load-bearing phrase. The characteristic serious incident involving an observed patient is not a level set too low; it is a level set correctly, recorded as delivered, and not delivered. A signature shows that a form was completed, and laying eyes on every patient is the only step here that checks the record against the world.

**IN INDIA**

None of the taxonomies above is Indian, and no Indian national standard for observation levels, intervals or observer-to-patient staffing is quoted here because none was available to quote. The operative document on any Indian unit is that hospital's own policy. The service reality bites hardest at the staffing cap: continuous observation, rotated as the guidance requires, consumes observer-blocks that a district unit with a thin night establishment cannot produce, and the gap is filled by a family attendant sitting with the patient. That is an understandable adaptation and it is not the intervention the guidance describes, because a relative has not been selected by profession and grade, cannot document, cannot be rotated off, and may be the person the patient least wants at the bedside. Where it is unavoidable, record the arrangement, state narrowly what it is relied on to prevent, and compensate through the environmental measures, which cost fixtures rather than nurses.

### 16.6 Privacy, dignity and the person being observed

The level that best protects life is the level that most intrudes on the body, and the documents handle this by requiring the intrusion to be planned rather than improvised. The Code makes the provider's policy on enhanced observation settle four things in advance: which profession and grade should hold the observation and when the duty may be delegated; how the observer is matched to the patient, with ethnicity, sexual identity, age and gender named; how the intervention is delivered so that it is least likely to be perceived as coercive; and how privacy is protected in states of undress, which the Code specifies as using the toilet, bathing, showering and dressing. The trust policy carries the same into the care plan for its closest level, requiring privacy, dignity and the gender of allocated staff to be written in, while stating plainly that observation is maintained when the patient uses lavatory or bathroom facilities.

The error this prevents is predictable. Faced with an undignified moment and no written plan, a nurse improvises, and the improvisation is almost always to relax the level informally for its duration: to step outside the bathroom door, or to turn away. That is the most predictable point of failure at an arm's length level, it is unrecorded by definition, and the next shift inherits a level that has quietly stopped meaning what it says.

### 16.7 Observation outside the psychiatric ward

Most patients who have just harmed themselves are not on a psychiatric ward. They are in an emergency department or on a medical ward, where the decision must be made by two teams sharing neither a policy nor a vocabulary nor a line of accountability. The English self-harm guideline makes close observation there a joint decision of mental health and acute ward staff, taken case by case with the person's views taken into account, and attaches three conditions: appropriately skilled and trained healthcare staff, the informed consent of the person or an appropriate legal framework, and regular review. Each fails in a recognisable way. Skilled and trained staff means a security guard posted at a bedside is not an observer, whatever the nursing note records. Regular review means an observation ordered on the night of admission does not

silently persist through a long medical stay. And the consent clause is the medico-legal hinge of the subject.

**The refusing patient.** Observation, and continued presence in hospital, are either consented interventions or legally authorised ones, and no third category exists. Where the patient does not consent and the judgement is that they must be observed, or must remain, the decision moves from a clinical footing to a legal one, and that transition is made deliberately and documented before the observation starts rather than reconstructed afterwards. Which route exists, on what grounds, for how long and on whose signature is a matter for the governing mental health legislation and is set out in the Mental health legislation and forensic psychiatry notes; capacity and the standard of consent belong to the Forensic ethics, consent and legal procedure notes. No statutory ground, procedure, time limit or authorised signatory is asserted here, because none is sourced in this section, and a half-remembered provision is more dangerous than an honest referral to the statute.

The emergency department carries one obligation that is purely architectural: the waiting area for people who have self-harmed must be close to staff who can provide care, support and observation. This is the one place where the requirement is expressed as a floor plan rather than as a level, and a patient waiting where staff cannot see them is unobserved whatever the notes say.

### 16.8 The ward and the department as physical objects

Environmental safety inside the hospital is a distinct construct from counselling a patient and family about access to lethal means at home, and the difference is one of responsibility: this one belongs to the hospital. The English regulator's ligature guidance requires risk assessments to cover both known and new forms of **ligature anchor point**, treats environmental assessment as an active search for new points and for those manipulated or worn, and reverses earlier practice in terms: in all cases, and contrary to previous guidance, low-lying ligature points should not be judged as low risk and should be removed where possible.

On the fabric of the ward the same guidance names collapsible furniture, reduced ligature fixtures and fittings, and removal of fixed ligature points where possible. Two are not discretionary. Providers must use collapsible shower and curtain rails, and an incident involving a rail that does not conform is reportable as a **Never Event**, the strongest statement of obligation in this material. Services must also regularly assess ward areas to identify and remove ligatures and anchor points where possible.

The counterweight is stated with equal force and candidates consistently omit it. Clothing and other items commonly available on wards and in the home are the main materials used as ligatures, but most items are not dangerous in everyday use, so services should avoid a blanket approach to restricting them. What is removed from a particular patient follows individual risk assessment, regularly reviewed, and denying access to clothing is a last resort. A ward that strips every patient of every cord has converted a targeted intervention into a collective punishment.

The regulator then makes the relationship between environment and level explicit, and this is the reasoning that ties the section together. Where environmental controls are limited, or impinge on the patient's care, privacy and dignity, both individualised and system controls must reduce ligature risk, and the controls it names are an observation level set from individualised risk assessment together with the processes that support it: multidisciplinary working, and the sharing of risk information at handovers and huddles. That is a substitution rule and it runs both ways. An old ward with anchor points that cannot be removed needs a higher observation level than a new one for the same patient; conversely, capital spending on fixtures permanently reduces the nursing hours the ward must otherwise buy.

One part of the physical environment is deliberately left open here. The room a patient is actually assessed in, the cubicle or interview room where a first conversation happens before any ward is involved, has its own requirements: whether it can be spoken in without being overheard, what it contains, and whether it can be left safely by either person. No comparable standard is available to quote for it, and none is invented here. Treat that as a gap to be closed by local policy rather than as a question this account has answered.

### 16.9 The admission decision at the door

Two questions get collapsed into one at the emergency department door. The first is whether this person needs to be in a hospital at all; the second is which hospital, and the answer is not always the psychiatric one.

The Indian Psychiatric Society's guideline on suicidal behaviour answers the first with two separate lists, and the separation is the teaching point. The standing-risk list sets out situations in which hospitalisation should be strongly considered, and it reads as four clusters: the act and its planning, being a prior attempt of high lethality, a well-thought-out plan and access to lethal means; the current state, being hopelessness and being uncommunicative; the social surround, being a recent major loss and social isolation; and what is untreated or destabilising, being a history of impulsive, high-risk behaviour, active substance abuse or dependence, and untreated mood, psychotic or personality disorder. Read as clusters, the list becomes a set of questions that can be asked in order.

The second list applies after a suicide attempt or an aborted attempt, and is more specific because there is now an act to interrogate. Hospitalisation is indicated where the patient is psychotic; where the attempt was violent, near-lethal or premeditated; where precautions were taken to avoid rescue or discovery; where a persistent plan or intent is present; where distress is increased or the patient regrets surviving; where the patient is male and older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking; where family or social support is limited; where current impulsive behaviour, severe agitation, poor judgment or refusal of help is evident; or where there is a change in mental status with a metabolic, toxic, infectious or other aetiology requiring further workup in a structured setting.

That last item is where the psychiatric admission decision and the medical decision stop being two decisions, because a patient whose mental state has altered for a reason not yet established is admitted in order to establish it, and the correct destination may then not be a psychiatric bed. Which brings in the second question. The English self-harm guideline gives three indications for considering admission to a general hospital after an episode of self-harm: concerns about the person's safety, for example risk of violence, abuse or exploitation, where psychiatric admission is not indicated; safeguarding planning still to be completed, again where psychiatric admission is not indicated; and the person being unable to engage in a psychosocial assessment, for example because they are too distressed or intoxicated. Two of the three are framed explicitly against psychiatric admission not being indicated, which makes this a separate decision rather than a weaker version of the same one.

### 16.10 Discharge, and the patient who will not stay

Discharge after self-harm is governed by preconditions rather than an overall impression, and they are conjunctive: all must hold, not most. Before a person who has self-harmed leaves a general hospital, the English guideline requires that each of the following is in place:

- a psychosocial assessment has taken place;
- a plan for further management has been drawn up with all appropriate agencies and people;
- a discharge planning meeting with all appropriate agencies and people has taken place; and
- arrangements for aftercare have been specified, including clear written communication with the primary care team.

The last is the one that quietly fails. Where the receiving service is a private practitioner, a distant district hospital, or nobody at all, that written communication is the entire handover, and the working rule is to treat the discharge as incomplete until it has left the building.

The harder case is the patient who waits for none of this. The guideline treats discharge against advice as a service-design requirement rather than a judgement improvised at the door, requiring standing policies for the person who wishes to leave, and for the person who has already left, before physical and mental health assessment and care is complete. Both limbs matter and they are different problems. The person still in the department needs a procedure executable in minutes by whoever is standing there; the person already gone needs one naming who is contacted, by whom and within what period, and that second procedure is the one almost no department writes until after it has needed it.

One response is closed off explicitly. Mechanical restraint must not be used in emergency departments to prevent self-harm or to prevent a person from leaving the emergency department. Removing the reflex answer is the point of the prohibition: it forces the question back onto the only two legitimate footings, consent and the applicable legal framework, and obliges the department to decide which it is relying on before the patient is at the door. The statutory framework for

detention, and for restraint itself, belongs to the Mental health legislation and forensic psychiatry notes and is named here rather than restated.

> An observation level is a prescription: a named person who set it, a stated frequency or distance, a named reviewer with their title, a stated review time, and a written condition that would bring it down.

## 17 · Management of acute psychotic and manic emergencies

**Why the marks are here.** The examinable question about psychotic emergencies and manic emergencies is almost never what the syndrome is. It is what is done with the man brought to casualty at two in the morning by his relatives, who has not slept for several nights, talks over everyone in the room, and has given away money the family does not have. The syndrome, its neurobiology and the agents that treat it belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes and to the Mood disorders: pharmacotherapy notes. What is taught here is the decision sequence at the door: what is referred and how quickly, what is excluded before the psychiatric label settles, who may consent to what, which harms are already being done while the assessment proceeds, what is started before the diagnosis is settled, and where the patient goes next.

Two features separate this from every other behavioural emergency. The decision must usually be taken before the diagnosis is available, because a first episode arrives without a history and organic and substance-induced states sit in the same differential. And the harm is not principally violence: much of it is financial, sexual and relational, it is done by a patient who may be cheerful and cooperative, and it accrues by the hour. An answer built around sedation and restraint has addressed the smaller half of the problem, with material owned by other sections of this chapter.

### 17.1 The decision is triggered by suspicion, not by a settled diagnosis

The referral rule is unusually clean and unusually easy to misquote. The National Institute for Health and Care Excellence guideline on bipolar disorder, **CG185**, written for England and Wales, published in 2014 and last updated in **2025**, recommends referring people urgently for a **specialist mental health assessment** if mania or severe depression is **suspected**, or if they are a danger to themselves or others.

Read the limbs as separate doors into one pathway, because the source joins them disjunctively and either alone suffices. A dangerous patient is referred urgently even where mania is not suspected; a patient in whom mania is suspected is referred urgently even where nothing dangerous has happened. Candidates who remember only the danger limb convert an urgent referral rule into a violence rule, and then have no answer for the patient who is manifestly unwell and manifestly not aggressive.

The word carrying the weight is suspicion. Not confirmation, not a provisional diagnosis, not a specialist opinion. That choice is the point this section is built on, because the information that would settle the diagnosis is unavailable when the decision must be made: a first episode has no prior history to appeal to, the person who could describe the past fortnight is outside the room, and the organic alternatives are excluded by work that takes time the decision does not have. If the trigger were confirmation, every referral would be made after the harm rather than before it.

RULE **The threshold for acting is suspicion of the state or the presence of danger, never a confirmed diagnosis.** This inverts the order candidates are trained into everywhere else in medicine, and it is defensible because what is triggered is itself an assessment rather than a treatment. Nothing irreversible follows from referring urgently and finding no mania. A great deal follows from waiting for certainty in a condition whose defining features include impaired judgement about money, sex and personal safety, all of which keep operating during the wait.

### 17.2 What is excluded before the psychiatric label is allowed to settle

Before excitement, overactivity or florid psychotic phenomena are accepted as psychiatric, a physical exclusion runs. The most useful statement of it for this setting comes from the World Health Organization mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, issued in **2016**. Before settling a psychosis or mania label, the clinician evaluates by history, clinical examination or laboratory findings for signs and symptoms suggesting **delirium** due to an acute physical condition. The guide names what to look for:

- infection, and **cerebral malaria** specifically;
- dehydration;
- metabolic abnormalities, hypoglycaemia and hyponatraemia being the examples given;
- medication side effects, with some antimalarial medication and steroids named.

The choice of source matters. This is a guide written explicitly for non-specialised settings, and its list is populated by what actually presents in them: a high-income emergency guideline would not have named cerebral malaria or antimalarial medication at all, and an answer written for Indian practice needs the version that does. The delirium syndrome itself, its criteria, subtypes and assessment belong to the Stroke, TBI, delirium and focal brain syndromes notes and are named here rather than taught; the front-door triage of the undifferentiated confused patient is dealt with elsewhere in this chapter.

Three observations make the list usable rather than decorative. Steroids and antimalarials are prescribed medicines, so the exposure is documented somewhere and discoverable by asking one question of the person who brought the patient, before that person leaves. Hyponatraemia produces nothing visible at the bedside, so it is excluded by a sample or not at all. And dehydration sits here as a cause of delirium while also being a consequence of sustained mania: a patient who

has not drunk anything for three nights can arrive with a confusional state layered on the excitement that produced it, and the two are then read as one.

None of this defers the act. The exclusion runs alongside the containment and the collateral history, and the sequence that opens every behavioural emergency is set out elsewhere in this chapter. What it buys is permission to let the label settle; until then the working formulation is an undifferentiated disturbance in a patient who may turn out to be manic.

### 17.3 Capacity in mania: the fluent examination that hides the failure

Capacity here separates good answers from adequate ones, because the examination that ought to detect the problem is the one that conceals it. A capacity assessment asks whether the patient can take in the information relevant to the decision, hold on to it, weigh it in arriving at a choice, and communicate that choice. The manic patient performs most of those beautifully: orientation is intact, speech is fluent, and information given a minute ago comes back verbatim. The failure is confined to the weighing, where elevated mood has altered not the reception of the facts but their appraisal, so the risk is understood, retained, restated accurately and then judged not to apply. An assessor who stops when the patient answers well has tested everything except the limb that fails.

The sourced counterpart is easy to skate past. Alongside its environmental advice, the bipolar guideline recommends advising people with mania or hypomania not to make **important decisions** until they have recovered. That is a substantial statement dressed as housekeeping. It concedes that decisional impairment is a feature of the whole episode rather than of its worst hour, and that it extends to the ordinary consequential decisions of a life: selling land, resigning a post, marrying, investing, standing surety. Those are decisions no consent form covers and no ward round asks about, and they do the lasting damage.

The same recommendation adds a third limb, that the person be encouraged to maintain their relationships with their carers where possible. It belongs in the same sentence because the people who will actually hold those decisions during the episode are the carers, and mania ruptures exactly those relationships at the moment their protection is most needed. Preserving the relationship is the mechanism by which the advice is enforced.

Two boundaries close this off. The authority question for the specific act of giving a drug to a patient who has not agreed to it is dealt with elsewhere in this chapter. The statutory basis on which a patient may be admitted or treated without consent in India, and the consent doctrine behind it, belong to the Mental health legislation and forensic psychiatry notes and the Forensic ethics, consent and legal procedure notes; no statutory provision is asserted here.

### 17.4 The risks specific to mania, and the act of assessing them

The risk assessment here has a stated form before it has content, and the form is itself an act. The bipolar guideline recommends carrying it out in conjunction with the person, and with their carer if possible, focusing on the areas likely to present possible danger or harm. Two things follow. It is done with the patient rather than about them, which in an irritable patient is also efficient de-

escalation. And the carer is written into the method rather than consulted afterwards, because most of the domains below are invisible to anyone who has not seen the household.

| DOMAIN NAMED IN THE GUIDELINE | WHAT IT LOOKS LIKE IN THE FIRST HOUR | WHAT ANSWERS IT NOW |
|---|---|---|
| **Self-neglect** | No sleep for several nights, no meals, no fluids, medicines for physical illness abandoned | Physical observations, hydration, and an explicit question about chronic medicines the family assumes are still being taken |
| **Self-harm, and suicidal thoughts and intent** | Irritable dysphoria inside an elevated state, the patient whose mood has begun to fall | Asked directly at this contact; the assessment framework belongs to the Somatic-symptom, sexual, impulse-control disorders and suicide notes |
| **Risks to others, including family members** | Irritability on being contradicted, an argument at home that preceded the attendance, children in the house | Who is at home tonight, who has already been hurt, and whether anybody is frightened to take the patient back |
| **Driving** | A patient who drove himself in and intends to drive home, at speed, on no sleep | Advice to patient and carer, keys accounted for, and the advice recorded rather than merely delivered |
| **Spending money excessively** | Purchases and gifts already made, loans taken, a business commitment entered into this week | What the patient can spend or transfer tonight: cash, cards, the banking application on the phone |
| **Financial or sexual exploitation** | New acquaintances of a few days' standing, generosity noticed outside the family | Who has access to the patient and to the patient's money, and who has recently acquired both |
| **Disruption in family and love relationships** | An engagement announced or ended this week, a resignation, an accusation made to relatives | Naming it as a feature of the episode in front of the carer, so it is not later read as settled intention |
| **Disinhibited and sexualised behaviour, and risks of sexually transmitted diseases** | Behaviour in the department itself, and contacts in the days before attendance | Sexual health follow-up arranged into the disposition, not deferred to a recovery nobody schedules |

Two further risks belong to any honest account of the manic emergency and are not among the domains the guideline names: physical exhaustion from sustained sleeplessness and overactivity, and dehydration in a patient too preoccupied to drink. Both are stated as clinical observations with no figure attached, because none is available to quote. They matter because they are the limbs by which a behavioural emergency becomes a medical one.

| Suspicion | Before the label | Environment | Outside hospital |
|---|---|---|---|
| THE TRIGGER FOR URGENT SPECIALIST REFERRAL WHEN MANIA IS SUSPECTED | WHEN DELIRIUM FROM AN ACUTE PHYSICAL CONDITION IS EVALUATED FOR | WHAT THE GUIDELINE ASKS FOR IN MANIA BEFORE ANY DRUG DECISION | WHERE THE WORLD HEALTH ORGANIZATION PLACES LONGER-TERM CARE |

### 17.5 Harm realised by the hour, and what can be done about it tonight

**Why this is not the aggressive patient's emergency.** In most behavioural emergencies the risk under discussion is a future event whose probability the clinician is estimating. In mania a substantial part of it is not prospective at all. Money is being moved now, contracts entered into now, contacts made now, and each hour of delay is an hour in which more of it happens rather than an hour of exposure to a possibility. That changes what the risk assessment is for: not only a prediction feeding a disposition, but a list of things to interrupt before the patient leaves the room. The interruptions available are modest, mostly non-clinical and almost never written down, and they are worth rehearsing because examiners ask what you would actually do and candidates answer with a drug.

- Establish what the patient can spend or transfer before morning, which means the phone as much as the wallet, and agree with patient and carer together who holds what tonight.
- Account for vehicle keys, and give driving advice to both rather than assuming the topic is covered by the admission.
- Identify who has newly acquired access to the patient or the patient's money, which is the practical form of the exploitation question.
- Name to the carer, in the patient's presence, which recent decisions are being treated as features of the episode, so a resignation is not later defended as a settled choice.
- Ask who is at home tonight and whether anybody there is frightened, because the answer changes the disposition more often than any symptom does.

Nothing here authorises confiscating property, and the boundary between what a clinician may do and what only a family or a court may do is not identical across jurisdictions. What is described is advice, negotiation and documentation, and the recorded fact that it was attempted is often the most useful thing in the notes a month later.

TRAP **Reading the absence of aggression as the absence of an emergency.** The manic patient who is euphoric, charming and grateful for the attention presents as the least urgent person in the department, and is given an outpatient appointment and sent home. The error is a category mistake: urgency has been tested against the danger limb of the referral rule while the state limb, which fires on suspicion alone, has been ignored. Candidates make it because emergency teaching is dominated by containment, so an emergency comes to mean a person who must be restrained. The correction is to ask what will have happened by the time that appointment arrives: what will have been spent, signed, promised, driven or contracted in the interval.

### 17.6 What is started before the diagnosis is settled

Something is done for this patient before anyone knows the diagnosis, and what the guideline asks for is not a drug. It recommends ensuring that people with mania or hypomania have access to **calming environments** and **reduced stimulation**. That is an environmental prescription, available immediately, requiring no consent and not waiting on the label. In an answer it is the cheapest mark on the page and the one most often left uncollected.

It is also mechanistically coherent rather than merely kind. The manic patient's difficulty is a failure to filter and prioritise incoming stimuli, so a crowded casualty with overhead lights, a television and six relatives all speaking is not a neutral background against which the illness is observed. It is an active driver of the presentation being assessed, and reducing it lowers the arousal generating the behaviour.

The physical acts running in parallel are unglamorous and belong here rather than in any pharmacology section: fluids offered and accepted, food offered, a place to lie down, and sleep protected rather than interrupted by the department's own routines. No target figure is attached to any of these, and none should be invented.

Deliberately absent is any drug. The staged escalation ladder, the agents and every first-dose figure belong to the Schizophrenia: management, antipsychotics and adverse effects notes; the choice of antimanic agent and everything about maintenance belongs to the Mood disorders: pharmacotherapy notes; and the rapid tranquillisation protocol considered as a protocol sits elsewhere in this chapter. The ordering taught here, environment before pharmacology, is lost the moment a drug appears in the same paragraph.

MNEMONIC

#### Suspect, Sweep, Settle, Secure, Site

**Suspect**: the referral is triggered by suspicion of the state or by danger, not by a diagnosis. **Sweep**: the evaluation for delirium from an acute physical condition runs before the label is allowed to settle. **Settle**: a calming environment with reduced stimulation is what is asked for first, before any drug decision. **Secure**: the risks being realised tonight, meaning money, driving, exploitation, sexual disinhibition and the safety of the household, are addressed as acts and not only as predictions. **Site**: where the patient is nursed tonight and where care sits once the episode has settled are two different decisions.

### 17.7 Where the manic emergency is routed, and what the routing tells you

There is no bipolar-specific emergency algorithm, and the bipolar guideline says so in the plainest possible way. Where people with bipolar disorder pose an **immediate risk to themselves or others** during an acute episode, it directs the reader out of itself: to the guideline on violence and aggression for advice on managing agitation, challenging behaviour and imminent violence and on rapid tranquillisation, or to the guideline on self-harm for advice on managing acts of self-harm and suicide risk.

That is worth more than its content: a major guideline devoted to a mood disorder, at the point where the disorder becomes an emergency, hands the reader to guidance organised around the behaviour rather than the diagnosis. The implication is direct. The label changes the risk profile and the disposition, but not the act performed in the first hour. The same de-escalation, the same parallel physical assessment, the same authority question and the same monitoring apply whether the excitement is manic, schizophrenic, substance-induced or organic.

| WHAT IS IN FRONT OF YOU | WHERE THE BIPOLAR GUIDELINE SENDS IT | WHAT THAT MEANS FOR THE ACT |
|---|---|---|
| **Suspected mania or severe depression, no immediate danger** | Urgent referral for specialist mental health assessment | The referral is the act, and is not deferred pending diagnostic certainty |
| **Immediate risk to self or others, with agitation or imminent violence** | The guideline on violence and aggression, including its advice on rapid tranquillisation | Generic behavioural-emergency management, taught elsewhere in this chapter and in the Schizophrenia: management, antipsychotics and adverse effects notes; none of it is mania-specific |
| **Acts of self-harm, or suicide risk within the episode** | The guideline on self-harm | Risk assessment and the observation decision, both dealt with elsewhere in this chapter |
| **Excitement or psychosis with a pointer to an acute physical cause** | Evaluation for delirium due to an acute physical condition, before the label | The label is withheld, not the treatment; the syndrome belongs to the Stroke, TBI, delirium and focal brain syndromes notes |
| **The episode settling, and where care continues** | A supportive environment with family or community members outside the hospital setting | A principle for longer-term care, not an argument about tonight's bed |

### 17.8 The admission decision, and the counterweight that is routinely misquoted

Admission here is not decided by the severity of the mental state, which is the reasoning candidates reach for and which produces both unnecessary admissions and dangerous discharges. It is decided by whether the risks identified above can be held where the patient would otherwise be. Framed that way the question becomes answerable at the door. Can somebody at home stay awake with a patient who will not sleep. Can the money, the phone and the vehicle be secured without a confrontation the household cannot survive. Is anybody in that house afraid. Is the physical exclusion complete, or does it need a setting where blood can be sent and repeated.

What admission buys is the substance of the answer. A place where sleep can be re-established and protected, which is the single change most likely to alter the trajectory. Separation from the instruments of financial and sexual risk for as long as the disinhibition lasts. The physical care a patient in sustained overactivity will not organise for himself. Observation at a level somebody has actually decided upon, that decision being taught elsewhere in this chapter. And completion of the

medical exclusion a busy casualty rarely finishes. Where the presentation is life-threatening, manic exhaustion with refusal of fluids being the classic example, electroconvulsive therapy is among the interventions considered; its indications and technique belong to the ECT and neurostimulation notes and are named here and not taught.

Against that sits a principle quoted constantly and almost always out of position. The mhGAP guide states that in general it is better for the person to live with family or community members in a supportive environment outside of the hospital setting, and that **long-term hospitalisation** should be avoided. It sits in general advice for people living with psychosis and those who care for them, and it speaks to where life is lived over months and years. It is not a statement about tonight and it does not discourage emergency admission. Quoted at the door it becomes an argument for sending home a patient whose risks nobody can hold. Quoted in its proper place it makes admission a bounded intervention with an exit, and puts the burden of justification on continued hospitalisation rather than on discharge.

**IN INDIA**

Every element of this pathway assumes a service that may not exist where the patient presents. Urgent referral for specialist assessment presupposes a specialist within reach of a district hospital at two in the morning; in much of the country it names a destination that is a bus journey away and open in the morning. Reduced stimulation presupposes a room, and a general casualty with one corridor and a queue offers none; the honest substitute is the quietest available corner with one relative rather than six. Observation presupposes staff, and where it cannot be staffed the family becomes the observation level by default, which should be acknowledged and instructed rather than left to happen silently. The financial acts above are entirely family-operated, because no service mechanism secures a patient's account. And the counterweight against prolonged hospitalisation reads differently where a private nursing home bed is the only one and its cost decides the length of stay. None of this changes the standard. It changes what has to be written down when the standard cannot be met.

### 17.9 What must be true before the decision is handed on

The handover is best stated as conditions rather than narrative. Before the acutely manic or floridly psychotic patient leaves the assessment area, whether to a ward, another hospital or home, the following should be true and recorded.

- The referral decision has been made against the stated trigger, and where urgent referral was not made in a patient in whom mania was suspected, the reason is written.
- The evaluation for an acute physical cause has been started and one named person owns finishing it, with existing medicines, steroids in particular, asked about while the family is present.
- A capacity assessment relevant to the decision being taken has been attempted and recorded, including what the patient could and could not do with the information.

- Each risk domain has been asked about with the patient and, where possible, the carer, and those being acted on tonight are distinguished from those being watched.
- The advice against important decisions has been given to patient and carer and written down.
- The disposition has been decided by a named person, with the level of care and the observation decision made rather than defaulted to.

**GOOD TO REMEMBER**

Two objects decide more of the outcome of a manic emergency than anything you will write in the mental state examination: the phone and the vehicle keys. The phone carries the banking application, the contacts, the messages sent at four in the morning and the purchases that clear before anyone wakes. The keys carry the collision. Both are missed because they feel administrative rather than clinical. Build them into the same breath as the advice against important decisions: ask who has the keys, ask what the patient can spend tonight, agree an answer in front of both parties, and record that you did.

In a manic emergency the trigger for urgent specialist assessment is suspicion and not diagnosis, the physical exclusion precedes the label, and the risks that decide disposition are financial, sexual and relational at least as often as they are violent.

## 18 · Deliberate self-harm and overdose triage

**Why the marks are here.** A patient who has taken an overdose arrives as a medical problem and is remembered as a psychiatric one, and the interval between those two descriptions is where the avoidable deaths sit. The question here is not whether you can estimate intent: that framework, and the intent-scale domains that go with it, belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes. What is asked here is narrower and harder to improvise. What is done in the first hour, what has to be true before the patient becomes yours, who is entitled to say that it is true, and where the patient goes next.

Three things make the medical triage of an overdose a psychiatric responsibility rather than a borrowed one. The psychiatrist is often the only clinician who knows what the patient was prescribed, and so what is plausibly inside them. The psychiatrist is who the emergency department is waiting to hand over to, so the handover criteria get set by whoever will state them. And the psychiatrist is the one asked afterwards why an assessment was recorded at an hour when the patient could not have participated.

### 18.1 Ordering the two assessments, and what medical priority does not buy

The version most of us were taught is a sequence: stabilise, clear, then assess. Two recent national guidelines do not.

The self-harm guideline of the National Institute for Health and Care Excellence, published in 2022, refuses the sequential model: physical healthcare and the psychosocial assessment are carried

out concurrently. It then closes the two devices used to postpone the second, and closes them as prohibitions rather than preferences. The psychosocial assessment is not to be delayed until after medical treatment is completed, and breath or blood alcohol levels are not to be used to delay it. Where the person cannot participate, what follows is regular review and completion as soon as possible, not an open wait. Alcohol withdrawal scoring is the Substance use disorders notes'.

The Indian Psychiatric Society guideline on suicidal behaviour, issued in 2022, describes the same moment from inside an Indian casualty and reaches a priority rule instead. It tells the clinician to wait until conditions become conducive to assessment, and states that where the patient becomes drowsy from intoxication, medical management and stabilisation becomes a priority.

These are not contradictory once you see what each protects. A priority rule allocates the resource in the room at a given minute, and a falling conscious level takes it. A concurrency rule stops the assessment being deferred by a treatment with no natural end point.

RULE **Medical priority is a claim on resources, not a licence to postpone.** Stabilisation outranks assessment for the minutes in which it is actually happening and buys nothing beyond them. It is not permission to leave the psychiatric assessment until medical treatment is finished, nor to wait for a number before speaking to the patient. Where the patient truly cannot participate, what replaces the assessment is a stated review interval, not silence.

| DOCUMENT, JURISDICTION AND YEAR | WHAT IT FIXES ABOUT THE ORDERING | WHAT IT FORBIDS OR SUBORDINATES |
|---|---|---|
| **Self-harm guideline of the National Institute for Health and Care Excellence, England, 2022** | Physical healthcare and the psychosocial assessment run concurrently, both as soon as possible after the self-harm episode | Delaying the psychosocial assessment until medical treatment is complete, and using a breath or blood alcohol level as the gate on it |
| **Indian Psychiatric Society guideline on suicidal behaviour, India, 2022** | The clinician waits until conditions in the emergency department become conducive to assessment | Assessment is subordinated where the patient becomes drowsy from intoxication and stabilisation becomes the priority |
| **Task force of the American Association for Emergency Psychiatry, United States, 2017** | Every patient is medically evaluated before transfer to a psychiatric setting, with the judgement recorded in writing | An unresolved question of delirium against psychiatric disorder resolves to medical observation or hospitalisation, never to psychiatric transfer |

### 18.2 Refusing the phrase that used to end the argument, and stating what replaces it

Ask an emergency physician for **medical clearance** and you are asking for something the specialty has formally stopped offering. The American Association for Emergency Psychiatry task force on the medical clearance of adult psychiatric patients rejected the phrase on two grounds: it minimises the presence of chronic medical problems, and it is out of line with the terminology the rest of the

emergency department now uses. Nobody is cleared of diabetes at transfer; they are transferred with it.

What replaces it is not a phrase but an assertion with two limbs. The note travelling with the patient states that the patient is **medically stable and appropriate for treatment in a psychiatric setting**: first that the behavioural disturbance is unlikely to be due to a medical condition or physical trauma, and second that medical or surgical treatment for any concomitant conditions falls within the capabilities of the receiving facility. Read the second limb again. It is a statement about your service. The same patient is appropriate for a general hospital unit with a physician on site and inappropriate for a stand-alone facility an hour away, with nothing about the patient changed in between, and saying so is the mark.

The task force also states what the medical assessment hunts for, and it is two things. The first is **medical mimics**, the potential causative factors for the presenting complaint, with encephalopathy, substance intoxication or withdrawal, infections and central nervous system disease as the examples. The second, dropped under pressure, is medical problems needing ongoing care that contribute nothing to the psychiatric picture. Where the two cannot be separated, the recommendation supplies a decision rule: if there is a question whether the patient has delirium or a psychiatric disorder, that patient is medically observed or hospitalised. The delirium entity itself is the Stroke, TBI, delirium and focal brain syndromes notes' and is named here rather than restated. What belongs here is the direction the doubt resolves in: towards the medical bed, never the psychiatric one.

### 18.3 Screening every patient, and deciding who needs more than the screen

The same task force sets a deliberately unglamorous floor for universal screening: vital signs, history, physical examination and an assessment of mentation. It then does something more useful than listing them. It prefers a brief cognitive examination to a simple assessment of mentation, because the latter records nothing but alertness and orientation, and says it should ideally cover attention, executive function, orientation and recent memory. The gap between the two is the whole argument: a patient who is alert and oriented but cannot sustain attention or sequence a task has an abnormal **brief cognitive examination** and a normal assessment of mentation, and is precisely the patient the transfer note should not be written about.

Above the floor, the task force lists eight triggers for extending the medical evaluation:

- new-onset psychiatric symptoms after the age of **45 years**;
- advanced age, which the task force gives as 65 years of age and older;
- cognitive deficits or delirium;
- a positive review of systems indicating a physical aetiology, such as cough and fever;
- focal neurological findings, or evidence of head injury;
- substance intoxication, withdrawal, or exposure to toxins or drugs;

- a decreased level of awareness;
- other indications, such as abnormal vital signs that direct further assessment.

Notice how many of these an overdose carries automatically. Substance exposure is the presentation itself, a decreased level of awareness and abnormal vital signs are common, and in an older patient with no psychiatric history three of the eight are live before anyone has taken a history. Self-poisoning is therefore close to a standing indication for evaluation beyond the universal minimum.

The task force also reports an operationalised version of medical fitness that was actually tested. A retrospective review of 485 charts of psychiatric patients evaluated by attending emergency physicians used a five-item screen: stable vital signs, a prior psychiatric history, alert and oriented times four, no evidence of an acute medical problem, and no visual hallucinations. Patients answering yes to all five went to a psychiatric receiving facility without further testing, and only six, 1.2 per cent, came back for further workup, none needing medical or surgical admission. That is a screening algorithm reported inside a consensus statement rather than a validated instrument, reported here at second hand, and its last two items are judgements rather than observations. Its value is the shape of the argument: a short structured screen applied to everyone beats an unstructured impression applied to some.

### 18.4 Working out what was taken when nobody can tell you

Everything downstream, the decontamination decision, the observation period and the disposition, is a function of the substance and the amount. Yet identification is the part of overdose triage treated as clerical, and the part a psychiatrist is best placed to solve.

The Indian Psychiatric Society guideline on substance intoxication in the emergency setting specifies the task rather than leaving it to instinct. Details of the consumed substances are elicited from the patient if responsive and from attendants; medical records are consulted where available for substance use history and prescription details; past episodes of overdose or seizures are noted; and comorbid psychiatric illness and current psychotropic medication are identified in order to understand drug and substance interactions. That last item changes practice: the current prescription list is part of the toxicological history, not psychiatric background for later, because it names the tablets that were in the house.

Where the history fails, the same guideline turns the examination into the identification tool. Vital signs are monitored, specifically heart rate, blood pressure, respiratory rate, temperature and oxygen saturation, and consciousness is assessed serially; the complete physical examination looks for pupil size, peripheral cyanosis, characteristic odours from the nose or mouth, needle track marks and other tell-tale signs of what was consumed, with the systemic examination weighted towards the central nervous and cardio-pulmonary systems. Serially is the operative word: a single conscious-level entry describes a moment, and the triage decision needs a direction of travel.

For children and adolescents the guideline raises the standard explicitly. The nature of the substance ingested and its dosage per kilogram body weight are to be identified as accurately as

possible, and where substance use is suspected but cannot be confirmed by clinical history, a detailed physical examination including a full neurological assessment becomes an important part of substance identification. A dose per kilogram is not a refinement here. It decides whether an ingestion is a reassurance or an admission, and it is unavailable unless somebody weighs the child and counts the strip.

**GOOD TO REMEMBER**

The prescription is a physical object, usually in somebody's bag in the corridor. Ask for the strips, the bottle and the last prescription while the attendants are still there: once the patient moves to a ward nobody goes back for them, and the tablets missing from a strip are often the only quantitative datum anyone will have. Recording that you asked and were told nothing distinguishes an unknown ingestion from an unexplored one.

### 18.5 Deciding whether to decontaminate, and how long that decision stays open

Most of us learned a single number for activated charcoal, and it is no longer the recommendation. The Clinical Toxicology Recommendations Collaborative, sponsored by the American Academy of Clinical Toxicology, the Asia Pacific Association of Medical Toxicology and the European Association of Poison Centres and Clinical Toxicologists, published recommendations in 2026 whose conclusions name the traditional **1 h** post-ingestion point as superseded. Single-dose charcoal is recommended beyond it in selected poisons, and a new category, **additional-dose activated charcoal**, is introduced for poison that may remain in the gastrointestinal tract for prolonged periods. Teaching that stops at the single-hour window is out of date.

What replaces it is a window belonging to the poison and its formulation. On an individualised risk assessment, charcoal is appropriate up to 6 h after ingestion for many poisons, and may be given beyond that where ongoing absorption is suspected, with **pharmacobezoar** formation, certain modified-release preparations and a drug burden exceeding the limits of solubility named as the mechanisms by which absorption keeps going.

The dose does not change between the single and the repeated use, and it is the same dose whatever the poisoning: 50 g of activated charcoal in an adult, or 1 g/kg in a child up to the adult dose. The recommendation as issued does not state a route in that passage and none is supplied here. Two repeat concepts sit on top of it and are routinely conflated. An additional dose is given at any point after the single dose where there is evidence or suspicion of ongoing absorption, so its timing follows the suspicion rather than the clock. **Multiple-dose activated charcoal** is a regimen: the same dose repeated every 4 h, or a half-dose every 2 h, to enhance elimination rather than to prevent absorption.

One question settles the matter for some patients entirely. The collaborative concluded that charcoal has no role at all in poisoning by arsenic, caesium, copper, ethanol, methanol, ethylene glycol, iron, lead, lithium and metformin. Three turn up at the psychiatric front door constantly: ethanol, methanol and lithium. For lithium the recommendation is against charcoal in every mode

and both formulations, the cleanest example of a decontamination decision settled by the identity of the drug alone. The serum-level bands, precipitants and dialysis chain are the Mood disorders: pharmacotherapy notes'; the acute against chronic against acute-on-chronic typology sits with lithium toxicity and overdose management.

MNEMONIC

### What, then when, then who

Taken in that order the decision holds. **What** was taken decides whether charcoal has any role at all, because for a defined list of poisons it has none, at any interval. **When** it was taken sets a window belonging to that poison and that formulation, not to a single remembered figure. **Who** is in front of you decides last, and can withdraw what the first two steps allowed: airway reflexes, peristalsis, perforation risk and the prospect of endoscopy all veto.

| THE INGESTION | WHAT THE COLLABORATIVE RECOMMENDS FOR SINGLE-DOSE ACTIVATED CHARCOAL |
|---|---|
| **Immediate-release paracetamol at or above 200 mg/kg** | Charcoal recommended up to 2 h after an immediate-release paracetamol ingestion, suggested up to 3 h, suggested against beyond 6 h |
| **Modified-release paracetamol at or above 200 mg/kg** | Charcoal recommended up to 5 h after a modified-release paracetamol ingestion, the formulation moving the window outwards |
| **Tricyclic antidepressants, at a dose threshold of 10 mg/kg** | Charcoal recommended up to 2 h after a tricyclic antidepressant ingestion, suggested up to 3 h, suggested against beyond 6 h |
| **Lithium, immediate-release or modified-release** | Recommended against for lithium as single-dose, additional-dose and multiple-dose charcoal alike, for both formulations |
| **Ethanol, methanol and ethylene glycol** | No role for charcoal in poisoning by ethanol, methanol or ethylene glycol, alongside arsenic, caesium, copper, iron, lead and metformin |
| **Many poisons, as a general position** | Charcoal appropriate up to 6 h after ingestion for many poisons on an individualised risk assessment, and beyond 6 h where ongoing absorption is suspected |

| | | | |
|---|---|---|---|
| **50 g** SINGLE DOSE OF ACTIVATED CHARCOAL IN AN ADULT | **6 h** CHARCOAL APPROPRIATE UP TO THIS POINT FOR MANY POISONS | **24 hours** MINIMUM OBSERVATION AFTER EXTENDED-RELEASE BUPROPION OVERDOSE | **31.6%** SEIZED AFTER EXTENDED-RELEASE BUPROPION OVERDOSE IN HOSPITAL |

### 18.6 Withholding charcoal, and refusing to secure an airway in order to give it

The contraindications are graded by strength of recommendation, and the grading is the teaching: it tells you which is a discussion and which is not. There are strong recommendations against giving

activated charcoal where:

- airway protective reflexes are absent in a patient who is not endotracheally intubated;
- those reflexes are at risk, or are expected to become absent;
- the patient is at risk of gastrointestinal perforation.

There are weak recommendations against giving it where:

- administration may increase the risk of aspiration;
- peristalsis is absent;
- the patient is likely to require upper gastrointestinal endoscopy.

The second strong item is prospective, and that is the point. A patient whose reflexes are intact now but who has taken something that will remove them shortly is already in the strong-against group: the reflexes that matter are the ones that will exist when the charcoal is in the stomach.

The drowsy overdose patient generates the question every shift: should the airway be secured so that charcoal can be given? Endotracheal intubation should not be performed solely to administer activated charcoal in patients not anticipated to develop clinically significant complications of poisoning. Where intubation is already indicated on its own merits, the examples given being a compromised or unprotected airway, respiratory failure, a significantly diminished level of consciousness, refractory seizures or haemodynamic instability, a nasogastric or orogastric tube for decontamination is reasonable. A separate statement forbids passing a gastric tube without intubation purely to give charcoal. The logic generalises: an intervention carrying its own mortality is not justified by one of uncertain benefit downstream.

**Gastric lavage** has left the answer. The joint position paper update of the American Academy of Clinical Toxicology and the European Association of Poisons Centres and Clinical Toxicologists, published in 2013, concluded that it should not be performed routinely, if at all, in poisoned patients, and that where it is indicated it should only be performed by individuals with proper training and expertise. The second clause is where the mark is lost: a rarely-indicated procedure done by whoever is on duty is worse than the same procedure done competently.

### 18.7 Refusing to be reassured by the patient who looks well

**The trap this section exists to close.** Triage rewards the sick-looking patient, and self-poisoning contains a class of agents whose early appearance is uninformative. Getting this wrong does not feel like an error at the time. It feels like prioritisation.

Paracetamol is the archetype and the regulator states it plainly. The approved product information tells prescribers that despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention, and that symptoms may be limited to nausea or vomiting and may not reflect the severity of the overdose or the risk of organ damage. The time course explains why. Symptoms in the first 24 hours after a paracetamol overdose are pallor, nausea,

vomiting, anorexia and abdominal pain, while liver damage may become apparent only **12 to 48 hours** after ingestion, and acute renal failure with acute tubular necrosis may develop even without severe liver damage. Injury and presentation are separated in time, so the triage decision cannot be made on how the patient looks: an asymptomatic patient after a paracetamol overdose is not a reassured patient.

The psychotropic version of the same trap is the modified-release agent. A multi-poison-centre observational study of one hundred seventeen patients hospitalised after extended-release bupropion ingestion, published in the American Journal of Emergency Medicine in 2009, found seizures in 37 of them, 31.6 per cent, with the first seizure anywhere from 0.5 to 24 hours after ingestion. Of those who seized, 12 patients, 32 per cent of the seizing group, had their first seizure later than **8 hours**, and further seizures followed in 49 per cent. The authors turned that into the disposition rule: the delayed onset suggests a minimum observation period of 24 hours after an extended-release bupropion overdose, and while agitation or tremor may mark greater risk, seizures can occur without preceding central nervous system toxicity. An untroubled early mental state is therefore not a discharge criterion here, which is exactly the criterion a busy department reaches for.

The teaching would be dangerous if it stopped there, because the opposite pole is also a psychotropic. The collaborative records, appraising tricyclic antidepressants, that they are associated with a rapid onset of symptoms and high lethality in overdose. Here the early picture does track the danger, which is why the decontamination window is short and why disposition cannot be deferred. So the discipline is not that appearances always deceive; it is that the relation between early appearance and outcome is a property of the drug, and therefore something you look up rather than judge. The toxidrome, the electrocardiographic picture and the antidotal management belong with anticholinergic toxicity and the other psychotropic overdose syndromes in these notes, where the antidote question is taken agent by agent and the serotonergic antidepressant and antipsychotic overdoses are set out as acts.

TRAP **Reading an asymptomatic overdose patient as a low-acuity one.** Candidates make it because every other part of emergency medicine trains them to triage on appearance, and because a reassuring examination usually is reassuring. The correction is not to distrust every well patient, which is unworkable, but to make disposition depend on the agent and the elapsed time rather than the mental state at the bedside. The question is never whether this patient looks unwell, but whether, for this drug at this interval, a patient who is going to deteriorate would look any different yet.

### 18.8 Deciding whether to reverse, and what reversal does not end

Antidotes are attractive at three in the morning because they promise to convert a monitoring problem into a completed task. In the undifferentiated overdose that promise is where the harm comes from.

The approved product information for flumazenil requires particular caution in mixed-drug overdose and supplies the mechanism rather than leaving it as a warning. Where benzodiazepines have been taken together with cyclic antidepressants, toxic effects such as convulsions and cardiac arrhythmias, which are caused by the antidepressants but emerge less readily while benzodiazepines are on board, are exacerbated by giving flumazenil. The benzodiazepine has been partly masking a second poisoning, and reversal removes the mask. That is why this antidote is not routine in the undifferentiated overdose, and why the identification work described earlier is a precondition for the antidote decision rather than a parallel activity.

The Indian Psychiatric Society guideline puts the same caution in more portable terms for the polysubstance presentation. Antidotes such as naloxone and flumazenil may be used with caution to avoid **unmasking** the effects of substances with opposing psychoactive effects; definitive management depends on a confirmed report of the nature of the substances consumed; and sedatives are used judiciously to avoid worsening respiratory depression. In a polysubstance overdose almost every pharmacological act is provisional until you know what is in the patient.

Reversal also does not end the episode, the half of the decision forgotten once the patient opens their eyes. Patients who have received flumazenil are monitored for **resedation**, respiratory depression or other residual benzodiazepine effects for a period appropriate to the dose and duration of effect of the benzodiazepine involved, and with underlying hepatic impairment the effects may be delayed and an extended observation period required. No fixed interval is given and none is supplied here: the observation period follows the agent taken, not a standard number. No dose, route or rate for flumazenil is stated here either, and the full regimen must be read from the product information before the drug is drawn up.

**PITFALL**

Giving the benzodiazepine antidote to wake a patient so the psychiatric assessment can proceed. It inverts the logic of everything above: the assessment is not the emergency, and the drowsiness is information about the ingestion that the antidote deletes. In a mixed ingestion the same act can turn a sedated patient into a fitting one. Where the reason for reversal is diagnostic convenience rather than respiratory compromise, the answer is a documented review interval and a patient who is watched.

### 18.9 Setting the observation period, and handing the patient over

Disposition after an overdose has two components and only one is psychiatric. The first is how long this ingestion has to be watched, a property of the drug: the extended-release agent with a minimum observation period, the paracetamol whose injury declares itself long after the tablets, the tricyclic whose window closes fast. The second is the level of care the psychiatric risk requires, taken up where suicide risk assessment and emergency management are dealt with. They are decided together: a patient may need a medical bed for one reason and a particular kind of watching for the other.

What travels with the patient is a document, not a phrase. The task force specifies the contents of the **transfer note**: the details of the assessment performed, the results, and the medical decision-making that led to the judgement that the patient is appropriate for transfer, together with recommendations for the further assessment and care of any active medical problems. That last clause changes practice: active problems are handed over rather than closed. The task force adds a coda: documenting that a patient is stable for transfer to satisfy the American emergency-treatment statute should be treated as the minimum rather than the standard level of evaluation. A legal floor is not a clinical standard, and a note written to satisfy the first usually fails the second.

The psychiatric assessment then inherits three things, and in usable form only if the triage was done properly: a substance and an amount, an elapsed time with an observation period attached, and a list of medical problems that remain live, each with a named plan. An assessment beginning without those is not an earlier assessment. It is an assessment of a different patient.

**IN INDIA**

A structural gap explains why Indian answers here are assembled rather than looked up. The Indian Psychiatric Society guideline on substance intoxication in the emergency setting states its own scope exclusion: accidental ingestion, and ingestion of substances with intent for self-harm, are not catered to in it, referring the reader instead to the guideline on the management of suicidal behaviour, which carries nothing on decontamination, activated charcoal, gastric lavage, antidotes or toxidromes. The national stack routes deliberate self-poisoning away from its only toxicological chapter into one with no toxicology in it, so this triage must be taken from emergency-medicine and toxicology sources. The service consequence follows: a concurrency rule assumes a psychiatrist in the department at the same hour as the physician, and a minimum observation period assumes a monitored bed that stays free after the patient stops looking unwell. Where neither holds, name the assumption in the notes and record what was done instead.

An overdose is handed over with a document and not a phrase: what was assessed, what it showed, the reasoning that made the patient appropriate for a psychiatric setting, and a written plan for every medical problem that is still active.

## 19 · Restraint and seclusion (indications, ethics, monitoring)

**What is left once the law and the ethics have been taught.** When restraint may be used, on whose authority, and the principles constraining that choice belong to the Mental health legislation and forensic psychiatry notes and to the Forensic ethics, consent and legal procedure notes, and none of it is repeated here. Whether seclusion is lawfully available at all in India is likewise a question of statute for the first of those.

What is left over is the person on the floor with several pairs of hands on them, and that is where people die. A restraint correctly indicated, lawfully authorised and proportionate can still

asphyxiate a patient, arrest them, or leave them with a clot. None of that follows from the decision; it follows from the execution.

### 19.1 What a hold does to a body

The clearest statement of mechanism is an emergency medicine one. The Royal College of Emergency Medicine best practice guideline on acute behavioural disturbance in emergency departments, in its 2023 version, holds that ongoing restraint be removed at the earliest opportunity, because continued exertion under restraint can contribute to poor outcomes through rising catecholamine levels, worsening hyperthermia and metabolic acidosis. It adds what candidates least expect: no high-quality data suggest any risk-free method of restraining an undifferentiated, potentially co-morbid patient.

Read those three as a loop. A person fighting a hold does maximal isometric work against a chest wall loaded from outside, so lactate accumulates while the ventilation that would clear the resulting **metabolic acidosis** is mechanically restricted, heat is made by someone who cannot move to lose it, and the catecholamine surge sustaining the struggle is arrhythmogenic.

RULE **There is no safe way to hold a person against their will, only less dangerous ways, and the difference is how much weight sits on the chest and how long it sits there.** The answer names the two modifiable quantities, load and duration, and who owns each.

### 19.2 Weight, arms and the chest wall

Two experimental studies carry the mechanical teaching. A controlled crossover study in Annals of Emergency Medicine in 1997 concluded that, in its study population of healthy subjects, the prone maximal restraint position produced a **restrictive pulmonary function pattern** without clinically relevant change in oxygenation or ventilation. Carry the scoping clause: those subjects were healthy young men with a negative urine toxicology screen and obesity excluded, not the population who die in restraint.

The second study moved the variable from position to limb placement. Comparing three recognised prone restraint positions in Medicine, Science and the Law in 2013, it found anterior chest pressure substantially lower in the **supported prone position**, where the upper limbs come underneath the shoulder joint rather than abducted from the torso. All three restricted respiratory function, and the reported risk falls as that pressure falls.

| WHAT IS DONE TO THE BODY | WHAT WAS MEASURED OR STATED | WHAT IT CHANGES AT THE BEDSIDE |
|---|---|---|
| **Prone hold, arms abducted from the torso** | Mean anterior chest pressure of 102.6 mmHg and 101.4 mmHg across the two positions of this kind | Heaviest measured chest load, and the arms produce it |
| **Supported prone, upper limbs under the shoulder joint** | Mean anterior chest pressure of 72.7 mmHg in this position | Same patient, a third less load, adjustable mid-hold |
| **Placement of staff weight in prone containment** | Published Indian guidance bars sitting on any part of the patient, places staff weight to the side rather than on top, and prohibits significant body weight including knees, elbows and torso | The prohibited parts are the ones that load the thorax |

### 19.3 Positional asphyxia, and the argument about its name

The term the syllabus uses is contested, and teaching it as settled mechanism teaches a disputed claim. The United States federal regulation on hospital patients' rights, issued by the Centers for Medicare and Medicaid Services and current as published in 2026, requires staff trained to recognise and respond to signs of physical and psychological distress in restraint or seclusion, and offers **positional asphyxia** as its worked example.

Against that, a comprehensive review in Medicine, Science and the Law in 2021 argued that deaths associated with prone physical restraint are not the direct result of asphyxia but of cardiac arrest secondary to metabolic acidosis compounded by inadequate ventilation and reduced cardiac output, proposing **prone restraint cardiac arrest** as the apter name. Weigh it as a single-author narrative review. Between the two sits the emergency medicine guideline, which states the older prone theory is not supported by recent research and, in the same breath, that it remains prudent to ensure there is no obstruction to ventilation and to minimise the risk of asphyxiation.

**The disagreement is about mechanism, not about the act.** Whether the terminal event is asphyxial or arrhythmic, the instruction is identical: weight off the thorax, airway free, hold shortened, exertion stopped.

### 19.4 The positioning hierarchy, and where teaching loses it

The hierarchy comes from the National Institute for Health and Care Excellence guideline on violence and aggression in 2015, in three ordered limbs: avoid the floor at all; if that is unavoidable use the supine, face up, position if possible; and if prone, face down, is necessary, for as short a time as possible. Published Indian guidance in the Indian Journal of Psychiatry in 2019 arrives differently: prone restraint ideally not used; prone containment only where the immediate situation requires it to prevent imminent serious harm; the patient repositioned to sitting, standing or supine as quickly as possible with close attention to respiratory function.

Two features repay attention. Its escape route is a change of position, not release, so a team that cannot yet let go still has an act available. And the document is internally inconsistent: its narrative permits a conditional prone hold while its own precautions list says simply to avoid prone restraint. Follow the stricter limb, and say so.

TRAP **Answering "supine rather than prone" and stopping there.** Candidates make it because the supine against prone comparison is the memorable part, and examiners quote it. The flaw is that it is the second limb: the primary instruction is to avoid the floor at all, so a hold managed seated or standing has already satisfied a recommendation the supine answer is only a fallback within. Nor is supine a licence, since weight across the chest, or anything laid over the face, reproduces the hazard the position was chosen to avoid.

### 19.5 The airway, the face, and who is holding what

The prohibition defining a safe hold is stated as an absolute: do not use **manual restraint** in a way that interferes with airway, breathing or circulation, the examples being pressure to the rib cage, neck or abdomen, or obstruction of the mouth or nose. The Indian guidance adds what makes a supine hold survivable: the head is allowed to rotate freely, and the face is not covered with a towel, bag or similar. A restrained patient who vomits and cannot turn their head has no airway at all.

The same guideline bars restraint that obstructs the eyes, ears or mouth and so prevents communication, and the reason is clinical: breathlessness in restraint is reported before it is observed, so a patient who cannot be heard has lost the team's earliest warning. One staff member leads throughout the restraint, and that person's duty is not to hold but to ensure colleagues are supported and able to do three things:

- protect and support the head and neck if needed, which makes the head-and-neck hold a protective role and never a controlling one;
- check that airway and breathing are not compromised, a continuous task rather than a single observation;
- monitor vital signs, which needs somebody whose hands are free.

The allocation is to named people, not to the team in general: a hold in which everyone is holding has nobody watching, and that failure is silent.

### 19.6 The clock, and the rule that settles arguments inside a hold

Duration is the other modifiable quantity. The violence and aggression guideline sets a ceiling in one line: do not routinely use manual restraint for **more than 10 minutes**. The word routinely is part of the recommendation and must be carried: not an absolute prohibition, but a statement that a longer hold is an exception needing a recorded reason and a name against it. The alternatives that source offers include one whose lawful availability in India is a statutory question, left to the Mental health legislation and forensic psychiatry notes. Where sedation is chosen, its agents and first doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes.

The most useful sentence here is Indian and it is a tie-breaker: during an episode of restraint, **medical priorities** supersede psychiatric ones. Every hard moment inside a hold is the same conflict, between containing the behaviour and protecting the body, and this resolves it the same way. The patient who says they cannot breathe is answered before the argument about whether they are exaggerating; the patient who suddenly stops resisting is a physiological event, not a success.

MNEMONIC

### Airway, Weight, Clock, Eyes

What must be true at every moment of a hold. **Airway**: nothing pressing the rib cage, neck or abdomen, nothing over the mouth or nose, head free to rotate. **Weight**: to the side rather than on top, never the knees, elbows or torso. **Clock**: the hold not routinely prolonged, the position changed to sitting, standing or supine as soon as possible. **Eyes**: continuous visual observation, the condition written down at the stated interval.

### 19.7 Watched, assessed, written down: three separate duties

The commonest defect in a restraint policy is to collapse observation, assessment and documentation into one requirement. **Continuous visual observation** is a state holding for the whole restraint; documentation is a periodic act, signed and timed on a restraint form the facility itself has developed; nursing assessment is a clinical examination with its own cadence. A ward that writes an entry every quarter of an hour and never lays hands on the patient has satisfied one duty and failed another.

| WHAT HAS TO HAPPEN | WHO DOES IT | HOW SOON, AND HOW OFTEN | WHOSE STANDARD |
|---|---|---|---|
| **Visual observation of the restrained patient** | Trained staff | Continuous throughout the restraint | Published Indian guidance, 2019 |
| **Documentation of behaviour, potential injury, circulation and respiration, with observer, date and time** | Trained staff | **At least every 15 min** | Published Indian guidance, 2019 |
| **Assessment including respiration and other vital signs, circulation checked as containment begins** | A nurse | **Within 15 min of the restraint, then at least every hour while it continues** | Published Indian guidance, 2019 |
| **Face-to-face evaluation of the situation, the reaction to it, the medical and behavioural condition, and whether to continue** | A physician, another licensed practitioner, or a trained registered nurse | **Within 1 hour of the intervention starting** | United States federal hospital patients' rights regulation |

Compare those frameworks; do not merge them. The Indian document puts a nurse at the bedside fast, then hourly; the American regulation, which has no force in India, buys one early medical review instead, and states more plainly than anything else here what monitoring must cover: respiratory status, circulatory status, **skin integrity** and vital signs.

| 15 min | 10 minutes | 1 hour | 72.7 mmHg |
|---|---|---|---|
| FIRST NURSING ASSESSMENT AFTER A RESTRAINT BEGINS, PUBLISHED INDIAN RESTRAINT GUIDANCE | CEILING ON ROUTINE USE OF MANUAL RESTRAINT, VIOLENCE AND AGGRESSION GUIDELINE | FACE-TO-FACE EVALUATION AFTER RESTRAINT FOR VIOLENT BEHAVIOUR, UNITED STATES REGULATION | MEAN ANTERIOR CHEST PRESSURE WITH UPPER LIMBS UNDER THE SHOULDER JOINT |

**IN INDIA**

Read that cadence as a staffing statement. Continuous visual observation means one person whose only task is to watch, and on most general hospital psychiatry units that person is a family attendant rather than a nurse. A quarter-hourly record needs a form, and the guidance leaves that to the facility, so where nobody has made one the cadence quietly stops existing. Two free acts convert this into practice: name the watcher aloud when the hold starts, so the role is not assumed by everybody and performed by nobody, and keep the printed form in the drawer beforehand.

### 19.8 The body under a long hold: drink, toilet, movement, skin and clot

Once a restraint outlasts the crisis that began it, the hazard changes character: the acute risk was mechanical, the later risk that of any immobilised patient who cannot get up to relieve it. The Indian guidance requires physical needs, comfort and safety to be addressed by staff competent to recognise signs of distress, and names three provisions:

- the opportunity to drink, offered rather than waited for;
- the opportunity to go to the toilet, as requested;
- a **range of motion** as needed for comfort, which is also what relieves pressure areas and venous stasis.

No frequency attaches to any of the three: as requested and as needed is the whole of the timing given. The acts are offered actively and the offers recorded; for how often, no comparable standard is available to quote, and none is invented here.

The clot risk is real and measured. A retrospective case-control study at one metropolitan psychiatric hospital in Japan, in the Journal of Psychiatric Research in 2025, identified 108 patients, or 0.9 per cent, with venous thromboembolism among 11,819 patients hospitalised. Adjusted for confounders, physical restraint was associated with higher risk at an **odds ratio of 6.7 with a 95 per cent confidence interval of 3.4 to 13.3**. One hospital, and the affected patients were elderly, so it establishes the association and its magnitude, not a figure that transfers to a young man held in an Indian casualty. It grounds no prophylaxis threshold, duration or regimen.

**GOOD TO REMEMBER**

A restrained patient will not ask for water or for the toilet, because asking is what they have just been overpowered for attempting. The offer is the clinical act, not the response to it, and a declined offer written down is what a later review reads as care. Build the round: offer a drink, offer the toilet, move each limb through its range, check the sacrum and heels, and record the four as one timed line with a name against it.

### 19.9 Release, and the hour after it

Release is a transition, not an ending, and the Indian guidance treats it as one: upon release from restraint a nurse observes, evaluates and documents the patient's physical and psychological condition. It states who and what, and neither for how long nor at what interval, so no post-release observation period is asserted; no comparable standard is available to quote, and none is invented here.

The principle survives the missing interval. Acidosis, hyperthermia and a catecholamine surge do not reverse when the hands come off, the clot risk has already been incurred, and injury sustained in the hold is easier to find on a patient no longer fighting. The examination impossible during a restraint becomes possible the second it ends, which makes these the best diagnostic minutes of the episode and the ones most reliably spent on paperwork. What the record owes the next team is narrow and usually missing: when the hold started and ended, the position used, who led it, what the first and last assessments found, and the state of skin and limbs seen once the patient was free.

No restraint position is safe: weight off the chest and to the side, head free and face uncovered, the hold as short as it can be, and one person watching who is not holding.

# The rigid, hyperthermic and toxidromic emergencies

## 20 · Catatonia (types, Bush-Francis scale, lorazepam challenge, management)

**Why an emergency chapter carries catatonia at all.** The signs, their classification, the rating scale used to quantify them, the diagnostic threshold, and the benzodiazepine challenge with its dose, route and response criterion are set out in the Other psychotic disorders, delusional syndromes and catatonia notes, and none of that is repeated here. What is left over is the patient on the trolley: not moving, not drinking, not swallowing, not being turned. Almost everything that kills a catatonic patient in the first days kills through immobility rather than through catatonia, and almost none of it is treated by the drug that treats the syndrome.

Hold two clocks apart. The therapeutic clock runs from the challenge through the response to the treatment ladder, and it belongs to the Other psychotic disorders, delusional syndromes and catatonia notes. The immobility clock started before the patient reached you and is already well advanced when someone first writes the word catatonia in the notes. Answer only the therapeutic clock and you produce a correct account of the syndrome with an unsafe plan, because the pneumonia, the clot, the ulcer and the electrolyte disaster all mature inside the interval during which the treatment is still being titrated.

### 20.1 Why the immobile patient is admitted as a medical case

The clearest quantification comes from a retrospective cohort that split **1719 schizophrenia inpatients** into those who exhibited **catatonic stupor** during the hospitalisation and those who never did. Among those inpatients, catatonic stupor carried an increased risk of death against no catatonic stupor, with an **odds ratio of 4.8 and a 95 per cent confidence interval of 2.0 to 10.6**. It is retrospective, single-country and confined to one diagnostic group, so treat it as a signal about magnitude rather than a rate to quote at a family.

The same cohort names what that excess is made of, and it reads as a work list. Increased risk was found for **pneumonia, urinary tract infection and sepsis**; for deep venous thrombosis, pulmonary embolism, arrhythmia and disseminated intravascular coagulation; for rhabdomyolysis, renal failure, dehydration and hypernatraemia; for urinary retention and decubitus ulcers; and for liver dysfunction and neuroleptic malignant syndrome. Fifteen entries that collapse, on the authors' own reading, into **sympathetic hyperactivity, dehydration and immobility**, with the conclusion that meticulous care of both the mental and the medical condition is what reduces them.

**Read those three mechanisms as a division of labour.** Dehydration is answered by a fluid chart and a route for fluid, immobility by turning, stretching, prophylaxis and a bladder plan, sympathetic overdrive by observations frequent enough to show a trend rather than an event. None of the three is answered by the drug that treats the syndrome, which is why all three get left undone on a ward waiting for a response promised within hours.

RULE **The catatonic patient is nursed as an immobile medical patient from the hour of recognition, not from the hour the treatment fails.** Prophylaxis, skin care, hydration and a feeding decision are not what you escalate to when the benzodiazepine does not work. They run in parallel with it, because a patient who responds beautifully on the third morning can still have thrown an embolus the night before.

| 4.8 | 1719 | 10 kcal/kg/day | 5 days |
|---|---|---|---|
| MORTALITY ODDS RATIO, CATATONIC STUPOR AGAINST NO CATATONIC STUPOR, SCHIZOPHRENIA INPATIENTS | SCHIZOPHRENIA INPATIENTS IN THE COHORT BEHIND THAT ODDS RATIO | MAXIMUM STARTING RATE OF NUTRITION SUPPORT AT HIGH REFEEDING RISK | LITTLE OR NO INTAKE BEYOND WHICH FEEDING STARTS AT HALF OF REQUIREMENTS |

## 20.2 The examination that opens the admission

The examination that matters now is not the one that establishes catatonia. The **British Association for Psychopharmacology catatonia guideline of 2023** sets out a physical examination table with seven entries and no phenomenology anywhere in it. That omission is the teaching point: the specialist examination has done its work by now, and what changes the next hour is the examination any physician would perform.

| EXAMINATION DOMAIN IN CATATONIA | THE ACT IT GENERATES |
|---|---|
| **Volume and nutritional status** | Establish when this patient last drank and last ate, and get a weight; this fixes the route for fluid and stratifies the feeding decision. |
| **Temperature** | Record it and repeat it, because one reading cannot show a trend and a rising temperature is an escalation trigger. |
| **Cardiovascular examination** | Emphasised where electroconvulsive therapy is being considered, so it is done early rather than at the treatment decision. |
| **Respiratory status** | Emphasised in a patient already on opioids, and before a benzodiazepine is given; a pre-treatment safety check, not a routine observation. |
| **Neurological examination for localising signs** | Triggers imaging and a neurology opinion ahead of psychiatric treatment where anything localises. |
| **Evidence of deep vein thrombosis** | Converts prophylaxis into investigation where the clot has already formed. |
| **Pressure ulcers on all potential pressure points** | Requires the patient undressed and the heels, sacrum, elbows and occiput looked at, giving a documented baseline. |

Two entries carry a condition inside them that residents skip, and both are questions of sequence rather than content: the cardiovascular examination comes before the treatment decision it informs,

and the respiratory assessment before the sedating drug rather than after it. A list of this kind is an ordering instruction disguised as a checklist.

### 20.3 The deterioration criteria, and the escalation they trigger

Catatonia sits on a continuum: milder presentations at one end, termed simple or benign, and at the other more severe forms involving hyperthermia and autonomic dysfunction, termed **malignant**. That sentence is all this chapter needs from the entity, and it is used for one purpose. Those two features are the deterioration criteria, the observations that convert a psychiatric admission into a life-threatening one, and they change the level of care before anybody has finished arguing about the label. What malignant catatonia is, how it stands against neuroleptic malignant syndrome and what treatment follows are taught in the Other psychotic disorders, delusional syndromes and catatonia notes; the hyperthermic differential is drawn in the Schizophrenia: management, antipsychotics and adverse effects notes. Neither is redrawn here.

Because the criteria are a temperature and an autonomic pattern, they exist only if somebody is measuring, and measuring often enough for a trend to appear. One admission set of observations cannot demonstrate autonomic instability, which is by definition a variability rather than a value. The practical consequence is a monitoring decision taken at the front door and written down with a name against it. No temperature threshold and no autonomic parameter is asserted here, because none could be sourced for catatonia specifically.

### 20.4 Level of care: who is nursed where

The guideline answers this directly and narrowly: initial assessment and treatment of catatonia should be conducted within **secondary care**. Know the footing it stands on, because it is not a trial finding but a consensus position taken in the absence of systematic evidence, the weakest evidential class the guideline uses. That cuts both ways: it cannot be quoted as though outcome data established it, and equally nothing better exists, so a service treating catatonia in an unsupervised setting follows no evidence base at all rather than a weaker one. What secondary care buys can be named, and naming it is how an admission is justified: a bed where fluid can be given and charted, staff who can turn a patient and record it, laboratory access at short notice, and a physician who can be called to the bedside rather than referred to.

**IN INDIA**

That recommendation describes a United Kingdom service model and no Indian equivalent could be grounded, so the principle travels and the service architecture does not. The stuporous patient here often arrives at a district hospital or a small nursing home where the monitoring the guidance quietly assumes is uneven: continual cardiac rhythm monitoring may exist in one unit only, phosphate and magnesium assays may not run daily, pressure-relieving surfaces may be absent, and one-to-one nursing usually means a family attendant. State in the referral which of those capabilities the receiving setting actually has, and teach the attendant the turning schedule, the mouth care and the fluid chart explicitly, because they are the person who will do it. An unmeetable monitoring requirement is a transfer decision, not something to improvise around.

### 20.5 Airway, swallow and hydration before anything is given by mouth

Aspiration is what the sourced literature handles worst, and that should be said rather than papered over. The review that assembled the general guidance for this population searched on **4 medical complications: deep vein thrombosis and pulmonary embolism, pressure ulcers, muscle contractures, and nutritional deficiencies**. Airway protection is not among them. The grounding here is indirect: respiratory status is an examination domain, it is flagged before sedation, and pneumonia was among the commonest complications in the cohort. No aspiration protocol, swallow-screen instrument or nil-by-mouth rule specific to catatonia is asserted, because none was sourced.

The principle survives the missing protocol. A patient not swallowing saliva reliably will not swallow a tablet reliably, so assessment of swallow precedes the oral route rather than accompanying it. Sedation is subtractive: whatever lowers conscious level lowers airway protection in someone already immobile and often supine, which is exactly why the respiratory check sits before the benzodiazepine in the examination list. Positioning, suction and an explicit decision about the oral route are the acts; the fluid target that should accompany them is not sourced either.

### 20.6 Thromboprophylaxis in prolonged immobility

Of the four preventive limbs the guideline records for averting the medical complications of catatonia, **pharmacological thromboprophylaxis** has the clearest reasoning behind it and the least specific instruction attached. The synthesis review reached a decision rule rather than a prescription: prophylaxis guidelines support anticoagulant therapy for **patients with catatonia who are at lower risk of acute bleeding**. Bleeding risk is the variable that decides, and it is assessed and recorded before the first dose rather than after a complication. The underlying evidence is borrowed, and the borrowing must be declared: the **American Society of Hematology venous thromboembolism guidelines of 2018** made four strong recommendations in acutely and critically ill medical inpatients, not in catatonic patients.

- Give pharmacological prophylaxis to acutely or critically ill medical inpatients at acceptable bleeding risk.

- Use mechanical prophylaxis instead where the bleeding risk is unacceptable.
- Do not use direct oral anticoagulants for this purpose during the hospitalisation.
- Do not extend pharmacological prophylaxis after discharge from hospital.

**The fourth is the one answered wrongly.** A patient immobile for weeks feels like a patient who should go home on an anticoagulant, and the recommendation is explicitly against it: the risk being treated is that of the acute illness and its confinement, which falls when the confinement ends, while the bleeding risk does not. The population is medical inpatients, so applying any of this to a catatonic patient is an inference and should be stated as one. No agent, dose, route or duration specific to catatonia is grounded anywhere in this material, so none is printed; the choice follows local thromboprophylaxis policy, which is the honest answer in an examination as well as on a ward.

### 20.7 Skin, joints and bladder: the acts nobody writes down

The remaining preventive limbs are unglamorous and they are where the marks sit, because each has a nursing act and a documented interval attached. Pressure ulcer prevention rests on **frequent skin evaluation, support surfaces and repositioning**, with no interval, surface or frequency sourced beyond the word frequent. Contracture prevention is by **stretching**, and the evidence there is openly thin: it has to be extrapolated from studies of patients with neurological injuries, because catatonia-specific data do not exist. Say so when you quote it, because a resident who knows the evidence is borrowed involves physiotherapy early, while one who believes a protocol exists waits for it.

The bladder falls outside every review. Urinary retention carried increased risk in the cohort, and so did urinary tract infection, and that is the whole of the sourced case for attending to it. What follows is a decision rather than a protocol: retention is looked for actively, because a patient who is not speaking will not report it, and catheterisation is then a judgement between an undrained bladder and added infection risk in a patient who already carries one. No catheterisation criterion, residual-volume threshold or bladder-assessment interval is sourced, and inventing one would be worse than the silence.

MNEMONIC

**Clot, Skin, Stretch, Feed**

The four preventive limbs the catatonia guideline records, in roughly the order they are forgotten: **Clot**, pharmacological thromboprophylaxis; **Skin**, frequent assessment of pressure areas; **Stretch**, stretching to avoid muscle contractures; **Feed**, consideration of artificial feeding. Each carries a named person and a named interval in a good plan, and not one is a medication for catatonia.

### 20.8 The feeding decision, and the rate

Feeding is the limb where a wrong act does immediate harm, because a starved patient fed at full requirement is a patient in refeeding danger. No catatonia-specific feeding protocol exists, so the rules come from the National Institute for Health and Care Excellence nutrition support guideline,

learned as a stratification followed by a rate. Somebody mute and immobile for a week has met an intake criterion by definition, and the only question is which one.

| WHICH RULE APPLIES | WHAT HAS TO BE TRUE | HOW FEEDING STARTS |
|---|---|---|
| **The general rule for anyone who has not been eating** | Little or no intake for more than 5 days | **No more than 50 per cent of requirements for the first 2 days, then increase to full needs if monitoring shows no refeeding problems** |
| **High refeeding risk on one criterion** | Any one of: **body mass index below 16 kg per square metre; unintentional weight loss above 15 per cent in the last 3 to 6 months; little or no nutritional intake for more than 10 days; low potassium, phosphate or magnesium before feeding** | **A maximum of 10 kcal per kilogram per day, increased slowly to meet or exceed full needs by 4 to 7 days** |
| **High refeeding risk on two criteria** | Any two of: **body mass index below 18.5 kg per square metre; unintentional weight loss above 10 per cent in the last 3 to 6 months; little or no nutritional intake for more than 5 days; a history of alcohol misuse, or of insulin, chemotherapy, antacids or diuretics** | As for high risk above |
| **Extreme starvation** | **Body mass index below 14 kg per square metre, or negligible intake for more than 15 days** | Only 5 kcal per kilogram per day, with cardiac rhythm monitored continually in these patients and in any patient who has or develops an arrhythmia |

**Two things in that table are the examinable ones.** The stratification is met on history rather than investigation: weight, weight change and the date of the last proper meal decide the starting rate, and all three come from a relative rather than a laboratory. And the monitoring clause attached to the lowest rate is one of the few places in catatonia care where a guideline states what is watched and how often. Beside it sits the electrolyte cadence from the same source: **magnesium and phosphate at baseline, then daily where there is a risk of refeeding syndrome, then three times a week until stable, then weekly**, on the stated reasoning that depletion of both is common and under recognised. That laboratory table was written with parenteral nutrition principally in view and may be applied selectively to enteral or oral support, particularly in a patient who is metabolically unstable or at refeeding risk. The vitamin limb of the same recommendation is taught in the Substance use disorders notes.

**GOOD TO REMEMBER**

The date of the last proper meal is a prescribing datum, not social history, and it decays within a day as the family's account smooths into "he has not been eating properly". Take it at first contact in a form that can be counted, take a weight on arrival even if it must be estimated, and record who estimated it. Those two entries decide the starting calorie rate and neither can be reconstructed a week later.

### 20.9 The second episode, and what the handover carries

The most useful act-level rule here applies to the patient who has been in before. When a patient presents with a recurrent episode of catatonia, the assessing clinician should not presume that an adequate workup was completed previously; the **adequacy of prior medical evaluation** should be confirmed. It reads as an administrative courtesy and it is a safety rule, because the second and third presentations are where a medical cause hides: the first admission attracts a full investigation, the second attracts diagnosis by recognition, and "known catatonia" in a referral letter is an efficient way of stopping a physician from looking.

TRAP **Treating a recurrent presentation as a repeat of the first one, and inheriting its workup unread.** Clinicians and candidates both make this error because recurrence genuinely does raise the probability of an idiopathic or psychiatric cause, so the inference feels sound. The flaw is that it is an inference about the population while the question is about this patient, whose earlier evaluation may have been curtailed the moment the treatment worked. Confirming adequacy means reading what was done and finding the results. The correct answer to "was he worked up last time" is a list, never a yes.

What the emergency episode owes the team that inherits the patient is a record precise enough to make the next decision without repeating this one. Four entries belong in it and are routinely missing:

- the date and content of the last oral intake and the last drink, with the arrival weight and who measured it;
- the baseline observation set, the interval observations were then taken at, and who set it;
- whether thromboprophylaxis was started, when, on what bleeding-risk assessment, and if withheld, why;
- a pressure-area map from the admission examination, so a new ulcer can be told from an old one.

Catatonia kills through dehydration, immobility and sympathetic overdrive, so the first hour buys the clot, the skin, the airway and the feed while the diagnosis is still being settled.

## 21 · Neuroleptic malignant syndrome (features, diagnosis, management)

**Why this belongs in an emergency chapter at all.** The syndrome itself is taught elsewhere. Its clinical picture, its tempo, the risk factors, the agents used to treat it and the rule for restarting an

antipsychotic are set out in the Schizophrenia: management, antipsychotics and adverse effects notes, and none of it is repeated here. What is left over is where an emergency paper puts its marks, because the standard account of neuroleptic malignant syndrome describes the illness and then stops. It prints no formal criteria set, no scoring rule, no temperature functioning as a criterion rather than an observation, and no threshold at which a psychiatric inpatient becomes a critical-care one. Those four objects, with the laboratory limb the usual account leaves vague and the act performed while all of it is unsettled, are what is owned here.

Hold two decisions apart from the moment the patient arrives, because they run on different numbers at different speeds. The first is nosological: does this presentation satisfy a criteria set, and what must be excluded before that is said out loud. The second is dispositional: how deranged is this patient now, where can they safely be nursed, and who else needs to be at the bed. The second does not wait for the first, and it is the one that changes outcome. A candidate who fuses them describes the syndrome when asked what to do, and describes a ward round when asked how the diagnosis is made.

### 21.1 What kind of instrument the criteria set is

The criteria set to name in an answer came from a formal **Delphi** procedure over an international multispecialty panel in which psychiatrists were the largest group, alongside neurologists, anaesthesiologists and emergency physicians. That composition is not decoration. A syndrome recognised on the psychiatric ward, in theatre and at the front door accumulates three house styles of diagnosis, and the panel existed to force them into one statement. The instrument is a consensus product and not a trial-derived one: it encodes what experienced clinicians agreed they do, and inherits whatever they were collectively getting wrong.

The panel printed a caveat on its own work. The criteria were published with an explicit warning that they **required validation before clinical application**. That sentence is the difference between a criteria list and a decision rule, and it is the part most reproductions drop. A list says what a syndrome contains. A decision rule says what happens when it is applied to consecutive patients: how often it says yes when the answer is yes, and how often it says no when the answer is still yes. Until that is measured, a criteria set is a well-organised opinion.

RULE **Diagnosis and disposition are two decisions taken from two different sets of numbers.** The criteria and their critical values answer whether this is the syndrome. The temperature and the heart rate now answer where the patient is nursed and who is called. Fusing them produces the clinical failure in which a patient with a convincing story waits on an open ward for a creatine kinase result before anyone escalates, and the examination failure in which a candidate recites a presentation and never states a threshold.

### 21.2 The criteria themselves, and the values fixed to them

The consensus set runs to **eight** criteria, best held as four questions with an audit trail attached: was the dopaminergic system interfered with, is the patient hot and stiff, are the brain and the sympathetic outflow disturbed, and has anything else been ruled out. Four criteria carry a fixed

quantitative value. For the rest, no critical value is recorded in the consensus statement of critical values available here, which is a limit of what can be quoted rather than evidence that the criteria set left them open. The table sets each against its value and against what it obliges the clinician to do, because a criterion that generates no act at the bedside is an examination artefact.

| CONSENSUS CRITERION | CRITICAL VALUE FIXED WITH IT | WHAT THE CRITERION OBLIGES YOU TO DO |
|---|---|---|
| **Recent dopamine antagonist exposure, or dopamine agonist withdrawal** | No numerical value set | Reconstruct every dopamine-blocking exposure, including antiemetics prescribed by other teams and long-acting injectables given weeks earlier, and time the last dose. Stopping a dopamine agonist counts, and is missed because the chart records a subtraction. |
| **Hyperthermia** | **Temperature above 38.0 degrees Celsius, equivalently above 100.4 degrees Fahrenheit, recorded on at least two occasions** | Measure again, and write the second reading down. One elevated temperature does not satisfy this criterion, so the criterion is an instruction to re-observe rather than to conclude. |
| **Rigidity** | No numerical value set | Document tone now and again later, so a trajectory exists for whoever takes over. |
| **Mental status alteration** | No numerical value set | Record conscious level and orientation in enough detail that deterioration is visible to a clinician meeting the patient for the first time. |
| **Creatine kinase elevation** | **Creatine kinase at least four times the upper limit of normal** | Send it with renal function and potassium, and take the upper limit of normal from the laboratory running the assay, because the criterion is a multiple and not an absolute figure. |
| **Sympathetic nervous system lability** | **Blood pressure elevation at or above 25 per cent over the patient's own baseline, or blood pressure fluctuation of at or above 20 mm Hg diastolic or at or above 25 mm Hg systolic within 24 hours** | Find a baseline. The criterion is unusable where pre-morbid observations were never recorded, which is the argument for taking them on every admission that starts a dopamine antagonist. |
| **Tachycardia with tachypnoea** | **Heart rate at or above 25 per cent over baseline, together with respiratory rate at or above 50 per cent over baseline** | Count the respiratory rate yourself. It is the observation most often invented on a busy chart, and here it is half a criterion. |
| **A negative work-up for other causes** | No numerical value set | Do the work-up. This limb is satisfied not by considering alternatives but by investigations that come back and are recorded. |

Read those values as a family rather than as separate numbers. Most of the quantitative criteria are referenced to the patient's own baseline rather than a population figure. A young man whose resting pulse normally sits low satisfies the tachycardia criterion at a rate that would not trouble a medical ward, and a chronically hypertensive patient satisfies the blood pressure criterion at a figure that looks routine. Such criteria are sensitive to the individual and wholly dependent on documentation, which is why the observation chart of the first hours of an admission is a diagnostic instrument here and not an administrative one.

Two further points are examinable. Creatine kinase enters as a multiple of the upper limit of normal, a different object from the absolute figure the Schizophrenia: management, antipsychotics and adverse effects notes already teach; the two must not be merged in an answer. And leukocytosis, which almost every textbook description lists, is not among the criteria at all.

### 21.3 The negative work-up limb, where the work hides

The eighth criterion looks like a formality and is the most laborious of the set. Its content comes from the regulator: the **United States prescribing information for haloperidol injection** states that the diagnostic evaluation is complicated, and directs the clinician first to identify presentations in which serious medical illness, pneumonia or systemic infection for instance, coexists with untreated or inadequately treated extrapyramidal signs. That pairing rewards attention, because it is how the diagnosis goes wrong in both directions at once: a febrile parkinsonian patient with a chest infection can look exactly like the syndrome, and a patient with the syndrome can be dismissed as a chest infection in someone who was always stiff.

The same source then names what else must be considered before this limb is satisfied: central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. As a list of alternatives it is unremarkable, and that is not the point of it. As an instruction it is demanding, because every entry converts into an act with a time cost: an environment and exposure history, cultures, a lumbar puncture or imaging where the neurological picture warrants it, and a second reading of the drug chart for agents nobody thought of as psychotropic. Discriminating this syndrome from its hyperthermic mimics is taught in the Schizophrenia: management, antipsychotics and adverse effects notes and is not restated here; what belongs here is the obligation the criterion creates, that the exclusions are performed and written down rather than entertained.

**GOOD TO REMEMBER**

The exposure history is the one criterion nobody can reconstruct later. Which dopamine-blocking agent was given, when, by whom, and what was stopped lives in a drug chart, an emergency prescription and a relative's memory, and degrades within hours. Take it first, take it in writing, and take it before the patient moves to a department the chart travels to separately.

### 21.4 Scoring the criteria, and what a low score does not mean

The set is not applied by counting items met. Each criterion is weighted, so it is scored in priority points and a total is compared against a threshold. The threshold appeared only at validation, which was retrospective: it scored **archived reports of clinician-initiated calls to a national telephone consultation service** against the set. Agreement was best where the threshold was set at **74 priority points, which gave a sensitivity of 69.6 per cent and a specificity of 90.7 per cent** against the modified research criteria used as the reference standard.

| 8 | 74 | 4x ULN | >40 C |
|---|---|---|---|
| CRITERIA IN THE CONSENSUS SET | PRIORITY-POINT CUT-OFF SCORE | CREATINE KINASE CRITERION | TEMPERATURE DEFINING THE SEVERE BAND |

Read those two operating characteristics as clinical instructions. High specificity with modest sensitivity describes a rule-in instrument. Reaching the cut-off is strong evidence the syndrome is present. Failing to reach it means little, because a rule whose sensitivity sits below seventy per cent misses close to a third of true cases, and a third is not a rounding error when the missed diagnosis is this one. Use of the score is asymmetric: it can justify escalation to a sceptical colleague, and never justifies returning a patient to the ward.

State the limitation whenever you quote the cut-off. The criteria were scored against archived consultation records, not against patients examined prospectively at the front door, so the population in which the threshold performed as reported is one of cases already interesting enough to telephone about. That is not the undifferentiated patient in front of you, and the operating characteristics in that patient are unknown. This is not a reason to discard the cut-off, only to quote it as the best available calibration of a consensus instrument rather than a property of nature.

The same validation produced a second finding with direct bedside consequences. Experienced consultants' own diagnoses agreed considerably better with a modified reference standard, one that accepted less than **severe rigidity**, than with the original standard that demanded it, and the authors concluded that the severe rigidity requirement is more restrictive than what knowledgeable clinicians actually use. As an act: waiting for lead-pipe tone before treating a patient as having this syndrome is not what the criteria evidence supports, and the wait is paid for in hours during which the temperature and the muscle are still climbing.

TRAP **Treating a sub-threshold score, or an absence of severe rigidity, as evidence against the diagnosis.** Candidates make this error because a scored criteria set looks like a diagnostic test, and tests are taught as two-sided objects that confirm and exclude. This one is not. It was assembled by consensus to standardise agreement between specialties, calibrated against a selected population, and its sensitivity was never good enough to rule out. State the cut-off, then state in the same breath what a score below it does not entitle you to do.

### 21.5 The laboratory limb: what leukocytosis is worth

Leukocytosis is asserted in almost every description of this syndrome and almost never given a figure, leaving candidates repeating a finding they cannot quantify. Two things can honestly be said.

The first is a frequency with a population attached: in a systematic review of published case reports of neuroleptic malignant syndrome in children and adolescents, creatine kinase elevation and leukocytosis were the commonest laboratory findings, each present in **42.1 per cent** of cases. That figure belongs to **children and adolescents described in published case reports**, a population selected twice, first by being young and again by being interesting enough to publish. It is a proportion of cases and not a white cell count, and must never be transplanted into an adult sentence or quoted as a threshold. No adult numerical leukocyte cut-off is asserted here, because none could be sourced.

The second thing that can be said is that the standing of the leukocyte count as a criterion has been challenged directly. A single-centre retrospective case-control study of psychiatric admissions argued that the **neutrophil to lymphocyte ratio** and the lymphocyte percentage may serve as alternative minor criteria, more sensitive and more specific than the leukocyte level and creatine kinase. The direction of the finding is teachable. Its magnitude is not, because it rests on **a small single-centre sample of case and control hospitalisations drawn from the same patients**, and discrimination reported from a sample that size is almost certainly over-fitted. No ratio and no cut-off is printed here for that reason.

What survives at the bedside is short. A raised white cell count supports the picture and never establishes it, and a normal count is not reassurance. This syndrome's laboratory limb is dominated by muscle and kidney, and the tests that change the next hour are creatine kinase, potassium, renal function and a blood gas. Order the white cell count because sepsis sits on the exclusion list, not because it is a criterion, because it is not one.

### 21.6 The act in the department, stated without a single drug

The arrival sequence is common to every emergency in this chapter and is set out where that sequence is taught: recognise, stabilise, establish who holds the authority to act, act, monitor, decide the destination. What is specific here is that the first therapeutic move is a subtraction. The regulator states the management as three numbered steps, a structure worth keeping because it is the most authoritative statement available of what to do when the pharmacological evidence runs out. Per the **United States labelling for haloperidol injection revised in 2022**: immediate discontinuation of antipsychotic drugs and of other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problem for which a specific treatment exists. The same source adds the sentence that keeps an answer honest: there is no general agreement about specific pharmacological treatment regimens for the uncomplicated form. Which agents are used, when, and at what dose is taught in the Schizophrenia: management, antipsychotics and adverse effects notes and is deliberately not carried here.

The supportive half of that middle step has been put in more operational terms by the **British Association for Psychopharmacology catatonia guideline of 2023**, on a consensus footing

rather than a trial one, and it is the cleanest available statement of what intensive symptomatic treatment means:

- assessment and appropriate management of airway, ventilation, temperature and swallow;
- monitoring of fluid input and output, with aggressive fluid resuscitation where it is required;
- assessment for hyperkalaemia, renal failure and rhabdomyolysis;
- careful monitoring for cardiorespiratory failure, aspiration pneumonia, thromboembolism and renal failure, alongside early consideration of high-dependency care.

Notice what is absent. There is no drug in that list, and no interval either: the guideline says careful monitoring and does not say how often. No sourced observation cadence for this syndrome is asserted here, and an invented interval would read as universal when it would be nothing of the kind. The principle is defensible without a number: observation frequency is set by the rate at which the patient is changing, reviewed at every escalation, and recorded with the name of whoever set it. Note where "early" sits in that final clause: a higher level of care is considered alongside the surveillance, not after it fails.

> The criteria settle what to call it; the temperature and the heart rate settle where it is nursed, and the second decision never waits for the first.

### 21.7 Severity banding and the level-of-care decision

The same guideline bands severity by two observations available within a minute of arrival and needing no laboratory. The bands were written to structure a treatment choice; the treatment clause belongs to the chapter that owns the drugs, and what is used here is the half answering the question nobody else answers, which is where this patient should physically be. Two measurements needing no investigation are worth a great deal in an Indian emergency department, where the creatine kinase result may be hours away and the decision cannot wait.

| BAND | PHYSIOLOGY THAT DEFINES IT | WHAT THE BAND DECIDES ABOUT LEVEL OF CARE |
|---|---|---|
| **Mild, early** | **Temperature below 38 degrees Celsius with heart rate below 100**, with mild rigidity, catatonia or confusion | The patient may remain in a psychiatric setting only if repeated observations are genuinely taken and read by somebody competent to act on a change. If that is not true of the ward, this band does not apply to it. |
| **Moderate** | **Temperature between 38 and 40 degrees Celsius with heart rate between 100 and 120**, with moderate rigidity, catatonia or confusion | Medical co-management from here: a named physician, secure intravenous access, fluid balance charting and laboratory surveillance for the complications listed above. This is the band in which transfer is arranged rather than contemplated. |
| **Severe** | **Temperature above 40 degrees Celsius with heart rate above 120**, with severe rigidity, catatonia or coma | The critical-care conversation, not a further period of observation. Airway protection becomes an active question, and high-dependency or intensive care is the destination being negotiated. |

Two things about that table are this account's work rather than the guideline's. The third column is a level-of-care decision written here; the bands are the guideline's, but what each one buys in a district hospital is not, and no treatment recommendation is being lifted. And the bands are conjunctive, stating a temperature AND a heart rate, while real patients arrive discordant, hot with an unremarkable pulse or tachycardic and afebrile. No source consulted rules on that case, and none is invented. The working rule is that the higher band governs, because every consequence of over-calling is reversible and the consequence of under-calling is a patient watched on a ward that cannot watch.

A banding this crude is useful for a reason that is not biological. Temperature and pulse are continuous variables cut at round numbers, and their value here is procedural: they give two clinicians who disagree a common object to point at. A resident asking a physician at two in the morning to accept a patient is far stronger saying the temperature is above forty and the pulse above one hundred and twenty than saying the patient looks unwell. The bands convert an impression into a referral that is hard to refuse, and that is most of what a threshold is for. What they do not encode is speed: a patient climbing rapidly through the moderate band deserves the response of the band above.

**IN INDIA**

Each band assumes a service that may not be present. The mild band assumes observations are actually taken on an open psychiatric ward and that somebody reads them, where in practice the chart is often completed at the end of a shift. The moderate band assumes a physician will co-manage a patient who stays under psychiatry, usually achievable in a general hospital psychiatry unit and frequently not in a standalone mental hospital. The severe band assumes an intensive care bed exists and will accept a patient carrying a psychiatric diagnosis, which is where transfers stall. Plan for it before the patient arrives: know which medical unit takes your escalations, whether the laboratory runs creatine kinase after hours, where the nearest dialysis service is and whether it accepts referrals overnight, and record every refusal with its time. That is not defensive paperwork; it is the only thing that makes a delayed transfer visible afterwards.

### 21.8 Organ support and the renal replacement decision

The organ that fails first is the kidney, and the route is worth stating because it dictates early management. Sustained rigidity with hyperthermia produces rhabdomyolysis; myoglobin, with the volume depletion of a hot immobile patient who is not drinking, produces acute kidney injury; and that injury with the potassium released from the same muscle produces the hyperkalaemia that kills. The chain is why fluid resuscitation and potassium surveillance are early acts, and why the creatine kinase criterion has an operational meaning outliving its diagnostic one.

The threshold for replacing renal function is where candidates expect a number and there is not one to give. The **Kidney Disease: Improving Global Outcomes acute kidney injury guideline of 2012** states the emergent trigger as a clinical rule rather than as a value: renal replacement therapy is initiated emergently when life-threatening changes in fluid, electrolyte and acid-base balance exist. It then closes the door on the number explicitly, directing the clinician to the broader clinical context, to conditions that replacement therapy can modify, and to the trend of laboratory tests, **rather than to single urea and creatinine thresholds alone**. An account promising a dialysis number promises something the guideline deliberately declines to supply, and a candidate who produces one has invented it.

What does have operational content is the set of situations widely accepted as emergent indications, which the guideline names while acknowledging that no randomised trial exists for dialysis on life-threatening indications:

- severe hyperkalaemia;
- severe acidosis;
- pulmonary oedema;
- uraemic complications.

**Turn that into a psychiatric instruction.** The psychiatrist does not start dialysis and is often the only person who knows the patient is heading towards needing it. The act owned here is anticipatory: recognise that a rigid hyperthermic patient is a rhabdomyolysis patient, repeat the

potassium and renal function rather than sending them once, keep the fluid balance chart honest, and refer on the trend rather than a single value, because trend is what the guideline says the decision rests on. The equivalent statement for the airway is weaker and should be given as such: airway, ventilation and swallow are named as domains of supportive care, but no numerical threshold for intubation is asserted here, because none was sourced. The principle stands without a number. Swallow is assessed before anything is given by mouth, and a patient whose chest wall movement is limited by rigidity is an anaesthetic problem before a psychiatric one.

### 21.9 Disposition and handover

Disposition here is not one event but a series of transfers, and each loses information unless it is written to prevent that. The receiving team needs four things only the referring psychiatrist holds: the exposure history with times, which criteria were met and which explicitly were not, what the negative work-up covered and what is outstanding, and the observations establishing the trend rather than the single worst value. A referral saying the patient has the syndrome invites a debate about the diagnosis. One saying which criteria are satisfied, at what values, over what interval, and what has been excluded transfers the reasoning rather than the conclusion, and is much harder to send back.

The internal handover matters as much. Restarting an antipsychotic afterwards, including how long to wait and what to choose, belongs to the Schizophrenia: management, antipsychotics and adverse effects notes and is decided by the team carrying the psychiatric care, not at the front door. What the emergency episode owes that team is a record clean enough to make the later decision possible: the agent, the route, the cumulative exposure, the interval between exposure and onset, the peak physiology, and whether the diagnosis was made against a formal criteria set or on clinical impression. Two entries belong there that residents routinely omit:

- the score, where the criteria set was scored, together with the explicit note that a total below the threshold was not treated as exclusion;
- who decided the level of care, at what time and on what observations, since that is the decision reviewed first if the patient deteriorates afterwards.

One thing is worth carrying out of this section. Everything owned here is a discipline of writing things down while they are still measurable: a baseline observation set that makes a percentage criterion usable at all, a second temperature that turns the first into a criterion, an exposure history that decays within hours, a trend that justifies a referral, and a level-of-care decision with a name and a time on it. The syndrome is treated with drugs the Schizophrenia: management, antipsychotics and adverse effects notes teach. It is survived on organisation.

## 22 · Serotonin syndrome (Hunter criteria, differentiation from NMS, management)

**Why the marks sit on the rule and not on the syndrome.** What serotonin toxicity looks like, which agents produce it, and how it is told apart from the other hyperthermic emergencies is set out in the

Schizophrenia: management, antipsychotics and adverse effects notes, and none of that is repeated here. What that account does, in common with almost every textbook account, is name the Hunter criteria and move on. A criteria set that is named but never set out is a dangerous object in a curriculum: every candidate can produce the name, very few can say what the rule actually asks, and a rule nobody can state is a rule nobody can apply or properly refuse to apply. Setting it out, with the patients it was built on and the accuracy that bought, is owned here. So is everything that follows once it has returned an answer: what is stopped first, what is cooled, what is sedated, whether an antidote has any place at all, how long the patient is watched before anyone uses the word discharge, and where that watching happens.

One structural point governs how much weight the rule can carry. It was derived in a poisoning service, on patients whose exposure was already known and whose remaining question was diagnostic: given this overdose, is this serotonin toxicity. The psychiatric emergency runs the other way. The physiology is in front of you and the exposure is not, because an agitated, sweating, tremulous patient arrives with a relative unsure what was taken and a prescription list months out of date. The rule is commonly used backwards from the direction it was built in, and the consequence is that a positive result is worth far more than a negative one. That asymmetry, rather than the list of features, is the examinable content of this topic.

### 22.1 The instrument: a decision rule, and what it displaced

The set to name in an answer is the **Hunter Serotonin Toxicity Criteria, published in QJM in 2003**. The object it is always contrasted with is **Sternbach**'s earlier criteria, and the contrast is not about which features appear on which list. Sternbach's set was a list: features associated with the condition, assembled from the literature, applied by recognition. The Hunter set is a different class of instrument. It was derived empirically from a consecutive admission series, measured against a stated reference standard, and its output is a decision rather than an impression.

The derivation both makes the criteria defensible and bounds them. Every patient admitted to a single regional toxicology service after overdose of a serotonergic drug across a long consecutive series was studied, and the outcome everything was measured against was the diagnosis of serotonin toxicity made by a **clinical toxicologist**. Predictive features were identified first in a learning dataset restricted to overdoses of a selective serotonin reuptake inhibitor taken alone, which strips out the confounding of mixed ingestions, and the rules were then built by **classification and regression tree analysis** and tested on all serotonergic overdose admissions.

| 2222 | 473 | 84% | 97% |
|---|---|---|---|
| SEROTONERGIC OVERDOSE ADMISSIONS IN THE DERIVATION SERIES | SSRI-ALONE OVERDOSES FORMING THE LEARNING DATASET | SENSITIVITY OF THE HUNTER DECISION RULES | SPECIFICITY OF THE HUNTER DECISION RULES |

Two properties of that design need stating, because the accuracy figures are usually quoted without them. The reference standard is expert clinical judgement: there is no assay and no imaging finding that settles this diagnosis, so the criteria were trained to agree with experienced toxicologists rather

than with a biological truth, and that is the ceiling on the performance of every criteria set in this family. Second, a rule built by recursive partitioning is not a summary of what the condition contains. It is a sequence of questions chosen because they separate groups efficiently, so a feature can be entirely characteristic of the illness and still be absent from the rule, simply because another feature was already doing that work.

### 22.2 The features the rule uses, and the two that arrived by a different route

Counted as the criteria set enumerates them, the rule rests on **seven** features: **clonus** counted once, in any of its three forms, inducible, spontaneous or ocular, together with agitation, diaphoresis, tremor, hyperreflexia, hypertonicity and a maximum temperature above 38 degrees Celsius. Five of those were what was needed to predict the toxicologist's diagnosis and everything else associated with the condition fell out of the rule as redundant; the last two arrived by a different route, which is the next paragraph and is the examinable part.

Two further features were added afterwards, and the reason is itself examinable. The learning dataset contained no life-threatening cases, so features belonging to the sickest patients could not emerge from it statistically. Hypertonicity and a maximum temperature **above 38 degrees Celsius** were universal in such patients and were added on clinical grounds. The rule's coverage of severe toxicity therefore rests on expert consensus about what those patients look like, while the rest of it rests on the derivation that produced its accuracy figures. Two kinds of evidence sit inside one instrument, and an answer that notices the difference is better than one reciting the list.

The features are set out below as what they are, the inputs to a rule, and not as a portrait of the illness, which is taught elsewhere. The second and third columns earn the table its place: a feature never elicited cannot enter a decision rule at all, and the commonest way this rule fails is not disagreement about a finding but that nobody performed the examination which would have produced it.

| FEATURE THE RULE USES | HOW IT IS ACTUALLY OBTAINED | WHAT IT OBLIGES AT THE BEDSIDE |
|---|---|---|
| **Inducible clonus** | Sustained brisk passive dorsiflexion of the ankle. It is elicited, never observed. | Examine both legs deliberately and record that clonus was sought and not found, rather than leaving the entry blank. A blank is read later as an absent finding when it was an absent examination. |
| **Spontaneous clonus** | Present without any manoeuvre, and visible only on uncovered limbs. | Look before you cover the patient and before you sedate. Sedation suppresses the finding, so the observation must precede the treatment or be lost. |

| FEATURE THE RULE USES | HOW IT IS ACTUALLY OBTAINED | WHAT IT OBLIGES AT THE BEDSIDE |
|---|---|---|
| **Ocular clonus** | Sought by watching the eyes at rest and on pursuit, which requires looking at the eyes on purpose. | Make the eye examination routine in any hot or agitated patient with a possible serotonergic exposure. It is the feature most often absent from the notes and present in the patient. |
| **Agitation** | Observed, then distinguished from the agitation of whatever brought the patient into contact with services. | Establish whether this agitation is new and time it against the last known dose. Agitation attributed to the primary illness is the commonest route to a missed diagnosis in a psychiatric setting. |
| **Diaphoresis** | Recorded by touching the patient. | Make the observation rather than infer it. This is the finding most often transcribed from an earlier entry without anyone re-examining the skin. |
| **Tremor** | Observed in the outstretched limbs. | Document it at first contact, so that a change later has something to be a change from. |
| **Hyperreflexia** | Requires a tendon hammer and a neurological examination. | Do the examination. Reflexes are the limb of this rule most often skipped in an emergency room, and skipping them removes a feature the rule depends on. |
| **Hypertonicity, added for life-threatening presentations** | Assessed by passive movement of the limbs, and reassessed rather than assessed once. | Treat its appearance as a change of category, not one more positive item. Rigid muscle is the tissue generating the heat, so this finding sets the tempo of what follows. |
| **Maximum temperature above 38 degrees Celsius, added for life-threatening presentations** | Measured, ideally centrally, and recorded as the maximum reached rather than the most recent reading. | Chart the trajectory, not a value. The criterion refers to a maximum, so a falling reading taken after cooling does not undo a peak that has already occurred. |

TRAP **Treating the criteria as a checklist and counting how many features are present.** Candidates do this because the set being implicitly compared with was a list, and lists are counted, and because secondary reproductions lay the branch conditions out as bullet points that look countable. This set is a decision tree. Particular features in particular combinations are diagnostic and others are not, so two patients with the same number of positive items can fall on opposite sides of it. The verbatim branch structure is not reproduced here, because it could not be verified against the primary publication, and a branch condition recalled from a secondary source is the kind of detail that is wrong in a way nobody notices until it is applied to a patient.

### 22.3 What the accuracy figures actually bought

The rules were simpler than their predecessor and performed better on both axes: **84 per cent against 75 per cent for sensitivity, and 97 per cent against 96 per cent for specificity**. Read the two gains separately, because they are not of comparable size and do not carry the same meaning. The specificity gain is arithmetically trivial; both instruments were already highly specific, and what matters there is the level rather than the improvement, because within the population studied a positive result is close to conclusive, and that is what licenses acting on the rule instead of waiting for something else to confirm it. The sensitivity gain is the substantial one, and it is why the newer rule displaced the older, since it materially reduces the proportion of genuine cases missed while making the instrument simpler rather than more elaborate.

Turn both into instructions. A positive rule in the right setting is strong enough to justify stopping the drug, starting physical treatment and escalating the level of care over a colleague's scepticism. A negative rule is not strong enough to send anybody home, because an instrument that misses a meaningful minority of true cases is not an exclusion test, and because its sensitivity was measured against agreement with an expert rather than against a fact of nature. One further qualification changes the weight of both figures considerably, and it is the subject of the next section.

### 22.4 Where the rule was validated, and where you will be using it

The group that derived the criteria addressed this in the **Medical Journal of Australia clinical update of 2007**, and their statement is more restrictive than the way the criteria are usually quoted. The rules were validated in a **toxicology service** in which other drug-induced syndromes are frequent, and that setting is precisely why they are so much more specific than the older criteria for features belonging to serotonin toxicity alone. Because they are that specific, the authors say, they can be used for adverse drug reactions; but they have not been validated for that purpose.

Sit with what that excludes, because it describes most of the situations in which a psychiatrist reaches for the rule. A patient on therapeutic doses who becomes tremulous, sweaty and agitated after a prescription change is an adverse drug reaction, not an overdose. There is no time zero, no ingested quantity, and no toxicology service around the patient. Applying the criteria there is defensible and is what the authors themselves say the specificity permits, but the operating characteristics above were not measured in that population and are not properties of the rule in it.

What follows is a discipline of documentation rather than of treatment. Use a positive result to justify what you are about to do; do not use a negative result to justify not doing it, and write the reasoning in that form, because a note recording that the criteria were not met reads later as an exclusion when it was nothing of the kind. The honest entry names the setting, states which features were sought and which were found, and says explicitly that a negative rule was not treated as excluding the diagnosis.

### 22.5 The branch that changes the clock: severe toxicity

Severity, not the diagnostic label, determines the next hour, and the severe band has its own name and definition. Severe serotonin toxicity, or **serotonin crisis**, is characterised by a rapidly increasing temperature together with muscle rigidity, and it will progress to multiorgan failure if not treated within hours. It is a medical emergency, and it is almost exclusively associated with combinations of drugs acting at different sites rather than with any single agent. Three things follow, and each is an act.

The first concerns the word hours. Every other interval in this topic is counted in hours too, which is exactly why the distinction matters: the observation period and the expected recovery are periods during which you watch, while this is a period during which you must already have acted. It is the only clock here that finishes before a laboratory result does.

The second concerns the drug history. If the severe band is almost always a combination, the question asked of the patient and the relatives changes shape. It is not what was taken, it is what was taken together, over what period, and whether anything was started or stopped recently by a team other than yours. A single-agent answer, accepted and written down, closes the enquiry at the point where the severe band would have been identified.

The third concerns what is measured. The definition names a rapidly increasing temperature, not a high one, with rigidity beside it. A patient whose temperature has climbed steeply is in a different situation from one sitting at the same reading unchanged for some hours, and only one of those facts appears on an observation chart that records values without times. Insist on times.

> A rising temperature with rigidity is the branch that runs on hours, and it is answered by cooling, sedation and paralysis, never by an antidote.

### 22.6 What the differentiation from neuroleptic malignant syndrome actually changes

**The grid is not the teaching here.** How this syndrome is distinguished from neuroleptic malignant syndrome and the other hyperthermic emergencies is taught as a recognition exercise in the Schizophrenia: management, antipsychotics and adverse effects notes, and it is not redrawn on this page. What belongs here is the question a recognition exercise never answers: what the discrimination buys. A candidate who can separate the two syndromes on features but cannot say what changes when they do has learned the half that carries fewer marks.

- **Almost nothing changes in the opening minutes.** Both converge on the same physical act: airway, temperature, fluids, sedation, and a decision about where the patient is nursed. A resident who suspends cooling while the label is argued has the order of operations exactly backwards. The discrimination is made in parallel with resuscitation, never before it.
- **What is subtracted differs, so the history differs.** One picture asks what dopamine blockade was given or what agonist was withdrawn; this one asks what serotonergic agents were on board and, in the severe band, in what combination. That is a different conversation with the relative

and a different reading of the drug chart, and it has to happen early because the information decays.

- **The expected trajectory after stopping differs, and only one of them can be stated with a source here.** Serotonin toxicity has a recovery window, set out below; no equivalent interval for the other syndrome is asserted on this page. That asymmetry is useful rather than awkward, because it means failure to improve inside the stated window is a reason to reopen your own diagnosis and is not by itself evidence that the other syndrome was the answer.
- **The antidote question exists on one side and is unsettled even there.** Getting the discrimination right does not hand you a drug, which is what most candidates expect it to do.
- **The disposition logic differs because the exposures differ in shape.** One typically follows an ingestion with an identifiable time zero, which is what makes a fixed observation period meaningful. The other may follow an exposure running for weeks, where a period counted from a moment has nothing to be counted from.

## 22.7 The order of operations, and why the antidote is a second-order decision

RULE **Supportive care takes precedence over any specific pharmacological treatment.** The clinical update of 2007 states it in those terms and gives the reason: hyperthermia and muscle rigidity are the effects that matter, and it is supportive care that prevents the secondary complications, rhabdomyolysis, renal failure and disseminated intravascular coagulation. Every question about which drug to give is therefore asked after the physical work is under way, not instead of it.

The arrival sequence itself is common to every emergency in this chapter and is set out where that sequence is taught: recognise, stabilise, establish who holds the authority to act, act, monitor, decide the destination. What is specific here is the content of the stabilise step, which the same source names as four physical interventions:

- passive cooling, and active cooling where passive measures are not keeping pace;
- sedation;
- intubation;
- muscle paralysis.

Those four are less an escalating menu than a single mechanical argument. Rigid, active muscle is the tissue producing the heat, so sedation reduces the drive to it, paralysis stops the production outright, and cooling removes what has already been made. Intubation is not a complication of that plan but a precondition for its last step, which is why it sits among supportive measures rather than among disasters. Once the chain is understood the sequence stops needing to be memorised, and the reason the antidote question sits downstream becomes obvious: no antiserotonergic agent removes heat from a patient, and heat is what causes the harm.

State the limits of that list honestly, because it stops short of several numbers a candidate will expect. No temperature at which active cooling should begin is asserted here, and no criterion for

intubation, because neither could be sourced. The principle survives without them: the trigger for escalating physical treatment is the trajectory of the temperature and the presence of rigidity rather than any single reading, and the decision belongs to whoever will manage the airway. The sedative is named generically in the source and carries no dose there, so no dose, route or titration for sedation appears here either. A number invented at this point would be read as protocol, and there is no protocol behind it.

### 22.8 Stopping the agent, and the washout question

The first therapeutic act is a subtraction, and the same authors put cessation of the serotonergic medication alongside supportive care as the whole of what treatment should focus on. That is easy to say and routinely done incompletely, because stopping the drug that is charted is not the same as stopping the exposure. The relevant list is everything reaching the patient: what another department prescribed, what was bought without a prescription, what a relative supplied from home, and what was taken as a preparation the patient does not think of as medicine. Each entry needs a time against its last dose, because the times are what convert a list into a history.

**GOOD TO REMEMBER**

The exposure history is the one part of this presentation that cannot be reconstructed later. Names, doses and above all the timing of the last dose of each agent live in a relative's memory, a home strip of tablets and a chart that travels separately from the patient, and all three degrade within hours. Take it at first contact, take it in writing, and take it before the patient moves department. Record whether decontamination has been given, because it forecloses one of the treatment options discussed below.

The recovery window is the yardstick for everything afterwards: most patients improve within **24 hours** of ceasing the serotonergic medication. That figure earns its place by making an otherwise vague bedside question answerable. A patient not improving inside it has three explanations worth working through: the agent is still being absorbed or still present in quantity, an exposure has been missed and is continuing, or the diagnosis is wrong. Each has a different next action, and none of them is to wait longer.

The reintroduction question is where this section stops. How long to wait before any serotonergic agent is restarted is not sourced here, and it plainly cannot be a single number, because it depends on the elimination of the agents involved and on which combination produced the episode. The principle is stateable and the number is not: the wait is governed by clearance of what was taken, the decision belongs to the team carrying the longer-term psychiatric care rather than to the emergency episode, and what that team is owed is a record precise enough to make the decision possible.

### 22.9 The cyproheptadine decision, stated honestly

This is where most accounts produce a dose, and the most authoritative statement available does the opposite. The group that derived the criteria write that although some **antiserotonergic**

**agents** have been used in clinical practice, the preferred agent, the dose and the indications are not well defined. That sentence is the honest content of the decision. It is not a gap in this account; it is the state of the evidence, and an answer reporting it accurately is stronger than one reciting a regimen as though the question were settled.

One fact about the agent does more practical work than any regimen would, and it is a route constraint. Because **cyproheptadine** can only be given orally, it is unlikely to be effective in a patient who has been given activated charcoal, and it has limited use in severe toxicity. Follow that through and the antidote turns out to be least usable in exactly the patients who most invite the thought of using it: the patient in the severe band frequently has a compromised airway or is about to be paralysed, has often already been decontaminated, and may be vomiting, so the oral route either does not exist or cannot be trusted. The antidote is a second-order decision by construction rather than by preference, and that is a better answer than a dose.

No dose is printed here, and the reason should be given rather than left as an omission. The source most authoritative on this agent says its indications are unsettled, and printing a regimen beside that sentence would represent as protocol what is at best a practice habit. Where a dosing schedule is taught it belongs with the pharmacology of the antidepressants and not in an emergency pathway, and the division is the point: the pathway owns whether the agent has a place, the pharmacology owns what goes on the chart if it does.

### 22.10 Observation, disposition and what the receiving team is owed

The disposition rule has no counterpart anywhere else, and it rests on one physiological observation from the same clinical update: serotonin toxicity may increase progressively over a number of hours after ingestion. The patient assessed at the door and found well is therefore not a cleared patient but a snapshot taken early on a curve that may still be rising, and the whole logic of an observation period follows from that sentence.

Patients with moderate serotonin toxicity should be observed for **6 hours, extended to 12 hours where a slow-release formulation such as venlafaxine has been ingested**. The extension is not a safety margin added out of caution; it tracks the formulation, because a preparation designed to release drug slowly moves the patient up that rising curve slowly as well, and a period long enough for an immediate-release ingestion simply ends before the peak.

What the period does not come with is a cadence. How often the patient is examined during it, what is measured and by whom, is not sourced here, and an interval invented at this point would read as standard when nothing establishes that it is. The principle is defensible without a number: the frequency of observation is set by how fast the patient is changing and reviewed whenever that rate changes; the examination repeated is the one that produced the finding, so if clonus was what was found, clonus is what is re-elicited rather than a set of vital signs alone; and whoever set the level of observation is named in the notes with the time, because that is the decision reviewed first if the

patient deteriorates. Nor is there a sourced criterion here for fitness for discharge at the end of the period, beyond the period itself and the recovery window.

**IN INDIA**

An observation period is a service, not an instruction, and the two commonly come apart here. A stated period of several hours assumes somewhere with observations: a bed in an area where temperature and pulse are actually recorded at intervals, staff who read them, and someone competent to act on a change at three in the morning. A standalone psychiatric hospital often has none of that, so a patient needing the longer period after a slow-release ingestion needs it in a general hospital emergency department, which converts an observation decision into a transfer decision taken at the front door rather than six hours later. Physical treatment has the same problem, since active cooling and muscle paralysis require an anaesthetist and a monitored bed. Settle these before a patient arrives rather than during one: which medical unit accepts your escalations, whether an intensive care bed is negotiable for a patient carrying a psychiatric diagnosis, whether the pharmacy stocks an antiserotonergic agent at all, and whom you telephone when the answer is no. Record every refusal with its time, because a transfer that was sought and declined is invisible afterwards unless somebody wrote it down.

The handover is where this episode either survives or is lost, and the receiving team needs several things only the clinician who was present can supply:

- which features were sought, which were found and, explicitly, which were sought and absent, since a rule of this kind is unreadable later without the negatives;
- the exposure list with a time against the last dose of each agent, and whether a combination was involved;
- whether decontamination was given, because it removes the oral route for the antidote and changes what the next team can offer;
- the peak temperature with the time it was reached and the readings around it, so that the trajectory transfers and not just the worst value;
- the observation period chosen, the reason for the longer or shorter one, who chose it, and when it started.

Everything owned in this topic reduces to a single discipline. The rule is only as good as the examination that fed it, the severity branch is visible only to someone recording times as well as values, the recovery window is useful only to someone who knows when the drug was actually stopped, and the disposition is safe only if the place the patient is sent to does the thing the period assumes. The syndrome is named elsewhere and its pharmacology is taught elsewhere. What is decided here is whether anybody looked, when, and what they wrote down.

## 23 · Acute dystonia and other acute drug-induced emergencies

**Why an emergency chapter carries this at all.** What the reaction is, which agents provoke it, how it sits in relation to the other movement disorders of antipsychotic treatment, and the drugs that abolish it with their doses and routes are all set out in the Schizophrenia: management, antipsychotics and adverse effects notes, together with akathisia, drug-induced parkinsonism and tardive dyskinesia. None of that is repeated here. What is left over is the half that decides the outcome, and it is the half a ward improvises: whether anyone looked at the airway before the syringe was drawn, how long you are entitled to wait for the injection to work, what you do when it does not work, and why a patient whose spasm melted away in front of you can be back in casualty the same week on the same prescription. The Indian Psychiatric Society's guideline on medical emergencies associated with psychotropic medications settles the framing by classing **acute dystonia** as an emergency rather than as an adverse effect, and by attaching immediate intervention to it.

The second half of this topic is the wider class, and no chapter in these notes teaches it as a class: the acute emergencies that a psychotropic drug can produce in an organ system that is not the brain. Four of them are worth holding together, because they share one act-level spine and almost nothing else. Airway-threatening dystonia, the hypertensive crisis on a monoamine oxidase inhibitor, the severe cutaneous adverse reaction, and priapism all present to someone who is not a psychiatrist, all have a clock, and in all four the first act is not the antidote. It is stopping the drug and protecting the threatened organ while the antidote is being found.

### 23.1 The airway question, asked before the syringe is drawn

A dystonic reaction is usually described by where it is visible, which is why the neck and the eyes dominate the textbook picture and the throat does not. Read the same territories as an emergency map and the priority inverts. The Indian guideline maps each muscle group to the function it removes, and the **oromandibular territory** is where that mapping stops being cosmetic: most of those territories are swallow and airway problems wearing the label of a movement disorder. The guideline then singles one out from all the rest: **laryngeal dystonia** is the form that produces stridor and can be life-threatening.

United States approved labelling for a high-potency first-generation antipsychotic sets out the same escalation in the order it happens, which is more useful at the bedside than a list of sites: spasm of the neck muscles, then tightness of the throat, then difficulty swallowing, then difficulty breathing, with or without protrusion of the tongue. That ordering is what converts a dystonic reaction into an airway assessment. A patient with torticollis alone is at the first step of a sequence a regulator has written down, and the question the first clinician answers is not whether the posture is dystonic but how far along that sequence the patient already is: can they speak in full sentences, can they swallow their own saliva, is there stridor.

The *oculogyric crisis* belongs in the same first look for a different reason. It threatens nothing anatomically, but a patient whose eyes are locked upward cannot see the person examining them, is frequently terrified, and is very often read by a busy department as behavioural disturbance or as psychosis worsening. The act does not change. What changes is who gets called, and how long the patient waits.

RULE **The first decision in an acute dystonic reaction is anatomical, not pharmacological: which territory is involved, because only some of them can obstruct.** The drug that is given is the same either way, which is exactly why the question gets skipped. What differs is the setting the injection is given in and who stays at the bedside for the next twenty minutes. A neck held to one side and a throat that is tightening are the same diagnosis and a different level of care, and the second one is not safely managed in a side room by a single nurse who has been told to call if there is a problem.

### 23.2 The drug that caused it is usually not on the psychiatric chart

Dopamine blockade is not confined to antipsychotics, and the drug histories that produce this emergency most often are not psychiatric ones. Current United States labelling for metoclopramide, an antiemetic, records that dystonic reactions have rarely presented as stridor and dyspnoea, attributed to **laryngospasm**. That single sentence carries two teaching points. The airway presentation is a property of dopamine antagonism rather than a property of antipsychotic drugs, so a patient who has never been prescribed a psychotropic can present with it. And the causative drug will usually not be volunteered, because the patient does not think of an anti-vomiting injection as a medicine that acts on the brain.

**What this changes about the history.** The useful question at the door is not what psychiatric medication the patient takes. It is what has been given or swallowed in the last few days, including in another department, including by a general practitioner, including over the counter, and specifically including anything given for vomiting or for gastric upset. In a general hospital the reaction is frequently iatrogenic within the same building and within the same shift, and the drug chart that explains it sits in a casualty file rather than in the psychiatric notes.

GOOD TO REMEMBER

When you are called to a young patient with an odd posture, an arched neck or eyes rolled upward, and the referral says the presentation is functional, hysterical or behavioural, ask one question before you examine anything: what injection or tablet was given, anywhere, in the last few days. The commonest answer that changes the diagnosis is an antiemetic. The referral being wrong is not the interesting part; the interesting part is that the reaction is still being produced by a drug that is still being prescribed on that ward for other patients.

### 23.3 The timed act, the repeat interval and the failure ladder

The agents used and their doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes and are not printed here. What this section owns is the clock attached to them, and it is unusually well specified. The Indian guideline expects the symptoms to resolve within 15

to 20 min of the parenteral drug, and records that most patients respond to the first dose, with very few needing a second or third. That expectation is what makes the injection an assessment as well as a treatment: a reaction that has not settled inside that window is telling you something.

| 15 to 20 min | 30 min | 72 h | 4 hours |
|---|---|---|---|
| EXPECTED RESOLUTION OF ACUTE DYSTONIA AFTER THE PARENTERAL DRUG, INDIAN PSYCHIATRIC SOCIETY 2022 | INTERVAL AFTER THE INITIAL PARENTERAL DOSE BEFORE THE SAME DRUG IS REPEATED IN A PERSISTING EPISODE, INDIAN PSYCHIATRIC SOCIETY 2022 | WINDOW WITHIN WHICH CORTICOSTEROIDS ARE PREFERABLY STARTED IN STEVENS-JOHNSON SYNDROME AND TOXIC EPIDERMAL NECROLYSIS, INDIAN DERMATOLOGY GUIDELINE 2016 | ERECTION DURATION BEYOND WHICH ACUTE ISCHAEMIC PRIAPISM IS A MEDICAL EMERGENCY, AMERICAN UROLOGICAL ASSOCIATION AND SEXUAL MEDICINE SOCIETY OF NORTH AMERICA 2021 |

The **Indian Psychiatric Society guideline of 2022** then gives a repeat interval and a failure ladder, and the value of both is that neither contains a drug name. If the episode persists after the initial parenteral dose, the same drug may be repeated about 30 min later. If the patient has not responded to two doses, the medication is changed rather than repeated a third time. If the changed medication also fails, the instruction is to consider a diagnosis other than acute dystonia. That last rung is the one candidates omit and the one that protects the patient, because the differential at that point contains conditions that a further anticholinergic injection will not touch and may obscure.

The airway presentation is treated as a separate line in the same stepwise table, and the guideline names a different agent class as the treatment of choice for acute laryngospasm, stated to be equally efficacious with the first-line option used for dystonia generally. The agents and figures in that table cell are owned by the Schizophrenia: management, antipsychotics and adverse effects notes and are not reproduced here; what this section teaches is that the airway presentation has its own line rather than being the same treatment given more urgently. One thing the source does not give, and it should be said rather than filled in: no observation cadence is attached to that waiting period. How often the airway, the swallow and the saturation are rechecked between the first dose and the second is not specified anywhere retrieved for this section, so the interval is set locally and the principle is all that can be taught.

### 23.4 What runs after the spasm stops, and why discharge is a decision

The single most important thing about this emergency is that its resolution is not its end. Once the episode is managed, the Indian guideline recommends continuing anticholinergic cover for at least **24 to 48 h** specifically to avoid recurrence, and separately records that in routine Indian practice the cover is continued up to 4 to 7 days. Those are two different figures doing two different jobs, a recommended minimum and an observed habit, and they should be quoted as such rather than averaged into a single number.

Recurrence after an apparently complete response is not treatment failure. The injection that abolished the spasm is short-acting relative to the drug that caused it, so the cover falls away while the cause is still there.

The formal definition contains a limb that makes this concrete, and it is the limb most readers skip. Dystonia counts as antipsychotic-induced not only when it follows starting the drug or increasing its dose but also when it develops on reducing or removing the medication used to treat or prevent acute extrapyramidal symptoms. Stopping the cover is itself a recognised precipitant. That converts the taper from an afterthought into a planned act with a date, a person responsible for it and a warning given to the patient, which is exactly what a discharge prescription written as an open-ended supply fails to provide.

Prophylaxis is a separate decision and the guideline rules on it. Everyday prophylactic anticholinergic use is not recommended; where prophylaxis is used, three things are weighed:

- the patient's own risk factors for acute dystonia;
- the type of antipsychotic and the dose it is being used at;
- the other medications the patient is already taking.

Re-exposure is the last limb of the plan, and the hardest available anchor for it sits in regulatory text rather than in a guideline. For metoclopramide, a previous dystonic reaction to the drug is not a caution but a labelled contraindication to giving it again. That is drug-specific and must not be generalised: no equivalent labelled prohibition on antipsychotic rechallenge after a dystonic reaction was found for this section, and none is asserted. What survives generalisation is the discipline the contraindication models. A patient who has had an airway-threatening reaction to a named drug leaves with that drug named in the record as the cause, with the decision about ever giving it again recorded rather than left to whoever admits them next.

TRAP **Treating the response to the injection as the end of the episode.** The error is seductive because the response is genuinely dramatic and genuinely fast, and the patient is grateful and comfortable within the expected window. Candidates then write a management answer that finishes at resolution. What that answer omits is everything that determines whether the patient is back: the duration of continued cover, the fact that removing the cover is itself a precipitant, whether the causative drug is being continued, changed or reduced, and what the patient has been told to do if it happens again. An answer that stops at the injection has treated the spasm and not the patient.

### 23.5 The hypertensive crisis on a monoamine oxidase inhibitor

This crisis is the one psychiatric emergency in which the decision point sits before any measurement. The modern labelling for tranylcypromine instructs that therapy be interrupted on symptoms that may be prodromal, naming palpitations or headaches, and that the patient then be evaluated immediately. Read as an act, that means a patient who telephones with a bad headache is told to stop the drug first and be seen, not told to come in so that a blood pressure can decide the matter.

The same labelling supplies the threshold that turns a crisis into a **hypertensive emergency**: severe hypertension, given as a blood pressure of **more than 180/120 mm Hg**, together with evidence of organ dysfunction, requiring immediate attention. Having a criterion rather than an

adjective matters, because it is what lets a psychiatrist hand over to a physician in terms that will be acted on. The same source requires immediate blood pressure reduction once that combination is present, and separates the temperature problem into two: fever is managed by external cooling, while hyperthermia driven by psychomotor agitation, increased neuromuscular activity or persistent seizures may need measures aimed at those causes instead. Cooling a patient whose temperature is being generated by muscle activity treats the reading and not the cause.

The act for a hypertensive crisis on a monoamine oxidase inhibitor is written out in the approved labelling for phenelzine and is unusually complete: discontinue the drug immediately, institute blood-pressure-lowering therapy immediately, give **phentolamine 5 mg** intravenously, administer it slowly so as not to produce an excessive hypotensive effect, and manage fever by external cooling. Two honest limitations belong on the page with it. The labelling requires the reduction to be immediate but names no target pressure and no ceiling on the rate of reduction, so neither is taught here. And phentolamine's own approved labelling confines its indication to the prevention or control of hypertensive episodes in phaeochromocytoma during preoperative preparation and surgical excision; crisis on a monoamine oxidase inhibitor is not among its labelled indications. The antidote recommended by one label is therefore used outside the indications of its own. A candidate who knows that is not less safe, but better prepared for the conversation with the physician who is asked to give it.

Disposition carries its own instruction, and it is the one most often lost. Patients are told to avoid high-tyramine foods and drinks while on tranylcypromine and for **2 weeks** after stopping it. This is a dietary rule that outlives the prescription, and it is a different question from the washout arithmetic used when switching antidepressants, which belongs to the Mood disorders: pharmacotherapy notes. Merging the two is how a patient gets discharged as safe on the day the tablets finish.

### 23.6 The severe cutaneous reaction: the three acts that are the psychiatrist's

Telling a benign drug rash from a dangerous one, and the stop-rules for the anticonvulsant mood stabilisers, belong to the Mood disorders: pharmacotherapy notes. What this section owns begins one step later, at the moment someone has decided the reaction is serious, and the psychiatrist's part in it is three acts rather than a spectator role.

The first is cessation, and the Indian dermatology guideline puts it above everything else it recommends. Instant cessation of the offending drug is of supreme importance; the earlier the causative drug is withdrawn the better the prognosis; and patients exposed to causative drugs with long half-lives have an increased risk of dying. That last clause is the one that bites in psychiatry, because several of the agents that most often cause **Stevens-Johnson syndrome and toxic epidermal necrolysis** in our patients are long-acting anticonvulsant mood stabilisers. Stopping them is not a neutral act either, which is precisely why the decision is a psychiatric one.

The second act follows from polypharmacy. Where the culprit cannot be identified, the guideline says it is generally logical to stop every drug the patient is taking, and then carves out the case that matters here: where a drug is absolutely essential, naming patients with epilepsy explicitly, it may be substituted with a structurally unrelated agent, and that decision is taken jointly with the treating clinician through an interdisciplinary approach. Choosing the structurally unrelated substitute for a patient on an anticonvulsant is work no dermatologist can do alone.

The third act is knowing what is being decided around you. For a severe cutaneous adverse reaction, meaning Stevens-Johnson syndrome and toxic epidermal necrolysis, the **Indian dermatology guideline of 2016** recommends prompt withdrawal of the culprit drug, meticulous supportive care and early systemic corticosteroids, given as prednisolone **1 to 2 mg/kg/day** or equivalent by the oral or parenteral route, preferably started within 72 h and tapered rapidly within 7 to 10 days. A psychiatrist does not prescribe that, but a psychiatrist whose patient is transferred and who does not know that the steroid decision has a window will not ask whether it was taken. The same guideline asks for an isolation room where possible, for infection and temperature control, and names the disciplines the treating team should contain: dermatologist, physician, ophthalmologist, plastic surgeon, chest physician, dietician, and others as required. One of those referrals has a cadence attached and it is the one a psychiatrist is most likely to forget: daily examination by an ophthalmologist, with vigorous treatment, reduces the risk of long-term ocular complications. A patient survives the reaction and lives with the eyes.

**IN INDIA**

The Indian guideline is unusual and useful in that it writes down what to do when the setting it recommends does not exist. Admission to an intensive care setting or a burns unit is preferred where such facilities are available. Where resources are limited, in a rural or district hospital, or where the patient is unfit for transfer, it accepts management in the general or dermatology ward, or in a high-dependency unit, with strict infection control and with nurses trained to deal with such cases. That is the honest architecture of this emergency in most of the country, and it converts the referral question from an ideal into a decision with two named branches. The practical consequence for a psychiatrist is that the transfer conversation is about capability rather than about category: whether the receiving ward can nurse an exposed skin surface, control infection and get an ophthalmologist to the bedside every day.

### 23.7 Priapism, which is a clock rather than a symptom

Priapism is the drug-induced emergency most likely to be delayed by embarrassment, on both sides of the consultation, and delay is the only variable that determines the outcome. The guideline of the American Urological Association and the Sexual Medicine Society of North America defines **acute ischaemic priapism** as prolonged, meaning more than 4 hours, with little or no cavernous blood flow and cavernous blood gases that are hypoxic, hypercarbic and acidotic, and states plainly that it is a medical emergency which may lead to cavernosal fibrosis and subsequent erectile dysfunction.

The threshold and the consequence belong in the same sentence, because the consequence is what makes a four-hour threshold reasonable.

The act at the door is a test rather than a treatment. The **American Urological Association and Sexual Medicine Society of North America guideline of 2021** directs clinicians to obtain a **corporal blood gas** at the initial presentation, and records it as a clinical principle rather than as a graded recommendation. It separates the ischaemic emergency from the non-ischaemic form, which is not one, and it is what the urologist will ask for first. First-line management is then intracavernosal phenylephrine together with corporal aspiration, with or without irrigation, and the guideline places it before any operative intervention. The dose of intracavernosal phenylephrine is not stated here: the guideline places its dosing in an appendix and describes the use as off-label, and an incomplete dose is worse than a named referral.

The negative act is the one a psychiatric ward improvises when it does not recognise an emergency. In a patient with diagnosed acute ischaemic priapism the guideline states that conservative measures are unlikely to succeed and must not delay definitive therapy, naming four of them:

- observation, in the hope that it will settle;
- oral medication;
- cold compresses;
- exercise.

**The act that belongs at the point of prescription.** Current labelling for trazodone reports cases of priapism as painful erections greater than 6 hours in duration, warns that untreated priapism can cause irreversible damage to erectile tissue, and instructs that a man with an erection lasting greater than 4 hours, painful or not, should immediately discontinue the drug and seek emergency medical attention. Note the discrepancy inside the label itself: the reported cases are described at the longer duration, and the instruction to the patient triggers at the shorter one, which is also the guideline threshold. Teach the shorter one. The receptor pharmacology that explains why particular psychotropics do this belongs to the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes; what belongs here is that the counselling sentence is part of the prescription, and that a man who has not been given it will wait until morning.

### 23.8 The spine the four have in common

| PRESENTATION | WHAT MAKES IT AN EMERGENCY | THE FIRST ACT | WHAT FOLLOWS |
|---|---|---|---|
| **Airway-threatening acute dystonia** | Involvement of the laryngeal territory, which can produce stridor | Parenteral treatment, given where the airway can be watched while it works | Resolution expected within 15 to 20 min of the injection; a change of drug after two doses without response |
| **Hypertensive crisis on a monoamine oxidase inhibitor** | Blood pressure more than 180/120 mm Hg with evidence of organ dysfunction | Stop the drug and begin lowering the pressure immediately | External cooling for fever, with separate measures where agitation, neuromuscular activity or seizures are generating the heat |
| **Stevens-Johnson syndrome and toxic epidermal necrolysis** | A long half-life of the causative drug raises the risk of dying, so the interval to withdrawal is itself the emergency | Instant cessation, and all drugs stopped where the culprit is unclear | Intensive care or a burns unit where available; general or dermatology ward or a high-dependency unit where it is not |
| **Acute ischaemic priapism** | An erection lasting more than 4 hours, with the risk of cavernosal fibrosis behind it | A corporal blood gas at the initial presentation | Intracavernosal phenylephrine with corporal aspiration, before any operative intervention |

Read down the columns rather than across the rows and the shape of the class appears. Every one of the four is defined as an emergency by an interval or a threshold rather than by severity of appearance; in every one the first act is available to a non-specialist; and in every one the specialist act that follows is time-bound in a way that makes the referral itself urgent. That is why these four are worth learning together even though they involve four different organ systems and four different specialties. They fail in the same place, which is the gap between recognising and acting.

MNEMONIC

**Stop, Secure, Specific, Setting, Sign-off**

The act-level spine of any acute drug-induced emergency. **Stop** the drug, which is the only act whose value falls with every minute of delay. **Secure** the threatened organ: the airway, the pressure, the skin and the eyes, the corpora. **Specific** intervention within its stated window, whether that is the injection, the antidote, the steroid or the aspiration. **Setting**: the level of care the next hour requires, and its named fallback where the ideal one does not exist. **Sign-off**: the causative drug named in the record and the decision about ever giving it again written down rather than left to whoever admits the patient next.

In every acute drug-induced emergency the first act is stopping the drug and protecting the threatened organ, and the episode ends not when the sign resolves but when the cover, the taper and the re-exposure decision have been written down.

## 24 · Lithium toxicity and overdose management

**Why the marks sit on the history and not on the drug.** What lithium toxicity looks like, the serum bands that grade it, the precipitants behind it and the chain ending in extracorporeal treatment are set out in the Mood disorders: pharmacotherapy notes and are not restated here. What that account does not carry is the question an emergency team settles first: not how toxic is this patient, but which of three poisonings this is. The answer is not in the assay but in a history assembled from a relative, an empty strip and an outpatient card nobody brought.

Three things move with it: the kinetics, the meaning of a measured concentration, and the decontamination decision, which exists in one arm and not at all in another. That last is the only point here where acting early still changes the ceiling of the illness. The ordered first-hour sequence is set out in this chapter's section on assessing and managing the acutely agitated and aggressive patient; intent after a deliberate ingestion belongs with the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

### 24.1 Establish which of the three poisonings this is, and establish it from the history

The EXTRIP workgroup, in its 2015 systematic review of extracorporeal treatment for lithium poisoning, names **three** clinically recognised patterns and defines each by how it arose, not how it looks. **Acute lithium poisoning** occurs in a lithium-naive patient who overdoses. **Acute-on-chronic** poisoning occurs where an existing body burden from maintenance therapy meets an acute large exposure. **Chronic lithium poisoning** occurs on maintenance therapy where elimination has been compromised, by a recently increased dose, a decline in kidney function or an interacting drug; those precipitants belong to the Mood disorders: pharmacotherapy notes and appear here only because they are the definition.

The Indian Psychiatric Society's 2022 guideline on medical emergencies associated with psychotropic medications gives the same three types and controls Indian practice. It attaches a signature to each: acute manifests primarily with gastrointestinal symptoms and may progress to neuromuscular signs which usually appear after **2 to 3 days**; acute-on-chronic presents with both gastrointestinal and neurological symptoms; chronic presents primarily with neurological symptoms. It states the acute-on-chronic case separately, as long-term lithium plus an overdose taken either deliberately or accidentally. The second adverb catches teams out: an accidental overdose declares no intent, so nobody asks.

The bedside will not sort the arms out for you. EXTRIP is explicit that only the **gastrointestinal symptoms** tend to distinguish acute poisoning, where they are expected and prominent, from

chronic toxicity, where they are almost invariably absent. One discriminating clause is all the examination offers, which is why this is a front-door history-taking task.

MNEMONIC

### On it, on top of it, which tablet

**On it:** was there a maintenance body burden before today. **On top of it:** was something taken acutely as well, deliberately or accidentally. **Which tablet:** immediate-release or modified-release, because the formulation sets the absorption curve, the decontamination window and the risk after treatment.

| PATTERN | HOW IT ARISES | WHAT THE HISTORY MUST ESTABLISH | WHAT A CONCENTRATION TELLS YOU | DECONTAMINATION |
|---|---|---|---|---|
| **Acute** | A lithium-naive patient overdoses. | No prior maintenance therapy, and when the tablets were swallowed. | Risk ahead, not harm done: the brain has not yet received what the plasma reports. | On the table. Drug may still be in the gut. |
| **Acute-on-chronic** | A patient already on long-term lithium overdoses, deliberately or accidentally. | Both halves; the second is missed when no intent is declared. | Two overlapping quantities, so the least interpretable of the three. | On the table, and the arm where timing has been studied. |
| **Chronic** | Maintenance therapy in which elimination has become compromised. | That no acute ingestion occurred, a negative that must be sought. | The population the severity grading was written for. | Not on the table. Nothing recent to remove. |

### 24.2 Set the observation horizon from the kinetics, not from the first result

The typology changes the expected course because lithium is not a single-compartment drug. Its tissue distribution follows a **multiple compartment model** with delayed diffusion from the extracellular to the intracellular compartment; it is taken up rapidly by kidney, thyroid and bone, but its diffusion into the cerebrospinal fluid and the brain is delayed by approximately 24 hours compared with its appearance in plasma. In an acute ingestion, then, the sample in your hand reports the compartment that is not producing the illness you fear.

Clearance is equally uncooperative. The **terminal elimination half-life** is widely variable and depends on age, kidney function and duration of therapy, its upper end well beyond what a single overnight observation assumes. An identical swallowed amount in a naive young adult and in an older patient a decade into treatment is not the same exposure. The pattern therefore sets the observation horizon.

| 12 to 27 h | up to 58 h | 30 min to 2 h |
|---|---|---|
| TYPICAL TERMINAL ELIMINATION HALF-LIFE OF LITHIUM | HALF-LIFE IN THE ELDERLY AND IN PATIENTS TAKING LITHIUM CHRONICALLY | PEAK CONCENTRATION AFTER THERAPEUTIC IMMEDIATE-RELEASE LITHIUM |

### 24.3 Read the concentration as a guide to risk, never as a severity score

Candidates arrive carrying the severity grading. What is rarely taught with it is the population restriction the Indian Psychiatric Society attaches when introducing it: it is severity in patients with chronic intoxication, meaning those on long-term therapy, that the serum levels determine. The grading is a chronic-toxicity construct, never built for the acute ingestion in front of you, and the bands belong to the Mood disorders: pharmacotherapy notes.

EXTRIP supplies the mechanism that makes that restriction sensible rather than arbitrary: the delayed diffusion of lithium into the brain explains the absence or delay of symptoms in acute poisoning despite highly elevated concentrations. Serum concentrations are therefore only a guide to potential risk of toxicity, always read against three things:

- **The history**, meaning which pattern this is and when the exposure occurred, since a rising figure and a falling one carry opposite implications.
- **The clinical findings**, meaning what the patient is doing now, and whether the neurological picture is worsening between examinations.
- **Kidney function**, which sets how fast the burden falls and whether it falls at all, and which in the chronic arm is often why the poisoning happened.

The error runs both ways, and the guideline closes the second: the toxic effects of lithium may also be seen in patients with therapeutic serum levels. A figure inside the therapeutic range is not a discharge criterion. A patient on maintenance lithium who is ataxic, coarsely tremulous and confused has a clinical problem whatever the laboratory returns, and the discrepancy is answered by disbelieving the reassurance.

RULE **The pattern comes from the history; the concentration estimates the risk ahead, not the severity in front of you.** The observation horizon, the decontamination call and the transfer threshold all follow from which arm the patient is in. The assay contributes to that decision and does not make it, and a team that waits for the result has spent the only interval in which decontamination was possible.

TRAP **Grading an acute ingestion against a scale built for chronic intoxication.** The candidate applies the grading to a lithium-naive patient who swallowed a bottle two hours ago, finds a striking figure in someone who looks well, and either panics or, worse, is reassured an hour later when that patient still looks well. Both readings ignore that the brain has not yet received the dose. The examiner is testing whether you know whose severity the grading grades.

Which of the three poisonings this is comes from the history, not the assay; the concentration then estimates the risk ahead, and grades severity only in the patient who was already taking lithium.

### 24.4 Reject the reflex decontaminant, and choose against the drug you are actually treating

**Where the typology turns into an act.** After therapeutic dosing, immediate-release lithium is almost completely absorbed and peaks early, whereas modified-release preparations peak generally at **4 to 5 hours**. Overdose does not simply scale that curve up: prolonged gastric absorption and clumping from insoluble aggregates may occur, especially with lithium carbonate, the least soluble of the lithium salts, providing a **reservoir for continued absorption**. That reservoir is why a decontamination decision exists in the two acute arms and not in the chronic one.

The first branch is the one a generic overdose protocol gets wrong, and it is the reason this topic mentions decontamination at all: **activated charcoal** is not favoured after an acute lithium overdose, for the plain reason that it does not bind lithium. That is a lithium fact and it survives no matter what the general decontamination policy says; the current decontamination source carries the same position for lithium, and it is that source, not this one, which the overdose triage account in these notes holds. The general policy itself, including where gastric lavage now stands and what the current windows are, belongs with the medical triage of the overdose patient in these notes and is not restated here.

| OPTION | WHERE THE GUIDANCE STANDS | WHOSE POSITION, AND WHEN |
|---|---|---|
| **Activated charcoal** | Not favoured after acute lithium overdose, because it does not bind lithium. | EXTRIP workgroup, 2015 |
| **Gastric lavage** | May be performed if required, against a general position that it is not routine and belongs in trained hands. | EXTRIP workgroup, 2015; AACT and EAPCCT, 2013 |
| **Whole bowel irrigation with polyethylene glycol electrolyte lavage solution** | May be performed if required, and separately named for substantial lithium ingestion because morbidity is high and other options are lacking. | EXTRIP workgroup, 2015; AACT and EAPCCT, 2015 |
| **Sodium polystyrene sulfonate** | Suggested for this purpose, but yet to have a clearly demonstrable role. | EXTRIP workgroup, 2015 |

**PITFALL**

The commonest error is not a wrong drug but a reflex one. Charcoal given because the overdose protocol says so binds nothing here, the clock runs, and the notes record a decontamination that did not occur; with that box ticked nobody revisits the question while an option that might work is still open. Where a mixed ingestion makes charcoal right for a co-ingestant, give it for that and say so, leaving the lithium decision visibly open.

### 24.5 Rule whole bowel irrigation in, or rule it out before the patient rules it out for you

The joint position paper on **whole bowel irrigation**, updated in 2015, names lithium twice over. It can be considered for potentially toxic ingestions of sustained-release or enteric-coated drugs, particularly in patients presenting later than 2 h after ingestion when activated charcoal is less effective, which captures modified-release lithium by formulation; and separately for patients who have ingested substantial amounts of iron, lithium or potassium, because morbidity is high and other effective options are lacking, which captures it by name. The same paper records what makes it unavailable:

- **Bowel obstruction, perforation or ileus**, a mechanical bar to committing litres of solution to a gut that cannot move them.
- **Haemodynamic instability**, since the procedure is neither brief nor undemanding and an unstable patient needs the team elsewhere.
- **A compromised unprotected airway**, for lithium the contraindication with teeth, since the neurotoxicity itself is what produces it.

That last gives the decision its expiry date. A patient far enough into lithium neurotoxicity to be obtunded is by that fact no longer a candidate for the decontamination that could have helped an hour earlier. The option closes as the illness advances, which inverts the instinct to wait and see how bad this becomes: waiting removes the intervention. One thing is deliberately not asserted here. The volume and rate at which the polyethylene glycol solution is run, and the amount of sodium polystyrene sulfonate, come from the receiving unit's poisons protocol, and no figure for either is asserted.

**IN INDIA**

The typology gets settled at the door in most Indian emergency rooms whether the team intends it or not, because serum lithium is often a send-out assay returning after the decontamination window has closed. That is not a reason to defer the decision; it is why the history is the instrument. Whole bowel irrigation is also a staffing question before a clinical one: a nasogastric tube, a large volume of solution, a nurse to keep it running and an airway-capable clinician are rarely available together at night in a district hospital. Where they are not, what remains is early transfer, decided on the pattern and the clock.

### 24.6 Treat the decontamination decision as a timed one, and know how contested it is

The evidence is thin and divided, and presenting it as settled overstates it. EXTRIP records that gastric lavage or whole bowel irrigation may be performed if required, while stating in the same breath that there are no data to show improved outcome with any decontamination procedure. Against that sits the one cohort assembled inside this typology, a retrospective observational study from the Angers Poisons and Toxicovigilance Centre, published in 2013, which took acute-on-chronic overdoses and divided them into those undergoing **early decontamination**, by sodium polystyrene sulphonate or whole bowel irrigation or both, and those in whom decontamination was delayed beyond **12 h** or not performed.

On multivariate analysis, early digestive tract decontamination was significantly associated with a lower risk of severe poisoning, with an odds ratio of 0.21, a 95 per cent confidence interval of 0.04 to 0.99 and a p value of 0.049, and the association held regardless of the lithium dose ingested or the serum concentration. Read the caveats with the estimate: a retrospective design, so those decontaminated early may simply be those who arrived early; an interval that nearly crosses one; a single centre. What survives is the final clause: any benefit was independent of dose and of concentration, which describes the shape of the decision rather than its size.

**GOOD TO REMEMBER**

Establish the formulation before the evidence of it disappears. Ask the family to bring the strip, the bottle or the outpatient card, and ask whether the preparation was modified-release, because the answer changes the absorption curve, the case for irrigating rather than lavaging, and the risk in the hours after treatment. None of it can be reconstructed from a serum concentration.

### 24.7 Plan the period after treatment from the formulation that was swallowed

The typology has one more consequence, and it falls after the intervention rather than before it. EXTRIP distinguishes two kinds of rebound following extracorporeal treatment, and the one that concerns an emergency team is **rebound from ongoing absorption**. It occurs with extended-release formulations or decreased gastrointestinal motility, can be noticeably much greater in extent, and may be associated with recurrence of symptoms or clinical deterioration, because the absorbed drug will ultimately distribute into the central nervous system and other tissues. The indications for extracorporeal treatment are taught in the Mood disorders: pharmacotherapy notes; the corollary belongs here, that a good result at the end of a session does not close the episode.

This is where the arms separate for good. The chronic patient's burden is a distribution problem, and it descends predictably once the precipitant is corrected; the modified-release ingestion carries a second event in the gut whose timing nobody can specify, and the monitoring plan is written for that. Disposition is not answered by one improving result.

The handover carries the same content. A patient handed over as lithium toxicity with a number attached has been handed over with the least useful part of the assessment. Handed over as an acute-on-chronic ingestion of a modified-release preparation taken at a stated hour,

decontaminated or explicitly not and why, tells the receiving team what to do next. The typology is not a classification appended to the case. It is the case.

## 25 · Anticholinergic toxicity and other psychotropic overdose syndromes

**Why the marks sit on the act and not on the picture.** What anticholinergic toxicity looks like, and how an antimuscarinic overdose is told from the other hyperthermic emergencies, belongs to the Schizophrenia: management, antipsychotics and adverse effects notes, and none of that is repeated here. Those accounts reduce the antidote to one clause: physostigmine, for specialist hands. What follows recognition is owned here: whether an antidote question has arisen, what is read before the drug is drawn up, who it must be refused to, and what is done instead.

The organising fact is an overlap: the commonest deliberate overdose presenting as antimuscarinic is a tricyclic antidepressant, which is also the overdose in which this antidote has killed people. So the first act is not pharmacological but an electrocardiogram.

### 25.1 Deciding whether an antidote question has arisen at all

The labelled indication is narrower than the drug's reputation. The United States prescribing information for **physostigmine salicylate injection**, in the label version updated in January 2023, indicates it to reverse the effect upon the central nervous system caused by clinical or toxic dosages of drugs capable of producing the anticholinergic syndrome. The operative word is central. A patient with peripheral effects alone, awake and oriented, is not what the indication describes.

Nor is the agent interchangeable with what a pharmacy is likelier to stock. Physostigmine contains a tertiary amine and penetrates the blood brain barrier easily, whereas **neostigmine** carries a quaternary ammonium ion and cannot cross it.

RULE **The antidote decision in an antimuscarinic overdose is made on the agent, the electrocardiogram and the contraindication list, never on how antimuscarinic the patient looks.** Recognition names the family of poisons, not the member, and members diverge on whether this drug helps or kills. Where a tricyclic or other sodium-channel-blocking agent is known or suspected, physostigmine is refused whatever the current QRS, because a narrow complex early does not exclude progression.

### 25.2 Reading the electrocardiogram before anything is given

A prospective study of 49 patients with acute tricyclic antidepressant overdose, in the New England Journal of Medicine in 1985, set serum drug levels against **maximal limb-lead QRS duration** as predictors of seizures and ventricular arrhythmias. It concluded that QRS duration predicts the risk of seizures and ventricular arrhythmias while serum drug levels are not of predictive value. Where a level cannot be had in useful time, that is what makes it usable.

Among the 13 patients whose maximal limb-lead QRS duration was less than **0.10 second** there were no seizures and no ventricular arrhythmias; among the 36 whose duration was 0.10 second or longer, seizures occurred in 34 per cent and ventricular arrhythmias in 14 per cent. The

consequences then part company: seizures occurred at any QRS duration of 0.10 second or longer, while ventricular arrhythmias were seen only from **0.16 second** or longer. Collapsing them into one figure loses the point: the bed is earned at the lower line, the arrhythmia arrives at the upper.

The American Heart Association focused update on poisoning of 2023 states that characteristic electrocardiogram changes usually precede ventricular dysrhythmias in sodium channel blocker poisoning, and names two: intraventricular conduction delay, meaning QRS prolongation, and a terminal rightward axis deviation best appreciated in lead aVR. Precede is what makes a tracing a triage instrument rather than a record.

TRAP **Giving physostigmine because the presentation is antimuscarinic, when what was taken was a tricyclic antidepressant.** The report that changed practice, in Annals of Emergency Medicine in 1980, described two patients with tricyclic antidepressant toxicity who developed asystole after physostigmine was given to treat seizures, when the drug was a commonly used therapy for the antimuscarinic manifestations of tricyclic overdose. The tracing separates them first.

### 25.3 Giving sodium bicarbonate, and knowing when to stop

Where the QRS is wide the act is **sodium bicarbonate**, which the same guideline names the intervention with the most evidence in sodium channel blocker poisoning, typically given as bolus intravenous administration of hypertonic solutions, 1000 mEq per litre in adults and 500 mEq per litre in children. Its antidote table completes the tuple: for sodium channel blockers and cocaine, an initial adult dose of 50 to 150 mEq and an initial paediatric dose of 1 to 3 mEq per kilogram, with a maintenance infusion prepared as a 150 mEq per litre solution and infused at 1 to 3 millilitres per kilogram per hour, by the intravenous or intraosseous route, watching for hypernatraemia, alkalaemia, hypokalaemia and hypochloraemia.

What makes it an act rather than a prescription is the endpoint. Boluses are titrated to resolution of hypotension and of QRS prolongation, so the monitor stops treatment, not a cumulative total, and whether to follow them with an infusion is unsettled. Two ceilings then make it a monitored infusion: serum sodium is not to exceed 150 to 155 mEq per litre and serum pH is not to exceed 7.50 to 7.55. Potassium is replaced during treatment, since hypertonic bicarbonate causes hypokalaemia.

The antidote table's footnote belongs in any answer printing a dose: the maximum paediatric dose should not exceed the adult dose, most antidotes should be repeated frequently and titrated to control of critical signs and symptoms, and the ideal dose of most antidotes is not known and is often controversial.

### 25.4 Reading the contraindication list before the syringe is filled

It is printed whole, because a partial contraindication list is more dangerous than none. Physostigmine salicylate injection should not be used in the presence of asthma, gangrene, diabetes, cardiovascular disease, mechanical obstruction of the intestine or urogenital tract, or any vagotonic

state, and not in patients receiving choline esters or depolarising neuromuscular blocking agents, decamethonium and succinylcholine being named.

One clause carries almost all the mortality. **Cardiovascular disease** bars the drug in exactly the patient in whom the reflex to give it is strongest, because a poisoning that disturbs cardiac conduction presents as antimuscarinic at the same time.

The product record for this label also carries the marketing status of an unapproved drug, with a disclaimer that the drug has not been found by the regulator to be safe and effective and that the labelling has not been approved. It is the best primary statement of how to give the drug, and not an approval.

### 25.5 Pushing the drug slowly, and keeping its own antidote at hand

For overdose of drugs that cause anticholinergic effects the label gives physostigmine salicylate injection **2.0 mg** intramuscularly or intravenously at a slow controlled rate, repeatable if life-threatening signs such as arrhythmia, convulsions or coma occur. The repeat trigger is a sign, not a clock. The label's repeat interval of 10 to 30 minutes if the desired patient response is not obtained attaches to its post-anaesthesia indication, which carries a smaller amount; carrying it into a poisoning is a common transcription error.

The rate is the safety-critical figure and it governs the antimuscarinic-overdose dose too. In this poisoning as in every other indication the label carries, intravenous administration is to be at a slow controlled rate of **no more than 1 mg per minute**, and the reason belongs beside the syringe: rapid administration can cause bradycardia, hypersalivation leading to respiratory difficulty, and convulsions. Each converts a reversible delirium into an airway emergency.

Two preconditions remain. Because of the possibility of hypersensitivity in an occasional patient, atropine sulfate injection should always be at hand, since it is the antagonist and antidote for physostigmine, so the drug is not given anywhere its own antidote is not already drawn up. And overdose of physostigmine can cause a **cholinergic crisis**, for which the appropriate antidote is atropine sulfate, so one ampoule answers both.

> **GOOD TO REMEMBER**
>
> Write the clock time of the dose, the rate it was given over, and the time of the examination that follows. Without those three, bradycardia gets blamed on the poison rather than on the push, and recurrence reads as deterioration rather than as expected.

### 25.6 The airway question that gates decontamination in this poisoning

Whether gastric decontamination is worth attempting at all, which poisons are worth adsorbing, and for how long after ingestion each window stays open, is settled with the medical triage of the overdose patient elsewhere in these notes, and none of it is restated here: the windows are poison-specific, they have moved, and a chapter that fixes them in two places will eventually print them differently. What belongs to this topic is the question that gates the act whatever the window says.

Charcoal is not given to a patient whose airway is unprotected, and in an antimuscarinic overdose the relevant limb is prospective as well as present: a patient whose protective reflexes are at risk, or can be expected to become absent as the toxidrome advances, is a patient in whom the decision has already been made against. The airway question here is answered by where the patient is heading rather than by where they are, so a decision deferred while the toxidrome advances is usually a decision made. For an agitated patient that usually settles it.

Three questions settle it at the door:

- is the airway intact or protected now, by somebody who can keep it so if the patient vomits;
- how long since ingestion, counted from a stated time not from arrival, and is that past the measured window;
- does charcoal now foreclose something better later, since the oral route is spent afterwards.

| FINDING THAT FORCES A DECISION | ACT IT SELECTS | WHAT MUST BE TRUE FIRST | WHAT ENDS IT |
|---|---|---|---|
| **Antimuscarinic exposure, consciousness disturbed, tracing clear, and no tricyclic or other sodium-channel-blocking agent known or suspected** | Physostigmine considered | Contraindications read and clear, atropine drawn up, somewhere the patient is watched. A tracing is clear only if the QRS is inside the seizure line AND there is no terminal rightward axis in aVR, on a tracing repeated rather than taken once | Orientation returns, then a watch for recurrence |
| **Peripheral effects only, patient oriented** | No antidote, recorded as a decision | Conscious level assessed, not inferred | Nothing to end. Observe |
| **QRS past the seizure line after a tricyclic ingestion** | Bicarbonate bolus, physostigmine refused | Access, monitoring, and sodium, potassium and pH measurable on site | Hypotension and QRS prolongation resolve, inside the two ceilings |
| **QRS past the arrhythmia line** | The same act in a monitored bed, critical care in early | That the bed exists and was agreed beforehand | The same endpoint, and care not stepped down as the tracing narrows |
| **A charcoal-adsorbable ingestion, inside the window that poison and formulation actually carry** | Activated charcoal considered, per the overdose triage account | An intact or protected airway, and reflexes not expected to fail. If either is in doubt, the decision is made for you | Given per the regimen that account sets, never assumed to be a single dose |

### 25.7 Holding the patient when the antidote is refused or unavailable

**What the comparison against sedation showed.** A blinded randomised trial in Clinical Toxicology in 2021 enrolled patients aged at least 10 and under 18 with at least one central and two peripheral antimuscarinic symptoms, together with delirium and moderate agitation, an adolescent

population, not an adult one. Its physostigmine arm received a 0.02 mg per kilogram bolus followed by a four hour infusion at 0.02 mg per kilogram per hour, in adolescents. Physostigmine was superior to the benzodiazepine comparator in controlling delirium and agitation after bolus dosing and in controlling delirium at the fourth hour of infusion, with no serious adverse events in either arm, and the authors confined their recommendation to adolescent patients. The trial was small and its arm sizes are not asserted here.

Two things are deliberately absent. There is no sedative agent, dose, route or titration for the agitation: benzodiazepine dosing in the emergency belongs to the Schizophrenia: management, antipsychotics and adverse effects notes. Nor is there a temperature threshold at which cooling begins, a method or a target: no comparable standard is available to quote, and none is invented here. Heat here is generated by agitation in someone whose thermoregulation the poison has impaired, so sedation is a temperature intervention as well as a behavioural one, and what is charted is temperatures with times against them.

### 25.8 What changes at the door in the other psychotropic overdoses

The title of this topic promises more than one poison, and the promise is kept as acts rather than as a second toxidrome. Most psychotropic overdoses have no antidote of any kind, which makes what is examinable in each narrower and more useful than a picture: whether an antidote question arises at all, which single measurement selects the next act, and which reflexive act is refused.

For the serotonergic antidepressants the antidote limb closes at the first line. The approved product information for a **selective serotonin reuptake inhibitor** states that there are no specific antidotes to it, and directs instead an airway established and maintained, oxygenation and ventilation ensured where necessary, and general symptomatic and supportive measures; induction of emesis is not recommended. The measurement that does the work is the tracing. QTc prolongation and torsade de pointes have been reported following overdose, so electrocardiogram monitoring is recommended in all ingestions of it. In all ingestions is the phrase to hold: the tracing is not reserved for the patient who looks unwell, which is what makes it a triage instrument in a poisoning that has nothing else.

The negative act here is what separates this overdose from the one taught with the lithium toxicity account in these notes. Because the volume of distribution is large, forced diuresis, dialysis, haemoperfusion and exchange transfusion are unlikely to be of benefit. In the lithium overdose the decision at the door is precisely about elimination and level of care. Same word, opposite act, and the reason is pharmacokinetic and stated by the regulator rather than reasoned at the bedside. Where a second serotonergic agent is on board the question stops being overdose management altogether and becomes the serotonin toxicity decision rule, which the Hunter criteria account in these notes owns.

For the antipsychotics the shape repeats and the refusal is sharper. There is no specific antidote, and induction of emesis is not recommended. Cardiovascular monitoring is necessary to detect possible

arrhythmias, and close medical supervision and monitoring continue until the patient recovers, so here too the stopping rule is the patient and not a clock.

RULE **In an antipsychotic overdose that becomes hypotensive, adrenaline, dopamine and the other beta-agonist sympathomimetics are refused.** The approved product information directs treatment of hypotension and circulatory collapse and support of respiratory function, then states the bar in terms: those agents are not to be used, since beta stimulation may worsen the hypotension. It is a refusal and not a caution, and it names what a team reaching for a pressor reaches for first. No alternative pressor is recommended by the source and none is asserted here.

Nor is an antipsychotic overdose finished when the patient wakes. Neuroleptic malignant syndrome is listed among the medically significant sequelae of overdose, alongside delirium, convulsion, coma, respiratory depression, aspiration, blood pressure disturbed in either direction, cardiac arrhythmia and cardiopulmonary arrest. The consequence is a disposition one: the criteria set taught elsewhere in these notes can become the relevant instrument hours after the overdose itself has been survived.

The remaining members of the class are held elsewhere on this chapter and are named here so that nobody is sent looking:

- the benzodiazepine overdose, its reversal agent, and why that agent is not routine in an undifferentiated ingestion, with the medical triage of the overdose patient;
- the mixed or unidentified ingestion, and the overdoses whose early appearance is deceptively benign, with the same account;
- lithium, with the lithium toxicity account, where the ingestion typology governs the kinetics and the elimination decision;
- serotonin toxicity, with the Hunter criteria account, which owns the decision rule and the antidote question that follows it;
- the tricyclic antidepressant, which is the rest of this topic and the one member of the class in which an antidote decision is both live and lethal.

### 25.9 Deciding where the patient goes, and for how long

Disposition follows from one pharmacological fact. Reversal can be expected within minutes of intravenous administration if the diagnosis is correct and the patient has not suffered anoxia or other insult, but the duration of action of physostigmine is relatively short, approximately **45 to 60 minutes**. The agents reversed outlast that, so recurrence is expected rather than a complication, and one dose is a diagnostic and temporary act. A failure to respond is informative: either the patient was not antimuscarinic, or something the antidote cannot touch has done harm.

The antidote therefore changes a disposition, and there is evidence on which one. A single-hospital retrospective chart review in Annals of Pharmacotherapy in 2019 found no difference between groups in age, sex or initial heart rate, and concluded that physostigmine use was associated with decreased resource utilisation, including intubation and intensive care placement, without

increasing rates of bradycardia, vomiting or seizures. Retrospective, single-centre and unblinded, it gives a direction and not a cause.

| 141 | 46% | 32% | 20% |
|---|---|---|---|
| PATIENTS WITH AN ANTIMUSCARINIC TOXIDROME IN THE SINGLE-HOSPITAL REVIEW | PROPORTION OF THAT COHORT GIVEN PHYSOSTIGMINE | PROPORTION OF THAT COHORT ADMITTED TO INTENSIVE CARE | PROPORTION OF THAT COHORT INTUBATED |

Whether the drug can be had is a separate question. A series in the American Journal of Emergency Medicine in 2025 records that supply of physostigmine has been limited because the United States manufacturer stopped production, and proposes **rivastigmine**, a long-acting acetylcholinesterase inhibitor approved for dementia, as a potential alternative. Read that as a signal about scarcity, not a substitution you may make: no dose or regimen is asserted here.

**IN INDIA**

Physostigmine does not appear in the antidote section of the National List of Essential Medicines 2022, whose specific antidote list begins with atropine, calcium gluconate, D-penicillamine, desferrioxamine and methylthioninium chloride and continues to N-acetylcysteine, naloxone, neostigmine, pralidoxime chloride, snake venom antiserum, sodium nitrite and sodium thiosulphate, while activated charcoal is the sole entry under non-specific measures. The local position is exact: the antidote's own antidote is on that list, the anticholinesterase that cannot reach the brain is on it, and the drug itself is not. So the antidote limb usually ends in a decision about a drug that is not in the building. What is scarce is not a molecule but a monitored bed with an anaesthetist attached. Settle in advance which medical unit accepts a wide-QRS poisoning and whom you telephone when the answer is no, and record each refusal with its time.

Three things belong in the handover, which only the clinician present can supply:

- the tracings in sequence with times, since direction of change matters more than any width;
- whether physostigmine was given, refused or unavailable and on which ground, so a cardiovascular refusal is not quietly reversed by a fresh team;
- whether decontamination was given and when, since it changes what can be offered by mouth.

Read the electrocardiogram and the contraindication list before physostigmine is drawn up, keep atropine beside it, give it no faster than the label allows, and treat one dose as an act that wears off before the poison does.

# The medical emergency and the perinatal overlay

## 26 · Delirium triage and emergency management

**Why the marks sit on the first ten minutes.** What acute confusion is, how it is defined, separated from its mimics, investigated and prevented is set out in the Stroke, TBI, delirium and focal brain syndromes notes, and none of that is repeated here. That account, like almost every account in the literature, is written from the ward and the intensive care unit, and assumes a patient already recognised, admitted and labelled. This topic covers the window before any of that is true: an elderly man is brought in by relatives who say he has not been himself since morning, and nobody yet knows whether the answer is metabolic, a drug, a head injury, an infection or a psychiatric illness. What is done in that window, in what order, by whom, and where he goes at the end of it is a different object from the syndrome.

Two features make this a discipline of its own. Nothing is differentiated yet, so every act must be justifiable without a diagnosis; and the department is a throughput system with a queue, in which a quietly confused patient makes no demand at all. The general shape of the first hour, and the assessment of the patient who arrives agitated or aggressive, are taught where that assessment is set out in these notes. What follows takes the confused patient through it, built around acts rather than causes.

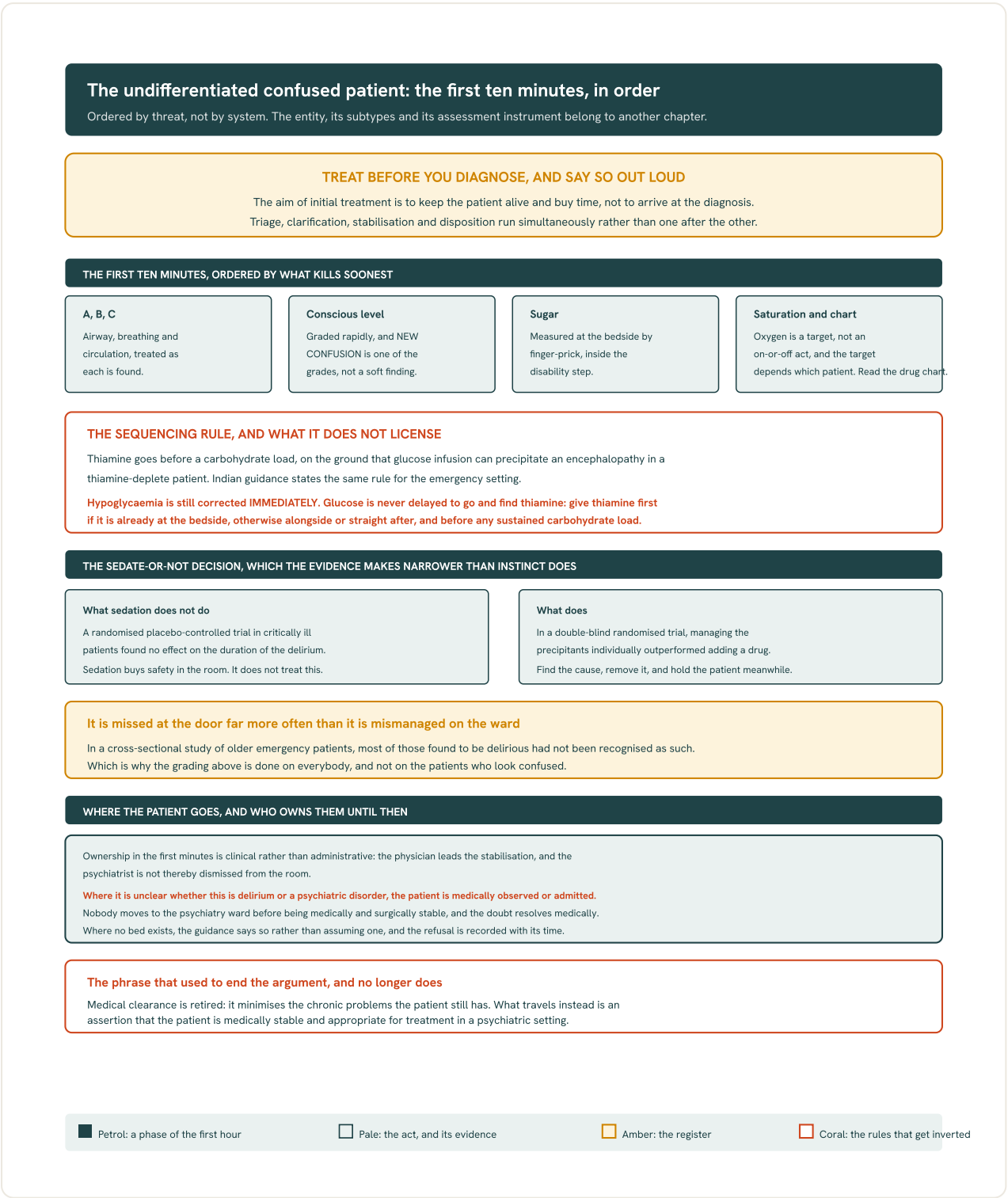


Fig 28.8. The undifferentiated confused patient at the front door drawn as a timed sequence ordered by threat, with conscious level, blood sugar, oxygen saturation and the drug chart taken in the first ten minutes, the thiamine and carbohydrate sequencing rule stated as a rule together with the correction that hypoglycaemia is never left waiting for it, the sedate-or-not decision set against the trial evidence on either side, and the disposition rule that doubt between delirium and a psychiatric disorder resolves towards the medical bed.

## 26.1 Recognising confusion at the door, and how often it is not recognised

The warrant for treating this as a separate skill is that the front door is where confusion is most reliably lost. In a cross-sectional study published in Academic Emergency Medicine in 2009 by Han

and colleagues, a convenience sample of emergency department patients aged sixty-five and over in a single tertiary care academic centre in the United States was assessed formally, and the result compared with the treating emergency physician's own conclusion. The great majority of those who were delirious had not been recognised as delirious by that physician.

| 19 of 25 | 76.0% | 54.9 to 90.6% |
|---|---|---|
| DELIRIOUS OLDER EMERGENCY DEPARTMENT PATIENTS NOT RECOGNISED AS DELIRIOUS BY THE EMERGENCY PHYSICIAN | THAT UNRECOGNISED PROPORTION, IN A SINGLE TERTIARY CARE ACADEMIC EMERGENCY DEPARTMENT | 95 PER CENT CONFIDENCE INTERVAL AROUND THE UNRECOGNISED PROPORTION |

Read the estimate honestly: one department, one convenience sample, a small numerator and a wide interval. What is secure is a direction and an order of magnitude, not a precise failure rate, and the direction is the justification for the topic.

The reasons are structural rather than a matter of individual carelessness. Confusion without agitation makes no noise, and a system that allocates attention by noise allocates none to it; the history that would establish an acute change from baseline is not in the patient but in the relative sent to the registration counter; and the vital signs chart has no field into which a change in thinking can be written unless somebody creates one.

### 26.2 Treating what will kill the patient before naming what is wrong

Assessment of the undifferentiated patient is ordered by threat rather than by diagnosis. In **the ABCDE approach**, set out by the Resuscitation Council UK and last updated in 2024, the stated underlying principles carry the whole front-door lens. Each life-threatening problem is treated at the point in the assessment where it is found, before the assessment moves on. The effect of that treatment is then assessed rather than assumed. And the need for extra help is recognised and called for early, rather than once the assessment is complete.

RULE **Treat the life-threatening problem at the moment you find it and then reassess; do not carry it forward to the end of the assessment.** A candidate trained to take a history, examine, formulate and then act will complete the survey before intervening, because every clinical method they have been examined on is built that way. In an undifferentiated patient that is the wrong order: the problems which kill in the first minutes are the ones correctable in the first minutes, and each window closes while the survey goes on.

The same source states the aim of initial treatment explicitly, and it is worth quoting to yourself when a senior colleague asks what you think is going on: the aim is to keep the patient alive and achieve some clinical improvement, and doing so buys time for further treatment and for making a diagnosis. The diagnosis is not the first task and is not delayed by stabilisation; it is what stabilisation makes possible. And because every act here is justified by threat rather than by diagnosis, none of it is invalidated when the diagnosis turns out to be psychiatric; whereas deferring a correctable physiological problem because the presentation looked psychiatric is indefensible on any account of what happened.

### 26.3 Deciding who owns the patient, and running the first hour in parallel

Ownership in the first minutes is a clinical question, not an administrative one, because a patient who belongs to nobody is a patient in whom every act waits for a conversation. In the Indian Psychiatric Society's 2023 clinical practice guidelines on elderly patients presenting with psychiatric emergencies, first importance in clinical stabilisation is given to airway, breathing and circulation, and the physician rather than the psychiatrist should primarily do this. The psychiatrist is not thereby dismissed from the room: the psychiatric contribution in that window is to manage the psychiatric manifestations that would otherwise obstruct physical stabilisation, since a patient pulling out a cannula or striking at the person taking blood is one in whom the physician cannot proceed.

The same guidance corrects a second misunderstanding: the measures of an emergency episode are carried out almost simultaneously rather than sequentially. A chapter that presents the first hour as a numbered list teaches it wrongly, because a numbered list implies each step waits for the one before it.

- **Triage and prioritisation**, beginning the moment the patient is inside the door and not when a bed is found.
- **Diagnostic clarification and clinical stabilisation**, each informing the other.
- **Patient safety and prescribing decisions**, taken while the physiology is still being corrected.
- **Briefing the family**, who in Indian practice are the history, the consent conversation and often the observation, and can supply none of it from the corridor.
- **Monitoring and the treatment-setting decision**, formed from the first minute and not announced at the end.

The work is therefore distributed rather than serialised, and the commonest reason a confused patient waits is that one clinician has taken all of it on and is doing it in sequence.

> **GOOD TO REMEMBER**
>
> When acts run in parallel, the record is the only thing that can reconstruct them afterwards. Write the clock time beside each act and the reassessment that followed it: the time the sugar was taken and its value, the time glucose was given and the conscious level afterwards. The instruction to assess the effects of treatment is unverifiable without it.

### 26.4 Triaging the confused patient: managing the environment as the first intervention

**Triage** is usually taught as a sorting decision made at a desk, determining how long somebody waits. For the confused older patient it is better understood as the first clinical intervention, because the environment the patient is placed in changes the presentation before any drug is given. Indian guidance is the one source here that describes the act concretely rather than merely naming it, and the five measures it names are worth learning as a set.

- **Reduce the waiting time.** Waiting is unstructured time in an unfamiliar place with nobody attached to the patient, and it worsens both the presentation and the assessment.
- **Ensure the patient's physical comfort.** Pain, a full bladder, cold, thirst and an uncomfortable trolley are all correctable, and all are commonly read as agitation belonging to the illness.
- **Reduce external stimuli.** The department is bright, loud and continuously in motion, which is the environment a disturbed sensorium handles worst.
- **Manage the patient in an isolation room where possible.** A single-patient space for the patient's benefit, not a segregation measure; the qualification is in the guidance itself.
- **Ensure there are no potentially dangerous objects in the treatment setting.** Done to the room before the patient arrives in it, not to the patient after something has happened.

These are interventions with an expected effect, not courtesies. A patient who settles once the lights are lowered and the bladder is emptied has told you something clinically useful, without a sedative and without confounding the neurological examination that follows. The environment is also the only intervention deliverable before the patient is assessed, which is why it belongs to triage rather than management.

### 26.5 Grading conscious level inside the primary survey

The single change that most improves recognition costs nothing and takes seconds: conscious level is graded during the primary survey, in the same pass as airway, breathing and circulation, and new confusion is one of the available grades. The Resuscitation Council UK approach makes a rapid initial assessment of conscious level by the **ACVPU** method, and offers the Glasgow Coma Scale as the alternative.

- **Alert.** Awake and engaged, with no qualifier attached.
- **Newly Confused.** A grade in its own right, and the one that matters here, because it gives the emergency chart a place to record disordered thinking at the moment it is noticed.
- **Responding to Vocal stimuli.** Not spontaneously awake, but rousable by voice.
- **Responding to Painful stimuli.** The stimulus the guidance names is supra-orbital pressure, applied at the supraorbital notch.
- **Unresponsive** to all stimuli.

For a psychiatric reader the placement matters more than the letters. New confusion is recorded inside the primary survey, alongside airway and circulation, not deferred to a mental state examination performed later by somebody else. That puts the observation in the hands of whoever meets the patient first; it timestamps the finding, so a later deterioration has an earlier grade to be a deterioration from; and it makes the observation part of the physiological record rather than the psychiatric one, which is what stops it being filed as somebody else's business.

The word new cannot be verified from the patient: establishing it requires somebody who knew the patient last week, which in an Indian department is the attendant in the corridor, so obtaining that comparison is part of grading the level, not a separate exercise afterwards.

### 26.6 Excluding reversible causes as a timed act rather than a list

Every textbook lists the reversible causes of an acute confusional state, and candidates reproduce the list well. What it does not carry is what makes it usable in an emergency: each item has a specific act, a specific moment at which that act must happen, and a specific result that looks reassuring and is not. Reorganised that way it becomes a sequence to be performed rather than a taxonomy to be recalled. The acts below are those the primary survey contains; the wider aetiological workup belongs to the Stroke, TBI, delirium and focal brain syndromes notes.

| THE ACT AT THE DOOR | WHAT IT IS LOOKING FOR | WHY IT IS TIMED, NOT MERELY LISTED | THE RESULT THAT MUST NOT REASSURE YOU |
|---|---|---|---|
| **Grade the conscious level** | New confusion as a recorded grade rather than an impression | Taken inside the primary survey, so it exists before any history or label | An impression of alertness in a patient never actually graded |
| **Measure the blood glucose at the bedside** | Hypoglycaemia, correctable within a minute and lethal if left | The correction is given where the result appears, not after the survey | A normal finger-prick in a shut-down or peri-arrest patient, where the method is unreliable |
| **Set the oxygen target, then give oxygen** | Hypoxaemia, and the wrong target for this patient | The target is chosen when oxygen is started, and both errors follow that decision | A saturation inside the general target in a patient at risk of hypercapnic respiratory failure |
| **Order thiamine and carbohydrate correctly** | The patient in whom giving glucose is not a neutral act | Thiamine first if it is already at the bedside, otherwise with or straight after the glucose, and always before any sustained carbohydrate load | A low sugar treated as a self-contained problem with a self-contained answer |
| **Read the drug chart and reverse what is reversible** | Depressed consciousness that has a specific antagonist | An antagonist not given in this window is usually not given at all | A plausible psychiatric or social explanation that quietly ends the search |

MNEMONIC

### Conscious level, Sugar, Saturation, Chart

What is done at the bedside before anyone commits to a diagnosis: **Level** of consciousness graded inside the primary survey, blood **Sugar** measured and corrected where low, oxygen **Saturation** measured against a target chosen for this patient, and the drug **Chart** read for a reversible drug cause. The thiamine sequencing rule sits inside the sugar step.

## 26.7 Measuring the blood sugar, and knowing when not to believe it

Blood glucose is measured to exclude hypoglycaemia by a rapid finger-prick bedside method, inside the primary survey rather than in the batch of blood sent afterwards. The reason is arithmetic about time: hypoglycaemia is the fastest exclusion on the list, and a process that defers it to a laboratory result has spent an hour on it.

The correction follows local protocols, and the worked example the Resuscitation Council UK gives is a complete instruction rather than a bare number: in an unconscious patient whose blood sugar is **less than 4.0 mmol/L**, an initial dose of **50 mL** of 10 per cent glucose solution is given intravenously. Note what that threshold is and is not. It is a treatment threshold for hypoglycaemia in an unconscious patient at the front door, not a diagnostic band for any psychiatric syndrome; it does not define a level below which confusion is explained, and a patient whose sugar sits above it has not acquired an alternative diagnosis.

The caveat attached to the method is the part most often dropped in reproduction, and it matters most in the sickest patients. In a **peri-arrest** patient a venous or arterial sample is used instead, because finger-prick glucose measurements can be unreliable in sick patients. The reason: a finger-prick samples capillary blood from a peripheral bed, and peripheral perfusion is exactly what fails in shock.

PITFALL

A normal finger-prick reading in a cold, shut-down, peripherally vasoconstricted patient is not a negative result. It is an unreliable result that happens to be reassuring, which is worse than no result, because it goes on the chart and is read thereafter as an exclusion. In any patient who is peri-arrest or profoundly shocked, take the glucose from a venous or arterial sample and record which you used, so a later reader can tell whether hypoglycaemia was excluded or merely tested for.

## 26.8 Giving thiamine before carbohydrate

Two acts each correct alone can be harmful in the wrong order, and this is the sequencing rule of the first minutes. Thiamine is given before any sustained carbohydrate load. Read that precisely, because the common misreading is dangerous in the other direction: a documented low sugar is corrected immediately and glucose is never held back while thiamine is looked for. Give thiamine first where it is already at the bedside, otherwise with the glucose or straight after it, and before any infusion, feed or oral intake that follows. The European Federation of Neurological Societies, in its

guideline on Wernicke encephalopathy published in the European Journal of Neurology in 2010, states the rule and its ground together: it is important to give thiamine before any carbohydrate, because glucose infusion precipitates Wernicke encephalopathy in thiamine deficiency.

Indian guidance states the same rule for the emergency setting and supplies the mechanism, which is the version worth carrying into an examination because it explains rather than asserts. In the Indian Psychiatric Society's 2023 guidelines on patients with substance intoxication presenting to the emergency department, thiamine is administered before glucose replenishment so that the glucose is used in ATP generation, a process which itself uses thiamine as a co-factor. Giving carbohydrate first therefore sequesters an already limited store into metabolism, and that sequestration precipitates the encephalopathy. The glucose is not toxic; it is a demand placed on a supply that is not there.

The rule applies to the undifferentiated patient, because the population at risk is defined by nutritional state and alcohol history and neither is known at the door: the safe reading is that thiamine goes in first, or at latest with the glucose, in any confused patient in whom deficiency is even plausible. It requires no diagnosis, because the order is fixed before anyone has decided what is wrong. The thiamine dose, its route and duration, and the syndrome of Wernicke encephalopathy itself are taught in the Endocrine and metabolic psychiatry notes, and the withdrawal regimens carrying their own thiamine schedules belong to the Substance use disorders notes. No dose is asserted here, deliberately, because a half-remembered regimen is more dangerous at this point than an explicit handover.

### 26.9 Setting an oxygen target rather than turning oxygen on

Oxygen is prescribed to a target, not delivered at maximum because the patient looks unwell, and the confused patient is where that distinction is most often lost. The Resuscitation Council UK gives two targets. In acute respiratory failure the aim is to maintain an oxygen saturation of **94 to 98 per cent**. In patients at risk of **hypercapnic respiratory failure** the aim is lower, at **88 to 92 per cent**.

The teaching lies in the existence of two targets rather than in either figure. A confused patient is not simply given the highest available flow, because the correct target depends on which failure is in front of you, and choosing wrongly is an error in both directions. Under-oxygenating a hypoxaemic brain prolongs exactly the state you are trying to reverse. Over-oxygenating a patient at risk of hypercapnic respiratory failure produces a rising carbon dioxide, and a rising carbon dioxide produces a drowsy, confused patient: the treatment reproduces the presenting complaint, and reads as deterioration of the original illness. The same saturation reading is therefore a success in one patient and a warning in another, and the chart cannot distinguish them unless somebody has written down which target was aimed at. Where the risk of hypercapnic failure is unknown, that uncertainty is handed over rather than resolved silently by turning the flow up.

### 26.10 Reading the drug chart, and giving an antagonist where one exists

Within the same step of the primary survey the drug chart is checked specifically for reversible drug-induced causes of depressed consciousness, and an **antagonist** is given where appropriate; the example the guidance names is naloxone for opioid toxicity. The important word is specifically: not the general medication review that happens later on the ward, but a targeted search, performed during the survey, for a cause with an immediate reversal.

Framed as a decision rule rather than as poisoning management, each part of it is a separate failure point. A reversible drug cause is actively looked for, which means somebody obtains the chart or the tablets the family brought, rather than recording that the history was unavailable. If one is found the antagonist is given, meaning now and not requested for later. And the effect is then assessed, because an antagonist given and not evaluated has produced a record rather than a result.

The opioid toxidrome, the naloxone dose, its titration and its re-dosing are taught in the Substance use disorders notes; what belongs to the front door is only the decision that a reversible drug cause is sought and reversed. In a psychiatric population the drug chart is two-sided: a list of possible causes, and a list of what the patient may have stopped taking. Neither reading is available unless somebody finds the chart, which in Indian practice usually means asking an attendant to bring the medicines from home, in the first minutes rather than at the end of the shift.

### 26.11 Deciding whether to sedate, and knowing what sedation does not buy

**What the decision to sedate is actually for.** A confused patient climbing off the trolley or pulling at lines obstructs the very stabilisation the preceding steps require, so there are legitimate reasons to sedate. What a candidate must be able to say is what sedation achieves and what it does not, because the commonest error is to treat a sedative as a treatment for the confusional state itself. Two trials settle it, and neither concerns dosing.

The first is the randomised, double-blind, placebo-controlled trial reported in the New England Journal of Medicine in 2018 by Girard and colleagues, in critically ill patients with acute respiratory failure or shock who were delirious in the intensive care unit. Haloperidol and ziprasidone, compared with placebo, did not significantly alter the duration of delirium. Whatever a sedative buys in that setting, it does not buy a shorter confusional state, and a plan built on the assumption that it does is a plan with no endpoint.

The second identifies the comparator that does work. In a double-blind, dose-titrated randomised trial in inpatient hospice and hospital palliative care services in Australia, reported in JAMA Internal Medicine in 2017 by Agar and colleagues, individualised management of the **delirium precipitants** together with supportive strategies produced lower scores and a shorter duration of the targeted distressing symptoms than the same care with risperidone or haloperidol added. What beat the drug was not nothing; it was doing the precipitant work properly. The caveat travels with the finding: these were palliative care patients with life-limiting illness, and the result is not transposed unqualified onto an undifferentiated emergency population.

TRAP **Recording the decision to sedate as the treatment of the confusional state.** Candidates make this error because sedation is the only act that visibly changes the patient in front of them, and because the notes have a space for what was given and none for what was corrected. Written as treatment it closes the episode: the patient is settled, the search for the precipitant stops, and the next clinician inherits a quiet patient with an unexamined cause. Written correctly it is an enabling act with a stated purpose, to let the physical assessment, the access and the imaging proceed, and it leaves the precipitant work still owing. The agent, its dose and the cardiac monitoring attached to it are taught in the Schizophrenia: management, antipsychotics and adverse effects notes.

### 26.12 Deciding where the patient goes, and writing the handover that says so

Disposition is where a wrong decision costs most, because the emergency department is the last point at which medical and psychiatric resources are both immediately present. Four questions arise, each answered in a named document from a named body.

| THE QUESTION AT THE DOOR | WHAT THE GUIDANCE SAYS TO DO | WHOSE RULE, AND WHEN |
|---|---|---|
| **It is not clear whether this patient has delirium or a psychiatric disorder** | The patient is medically observed or hospitalised, after an appropriate medical screening examination and appropriate documentation for the presenting complaint | American Association for Emergency Psychiatry Task Force, 2017, by expert consensus |
| **Can this patient be moved to the psychiatry ward** | Not until the patient is medically and surgically stable | Indian Psychiatric Society, 2023, written for elderly patients |
| **How long should the patient remain in the emergency setting** | The shortest possible time; the emergency department is transit and not a destination | Indian Psychiatric Society, 2023, written for elderly patients |
| **What does the transfer note actually say** | That the patient has been evaluated medically and is medically stable and appropriate for treatment in a psychiatric setting, rather than that the patient is clear | American Association for Emergency Psychiatry Task Force, 2017 |

The first row is the most useful decision rule here. Uncertainty between a confusional state and a psychiatric disorder resolves towards medical observation, because the two errors are not symmetrical: a patient with a primary psychiatric illness observed medically for some hours loses very little, while a patient with an unrecognised medical cause admitted to a psychiatric ward loses the monitoring, the investigations and the medical team in one movement. Quote the grading with the rule, since the task force states its recommendations rest on expert consensus and should be treated as preliminary until further evidence is obtained. Note too what the requirement to be **medically and surgically stable** does to the sequence: it makes the physical stabilisation of the preceding steps a precondition for the psychiatric disposition rather than a parallel courtesy.

The fourth row is a point about language that turns out to be a point about safety, and it is made in full with the medical triage of the overdose patient in these notes rather than here: the same task

force retires the term **medical clearance**, and what replaces it keeps the two claims a handover can actually support. What this topic needs from that argument is only its consequence for the confused patient, which is the row above: where it is unclear whether this is delirium or a psychiatric disorder, the doubt is resolved medically and not by transfer.

**IN INDIA**

Indian guidance addresses the case protocols elsewhere assume away. Where a patient requires inpatient care and cannot be moved to an inpatient ward or intensive care unit because no bed is available, the Indian Psychiatric Society's 2023 guidance states that the family should be allowed to shift the patient to another treatment setting. Disposition here is therefore partly a decision about where a bed exists, so the enquiry begins early rather than after the decision to admit. And the transfer that follows is a clinical act: the receiving setting must be told what has been done, what is still owed and what the patient was stable enough for, because a patient moved by a family without that handover arrives as an undifferentiated confused patient for a second time. The same reasoning covers the single room, the observation and the monitoring these pathways assume: where the department cannot provide them, that is recorded and factored into the disposition, not quietly assumed met.

In an undifferentiated confused patient, each life-threatening problem is treated the moment it is found and its effect reassessed; conscious level is graded inside the primary survey with new confusion as a grade of its own; glucose and oxygen are corrected to a target, thiamine before any carbohydrate; sedation is an enabling act, not a treatment for the confusional state; and where it is unclear whether this is delirium or a psychiatric disorder, the patient is medically observed or hospitalised rather than sent to a psychiatric bed.

## 27 · Acute alcohol withdrawal and delirium tremens (emergency aspect)

**Why this is examined as an act.** A man is brought in at night by relatives who say he drinks. He is drowsy, sweating, pulling at the trolley rails, and cannot account for himself. Nothing in that sentence is a diagnosis, and the one word everybody in the room has already supplied is the word that must be withheld longest. What the withdrawal syndrome is, when it declares itself, how its severity is scored and which regimens treat it belong to the Substance use disorders notes, which own that entity in full. What is owed here is the sequence that runs before any of it is known, and the decision about where this patient spends the night.

The examination question has the same shape: what is done first, what is excluded before anything is attributed, and which of three destinations the patient leaves for. The ordered sequence of arrival, safety, parallel differential, act and disposition is the spine every emergency presentation runs on, set out in the section of these notes on the assessment and management of the acutely agitated and aggressive patient, with the general front door of the confused patient in the section on delirium triage and emergency management. This section takes the version alcohol distorts.

### 27.1 The patient who arrives before the history does

The structural difficulty is that the diagnosis arrives ahead of the patient, and from somebody else. The escort supplies it, the smell appears to confirm it, and the patient cannot contest it, because the state being explained is the one that stops him explaining anything. Treat the reported drinking history as collateral information with a source and a reliability, not as an established mechanism.

Before any of that is adjudicated, the same priority governs this arrival as every other. NICE guideline NG232 on head injury assessment and early management, published in 2023, sets it in one line: stabilise airway, breathing and circulation before attending to other injuries. In a patient who may be intoxicated this is not a formality. A depressed conscious level, a blunted gag, vomiting and the flat position he has been laid in make an aspiration set, and the restlessness that follows hypoxia is indistinguishable at the door from the restlessness of withdrawal. The airway is answered on the state in front of you, never on the mechanism you suspect.

### 27.2 Exclusion first, attribution second

The sentence this lens turns on is one recommendation from the same guideline, and its grammar teaches as much as its content. A depressed conscious level may be assumed to be due to intoxication only after an **important traumatic brain injury** has been excluded. The permission is genuine, but conditional, and it sits at the end of the sequence rather than the start. The injury itself and its imaging decision rules belong to the Stroke, TBI, delirium and focal brain syndromes notes; the order is what is owed here.

RULE **Intoxication is a conclusion, never a premise.** It is the label you arrive at once the exclusions have been performed, not the one you begin with and then defend. Written the other way round the assessment has no stopping rule: every abnormal finding is absorbed into the explanation already chosen, and the patient improves on paper by being observed rather than examined.

The order matters because the two states share almost every surface feature, diverge completely in what the next hour requires, and coexist in any drinker who has fallen. The wrong order also fails silently: a missed injury in a patient assumed to be drunk produces exactly the course everyone expects, and the deterioration reads as the alcohol taking its time.

TRAP **The smell closes the assessment.** The smell of alcohol is evidence of recent drinking, a different proposition from the cause of the conscious level, and compatible with every other diagnosis on the list. The examined version is the patient documented as sobering up while an extradural collection fills.

### 27.3 The parallel sweep, and what it is looking at

The 2023 Indian Psychiatric Society clinical practice guideline on substance intoxication presenting to the emergency department instructs that other causes of **altered sensorium** be ruled out, naming the metabolic set first with the investigations that answer it. The word carrying the teaching is parallel: the sweep does not wait for the alcohol assessment to finish, and is not a second opinion sought when the first explanation disappoints.

The same guidance adds a bedside step routinely skipped in a psychiatric assessment. Unresponsive patients may be harbouring an **occult head injury** identifiable from raised intracranial pressure, so direct ophthalmoscopy is advised, looking for papilloedema as a clinical sign of that pressure. It carries its own qualification: papilloedema without raised intracranial pressure may also be seen in **methyl alcohol poisoning**, which matters greatly in Indian practice, so the sign narrows the field without settling it.

| LIMB OF THE SWEEP | WHAT IS BEING EXCLUDED | THE ACT THAT ANSWERS IT |
|---|---|---|
| **Metabolic** | Hypoglycaemia, electrolyte imbalance, hyperosmolar hyperglycaemic state, diabetic ketoacidosis, metabolic acidosis | Blood glucose, renal function tests, arterial blood gases |
| **Traumatic** | An important traumatic brain injury, excluded before a depressed conscious level is attributed to drink | The head injury pathway, with imaging where it indicates |
| **Raised pressure, at the bedside** | Occult head injury in the unresponsive patient | Direct ophthalmoscopy, looking for papilloedema |
| **Toxicological look-alike** | Methyl alcohol poisoning, in which papilloedema appears without raised intracranial pressure | Raised whenever the fundal sign appears and the pressure story does not fit |

MNEMONIC

### Sugar, salts, gases, fundi

Blood glucose, renal function tests, arterial blood gases, then the fundi through a direct ophthalmoscope. The first three go with the first draw; the fourth costs nothing, needs no laboratory, and is available in every room where this patient is seen.

## 27.4 What converts a behavioural presentation into a medical one

The sweep answers what to exclude. When a patient presenting behaviourally should be pushed towards medical assessment at all is a separate question, and it is answered by a consensus TRIGGER LIST rather than by a battery. That list, its provenance and each of its items are taught with the medical triage of the overdose patient in these notes and are not restated here. What belongs to this topic is that intoxication and withdrawal sit ON that list: they are reasons to do MORE medicine rather than less, which is the exact inversion the drinking history invites.

Read where alcohol sits in that list. Substance intoxication and withdrawal appear as reasons to do more medicine, not as explanations permitting less, which is the exact inversion made at the door every night. Two other entries repay attention: age alone triggers the evaluation with no abnormal finding, and abnormal vital signs are a trigger rather than an expected accompaniment of agitation.

The task force calls its own recommendations consensus and preliminary, so this is a prompt to think rather than a validated rule.

**Airway, breathing, circulation**
STABILISED FIRST IN EVERY EMERGENCY DEPARTMENT ARRIVAL, BEFORE OTHER INJURIES ARE ATTENDED TO

**Never assumed**
THAT A CONFUSED DRINKER IS CONFUSED BECAUSE OF THE DRINK, WHICH IS THE INVERSION THIS TOPIC EXISTS TO STOP

**Papilloedema**
BEDSIDE SIGN OF RAISED INTRACRANIAL PRESSURE SOUGHT ON DIRECT OPHTHALMOSCOPY IN THE UNRESPONSIVE PATIENT

**Intoxication**
LISTED FIRST AMONG THE FACTORS THAT WITHHOLD DISCHARGE AFTER A HEAD INJURY ASSESSMENT

### 27.5 Two diagnoses missed in the state that hides them

**Where suspicion collapses.** Some diagnoses are missed at random. Two here are missed systematically, because the feature that should raise suspicion is the feature that lowers it. NICE clinical guideline CG100 on the physical complications of alcohol use disorders, published in 2010 and last updated in 2017, meets this head on: maintain a high level of suspicion for the possibility of **Wernicke encephalopathy**, particularly if the person is intoxicated. That clause names the very situation in which the diagnosis is lost, since confusion and unsteadiness in a man who smells of drink are read as drunkenness. The clinical picture defining the syndrome belongs to the Endocrine and metabolic psychiatry notes, and the parenteral thiamine that follows suspicion, with its route and duration, to the Substance use disorders notes. What belongs here is the direction of travel: intoxication raises suspicion, it never lowers it.

The second runs the same way in a patient with liver disease. The 2014 joint American and European hepatology practice guideline on hepatic encephalopathy in chronic liver disease records that overt hepatic encephalopathy remains **a diagnosis of exclusion** in a population itself highly susceptible to mental state abnormalities from medications, alcohol misuse, drug use, the effects of hyponatraemia and psychiatric disease, so exclusion of other aetiologies by laboratory and radiological assessment is warranted, as clinically indicated, in such a patient with altered mental status. One sentence names three traps at once: the confused drinker with cirrhosis can be misattributed to the alcohol, to the liver, or to a psychiatric illness, each error made by a different team on grounds that look reasonable from where it stands. The safeguard is the head injury rule again: attribution after exclusions that were performed rather than assumed.

### 27.6 The level-of-care decision

Disposition is where this presentation is most often settled by habit. The Indian guidance draws the line at consciousness and medical involvement rather than at any score: mild and moderate cases, meaning those without impairment of consciousness or significant medical issues, can be managed in relatively simple surroundings without much medical intervention, while those who are **severely intoxicated** should be admitted and managed where high-dependency or intensive care can be provided. Two clinical variables carry the decision, and both are assessable without a laboratory.

Where the presentation is withdrawal rather than intoxication, NICE CG100 gives the admission rule a different logic. Admission for **medically assisted alcohol withdrawal** is offered to people in acute alcohol withdrawal who have, or are assessed as being at high risk of developing, alcohol withdrawal seizures or delirium tremens. The decision is driven by predicted complication and not by present distress, which inverts how emergency beds are usually allocated: a distressed, tremulous, fully oriented patient may not need one, and a quieter patient with the risk profile does. The severity instrument, the withdrawal time course and the epidemiology of delirium tremens belong to the Substance use disorders notes, and none of them replaces this decision.

The line then moves with the person. For **certain vulnerable people** in acute alcohol withdrawal a lower threshold for admission is considered: those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties, or are **16 or 17 years old**. Read as a group, those examples are not about severity. They describe who will be unobserved, unable to report deterioration, or unable to come back, none of which a severity score sees. Disposition is a clinical judgement with a score inside it, not a score with a clinician attached.

| DESTINATION | WHAT SELECTS IT | WHAT MUST BE TRUE FIRST | WHAT FOLLOWS |
|---|---|---|---|
| **Relatively simple surroundings, little medical intervention** | Mild and moderate presentations: no impairment of consciousness, no significant medical issues | The sweep performed and negative, not waived | Observation by a named person, and a stated point of review |
| **Admission for medically assisted alcohol withdrawal** | Acute alcohol withdrawal with, or at high risk of, withdrawal seizures or delirium tremens | A threshold lowered where the person is vulnerable, isolated or very young | The regimen itself, owned by the Substance use disorders notes |
| **A setting providing high-dependency or intensive care** | Severe intoxication | Capability actually present, not a monitored bay nobody watches | Care led by the team the indication selects, psychiatry alongside |

### 27.7 Admission, and who owns the bed

The Indian guidance is unusually concrete here. Inpatient admission of an intoxicated patient may be considered for:

- severe intoxication, or persistent disorientation;
- medical complications such as Wernicke encephalopathy or alcoholic hepatitis;
- dysrhythmias or convulsions, or continued abnormality of cardiopulmonary parameters;
- known chronic systemic illnesses requiring independent medical attention;
- prolonged aggressive behaviour, or perceptual abnormalities.

It then adds the clause psychiatrists most often skip, and it is the useful one: the speciality under which the patient is admitted is determined by the indication for admission. That settles the corridor argument. A patient admitted for dysrhythmias or a continued cardiopulmonary abnormality is a medical admission with psychiatric input, not a psychiatric admission with a medical consultation pending; one admitted for prolonged aggression or perceptual abnormality is the reverse. It also produces a defensible record, since the reason for the bed and the owner of the bed become one fact written once.

**IN INDIA**

The sweep assumes a working blood gas analyser, an urgent renal panel and a functioning ophthalmoscope at two in the morning. Many district emergency rooms have a glucometer, a slower overnight biochemistry and a borrowed fundoscope, so the honest local version is to do the bedside sugar and the fundi at once, send what the laboratory will process at night, and record which exclusions were performed and which deferred. The speciality rule assumes more than one speciality is admitting; where the bed goes to whoever has one free, that rule is the corrective, turning an availability decision back into a clinical one.

### 27.8 Discharge, and what this section hands on

The last decision is made quickest and defended worst. Returning to the head injury guideline: where imaging is not indicated and there is no suspicion of clinically important traumatic brain injury, discharge still requires that there be no other factors warranting hospital admission, and drug or alcohol intoxication is listed first among them, alongside other injuries, shock, suspected non-accidental injury, meningism and cerebrospinal fluid leak. Discharge additionally requires appropriate support structures for safe discharge and subsequent care, the example given being **competent supervision at home**.

Two consequences follow. Intoxication is not merely a confounder of the assessment; on its own it is a reason the patient does not go home yet, so a negative scan and a normal examination are not between them a discharge. The second requirement is about the destination rather than the patient: someone safe to leave has somewhere to be watched, which the department must ask about rather than infer from a relative in the waiting area.

What is not available here is the cadence. For the patient held because of intoxication, no comparable standard is available to quote, and none is invented here. Teach the principle instead: the reason for keeping the patient dictates what is watched for, that determines how often somebody must look, and the interval is agreed and recorded by name.

**GOOD TO REMEMBER**

Record which exclusions were performed and which were assumed. Notes on these patients carry the conclusion and not the work, so a later reader cannot tell whether the metabolic set was sent or the fundi seen. Three lines close it: what was excluded and by what test, why the patient is or is not going home, and who is watching him and where.

At handover the receiving team needs what cannot be reconstructed afterwards: which exclusions were completed, what was still pending when the patient moved, the indication that selected both bed and speciality, and who was told to look at him and how often.

In a drinker with a depressed conscious level, exclusion comes first and attribution second: an important traumatic brain injury is excluded, the metabolic sweep and the fundi run alongside, and intoxication is the label you arrive at, never the one you begin with.

## 28 · Psychiatric emergencies in pregnancy and the postpartum period

**Why the marks are here.** Psychiatric emergencies in pregnancy and after it are not different emergencies. An acutely agitated woman is still an acutely agitated woman, an overdose is still an overdose, a collapse is still a collapse. What changes is the act: where she is put, what may be used, what must not follow it, who is standing in the room while it happens, what is watched afterwards, and where she goes next. That is a short list, and it is examinable precisely because almost nobody rehearses it. Every one of the underlying conditions is taught in full elsewhere in these notes and none is restated here. What this section owns is the overlay: what is done differently, emergency by emergency, because the patient in front of you is pregnant or has recently delivered.

Two facts make this the highest-stakes intersection in emergency psychiatry. The first is that there are two patients and only one can be interviewed, examined or consented; the second is silent, is affected by every drug and every position, and is the one most often missing from the note. The second fact is where the mortality actually sits. On the confidential enquiry into maternal deaths for the United Kingdom and Ireland, reporting in 2025, suicide is the most common cause of maternal death in the period between six weeks and one year after the end of pregnancy, and mental health conditions together account for **over one third** of the deaths in that same late period. The dangerous window is not the pregnancy, where obstetric attention is concentrated, but the postnatal year, where nobody is looking.

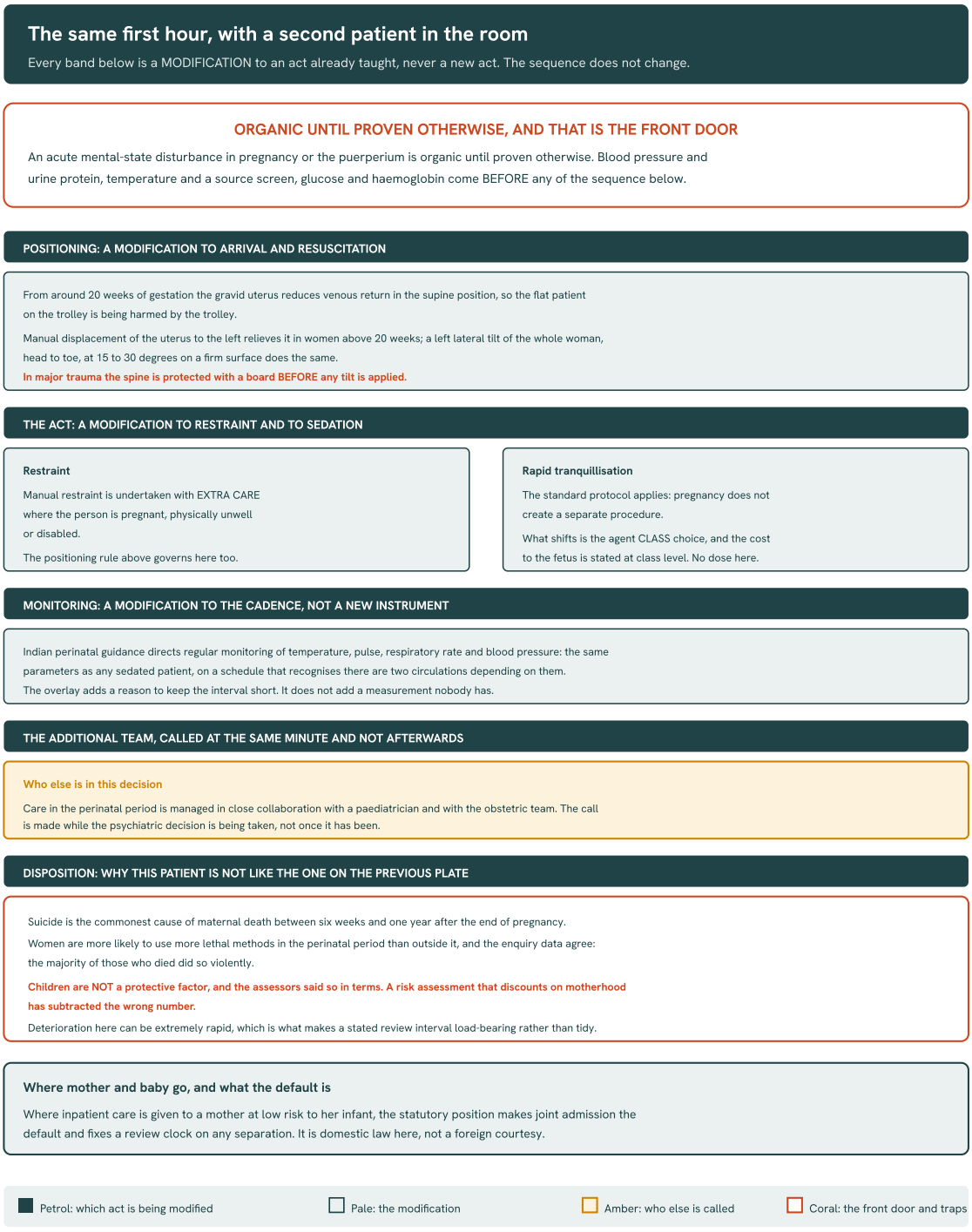


Fig 28.9. What changes when the emergency patient is pregnant or newly delivered, drawn as modifications overlaid on the first-hour sequence rather than as a separate algorithm: the organic exclusion that comes before everything, the positioning rules from around twenty weeks and the trauma exception to them, the extra care in restraint and the class-level agent shift in sedation, the monitoring cadence, the obstetric and paediatric team called at the same minute, and the disposition facts that make this patient's risk assessment different, including that children are not a protective factor.

## 28.1 Establish the second patient before you do anything to the first

The first act in a perinatal emergency is neither pharmacological nor physical. It is to establish, and to write down, that there are two patients and how far along the second one is. Everything

downstream keys off that determination: the positioning rule, the resuscitation algorithm, the agent-class decision, the monitoring set and the destination.

The obvious problem is that the woman who most needs this determination is the one least able to give it. She may be agitated, mute, intoxicated, thought-disordered or brought in by neighbours who know nothing about her. Resuscitation guidance solves this with a physical criterion rather than a historical one: the manoeuvres that follow are indicated in women above 20 weeks of gestation, or wherever the uterus is palpable at or above the level of the umbilicus, on the Royal College of Obstetricians and Gynaecologists guidance on maternal collapse in pregnancy and the puerperium (2019). The second limb is the clinically useful one for us: an abdominal palpation takes seconds, needs no cooperation and no dates, and converts an unknown into a rule the whole team can follow. It also protects against the opposite error, since the positioning rules below answer a specific mechanical problem that does not exist early in pregnancy.

On the postnatal side the equivalent determination is the interval since delivery and whether an infant is physically present. The interval decides whether an obstetric team still has an active interest in her; the presence of an infant decides who is holding that infant while the emergency is managed, which has to be answered out loud in the first minutes. The wider framework for weighing a decision made for a mother and a fetus or infant at once, including the risk of the untreated illness as one of the risks being weighed rather than as the baseline, belongs to the topic on prescribing psychotropics in pregnancy in these notes and is not re-derived here.

### 28.2 Exclude the organic causes before you run any of what follows

**This section comes first because everything after it assumes the answer.** Acute disturbance of mental state in pregnancy or the puerperium is organic until proven otherwise, and the proving is done at the door rather than after admission. The reason is not caution in the abstract. The conditions that present this way are common, they are time-critical, and several of them are found by measurements a district casualty already has at the bedside.

Take the blood pressure and test the urine for protein, because hypertensive disease of pregnancy reaches well beyond delivery and can present as headache, visual disturbance, confusion or seizure in a woman whose pregnancy ended weeks earlier. Take the temperature and look for a source, because puerperal sepsis presents as agitation and confusion before it presents as anything a psychiatrist recognises. Take a capillary glucose. Look at the haemoglobin, because severe anaemia after obstetric haemorrhage produces exactly the picture that gets referred. None of these is a psychiatric act, and all of them precede one.

The trap is structural rather than clinical: a woman who arrives disturbed in the puerperium arrives with a psychiatric referral already attached to her, and the referral is itself a piece of anchoring. The general approach to the acutely confused patient, and what an organic screen contains, is taught with the emergency triage of the confused patient elsewhere in these notes. What belongs here is the order. No comparable perinatal standard is available to quote for which tests, at what threshold,

in what sequence, and none is invented here; the acts above are named without figures for that reason.

RULE **A psychiatric diagnosis in the puerperium is a diagnosis of exclusion made at the door, not a diagnosis of first resort made in the referral.** The positioning, sedation and disposition decisions that follow are all correct, and all of them are wrong if the woman is eclamptic or septic.

### 28.3 Decide the position she is left in, and treat it as an intervention

This is the act most often omitted, and the omission is invisible because a woman lying flat looks like a woman lying down. From around 20 weeks of gestation the gravid uterus reduces venous return in the supine position, and cardiac output falls in consequence by **up to 30 to 40 per cent**. That is **aortocaval compression**, and it is the physiological fact that turns a positioning instruction into a clinical intervention rather than a comfort measure. A restrained or sedated pregnant woman left flat is not merely uncomfortable; she is being actively harmed by an omission no drug chart records.

| 20 weeks | 15 to 30 degrees | 4 minutes | 5 minutes |
|---|---|---|---|
| GESTATION FROM WHICH THE SUPINE POSITION REDUCES VENOUS RETURN | ANGLE OF WHOLE-BODY LEFT LATERAL TILT, ON A FIRM SURFACE | CORRECTLY PERFORMED CPR WITHOUT RESPONSE BEFORE PERIMORTEM CAESAREAN SECTION | TARGET FROM MATERNAL COLLAPSE TO DELIVERY AT PERIMORTEM CAESAREAN SECTION |

The corrective act has three checkable elements, and candidates lose the marks on the second and third rather than the first. A **left lateral tilt** of the woman from head to toe, at an angle of 15 to 30 degrees, on a firm surface, relieves the compression in the majority of pregnant women while still allowing effective chest compressions. Head to toe matters because tilting the trunk alone folds her at the waist and leaves the uterus where it was. The stated angle matters because a token lean achieves nothing and an extreme one rolls her off. The firm surface matters because a soft mattress absorbs the tilt and, if she arrests, makes compressions useless.

Where a tilt cannot be achieved, or where compressions are being given, the alternative is **manual displacement of the uterus to the left**, described in the same guidance as an up, off and over movement. Its value is that it relieves the compression while she stays supine, which is the only way to keep compressions effective during an arrest, and it needs no equipment.

One situation subordinates the whole positioning rule. In major trauma the spine is protected with a **spinal board** before any tilt is applied, and where no board is available manual displacement of the uterus is used instead. This is not an obstetric footnote for us. A pregnant woman who has jumped, fallen, been assaulted or been taken to the floor during a struggle on the ward is a trauma patient first, and tilting her may be the wrong act performed with the right intention.

| SITUATION AT THE BEDSIDE | WHAT IS DONE | WHY IT IS THAT AND NOT SOMETHING ELSE |
|---|---|---|
| **Uterus palpable at or above the umbilicus, and she is sedated, restrained or otherwise unable to move herself** | Whole-body left lateral tilt, head to toe, at an angle of 15 to 30 degrees, on a firm surface | A tilt of the trunk alone bends her at the waist and does not lift the uterus off the great vessels |
| **Chest compressions are needed** | Keep her supine and displace the uterus manually to the left | Compressions are ineffective on a tilted or yielding surface; displacement relieves the compression without tilting her |
| **Major trauma: a fall, a jump, an assault, or a struggle that ended on the floor** | Protect the spine with a spinal board before any tilt is applied | Spinal protection outranks the positioning rule, and tilting an unprotected spine turns one injury into two |
| **Major trauma, and no spinal board on the premises** | Use manual displacement of the uterus instead of a tilt | It relieves the same compression without moving the spine, which is why it is the named fallback |
| **An observation area with no tilting trolley and no firm wedge** | Nurse her supine with the right hip elevated | Elevating the right hip is the same manoeuvre described from the other side, and it can be improvised |

MNEMONIC

### Board, then tilt, and displace when you cannot tilt

The precedence order for any pregnant woman who has to be laid down. The board comes first where there has been major trauma, because spinal protection outranks the positioning rule. Where there is no trauma, the whole-body left lateral tilt on a firm surface is the manoeuvre. Where a tilt cannot be achieved, where compressions are being given, or where no board is available, manual displacement of the uterus to the left does the same physiological work.

RULE **The position a sedated or restrained pregnant woman is left in is part of the prescription, not part of the nursing.** A woman who has just been given a sedating drug, or who is being physically held, cannot reposition herself. The position therefore stops being something she adopts and becomes something the team has chosen for her, and must keep choosing at every observation and handover. Written into the order alongside the drug, it survives the shift change; left to whoever last moved the trolley, it does not.

## 28.4 Adapt the restraint, and be honest about where the guidance stops

Pregnancy is named explicitly in general restraint guidance: manual restraint is to be undertaken with extra care if the service user is physically unwell, disabled, pregnant or obese, on the National Institute for Health and Care Excellence guideline on the short-term management of violence and aggression (2015). The perinatal guidance from the same body adds, inside its rapid tranquillisation recommendation, that restraint procedures should be adapted to avoid possible harm to the fetus.

Both statements stop at the level of principle. Neither specifies a hold, a position, a maximum duration, an observation interval or a gestational threshold at which the adaptation begins. That gap is load-bearing and should be stated rather than papered over: for how a hold is to be modified in pregnancy, no comparable standard is available to quote, and none is invented here. What can be said is what follows from sourced material, and a good answer says that and no more.

Three things follow. The positioning rule is the substance of extra care once the uterus is palpable at or above the umbilicus, so a hold that ends with her flat on her back and held there is the one configuration that must not become the resting state. Force applied over the gravid abdomen has no place in any hold, which is a statement about where hands go rather than about which technique is taught. And a woman taken to the floor has been through a mechanism of injury, so the trauma precedence above applies from the moment the hold ends. The general physical safety of any person in restraint, including the prone hazard, airway access and the risks of prolonged immobilisation, is the business of the topic on restraint and seclusion in these notes; the statutory authority for restraining anyone at all belongs to the Mental health legislation and forensic psychiatry notes, and the test of least restriction to the Forensic ethics, consent and legal procedure notes.

### 28.5 Choose the agent class, and refuse the seclusion that would normally follow

A pregnant woman who requires rapid tranquillisation is treated according to the standard guidance on violence and aggression, on psychosis and on bipolar disorder, with two named exceptions, on the perinatal guideline of the National Institute for Health and Care Excellence (published 2014, last updated 2020):

- she is not to be secluded after rapid tranquillisation;
- restraint procedures are to be adapted to avoid possible harm to the fetus.

Notice what those two have in common: neither is a dose. The protocol is not softened and the ladder is not rewritten. What changes is that two of the things normally available afterwards are withdrawn. The seclusion exception repays a moment's thought, because candidates reproduce it without being able to justify it. Seclusion is by construction a place where a patient is neither continuously observed nor physically accessible. A woman sedated in the second half of pregnancy needs the opposite: someone to keep her off her back, to take observations that include the fetus, and to reach her quickly if either patient deteriorates.

The agent decision is stated at the level of drug class and of the neonate, which is the level this section owns. When choosing an agent for a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used it should be at the minimum effective dose, because of **neonatal extrapyramidal symptoms**, and if a benzodiazepine is used the risks of **floppy baby syndrome** are taken into account. The short half-life preference and the minimum effective dose rule are one idea applied twice: what matters is the exposure still present in the neonate at delivery, so duration is being minimised alongside amount.

No dose appears in this section, deliberately. The rapid tranquillisation ladder and every first-dose figure belong to the Schizophrenia: management, antipsychotics and adverse effects notes, and a dose recalled from memory into a pregnancy answer is the error this material exists to prevent.

### 28.6 Monitor two patients afterwards, and give the cadence a name

Standard post-sedation monitoring watches one person. The Indian Psychiatric Society's guidance on the management of psychiatric disorders during the perinatal period (2022) extends the set: regular monitoring of temperature, pulse rate, respiratory rate, blood pressure and **fetal wellbeing measures** may be essential, and care is taken to ensure the patient is lying supine with **right hip elevation** to avoid compromising the blood supply to the fetus.

Two things there are worth separating. Right hip elevation and the left lateral tilt of the resuscitation guidance are the same manoeuvre described from opposite sides, and a resident who has memorised one phrasing will not always recognise the other. And the addition of a fetal parameter to a routine observation set is what makes this a two-patient protocol rather than an obstetrically flavoured version of the usual one.

What no sourced statement gives is a frequency. Neither the perinatal guidance nor the general restraint guidance sets an interval for observations after sedation or during restraint in pregnancy: for that cadence, no comparable standard is available to quote, and none is invented here. The principle is still teachable and is the operationally important part. An observation described only as regular belongs to nobody. Whoever writes the sedation order writes the interval and the parameters beside it, names the person who will take them, and states what change triggers a call. Observation levels as a construct are developed in the topic on suicide risk assessment and emergency management in these notes.

**IN INDIA**

The monitoring set above is national guidance, and its fifth item meets a wall. Fetal wellbeing measures need equipment and someone competent to interpret the trace, and in most district hospitals and general psychiatry units that person is in another building and off duty at night. The honest position is not to pretend the standard is met but to plan around it: for a woman beyond the middle of pregnancy who is likely to need sedation or restraint, the siting decision comes before the drug decision, and an observation area within reach of an obstetric response is worth more than a quieter one that is not. What is genuinely portable costs nothing, which is the positioning, the four maternal parameters and a named interval. Where guidance names a specialist perinatal mental health service as the destination, most of the country does not have one, and the referral that exists is to a general unit with an obstetric department attached.

### 28.7 Assess self-harm on the perinatal method profile, not the general one

**What the lethality profile changes at the door.** A general risk assessment weighs stated intent heavily and reads a low-lethality act as reassuring. That inference is unsafe here. On the same confidential enquiry, the majority of women who died by suicide died violently, and the commonest

mode was hanging, accounting for **66 per cent** of those deaths, 58 women in the reporting period. Indian perinatal guidance (2022) states the same clinical point from the other direction: women are more likely to use more lethal methods in the perinatal period.

Three consequences follow, and all three are acts rather than formulations. Method and access are asked about specifically and early, because the method distribution in this population is shifted towards those that leave little margin for rescue. An index act of apparently low lethality earns less reassurance than the same act would in a general presentation, so it raises rather than settles the question of admission. And the enquiry is not about one person: Indian guidance states that suicidal risk and infanticidal risk may occur together and require attention, so the infant's safety is asked about in the same conversation and recorded in the same note.

What this section does not do is re-teach the assessment itself. The framework, the disposition ladder, means restriction and the structured enquiry into intent are the property of the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The classification of filicide and the forensic frame around it belong to the Mental health legislation and forensic psychiatry notes, and the assessment of the mother's relationship with her infant to the topic on mother-infant bonding and infanticide risk in these notes. What is owned here is narrower: the perinatal method profile changes what a given act means, and the risk assessment covers two people.

### 28.8 Refuse the two reassurances that discharge a woman who should be admitted

Most perinatal disasters are not diagnostic failures. The illness was recognised; the disposition was wrong. Two specific reassurances do that work, and both are addressed in the confidential enquiry material.

The first is the reassurance of the cross-sectional appearance. Deterioration of mental health in pregnancy or the postnatal period can be extremely rapid, so how she looks in the room now is a poor guide to where she will be tomorrow. The enquiry names the changes that must not be underestimated and that should prompt early review, urgent assessment and intervention, and two of the four appear in no general risk formulation:

- a significant change in mental state;
- the emergence of new symptoms;
- thoughts or acts of violent self-harm;
- expressions of incompetency as a mother, or estrangement from the infant.

Those are **red flags** in the strict sense: each is a trigger for an act, not an item to be scored and weighed against protective factors. The last is the one a general assessment reliably misses, because a woman saying she is not a good enough mother sounds like a depressive cognition and gets filed as one. Read as a red flag, it brings the review forward. The practical translation is that a perinatal presentation is triaged on its trajectory over recent weeks, so the collateral history covers direction of travel and not only the current picture.

TRAP **Counting her children as the reason she will not act.** The enquiry assessors concluded that the idea of children as a protective factor against suicide and substance use should be challenged and not taken as a matter of fact, even where the woman herself expresses it, because some women may be too unwell to keep themselves safe despite wanting to protect their children from harm. Candidates write "protective factors: young children at home" and then discharge, and the sentence does double duty it has not earned: it is treated as evidence about her intentions when it is only evidence about her values. Devotion is not capacity for self-protection, and in severe illness the two come apart.

### 28.9 Decide the mother and infant question as a decision with a clock on it

When an acutely unwell mother is admitted, somebody decides within the first hour whether her infant stays with her. In most Indian units that decision is made at night, by the duty team, on incomplete information, and is then never revisited because nobody was appointed to. Indian perinatal guidance (2022) restates the statutory position that stops this.

Where inpatient care is given to a mother at low risk of suicidal or infanticidal risk, **rooming-in** of mother and infant is the position Indian law takes, and the shape of that rule is what a candidate must be able to state. Rooming-in is the default up to a stated age of the child. A decision to separate is the deviation, it must be authored by the treating psychiatrist, it EXPIRES at a fixed statutory interval rather than running until somebody revisits it, and beyond a further fixed period it stops being the clinician's decision at all and passes to an external review body. The age, the two intervals, the body and the section they sit in are restated with the Mental health legislation and forensic psychiatry notes and are not reproduced here. What matters at the bedside is that in India the review clock is not the team's to set.

Read the structure rather than the numbers. Joint care is the default and separation the deviation, so the burden of justification sits on whoever proposes to separate. Separation is a decision and not a ward arrangement, which means it has an author, a reason and an expiry. The review interval is fixed in law rather than left to the team's convenience, so a separation that quietly persists is a lapse against a statutory duty. And beyond a defined period the decision leaves the clinician altogether and needs external permission, which is the statute's way of saying that indefinite separation is not a clinical decision at all. What a mother-baby unit is, and how the separation decision is worked up where there is a unit, are developed in the topic on lactation and mother-baby unit care in these notes; what is owned here is that decision taken in the emergency, before any of that assessment exists.

**GOOD TO REMEMBER**

Three lines that change what an admitting resident writes tonight. First, the gestational age or the interval since delivery, with how it was established, including by palpation where no history was available, because every rule below it depends on that entry. Second, the position she is to be nursed in, written in the same entry as the sedation or restraint order rather than left to the nursing note, with the observation interval and who takes it. Third, where mother and infant have been separated, the statutory review date entered as an actual date, since that interval is fixed in law and is not the team's to set.

### 28.10 Call the right team early, because the clock is shorter than the corridor

The same perinatal guideline of the National Institute for Health and Care Excellence attaches a team requirement to the rapid tranquillisation recommendation itself, which is deliberate placement: during the perinatal period the woman's care is to be managed in close collaboration with a paediatrician and an anaesthetist. Those two disciplines, named by title, are not the ones a psychiatrist instinctively calls. The anaesthetist is there for the airway of a sedated woman whose physiology has changed and who may need an operative delivery at short notice; the paediatrician for a neonate just exposed to whatever was given to the mother. Calling the obstetrician alone is the common half-answer. No timing threshold is attached to either involvement, so how early each is brought in is not sourced and no interval is invented here; the defensible position is to inform both when the decision to tranquillise is taken rather than after it.

The reason to build that habit is the arrest clock. In women over 20 weeks of gestation, if there is no response to correctly performed cardiopulmonary resuscitation within 4 minutes of maternal collapse, or if resuscitation continues beyond that point, **perimortem caesarean section** is undertaken to assist maternal resuscitation, ideally achieved within 5 minutes of the collapse, on the same Royal College of Obstetricians and Gynaecologists guidance (2019). The teaching point is arithmetical rather than surgical: both intervals are shorter than the time it takes to summon an obstetric and neonatal team from another building, so the call goes out at the moment of collapse and not at the four-minute mark. The procedure is performed to resuscitate the mother, which is the part most often misunderstood.

| THE EMERGENCY AT THE DOOR | WHAT CHANGES BECAUSE SHE IS PREGNANT OR NEWLY DELIVERED | WHO IS BROUGHT IN, AND WHEN |
|---|---|---|
| **Acute agitation requiring rapid tranquillisation** | Short half-life agent class considered; an antipsychotic used at the minimum effective dose; no seclusion afterwards; she is not left supine and unattended | Paediatrician and anaesthetist, from the point the decision is taken |
| **Manual restraint of a disturbed woman** | The procedure is adapted to avoid harm to the fetus; the resting position is the tilt or the displacement, never flat and held | Ward team briefed on the position before the hold; obstetric advice once the uterus is palpable at or above the umbilicus |
| **Collapse or cardiac arrest on the ward** | Uterine displacement to the left so compressions remain effective; spinal protection takes precedence in trauma | Obstetric and neonatal teams summoned at the moment of collapse, not once the arrest is established |
| **Self-harm or overdose presentation** | Method and access asked about specifically; low apparent lethality earns less reassurance; the infant's safety is asked about in the same conversation | Medical or toxicology team in the usual order, with obstetric review to follow |
| **Sudden disturbance in the postnatal weeks** | Assessed against the perinatal red flags and on trajectory rather than cross-section; a timed referral standard applies | Secondary mental health service, preferably a specialist perinatal service where one exists |
| **Admission of an acutely unwell mother with her infant** | Rooming-in is the default where suicidal and infanticidal risk are low; any separation is authored, time-limited and statutorily reviewable | Paediatrician for the infant; the review board where separation runs long |

One disposition interval deserves naming, because it is the only perinatal response time counted in hours. Where a woman has sudden onset of symptoms suggesting postpartum psychosis, she is referred for immediate assessment inside a response time that the same English perinatal guideline counts in hours and that the topic on postpartum psychosis prints; the presentation itself is developed in the topic on postpartum psychosis in these notes and in the Other psychotic disorders, delusional syndromes and catatonia notes. No equivalent Indian standard is available to quote, and none is invented here, so what transfers is the principle that a perinatal emergency referral is timed and audited rather than queued. Where the emergency is a woman who is not eating or drinking, or whose suicidality does not remit, electroconvulsive therapy remains a live option in pregnancy, and its indications, modifications and outcome data are the ECT and neurostimulation notes' in full and are not restated here.

Three acts in a perinatal emergency belong to the psychiatrist and to nobody else: the position she is left in once she has been sedated or held, the seclusion that must not follow rapid tranquillisation, and the call that brings obstetric, paediatric and anaesthetic colleagues into the room rather than after it.

# Cross-cutting synthesis

## 29 · Cross-cutting synthesis

**Every other account in this chapter teaches one presentation; this one is about what all of them have in common.** What the two bands of this chapter share is an interlock rather than a boundary. The material looks like two bodies of knowledge sharing a cover, and that reading survives until the first patient who is both. What runs underneath is the same kind of object, and it is not a body of fact. Both halves are **sequences of decision**: ordered, timed, answerable in the order given rather than the order the information arrives. The entities are taught elsewhere, in full and with their numbers. What is left over, and what is examined, is the order.

Owned here and nowhere else: how the two seams sit against one another, where they repeat the same reasoning in different clothes, and what happens where they cross. Named in a clause and never re-derived: the front of the emergency sequence, the two-patient framework, and every entity, dose, level, interval and criterion belonging to either half. No figure appears on this page, because a number lifted out of the account that grounds it arrives without the conditions that made it true.

| Sequence | Second patient | Written down |
| --- | --- | --- |
| WHAT BOTH HALVES OF THIS CHAPTER TURN OUT TO BE, RATHER THAN BODIES OF FACT TO BE RECALLED | THE PERINATAL SEAM, ASKED OF EVERY STEP OF THE EMERGENCY ONE | WHAT SEPARATES AN ORDER FROM A DISPOSITION ON EITHER SEAM |

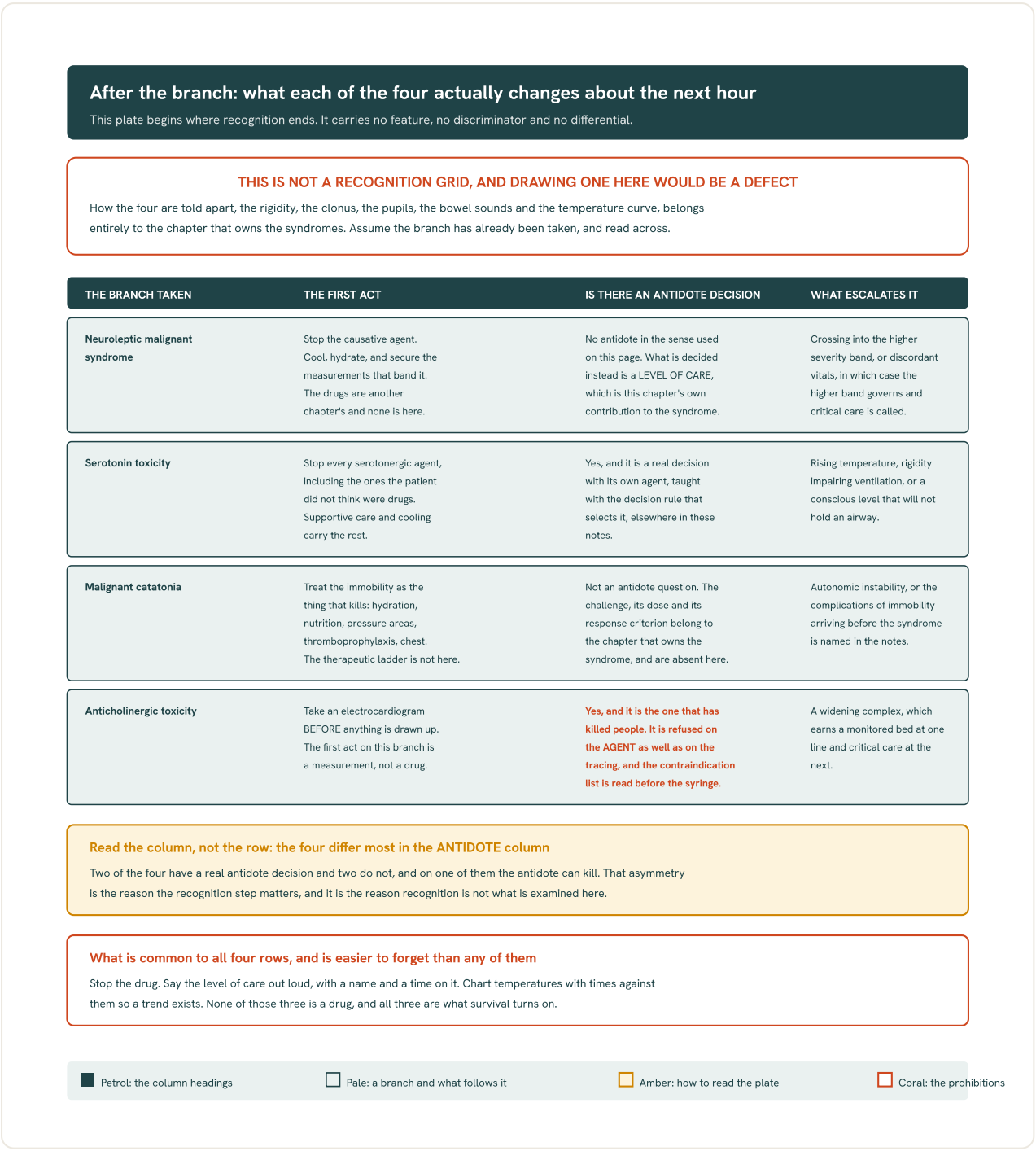


Fig 28.10. What follows each branch of the hyperthermic and toxidromic differential once the branch has already been taken, giving for neuroleptic malignant syndrome, serotonin toxicity, malignant catatonia and anticholinergic toxicity the first act, whether an antidote decision exists at all, and what escalates the level of care, with no discriminating feature anywhere on the plate because recognition belongs to the chapter that owns the syndromes.

## 29.1 Two seams, and the same kind of object underneath both

The emergency half turns on an ordered sequence every one of its presentations invokes: recognise, stabilise, establish who holds the authority to act, act, monitor, dispose. The order is the content. It is not a list of things that must all happen, but a statement about which question may not be answered until an earlier one has been. Its front end, from arrival to the treatment decision, is developed in this chapter's account of the acutely agitated and aggressive patient.

The perinatal half looks different and behaves the same. Every decision in it is made for a mother and a fetus or infant at once, only one of whom can be asked what she wants, and the risk of the untreated illness is one of the risks being weighed rather than the baseline the others are measured against. That framework belongs to this chapter's account of prescribing psychotropics in pregnancy. What it shares with the emergency seam is its form: it too fixes an order of questions, and it too goes wrong when they are answered in the order the information arrives. The second seam is not a separate structure. It is the first one asked twice.

| THE STEP | WHAT IT ASKS WHEN THERE IS ONE PATIENT | WHAT THE SAME STEP ASKS ONCE THERE ARE TWO |
|---|---|---|
| RECOGNISE | What is this, with the psychiatric answer reached last rather than assumed first, and the presumption of a physical cause carried until actively displaced. | Who else is here, established by examining her rather than by history, because the woman who most needs this is least able to supply it; and if an infant is present, who is holding it meanwhile. |
| STABILISE | Treat the life-threatening problem when it is found and reassess it, rather than carrying it to the end of an assessment that runs alongside the talking. | The same work, plus a position that is itself an intervention. A sedated or held patient cannot reposition herself, so the position is something the team chose and must keep choosing. |
| ESTABLISH AUTHORITY | Who may act for a patient who cannot agree, recorded as an assessment with a basis rather than inferred from how disturbed she looks. | Only one of the two can be asked, and she is not always the one at greater risk of being forgotten. Doing nothing is itself an exposure for both. |
| ACT | The intervention this presentation calls for, performed as a discrete act with a named reviewer rather than as a standing permission. | The same intervention, chosen additionally for the exposure still present in the second patient later, and stripped of whatever normally follows it that would put either out of reach. |
| MONITOR | A stated interval, a named person who takes it, an endpoint at which it stops, and a written change that triggers a call. | The observation set acquires a parameter belonging to the other patient. That single addition makes it a two-patient protocol rather than the usual one with an obstetric flavour. |
| DISPOSE | Where the patient goes, decided by somebody rather than defaulted to by nobody, and handed over as reasoning rather than as conclusion. | The destination must accept both, and any decision separating them is authored, timed and reviewable rather than a ward arrangement nobody remembers making. |

### 29.2 The same error twice, in two different costumes

The commonest failure in each half is one failure. The emergency half states it repeatedly: a behaviour is a presentation and never a diagnosis; the smell of alcohol is evidence of drinking, not of the cause of a conscious level; intoxication is a label you arrive at, not one you begin with and then defend. The perinatal half states it as often, and almost nobody sees it is the same sentence. A reproductive event is a **context** and not a diagnosis. A context tells you what else to ask and whom to involve, not what to treat.

Both guard against a ready-made explanation that closes a question before it is asked. In the emergency half that explanation is the psychiatric history, which is why the patient with an established diagnosis is the one in whom a physical cause is missed: the history explains why this person might become disturbed, a different question from why they are disturbed today. In the perinatal half it is the pregnancy or the puerperium. An episode is attributed to a transition and goes untreated; a distressing answer is attributed to mood, and the bond with the infant is never enquired about separately, so a negative mood enquiry is read as excluding something it never examined.

Only the costume differs, which gives the rule a usable form as a question about direction. Ask whether the account in your head was generated by this patient today or supplied by something you knew before meeting them. Explanations of the second kind are often correct; they are simply not entitled to close an enquiry, because they were equally available whatever the answer turned out to be. **Attribution** is the last act on both seams.

### 29.3 The option that looks careful is the one that has to be argued for

A second pattern crosses both halves and inverts an intuition. In each there is a choice presenting itself as the cautious one that is in fact the **deviation**, carrying the burden of argument and requiring a written reason.

The perinatal half says so explicitly. Stopping a drug is not a move into an unexposed condition, because no arm of that decision has nothing in it; the apparently careful option is a different exposure, usually the more poorly characterised. Separating a mother from her infant looks like safety and is the deviation from a default of joint care, which is why it needs an author, a reason and an expiry rather than a bed allocation. The emergency half runs the same inversion without naming it. Discharging the patient who looks well after an overdose feels like proportionate triage, and is the deviation in a presentation that may still be climbing. Routing a confused patient to a psychiatric bed while it is unclear whether the confusion is medical feels like appropriate referral, and is the deviation from continued medical observation. Recording that sedation was given feels like recording a treatment, and is the deviation from recording what was corrected. What makes one member of each pair the default is not that it is gentler. It is that it can be reviewed, reversed and undone while the other cannot, or cannot in time.

RULE **The default is the option that can still be changed, and the deviation is the one that has to be written down with a reason.** Intuition sorts these pairs by which act feels more careful, and here it sorts them wrongly about as often as rightly. Sorting them by reversibility is mechanical, works in both halves, and produces what an incident review actually looks for, which is never what was decided but what it rested on and who could still have changed it.

### 29.4 What converts an act into an order

Strip both halves of their entities and almost everything this chapter owns is one discipline: writing things down while they are still measurable. That is why the material is examinable, because the acts are often obvious and it is their conversion into an **order** that separates a plan from a mood. Four elements appear wherever this chapter makes a clinical instruction out of something ordinarily left to whoever is nearest.

- **An author.** A named person who decided it, recorded with their title, so the decision has somebody attached to it at handover.
- **A quantity.** An interval, a distance, a frequency, a position, a duration: stated rather than described, because an act described only as regular belongs to nobody and cannot be audited.
- **A time.** Against the measurement, so a single value becomes a trend; and against the review, so the instruction expires rather than persisting because nobody was appointed to end it.
- **A condition that would change it.** Stated in advance and behaviourally, so whoever takes the observations knows what to watch for and when to call, and a step down is a decision rather than a drift.

Read the chapter through that filter and its scattered instructions resolve into one. The level at which somebody is watched is a prescription with a setter, a stated frequency or distance, a named reviewer and a review time. A tranquillising drug given urgently is a procedure rather than a prescription, with an indication, one dose, a named reviewer and a cadence running until somebody decides it may stop. The position a sedated or restrained patient is left in belongs in the order beside the drug, where it survives a shift change, not in the nursing note, where it does not. A reassuring judgment about a settling postnatal state is permitted only if the threshold that would unmake it is stated aloud and handed to somebody who will still be there.

**GOOD TO REMEMBER**

Three sentences turn a defensible emergency entry into an indefensible one by their absence, and none is a diagnosis. Who decided the level of care, at what time, and on what observations. What was measured while somebody else was talking, with a time against each value rather than a value alone. And what has been handed on: the person who will resume the interrupted assessment, the interval until then, and the change that brings somebody back.

### 29.5 What taking a branch actually buys

The rigid and hyperthermic presentations are where candidates expect the marks to sit on telling them apart. Telling them apart is taught in full by the Schizophrenia: management, antipsychotics and adverse effects notes; nothing on this page compares those presentations by their features. The question a recognition exercise never answers is the one this chapter owns: once the branch has been taken, what changes. The plate accompanying this account carries the answer as acts.

Two findings emerge only from looking across the branches. How little changes at the front: whichever branch proves correct, the opening minutes converge on the same physical work, so a clinician who suspends cooling, fluids or airway attention while the label is argued has the order reversed. And that the first therapeutic move on every branch is a subtraction.

| THE BRANCH, ONCE TAKEN | WHAT IS SUBTRACTED, AND HOW FAR | WHAT THIS BRANCH ADDS TO THE SHARED PHYSICAL WORK | WHAT SETTLES WHERE THE PATIENT IS NURSED |
|---|---|---|---|
| NEUROLEPTIC MALIGNANT SYNDROME | The offending agent and every other drug not essential to concurrent treatment, discontinued immediately rather than tapered. | Surveillance of the chain running from sustained rigidity through muscle breakdown to kidney injury and the potassium that follows, which is why fluid balance is charted honestly and the relevant bloods repeated rather than sent once. | Two bedside observations available within a minute and needing no laboratory, which convert an impression into a referral hard to refuse; then the trend, since the emergent decision on replacing renal function is a clinical rule and not a threshold. |
| SEROTONIN TOXICITY | Every serotonergic exposure, which is wider than the chart: what another department prescribed, what was bought without a prescription, what a relative supplied from home, each with a time against its last dose. | Cooling, sedation and, where rigid active muscle is making heat faster than it can be removed, paralysis with the airway secured first, which is why intubation sits among the supportive measures and not among the disasters. | An observation period keyed to what was swallowed rather than to how she looks, because a presentation seen early may still be rising; the antidote question sits downstream and never substitutes for this. |
| THE CATATONIC PATIENT | Nothing pharmacological first. The opening acts are nursing acts, begun at the hour of recognition rather than the hour a treatment is found to have failed. | Airway and swallow settled before anything is given by mouth, hydration, prophylaxis against the clot prolonged immobility invites, attention to skin, joints and bladder, and a feeding decision that names a rate. | Deterioration criteria, and the honest question of who can nurse an immobile medical patient overnight, which makes this a level-of-care decision rather than a psychiatric one. |
| THE ANTIMUSCARINIC BRANCH | The agent, on the same principle, with the subtraction treated as the first therapeutic act rather than a preliminary to it. | The one branch on which a specific antidote question genuinely arises, and the one place the answer is read off objective evidence gathered before anything is drawn up rather than off how the patient appears. Its indications, exclusions and alternative belong to this chapter's account of anticholinergic toxicity and psychotropic overdose. | The duration of the poisoning rather than the patient's condition when the decision is taken, which is the logic the other branches reach by different routes. |

That last cell deserves stating on its own, because three branches reach it independently and for unrelated reasons. Improvement is not clearance. A presentation may still be climbing when first assessed; a response to one intervention may outlast neither the poisoning nor the illness; a patient calmed and then left alone has received the half of the treatment given for the sake of the half then omitted.

### 29.6 Where the two seams cross

**The patient who is both is not a special case; she is the general case with both seams running at once.** Nothing about the emergency changes when the patient is pregnant or newly delivered. A disturbance is still a disturbance, an overdose still an overdose, a collapse still a collapse. What changes is every act performed on it, and that **overlay** is developed emergency by emergency in this chapter's account of psychiatric emergencies in pregnancy and the postpartum period.

The seams are ordered by different things. The emergency seam is ordered by time: a later question may not be answered before an earlier one. The perinatal seam is ordered by number: no question is finished when it has been answered once. Where they cross, both orderings apply at once, and the failure is not that a step is omitted but that it is completed for one patient and recorded as completed. The second patient is silent, is affected by every drug and every position, and is the one most often missing from the note.

The crossing is also where sourced guidance most reliably stops at principle. It says a procedure is adapted without saying how, that monitoring is regular without saying how often, that a specialist service is the destination without saying what to do where there is none. That is not a hole in the teaching; it is where the teaching is. State the principle, say plainly that no comparable standard is available to quote, then supply the quantity yourself under the discipline set out above: your interval, your name against it, your condition for calling somebody. A number you have authored is defensible; one you have recalled and cannot source is not.

### 29.7 The Indian seam, which has one shape in both halves

Read across both halves and the Indian difficulty is not a series of separate shortages. It is one shape repeating: the pathway exists on paper and the post does not exist on the roster. A de-escalation team of several trained people, a post-sedation cadence somebody takes and somebody else reads at three in the morning, an observation level that is a staffing decision wearing a clinical name, a fetal parameter needing equipment and a person competent with it, a joint mother-and-infant admission: each is a person on a duty roster before it is a line in a guideline. Neither easy answer earns marks. Claiming the specification is met collapses on the first follow-up question; abandoning it because it cannot be met locally throws away the standard the arrangement is judged against. What is defensible is the **substitution** stated in terms: name the standard, name what replaces it, name what that costs. Where staff are short, the parallel physical work is the first thing dropped and the last thing that should be, because the people who would have done it are the ones missing.

**IN INDIA**

Sort what this chapter asks for into what costs money and what does not, because the second list is longer than residents expect. Equipment and staffing decide the observation area, the trained team, the tracing somebody can interpret, the unit that admits a mother with her infant. Almost nothing else this chapter owns costs anything. The order of the sequence is free. Designating one person to hold verbal contact is free, and gets easier rather than harder when only two staff are on duty. Taking collateral from the people present before they leave is free and cannot be done later at any price. The position a sedated patient is left in is free, and so is a written interval with a name and a review time against it.

**MNEMONIC**

### Recognise, stabilise, establish authority, act, monitor, dispose - and name the second patient first

**Recognise**: what this is, with the psychiatric attribution reached last. **Stabilise**: treated when found and reassessed, alongside the talking. **Establish authority**: who may act, recorded with its basis. **Act**: one act, with a reviewer. **Monitor**: an interval, a person, an endpoint, a trigger. **Dispose**: decided by somebody, handed over as reasoning. The perinatal half adds no further step and changes none of these. It moves the last clause to the front, and every step above is then asked twice.

Both halves of this chapter are sequences of decision rather than bodies of fact: the emergency seam runs recognise, stabilise, establish who may act, act, monitor, dispose, and the perinatal seam asks every one of those questions for two patients of whom only one can be asked anything. An act anywhere on either seam becomes safe in the same four ways: a named person who decided it, a stated quantity, a time against it, and a written condition that would change it.

**TRAP** **Answering the crossing point for one patient and recording it as complete.** The seams of this chapter meet at the moment a decision taken for the person in front of you is also a decision taken for someone who is not: an infant who is not yet the ward's patient, a fetus with no chart of its own, a family who will be doing the observing tonight. A candidate who has learnt both halves separately will answer the emergency correctly and the second patient not at all, and the answer reads as finished because nothing in it is wrong. The check is mechanical: for every act named, say who else it was a decision about, and where that was written down.

# Apply and consolidate

## 30 · Applying the chapter

**A vignette in this territory almost never asks what the illness is called.** It asks what is done before the name is settled, on what ground it may be done to a person who has not agreed to it, who is watching afterwards, and where both patients are when the hour is over. Those are separate findings reached by separate reasoning, and a candidate who prepared this material as a set of syndromes answers a question nobody asked.

These cases assert nothing of their own. Every threshold, interval, dose and statutory provision they touch is taught, and cited to its source, by the account that owns it, and is named here rather than restated. Cover the answer, decide what you would do at the bedside, then read on.

| Act | Authority | Watch | Where |
|---|---|---|---|
| WHAT IS DONE IN THE FIRST HOUR, BEFORE THE LABEL IS ALLOWED TO SETTLE | THE GROUND FOR ACTING, ASSESSED AND WRITTEN DOWN RATHER THAN ASSUMED | WHAT IS MEASURED, HOW OFTEN, AND BY WHICH NAMED PERSON | THE DESTINATION DECIDED, NOT DEFAULTED TO BY WHICHEVER WARD HAS A BED |

### 30.1 How to work a vignette in this chapter

Read the stem and ask which kind of question it is putting to you, because each has its own source of authority and none supplies another's answer.

- An **act question** asks what is done now, in what order, while the diagnosis is still open and may never turn out to be psychiatric.
- An **authority question** asks on what ground a person who has not agreed may be treated, held, observed or kept, and is answered from capacity and statute, never from how unwell the patient looks.
- An **observation question** asks what is measured, at what interval, by whom, until when, and on whose review.
- A **disposition question** asks where the patient goes, who is going with them, and what has to be true before either moves.

Every case below is more than one of these at once, and the marks go missing where a candidate discharges the easy one and treats the paper as finished. Deciding that a presentation is a psychiatric emergency settles the act question and none of the other three.

RULE **The name of the condition is not the answer to any question in this chapter.** What these disorders are, how they declare themselves and how they separate from their mimics are taught in full by the chapters that own them, and reproducing that material here scores nothing. What is examined is narrower and much harder to improvise: the act, the ground for it, the watch that follows it, and the destination. A case that ends at the name has stopped exactly where the patient in front of you begins.

### 30.2 Vignette: the stop request that is not the cautious option

**Presentation.** A woman in her late twenties has been well for over a year on an antidepressant, after two severe depressive episodes, the second needing admission. She has missed a period and tested positive at home. She brings a printed sheet from the internet grading her tablet on the old lettered risk scale, which her mother-in-law has read aloud in the waiting area. She wants to stop today, and the resident agrees and writes that the patient wishes to stop and the medication has been stopped.

**Decision point.** What is actually being compared here, and what leaves the room with her.

**Reasoning to show.** Refuse the comparison as offered. There is no unexposed arm: she will carry drug exposure or illness **exposure** and usually some of each, so counselling that quantifies one arm and leaves the other qualitative is not balanced, however carefully the drug figures are quoted. That frame belongs to the section of these notes on prescribing psychotropics in pregnancy. Deal with the sheet as history: the scale was read as an ordinal grade the data never supported, implied that agents sharing a rung carried the same risk, could not separate animal evidence from human, and saw only structural harm, which for psychotropics is the decisive objection. It was withdrawn from labelling and replaced by a **narrative labelling** structure, and the prescribing account dates it at both ends and names its replacement. Reciting a rung from it is a factual error, not a shortcut.

Then take the request apart, because stopping is two decisions wearing one word. Whether to stop is largely hers; how to stop is entirely yours, and the manner changes the outcome as much as the choice. Name every arm aloud and price each in her hearing, since continuing, switching, reducing and stopping are each a positive act with a bill, and reducing is the arm that can buy the exposure without buying the benefit. The figures pricing each belong to mood and anxiety disorders in pregnancy in these notes and to the Mood disorders: pharmacotherapy notes; quote neither from memory. And stopping today does not undo an exposure that has already happened, so it has to be justified forward rather than as a retrospective repair.

**Answer.** Do not stop the drug this afternoon on a printed sheet. Say what the sheet is and what replaced it, put both arms on the table, price each, and let her choose. If she still chooses to stop, the task becomes damage limitation and the **taper** is the instruction rather than the decision, with restarting, switching, a psychological intervention and increased monitoring all still on offer. Then the disposition, where this case is usually lost: she does not leave without a review date, a named person who owns the dose as gestation advances and its reversal after delivery, and an entry written where the antenatal team will read it. Record what she decided in her own words and what would change it, so a later clinician can tell a settled choice from an unresolved one.

**PITFALL**

The act that is recorded rather than done. A note reading that medication was stopped is half an instruction, and the missing half predicts the outcome. The same defect runs through every case here in different clothing: observation signed for at the right interval and not delivered, a decontaminant charted for a drug it does not bind, an evaluation abandoned because the patient was disturbed and never diarised again, a referral written into a plan that will arrive long after the problem has resolved itself one way or the other. Each reads correctly and delivered nothing. The only step in this chapter that checks the record against the world is the one the shift handover names, which is to go and physically see the patient.

## 30.3 Vignette: the mother, the infant, and the appointment for next week

**Presentation.** A woman delivered a fortnight ago is brought to casualty at night by her husband and mother-in-law. Over several days she has stopped sleeping, become perplexed and frightened, and said more than once that the baby in the house is not hers. Between episodes she is lucid and apologetic. The infant is asleep in the mother-in-law's arms in the corridor. The duty resident, finding her settled and polite in the room, gives an outpatient appointment for the following week and records that she has good family support and would never harm her child.

**Decision point.** What happens tonight, and where do the two of them sleep.

**Reasoning to show.** Act before the diagnosis is available. The trigger is a sudden onset of symptoms suggesting the presentation rather than a confirmed one, and the response standard is a timed referral to a service that can admit; that standard and its interval belong to the postpartum psychosis account in these notes, and the disorder itself to the Other psychotic disorders, delusional syndromes and catatonia notes. It is classified as an obstetric and a psychiatric emergency at once, which is the operative part, because neither service may then hold her as a referral to the other. Begin the act, then call the other team. Two supervision rules bite from the moment the presentation is suspected, before the bed and before anyone agrees a name: she is not to be left alone, and she is not to be left unattended with the infant. The second is not a separation order but a statement about who else is in the room, compatible with feeding and holding. A **supervision plan** that names nobody is not a plan, so record which adult is with her, which adult is with the infant, who takes over at the next handover, and what would change the arrangement.

Then refuse both reassurances the resident relied on. How she looks now is a poor guide to tomorrow, because deterioration here can be extremely rapid and the triage is made on **trajectory** over recent weeks rather than on the cross-section, which is what the collateral history is for. And counting her children as the reason she will not act is to be challenged rather than accepted, even where she says it herself, because devotion is evidence about her values and not about her capacity to keep herself safe. The perinatal method profile is shifted toward acts leaving little margin for rescue, so an apparently minor act raises the admission question rather than settling it.

**Answer.** Assess her tonight, by somebody with the authority to admit. Put both supervision rules in force now and name the two adults who discharge them. Admit, and say what the admission buys, which is the physical evaluation that cannot be finished in a corridor and a place where sleep can be re-established; treat that evaluation and any sedation decision as one plan with one owner, or the workup is abandoned the moment she is disturbed again. On disposition, joint admission is the default and separation is the deviation that has to be argued in terms, authored, dated and reviewed, with the review interval and the point at which the decision leaves the clinician altogether fixed by statute rather than by the team's convenience. Where no mother and baby unit is within reach, which is the position of most Indian services, assemble what the ward permits: a side room rather than an open bay, a named female relative resident alongside with somewhere to sleep, infant care agreed with the family beforehand rather than assumed, and the separation reviewed out loud on a stated date. Hand over the clock, the risk assessment on both sides, the supervision instruction and the reason for the destination, because a handover carrying the diagnosis and not the supervision plan has passed on the label and dropped the safety.

### 30.4 Vignette: the injection, the authority for it, and the bed that does not exist

**Presentation.** A man in his thirties is brought to a district hospital casualty in the small hours by his brothers, who tied his wrists with a cloth for the journey. He has not slept for several nights, talks over everyone, has given away money the family does not have, and is certain nothing is wrong. His brothers say he was treated somewhere years ago. He is loud, has struck nobody, and refuses to sit. The resident is alone with one nursing officer and a security guard, wants to give an intramuscular injection, and plans to send him home afterwards because there is no bed.

**Decision point.** On what ground is the injection given, and where does he go when it has worn off.

**Reasoning to show.** Sedation is indicated by what the disturbance prevents, never by how disturbed the patient appears, so the clinician must be able to finish the sentence: this assessment cannot be made, this treatment cannot be given. Noise is not the indication, and a department that sedates noise will sedate distress and grief along with illness. Meanwhile the physical sweep runs alongside the talking rather than after it, because new agitation is presumed to arise from a general medical condition and a known psychiatric history is no exemption: the history explains why this man might become agitated, not why he is agitated tonight. Glucose, saturation and temperature cost minutes, and the brothers hold the only account of the past week and will be gone within the hour.

Then the authority, which is the half the resident has not begun. Incapacity is the likely finding in this population, and a likelihood is exactly what an assessment is for, so **capacity** is assessed and written down rather than inferred from the disturbance. Mania makes that harder, because the examination that ought to detect the problem conceals it: orientation intact, speech fluent, information returned verbatim, and the failure confined to the weighing, where the risk is understood, retained, restated accurately and then judged not to apply. The statutory ground for treating or holding a patient without consent in India belongs to the Mental health legislation and

forensic psychiatry notes and the consent doctrine to the Forensic ethics, consent and legal procedure notes; name the ground and improvise no provision. The competence half is separate and no statute answers it, since whoever gives a drug that may stop him breathing must be able to manage a man who has stopped breathing: the decision may be delegable and the airway is not. Every agent and first dose belongs to the Schizophrenia: management, antipsychotics and adverse effects notes and appears nowhere in your answer.

**Answer.** State the indication as an inability and record it. Sweep while somebody else talks, and take the collateral before the brothers leave. Assess capacity, write the finding, name the ground. Decide early that sedation is likely, and stop the cup of tea otherwise brought to a man who may shortly be unable to protect his airway. Write the order as a single dose with a named reviewer and a review time, because an open order hands the next decision to whoever holds the chart at the worst hour, and set the monitoring by route and by state rather than by agent, a sleeping patient being an escalation and not a solved problem. Where the equipment is in another building, what replaces it is a different observation set taken from the end of the bed with one person's name written against it, never an absence of observation. If he is held, the load goes to the side and never onto the thorax, the head stays free and the face uncovered, and one person watches who is not holding. Then refuse the disposition as proposed, because admission is decided by whether the identified risks can be held where he would otherwise be. Ask who can stay awake with a man who will not sleep, whether anybody in that house is frightened and whether there are children in it, what he can spend or transfer before morning, which means the phone as much as the wallet, and where the vehicle keys are. Where there is genuinely no bed, that is a thing to be escalated and recorded with the time of each refusal, never a clinical reason.

TRAP **Writing a plan with no person's name in it.** Monitor regularly, observe, family to watch, review, as per protocol: each reads as an instruction and none of them is one, because an interval assigned to a ward is assigned to nobody and a reviewer who is a role rather than a person does not in practice review. Candidates write this way because it is how the case sheets they have copied are written, and because naming somebody feels like an accusation waiting to happen. It is the opposite. Every duty in this chapter has an owner in the source material, and the mark is in supplying one: who set the level, who takes the observations, who reviews and when, who holds the infant, who finishes the evaluation that was interrupted.

### 30.5 Vignette: three antidotes offered, and which of them is read first

**Presentation.** A woman in her forties is brought some hours after being found drowsy at home beside empty strips. The family bring a cloth bag of tablets collected from three prescribers over several years and cannot say what she took or how much. She is flushed, dry, febrile, disoriented and has not passed urine. The intern proposes activated charcoal now, physostigmine to clear the delirium so that the psychiatric assessment can be completed, and asks whether flumazenil would speed matters up.

**Decision point.** Which of the three is given, in what order, and what is read before any syringe is filled.

**Reasoning to show.** Identification comes first, and it is a psychiatric job rather than a clerical one, because the psychiatrist is often the only person who knows what she was prescribed and therefore what is plausibly inside her. The prescription is a physical object in a bag in the corridor: ask for the strips, the bottle and the last outpatient card while the attendants are still here, count what is missing from a strip, and record that you asked and were told nothing, which distinguishes an unknown ingestion from an unexplored one. Then the antidote question, decided on the electrocardiogram and the contraindication list and never on how antimuscarinic she looks, because recognition names the family of poisons and not the member, and members diverge on whether this drug helps or kills. Where the width is past the line at which seizures become possible, the act is sodium bicarbonate and the antidote is refused; past the line at which ventricular arrhythmias appear, the same act happens in a monitored bed with anaesthesia and critical care in from the start. One clause of the contraindication list carries almost all the mortality, since cardiovascular disease bars the drug in exactly the patient in whom the reflex to give it is strongest. Given at all, it goes with the list read whole, atropine drawn up beside it because that is this antidote's own antidote, no faster than the label allows, and as one diagnostic dose that wears off long before the poison does.

The other two requests answer faster. **Decontamination** is settled by asking what, then when, then who. What was taken decides whether charcoal has any role at all, since for a defined list of poisons it has none at any interval; when it was taken sets a window belonging to that poison and that formulation rather than to a single remembered figure; and who is in front of you can withdraw what the first two allowed, because the airway reflexes that matter are those that will exist when the charcoal is in the stomach, and an airway is never secured in order to administer a decontaminant. The benzodiazepine antidote is refused on the right ground, which is not that it is unsafe in the abstract but that the reason offered is diagnostic convenience: the drowsiness is information about the ingestion that the antidote deletes, and in a mixed ingestion reversal removes a mask and can turn a sedated patient into a fitting one. Medical priority is in any case a claim on resources rather than a licence to postpone, so the psychosocial assessment is not deferred until treatment is finished, and where she genuinely cannot participate what replaces it is a stated review interval, not silence.

**Answer.** Electrocardiogram before anything is drawn up, and a second timed against the first, since direction of change matters more than any single width. Bicarbonate if the width demands it, and the antidote refused with the ground written down so that a fresh team does not quietly reverse a cardiovascular refusal. Charcoal only if the identified agent, the elapsed time and the airway all permit it. No flumazenil to make her interviewable. On disposition, refuse the phrase **medical clearance** and state the two limbs instead: that the disturbance is unlikely to be due to a medical condition or trauma, and that treatment of the concomitant problems falls within the capabilities of

the receiving facility, the second being a statement about your service and not about her. The observation period belongs to the drug rather than to the mental state, and modified-release agents declare themselves late, so an untroubled early picture is not a discharge criterion. Where doubt between a confused state of medical origin and a psychiatric one is unresolved, she is medically observed and never transferred; the syndrome itself is the Stroke, TBI, delirium and focal brain syndromes notes'. Hand over the tracings in sequence with their times, whether the antidote was given, refused or unavailable and on which ground, and whether decontamination was given and when.

**GOOD TO REMEMBER**

Almost everything you will need in these cases is standing in the corridor and is about to leave. The relatives who saw the patient yesterday and can date the change, the strip with the missing tablets, the outpatient card, the ambulance crew, the person who could hold the infant tonight, the answer to what else is in the house: none of it can be reconstructed at the ward round, and all of it can be had while the patient is being stabilised by somebody else. Assign it to the team member who is not holding verbal contact, ask before anybody is released, and write down who said what, because a disagreement about when this started is usually the first sign that the story offered is not the story that happened.

### 30.6 The four cases on one grid, and the thread through them

Set side by side, the cases are one discipline in different clothes, and the right-hand column is a single family of mistakes.

| VIGNETTE | THE QUESTION IT REALLY ASKS | WHERE THE ANSWER COMES FROM | THE CLASSIC WRONG ANSWER |
|---|---|---|---|
| THE STOP REQUEST | Which two exposures are being compared, and what leaves the room | The prescribing-in-pregnancy account, then the account that prices each arm | Stopping on a withdrawn scale, and recording a decision with no taper, no review and no owner |
| THE MOTHER AT NIGHT | What is done before the name is settled, and where the pair sleep | The postpartum psychosis account, and the perinatal emergency overlay | An appointment for next week, justified by how she looks and by the children at home |
| THE INJECTION IN CASUALTY | The ground for treating a man who has not agreed, and what holds the risk afterwards | The rapid tranquillisation account, the agitation assessment, and the statute named but not restated | An open order given on the disturbance itself, then discharge because the ward is full |
| THE UNKNOWN OVERDOSE | Which instrument selects the act, and what the receiving service can actually do | The overdose triage account, and the antidote and decontamination account | Charcoal by reflex, an antidote given on appearance, and reversal to make the patient interviewable |

**The thread, stated once.** Every case turns on refusing to let one finding stand in for another. A clinical indication does not answer an authority question. A reassuring appearance does not answer a question about trajectory. A recognised toxidrome does not select an antidote, because a measurement does that. And a decision recorded is not a decision delivered, which is why every act here ends with a person's name, an interval and a place.

IN INDIA

Four service facts decide these cases more often than any clinical one. No funded pathway puts a psychiatrist inside the antenatal clinic, so nearly every contact a pregnant woman has belongs to somebody who was never asked to ask, and an arm of a decision that cannot be delivered locally should change which arm is chosen rather than be recorded as though it had been offered. Mother and baby units are very few across low- and middle-income settings, so the disposition question is usually which relative rather than which agency, and whether she can genuinely do it. The monitoring a sedation protocol assumes is often in another building at night, so what is owed is a different observation set, a named observer, and an honest record of what was unavailable. And the antidote is frequently not in the hospital at all, which leaves the tracing and the bicarbonate as the limb you actually use; what is scarce there is a monitored bed with an anaesthetist attached rather than a molecule, so settle in advance which unit accepts such a patient and whom you telephone when the answer is no.

MNEMONIC

### Two patients, the inability, the name, the interval, the destination

Rebuild any case in this chapter from these when a vignette empties your head. **Two patients**: establish the second before doing anything to the first, whether that is a fetus, an infant in the corridor, or an untreated illness that is itself an exposure. **The inability**: the act is indicated by what the disturbance prevents, and if nobody can finish the sentence, nothing has been indicated. **The name**: an authority assessed and written down, and a person named against every duty, the reviewer, the observer, the adult with the infant, the owner of the evaluation that was interrupted. **The interval**: a cadence, a review time and an observation period belonging to the drug or the statute rather than to the ward's convenience. **The destination**: decided by whether the risks can be held where the patient would otherwise be, never by which bed happens to be free.

Every question in this chapter is answered in the imperative and ends with a destination: what is done now, on whose authority, watched by whom at what interval, and where both patients are when the hour is over.

## 31 · Consolidation

**The last useful thing to do with this material is not to read it again but to produce it from memory, with nothing in front of you.** Everything below is active recall against a risk category or a decision, and each is a question and nothing is answered, which is the design: **active recall** forces

an answer out before it can be checked, whereas an answer printed beside its prompt converts the exercise back into reading, which feels identical from the inside and does far less.

Two things separate this list from a summary. It asks almost nothing about what a syndrome is, because throughout this material the marks sit in **the act** and **the setting**: what is done, in what order, on whose authority, watched how often, and where the patient goes next. And it prints no figure at all, partly because an answer beside its question destroys the exercise, and mostly because the numbers belong to the chapters owning the entities: sedation and the escalation ladder to the Schizophrenia: management, antipsychotics and adverse effects notes, suicidal intent to the Somatic-symptom, sexual, impulse-control disorders and suicide notes, the confusional syndrome to the Stroke, TBI, delirium and focal brain syndromes notes, and the catatonic signs and the benzodiazepine challenge to the Other psychotic disorders, delusional syndromes and catatonia notes.

| Retrieve | Act | Authority | Destination |
|---|---|---|---|
| THE DEVICE THIS SECTION RUNS ON, NEVER REREAD | WHAT EVERY PROMPT ASKS FOR, NOT WHAT THE THING IS CALLED | NAMED BEFORE ANYTHING IS DONE TO A PATIENT WHO CANNOT AGREE | DECIDED BY SOMEBODY, NEVER DEFAULTED TO BY NOBODY |

## 31.1 How to use this list

Six groups follow the order the material was built in, one prompt per topic. Answer aloud or on paper, in sequence, because sequence is most of what is examined: correct acts in the wrong order satisfy nothing. Two habits are worth imposing. Name who performs each act, because almost every failure described here is an act nobody owned rather than an act nobody knew. And finish each answer where the patient leaves you, not where the patient settles.

RULE **Every question here is answered with an act, never with an entity.** Naming the syndrome earns very little, because it is taught in the chapter that owns it and the examiner knows that. What is asked is what happens in **the first hour**: what is excluded before anything is attributed, who has authority to act on a patient who cannot agree, what is done and by when, what is measured afterwards and how often, and which destination the patient leaves for. Answer the entity and you have written a correct paragraph from another chapter, scoring on none of it.

## 31.2 Group one: prescribing and treating in pregnancy and lactation

Every decision here is taken for **the second patient** as well, and no arm of any of them is unexposed.

1. A woman who may become pregnant needs a psychotropic. Which patients is the decision for, and why is doing nothing an exposure? Then: what replaced the withdrawn letter-based risk system, when did that take effect, why could one ordered label never carry the information, and what must a current label state instead?
2. She is breastfeeding. What does the standard exposure metric measure, and what does it silently omit? Why is a missing figure for an agent not a reassurance, which infants do the published figures not describe, and what is watched in the baby, by whom, and what would stop the drug?

3. She is already well on treatment and is pregnant or planning to be. Name the arms this decision actually has, price each against her illness rather than against nothing, and say which part is hers and which is entirely yours.

### 31.3 Group two: the postpartum period

Every prompt here has two subjects, and the second can report nothing at all.

1. Tearful and labile in the first days after delivery. What act does the front door owe her, into whose hands does the judgment then pass, and what must be said aloud and written down before that judgment is allowed to close?
2. Build the perinatal screening pathway as a service rather than an instrument: who is screened, at which contacts, by whom, and what actually happens to a woman who answers yes, and how soon? Then what does the Indian position supply, and what does it not?
3. A fortnight past delivery, behaving strangely, the family frightened. What does assessing her immediately oblige somebody to do, and by when? What does admission buy that no outpatient plan can, and which adults must be named before she or the baby is left alone?
4. Why is a mood enquiry not an enquiry about the relationship? How is the bond observed at the bedside rather than inferred from the mood, what does the formulation oblige you to arrange before she leaves your care, and when is the question asked again?
5. What is a mother-baby unit for, and which clause of its specification prevents which predictable failure? Where does the burden of proof sit when separation is considered, who reviews it, and what does an Indian team assemble when no unit is within reach?

### 31.4 Group three: women's mental health across the lifespan

Three of these are routing problems before they are clinical ones; the fourth has a statute inside it.

1. A week of irritability and hopelessness each month, lifting as her period starts. Where does the classification file this, and what does that do to your pathway? What must be documented before anyone commits to a label, and in which direction across time does that record run?
2. Low mood and broken nights in midlife, with the explanation already agreed by everyone. Why is the transition a context and not a diagnosis, what must be established before anything is attributed to it, and how is the decision divided where there is nobody to divide it with?
3. What has to be true before you are entitled to ask a woman about violence at home? How is the question put, what is done in the minutes after the answer is yes, and what changes in an emergency department? Then name the Indian legal and service frame in words.
4. Reproductive medicine hands psychiatry separate tasks. Take each: what must be discussed in a fertility clinic and on whose statutory duty; which question a termination opinion actually answers and on what ground; and what must be in place before a contraceptive conversation is defensible when the drug complicating it is your own.

**GOOD TO REMEMBER**

Do not run this list once, the night before. Sweep the six groups now and mark two kinds of failure apart: prompts you could not answer, and prompts you answered by describing a syndrome. The second matters more, because it is the exact error this material exists to correct and it feels like knowledge while you produce it.

### 31.5 Group four: the behavioural emergency

The sequence itself, door to destination. Answer as an ordered account of who did what, and resist starting at the drug.

1. Before any escalation ladder begins: what is settled about the room and its exits, how many people are in it and which one may speak, where do you stand and why does the geometry matter, what is measured while somebody else talks, and which presumption do you carry about new agitation until it is displaced?
2. Take the drug chart away from rapid tranquillisation. What is left: the indication in the form the guidance uses, the authority when the patient cannot consent, who must be competent and within reach, what is checked before, what is measured afterwards and until when, and what happens when it fails?
3. What is an observation level as an object rather than as a feeling? What must be written for one to exist, who may raise it and who must review it, what may the observer not simultaneously be doing, and what must the ward be checked for as a physical space?
4. Brought in at night, elated, sleepless, certain nothing is wrong. What triggers urgent specialist assessment, what is excluded before the psychiatric label settles, why is the capacity assessment in this state most often got wrong, which harms accrue while you deliberate, and where is he routed?
5. An overdose arrives. How are the two assessments ordered, and what does medical priority not license? What replaces the phrase that used to end this argument, how do you establish what was taken when nobody can tell you, how long does decontamination stay available, why is the well-looking patient dangerous, and what must the handover contain?
6. Somebody is being physically held. Where may the weight go and where may it not, and why? What is done about the head and face, what governs how long the hold lasts, which duties are separate from watching, what does the body need if it is prolonged, and what happens in the hour after release?

### 31.6 Group five: the rigid, hyperthermic and toxidromic emergencies

Each entity here is taught elsewhere, so each prompt asks only what follows recognition. An answer listing features, or comparing one with a mimic, has answered the wrong question.

1. An immobile, mute patient is admitted. Setting the challenge and the rating scale aside: what is secured in the first hours while the diagnosis is unsettled, which complications of immobility are

prevented rather than treated, what would convert this into a life-threatening emergency, and who nurses this patient where?

2. What kind of instrument is a formal criteria set, and what does its negative limb oblige you to do? What does a result below the threshold not mean, and which observations, quite separate from those criteria, decide where the patient is nursed and when organ support and renal replacement are called for?
3. The decision rule for serotonin toxicity: in what population was it derived, in which direction are you running it at a psychiatric front door, and why does that make a positive worth more than a negative? What does the distinction from the rigid hyperthermic alternative change about the next hour, and where does an antidote sit in the order of operations?
4. A patient's neck and eyes have deviated after a first injection. Which question precedes the syringe, why is the culprit drug often not on the psychiatric chart, how long may you wait and what follows when nothing happens, why is the episode not over when the spasm melts, and what do the drug-induced emergencies outside the brain share?
5. How do you establish which of the lithium poisonings is in front of you, and from what source? What does a measured concentration tell you about the patient you can see and what does it not, which decontamination decision exists in one pattern and not another, and what sets the length of observation?
6. An antimuscarinic picture follows an overdose. What is read before any antidote is drawn up, which overlap makes that antidote lethal, who must it be refused to, how is it given and what is kept beside it, and what is done instead for the patient who cannot have it?

### 31.7 Group six: the medical emergency and the perinatal overlay

The final prompt closes the loop, taking every emergency above and asking what changes when a second patient cannot be examined.

1. An elderly man, confused since morning. What is treated the moment it is found rather than carried to the end, how is conscious level graded inside the primary survey, which bedside measurements are taken and when is one not to be believed, what is given before any carbohydrate, what does sedation not buy, and where does he go when the answer is still unclear?
2. A man who drinks, drowsy and unable to account for himself. Which word has everyone already supplied, and why is it withheld longest? What is excluded before anything is attributed, what runs alongside it and what in that is routinely skipped, which diagnoses are missed in the state that conceals them, and where does he leave for?
3. The emergency patient is pregnant or newly delivered. What is established before anything is done to her? Why is the position she is left in after sedation or restraint part of the prescription rather than the nursing, how is a hold adapted and where does the guidance honestly stop, what

must not follow sedation, what is monitored afterwards and how often, and who is called into the room rather than after it?

**IN INDIA**

Several prompts above have an honest Indian answer that is not the specification, and saying so earns more than reciting a standard the setting cannot meet. The de-escalation team the consensus describes is not what a district casualty holds at two in the morning. An observation level is a person, so a service that cannot supply the person cannot supply the level, whatever the chart says. The monitoring a sedation protocol assumes needs equipment and somebody free to use it. A mother-baby unit may be hundreds of kilometres away, and the referral a violence pathway names may have nobody at the far end. In each case the marks are in naming what is substituted, who does it instead, and what has been accepted by substituting.

### 31.8 The answers this material punishes

**More marks are lost here to a small set of confident wrong answers than to genuine ignorance**, because each is a compact sentence that sounds like clinical sense and each answers a question that was not asked. If anything you produced matches the middle column, reopen that section first.

| AXIS | THE ANSWER THAT LOSES THE MARK | THE ANSWER THAT EARNS IT | WHERE TO REOPEN |
|---|---|---|---|
| THE AGITATED PATIENT | Starting at the escalation ladder, as though the question began at the decision to calm somebody | Room, team, one designated voice and the parallel sweep come first, and new agitation is presumed medical until displaced; the ladder is another chapter's | the acutely agitated and aggressive patient |
| SEDATING WITHOUT CONSENT | Answering with agents, sequence and doses, because the question looks like pharmacology | An indication stated as what the disturbance prevents, capacity written down, an airway-competent practitioner, one dose with a named reviewer, monitoring that outlives the drug | rapid tranquillisation protocols |
| HOLDING A PATIENT | Saying the patient is turned onto their back rather than their front, and stopping there | No position is safe: weight off the chest, head free and face uncovered, the hold as short as it can be made, one person watching who is not holding | restraint and seclusion |
| PRESCRIBING IN PREGNANCY | Reciting a letter from the withdrawn labelling system as though it were current practice | Name the system, date its withdrawal, name the narrative rule that replaced it, then reason from the evidence against a background rate that was never zero | prescribing psychotropics in pregnancy |
| THE WOMAN ALREADY ON TREATMENT | Stopping the drug the day the test comes back positive, and calling that cautious | The exposure has already happened, her untreated illness is the competing exposure rather than the baseline, and the manner of stopping matters as much as the decision | mood and anxiety disorders in pregnancy |
| THE CONFUSED PATIENT WHO DRINKS | Attributing the confusion to alcohol because there is a history of alcohol | Exclusion first, attribution second: injury and the metabolic causes are excluded alongside each other, and intoxication is a conclusion arrived at, never a premise begun from | acute alcohol withdrawal and delirium tremens |

PITFALL

One error runs underneath all six, and it is why this list prints no figures. Every number that answers a prompt above belongs to a document and to a population, and stops being true when separated from either. A guideline's threshold is that guideline's. A rule derived in a poisoning service behaves differently at a psychiatric front door. An exposure figure calculated for a term, healthy, exclusively breastfed infant says nothing certain about a preterm one. Quote a figure with its source and its population, or quote the reasoning and say plainly that you assert no figure.

### 31.9 The frame to run on an unseen question

All of it collapses into one procedure, run in order on anything familiar or not, so that an unseen presentation becomes a sequence of decisions rather than a search for the nearest remembered rule. The word names the mistake: the patient who gets missed is the one nobody established was there, and the half of the answer that gets missed is the half that comes second.

MNEMONIC

**SECOND**

**S**econd patient: before anything is done to the person in front of you, establish whether there is another, because every perinatal decision is taken for two at once and only one can be asked, examined or consented. **E**xclude before you attribute: the physical sweep runs alongside the talking rather than after it, and the psychiatric label is the last attribution made, not the first. **C**apacity and authority: written down before the act, never inferred from the disturbance, never confused with the judgment that the act is warranted. **O**n the clock: the act is timed and the window closes, so state how long you may wait and what follows when it does not work. **N**ame the cadence: what is measured, how often, by whom, until when, and the **level of care** that follows. **D**isposition: where the patient goes, who decided it, and a handover carrying what was assessed, what it showed, and what is still active.

TRAP **Ending the answer at the injection.** The commonest structural failure here is an answer that stops when the patient becomes calm, the spasm melts, the antidote is given or the diagnosis is finally named, as though the emergency were the problem and the calm were the solution. The avoidable deaths sit in the hour afterwards, which is why so much of this material is **monitoring cadence**, level of care and **disposition**. Whatever the question appears to be about, keep writing until you have said who watches this patient, how often, on whose authority, and where they are when the shift changes.

Establish whether there is a second patient before you touch the first, exclude before you attribute, settle whose authority the act runs on before it is performed, then name what is monitored, how often and until when, and where the patient goes: the marks here sit in the order of the acts and never in the name of the entity.

## Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so each row is marked Representative and written in the register an examiner uses. Almost every question in this area is a mixed question, and only one of its halves belongs here. The naming half has been taught elsewhere and is expected rather than supplied: the rigid and hyperthermic drug reactions by the Schizophrenia: management, antipsychotics and adverse effects notes, catatonia by the Other psychotic disorders, delusional syndromes and catatonia notes, the confusional state by the Stroke, TBI, delirium and focal brain syndromes notes, the withdrawal syndrome by the Substance use disorders notes, and the authority to act on a patient who cannot agree by the Mental health legislation and forensic psychiatry notes with the Forensic ethics, consent and legal procedure notes. Bring those. What the table asks for is the doing.

| QUESTION | FORM | ASKED |
|---|---|---|
| **A woman established on a psychotropic is confirmed pregnant. How is continuing, switching, reducing or stopping decided, and what must the record show?** | Long answer | Representative |
| **Choosing an agent for a mother who is breastfeeding, and what the usual metric leaves out.** | Long answer | Representative |
| **Screening after delivery as a service question: who screens, at which contacts, and what happens to a positive answer.** | Long answer | Representative |
| **Postpartum psychosis at the point of contact: the act, what admission buys, and who holds the infant.** | Long answer | Representative |
| **Assessing the mother and infant relationship, and how risk to the infant becomes supervision and a discharge plan.** | Long answer | Representative |
| **Intimate partner violence: the decision to enquire, the preconditions for asking, and support in an emergency department.** | Long answer | Representative |
| **The mother and baby unit, and what is done where there is none.** | Short note | Representative |
| **The psychiatric opinion sought before a termination of pregnancy.** | Short note | Representative |
| **Premenstrual dysphoric disorder and the menopausal transition: which clinic each woman reaches psychiatry from.** | Short note | Representative |
| **The acutely agitated patient from the door to the handover: the room, the team, the parallel sweep, and what must be true before it ends.** | Long answer | Representative |
| **Rapid tranquillisation as a procedure: the indication, the authority, the check before the drug, the monitoring after it.** | Long answer | Representative |

| QUESTION | FORM | ASKED |
|---|---|---|
| **Observation levels written as a prescription: the named levels, who may move a patient up, and the review that brings it down.** | Long answer | Representative |
| **Physical restraint: what a hold does to a body, the positioning hierarchy, the clock, and who watches.** | Long answer | Representative |
| **The confused patient at the front door, including the drinker: exclusion before attribution, and which bed he occupies.** | Long answer | Representative |
| **Deliberate self-harm and overdose at triage: the order of the two assessments, and the decontamination clock.** | Long answer | Representative |
| **The rigid, hyperthermic patient in casualty: the criteria set as an instrument, the level of care, and organ support.** | Long answer | Representative |
| **Serotonin toxicity: the decision rule, where it was validated, and the branch that changes the clock.** | Long answer | Representative |
| **Acute dystonia and the other acute drug-induced emergencies.** | Short note | Representative |
| **Lithium overdose, and the antidote decision in psychotropic poisoning.** | Short note | Representative |
| **A psychiatric emergency in a pregnant woman: the position she is left in, the adapted hold, and monitoring two patients.** | Long answer | Representative |

Two things about the wording repay attention before the content does. The first is the verb. Manage and describe what you would do ask for an ordered act with a time in it, answered from the first minute forwards; discuss asks for a decision and its reasoning, with the alternatives named and priced rather than listed. The second is the setting, written into almost every stem and used in almost no answer. Casualty at night, the antenatal clinic and the postnatal ward are not scenery: each fixes who is in the building, what can be monitored, and where the patient can be moved to. An answer that would read the same in all three has not used its stem. Two habits then earn marks

across the list. Answer in the order the marks sit in, what is done now, where, on whose authority and where the patient goes next, rather than opening with what the thing is. And where an answer needs a figure this material does not hold, name the source instead of the number: the serum bands are in the Mood disorders: pharmacotherapy notes, the risk-assessment instruments in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, and the infant-exposure metric in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. A candidate who reproduces a dose he has not checked is doing the one thing this material is arranged to prevent.

## The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, so a line you cannot recover is a topic to reread rather than a fact to memorise here. Five things are load-bearing across the chapter. Every section answers what is done now, where, on whose authority, and where the patient goes next, and none of them answers what the thing is, so a section that says little about a disorder you already know has been written on the assumption that you know it. In the perinatal half all four of those questions are answered twice over, because two patients are in front of you and only one of them can be asked, examined or consented. Exclusion runs before attribution everywhere: the psychiatric attribution is the last one made, and a known psychiatric history is the distractor rather than the answer. The default is the option that can still be changed and the deviation is the one that has to be written down with a reason, which sorts these decisions more reliably than asking which act feels more careful. And an act becomes an order the same way on both seams: a named person who decided it, a stated quantity, a time against it, and a written condition that would change it. The figures printed below are the ones this chapter itself owns, thresholds, intervals, cadences and denominators, each carried back from the section that grounded it; every treatment dose, and every figure that belongs to an entity rather than to an act, stays in the chapter that owns it, and those chapters are named here in words.

| ASK | HOLD |
|---|---|
| PRESCRIBING AND TREATING IN PREGNANCY AND LACTATION | |
| THE ARM OF THE DECISION WITH NO DRUG IN IT | There is no unexposed arm, only two exposures: she will carry drug exposure or illness exposure and usually some of each, untreated illness being itself an exposure. The illness arm is measurable and belongs in the same sentence as the drug arm. Among women euthymic at conception, 68 per cent of those who discontinued an antidepressant relapsed across pregnancy against 26 per cent of those who maintained it, a hazard ratio of 5.0; in bipolar disorder the overall recurrence risk in pregnancy was 71 per cent. Counselling that quantifies the drug arm and leaves the illness arm qualitative is not balanced counselling. |

| ASK | HOLD |
|---|---|
| THE LETTER GRID, AND THE ONLY WAY IT MAY BE USED | A historical object, admissible only with both ends dated on the page and the instrument that replaced it named. The pregnancy categories A, B, C, D and X were adopted in 1979 and ceased to apply to new labelling from 30 June 2015, when the Pregnancy and Lactation Labeling Rule replaced them with a narrative labelling structure; older products had to strip the letter from their labelling within 3 years of that date, so the disappearance was staggered product by product. Two boundaries are routinely misstated: the letters never covered breastfeeding, so a lactation category is something that never existed, and the instrument reached prescription products only. A bare letter offered as current practice is a factual error, not a shortcut. |
| HOW A TERATOGENIC RISK FIGURE IS QUOTED | Every figure is an increase above a background that is not zero, on a clock you must name. The background major birth defect rate is 2 to 4 per cent and loss is reported in 15 to 20 per cent of clinically recognised pregnancies, and both are stated before any drug is mentioned. Absolute risk is then separated from relative: a tenfold rise in one rare defect, from 0.04 per cent to 0.4 per cent, can leave the total rate across a population unmeasurably changed. And the harm is placed against the window that could produce it, organogenesis at 3 to 8 weeks after conception for gross structural harm, the brain's most critical period running 3 to 16 weeks and past it. The comparator that makes these numbers mean something is the untreated ill woman. |
| WHAT HAPPENS TO THE DOSE AS THE PREGNANCY RUNS | The dose that was right at booking is frequently not right at term, and that is pharmacokinetics rather than the illness worsening: a woman whose symptoms creep back in the second half may be underdosed by her own physiology. The worked example is glucuronidation, where pregnancy upregulates UGT1A4 and lamotrigine clearance rises by up to 330 per cent, quoted purely as kinetics and never as a statement about that agent's safety. The direction of change is broadly predictable from the elimination route, which makes it teachable rather than merely cautionary. The reversal after delivery is the step this material names as owned by nobody. |

| ASK | HOLD |
|---|---|
| WHAT A RELATIVE INFANT DOSE IS, AND IS NOT | An intake figure, not an exposure figure: calculated from what enters the infant and assuming he can clear it, with below 10 per cent of the maternal weight-adjusted dose treated as a notional line rather than as a test that settles anything. Every caveat in the topic, prematurity, the first postnatal days, dehydration, intercurrent illness and maternal genotype, is a statement about a clearance term the metric does not carry. Quote none of it without naming the metabolite it excludes and the infant it assumes, who is term, healthy and exclusively breastfed. What is acceptable in a thriving infant can be wrong in a jaundiced newborn on the same milk. |
| THE BLANK CELL, AND THE METABOLITE | Where an agent has an active metabolite the drug name and the number in front of you describe different molecules: measured with its metabolite, fluoxetine averages about 7 per cent across a range of 3 to 12 per cent, the upper bound crossing a line the average sits below. The spread across the table is the teaching rather than any single entry, quetiapine at 0.09 per cent at one end and lithium at 12.2 per cent at the other, the latter from a series of 11 mothers and the only central estimate above the notional line. A blank in the percentage column is neither reassurance nor warning: the calculation was not made, and the reason differs by agent, being methodological for the anticonvulsant mood stabilisers. What is watched is watched in the infant, by a named person. |
| THE FOUR ARMS, AND WHERE THE BURDEN SITS | Continue, switch, reduce, stop, each priced aloud in her hearing so the conversation stops being a request for permission. The default is not neutrality: for most people and most medications the risk of the exposure is lower than the risk of exacerbation or relapse, so continuation stands unless a case is made against it, and the clinician who stops owes the argument. Whether to stop belongs largely to her; how to stop belongs entirely to you, and the manner is itself measurable, median recurrence latency running 11 times shorter after abrupt or rapid discontinuation than after a gradual one, with 47 per cent of recurrences falling in the first trimester. A progressive taper over 2 to 4 weeks is the other half of the instruction. |

| ASK | HOLD |
| --- | --- |
| THE REFLEX STOP, AND THE WOMAN WHO HAS ALREADY DECIDED | Stopping the day the test comes back positive usually cannot reverse a first-trimester exposure that has already happened, and it adds a discontinuation in the very trimester in which recurrences cluster: a visible act substituted for a useful one. Where she has decided anyway the task becomes damage limitation, and the conversation carries restarting, switching and a psychological intervention. Antenatal anxiety and perinatal obsessive-compulsive symptoms are asked about in terms, because what you find depends on how you ask: obsessive-compulsive prevalence runs 1.08 per cent in the general population against 2.07 per cent in pregnancy and 2.43 per cent postpartum, while perinatal generalised anxiety reads 24.4 per cent by screening tool against 11.5 per cent by diagnostic interview, so roughly half the apparent prevalence is a property of the method. |
| THE POSTPARTUM PERIOD | |
| BLUES AS A DISPOSITION RATHER THAN A DESCRIPTION | The front door chooses between reassure and review, treat now, and do not discharge, and the choice turns on what is safe to do next rather than on which picture fits best. The act is reassure, inform, return: awareness raised rather than experience dismissed, information about the depressive episode and the symptoms that announce it, and a return threshold held by a named person who will still be there. You may record blues only if you also state what would make you unmake it. This is the chapter's one topic carrying no figure here, and that is a property of the ledger rather than of the state: onset, course, duration and the three-way separation are owned by the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and nothing quantitative about blues was grounded here to restate. |
| WHY A SCREEN IS NOT A SERVICE | Who is screened, at which contacts, with what enquiry, and what happens next. The instrument is the second step of the pathway and never the first. A pathway is judged against its intervals, assessment for treatment within 2 weeks of referral and a psychological intervention within 1 month of that assessment, with the one guaranteed postnatal review at 6 to 8 weeks after the birth. Where a service cannot say who assesses the positives, within what interval, and who follows her if treatment starts, a questionnaire increases documented distress without increasing treated distress. India is where that bites: against a stated requirement of one psychiatrist per 100,000 population, the reported range runs from 0.05 in the lowest state to 1.2 in the highest. |

| ASK | HOLD |
|---|---|
| THE SEQUENCING RULE INSIDE THE PATHWAY | Screening for bipolar disorder comes before pharmacotherapy for depression or anxiety is started, if it has not already been done. That is a rule about the order of the pathway rather than a fact about either illness, and it is the front door's most consequential ordering decision: a depression screen is cross-sectional and knows nothing of lifetime course, so a pathway beginning with a positive screen can end in a precipitated episode of a different kind. In India the contacts exist and the instruction does not. |
| POSTPARTUM PSYCHOSIS: ACTED ON BEFORE IT IS CONFIRMED | Immediate assessment within 4 hours of referral, by a secondary service that can admit, an admission that buys the medical evaluation, and a supervision plan naming an adult for the mother and an adult for the infant, written before either is left alone. It is the only perinatal presentation in the guidance given a response time in hours. Never alone, and never alone with the baby, the second being about who else is present rather than where the baby is. Both bite from the moment the presentation is suspected, which is the point of a rule that does not wait for confirmation. |
| THE TWO TEAMS, AND WHERE THE BURDEN OF PROOF SITS | Each service assumes the other owns her: the obstetric team sees a psychiatric problem in an obstetric bed, the psychiatric team sees a recently delivered woman with a wound, a fundus and a feeding infant, the referral moves sideways while the clock runs. Begin the act, then call the other team. Joint admission is the default and separation is the deviation that must be stated in terms with its reason, because a written reason can be dated, reviewed and reversed. |
| BONDING: MOOD AND BOND ARE SEPARATE ENDPOINTS | Enquired about separately, recorded separately and recovered from separately: two passes at the same interview, first how she feels in herself and then how she feels towards this baby, in that order because the second is harder to disclose. Bonding disturbance is present in 29 per cent of mothers diagnosed with postnatal depression, so a negative mood enquiry has excluded a mood disorder and nothing else. Among over 200 mothers referred to specialist services, 10.6 per cent showed established rejection and 14.6 per cent threatened rejection, while 28.6 per cent had pathological anger, severe in 8.3 per cent. Ask her, watch them, ask them. The bond is re-examined after the mood recovers, and that second answer decides who is watching the baby at discharge. |

| ASK | HOLD |
|---|---|
| THE INTRUSIVE-THOUGHT DISCRIMINATION | Distress about the thought is reassuring, conviction is not, and the enquiry continues either way. Reading a disclosed ego-dystonic thought as evidence that the baby is in danger costs both ways: the mother who described the most frightening thing in her head watches her infant removed and will not disclose again, while the presentation that genuinely warrants urgency, an idea held with conviction and without distress, is quieter, is not offered spontaneously, and is missed by a clinician whose alarm is already spent. The formulation becomes supervision, surrogate care and a discharge plan. |
| THE MOTHER AND BABY UNIT AS A SPECIFICATION | Read the definition as a specification and not as a description: an inpatient psychiatry service with at least four beds separate from other wards, a facility for joint admission of mother with baby, staffed 24 hours a day, 7 days a week by dedicated multidisciplinary staff. So is the reason there are so few of them, each network covering a population with between 25,000 and 50,000 live births a year. Joint admission is the default and separation the deviation that has to be justified, recorded and reviewed, and it happens: separations occurred in 23 per cent of consecutive joint admissions in one European series. The separation decision is made on safety and never on diagnosis; converting the diagnostic gradient into a decision rule fails both ways, separating manageable dyads and reassuring a team about a benign-sounding diagnosis attached to an unsafe home. |
| THE TWO LACTATION QUESTIONS, ASKED SEPARATELY | How much drug reaches the baby, which decides whether the feed is safe, and what the drug does to the mother's prolactin axis, which decides whether there is a feed at all. Both are answered explicitly, and the second is answerable: in the Indian cohort of 237 admissions with a mean stay of 17.23 days, lactation was restored in 75 of the 87 mothers who had stopped, 86 per cent, by dispelling myths, correcting positioning, timing the feed and using expressed milk when she is too sedated. The familiar argument from the harms of separation is a chain its own source states as what the absence of a unit may produce: a mechanism argument, not a measured effect, and presenting it as measured is overclaiming. Where there is no unit, the family-caregiver model and its scaled-down variants are named. |
| WOMEN'S MENTAL HEALTH ACROSS THE LIFESPAN | |

| ASK | HOLD |
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| PREMENSTRUAL DYSPHORIC DISORDER: FILED UNDER GYNAECOLOGY | Coded GA34.41, in the genitourinary chapter rather than among the mental disorders, so psychiatry must go and collect it, since adjacency will never hand it to a psychiatrist. A premenstrual complaint is a routing decision before it is a diagnosis and a diagnosis before it is a prescription, and what decides the routing is information about time, which cannot be had in the consultation where the question is first asked. So the record is kept forward across cycles, with a named reviewer and a plan for the interval; compressing that into one sitting substitutes recall for observation. |
| THE PERIMENOPAUSE IS A CONTEXT, NOT A DIAGNOSIS | The transition has a nosological home of its own, GA30, and it is not in the mental disorders chapter. Most depressive episodes in the transition occur in women who have been depressed before, so the transition is where the episode happened rather than what it is. A context tells you what else to ask and whom to involve, never whether to treat. Collapse it into the diagnosis and two opposite errors open at once, an episode explained away and untreated, and a transition needing a gynaecological opinion absorbed into a psychiatric formulation. Waiting for the transition to finish is the comfortable error, and she often offers it herself. The endocrine material sits in the Endocrine and metabolic psychiatry notes. |
| READING A VIOLENCE OR DISPARITY FIGURE | The denominator is part of the number: who was counted, over what period, and under whose definition, and a figure quoted without them is not the same claim. The sex difference in depression has a shape that constrains which explanations survive it, an overall female-to-male odds ratio of 1.95 that is already present at age 12, peaks at 3.02 at ages 13 to 15 and then narrows. In India the female risk of a common mental disorder runs 1.53 times that of men, and the treatment gap for women is 81.5 per cent, which is why the gap belongs beside the prevalence rather than after it: the excess sits inside a population that is overwhelmingly untreated. |

| ASK | HOLD |
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| ASKING ABOUT VIOLENCE IS A COMMITMENT, NOT A QUESTION | Alone, trained, and somewhere to send her. The size of the thing is not in doubt, 25.8 per cent of ever-partnered women worldwide reporting lifetime partner violence, 31 per cent in southern Asia, 22.3 per cent of ever-married Indian women and 2.7 per cent reporting physical violence during a pregnancy. Enquiry is targeted by presentation, unconditional inside those presentations, and routine in antenatal care alone; universal screening is the answer the guidance explicitly rejects where referral options are limited, because enquiry with nowhere to refer, no privacy and no trained response converts a disclosure into new risk she carries home. In an emergency department do everything at that contact, because there may not be another. The Indian civil statute is the Protection of Women from Domestic Violence Act, 2005, and the duties it places on medical facilities are named in words and never renumbered. |
| TERMINATION: WHICH STATUTORY QUESTION YOU ARE ANSWERING | The Medical Termination of Pregnancy Act, 1971, as amended in 2021, asks whether continuance of the pregnancy would involve grave injury to mental health, and grave injury to mental health is a statutory ground. It does not ask whether termination will damage mental health and does not ask you to predict outcome afterwards, so an opinion discussing later regret answers a question the statute does not pose and can defeat a lawful request while appearing thorough. Where she alleges the pregnancy was caused by rape, the anguish is presumed to constitute that injury; the extended window, beyond 20 weeks till 24 weeks on the opinion of two registered practitioners, turns on falling within a prescribed category of vulnerable women. Write about continuance. |
| INFERTILITY, AND READING THE ABORTION LITERATURE HONESTLY | The referral is mapped across the cycle, before, during and after treatment, on the psychosocial need domains, the burden being an outcome rather than a side issue: in a systematic review the commonest reason for discontinuing fertility treatment was postponement at 39.18 per cent, with psychological burden alone accounting for 14 per cent. Read the guidance's own caveat with it, only 45 of its 125 recommendations, 36.0 per cent, resting on strong evidence, and Indian law places a counselling duty on the fertility clinic. In the abortion literature the direction of a finding tracks methodological quality, the weakest designs generating the strongest claims of harm, and the comparison group is where most answers fail: comparing women who have an abortion with women never pregnant leaves the unwanted pregnancy itself, the exposure that predicts distress, uncontrolled. Calling the evidence conflicting and stopping there sounds balanced and is wrong. |
| THE BEHAVIOURAL EMERGENCY | |

| ASK | HOLD |
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| AGITATION IS A PRESENTATION AND NEVER A DIAGNOSIS | The physical sweep runs alongside the talking rather than after it, and the psychiatric attribution is the last one made. Assessment and calming are interleaved, not sequential: the examination may be interrupted by treatment and then resumed, which makes somebody the owner of resuming it. The commonest real failure is not that the sweep is refused but that it is deferred to a moment nobody owns, and the patient is found hours later, calm, undiagnosed and still in the corridor. |
| ROOM, TEAM, VOICE, SWEEP | The space and its exits settled before the patient is in it, with attention to doors, stimulus and ligature points; enough people and the right ones present before the approach, a de-escalation team of 4 to 6 in a busy emergency service; one designated person who makes and keeps verbal contact; and what is measured while somebody else is talking. Keep at least 2 arm's lengths of distance on the approach. Where you stand is part of the plan, including your own way out. Collateral is taken now, during stabilisation. When de-escalation has not worked yet, and when it cannot be attempted at all, are different situations. |
| RAPID TRANQUILLISATION IS A PROCEDURE, NOT A PRESCRIPTION | Indicated by what the disturbance prevents, never by how disturbed the patient appears, and everything else follows: the indication states a purpose, the purpose sets the endpoint, the endpoint is what the post-dose review tests, and the monitoring keeps the patient alive until that review can be made. Monitor side effects, pulse, blood pressure, respiratory rate, temperature, hydration and consciousness at least every hour until there are no further concerns about physical health, and every 15 minutes where the maximum dose has been exceeded or the patient appears asleep or sedated. A protocol entered without a stated purpose has no endpoint, and sedation without an endpoint becomes sedation renewed by habit. Agents and first doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes. |
| AUTHORITY, COMPETENCE, ONE DOSE, A CADENCE | Capacity is assessed and written down as a discrete step, before the drug rather than after it: severe disturbance makes incapacity likely, and likelihood is exactly what an assessment is for, so a correct conclusion reached without one is indistinguishable in the record from no conclusion at all. Somebody present who can manage the airway, and life-support-trained staff within reach. Who is less safe to sedate is checked first, the safety brief is run, and the order is written as a single dose with a named reviewer. Monitoring level is set by route and by state rather than by drug, stratified into four levels, and it runs until somebody decides the physical concern has ended. Name your parameters rather than assuming them: 97 per cent of 44 surveyed protocols specified monitoring parameters, and between them they listed 14 different ones. |

| ASK | HOLD |
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| AN OBSERVATION LEVEL IS A PRESCRIPTION, NOT A MOOD | A named person who set it, a stated frequency or distance, a named reviewer recorded with their title, a stated review time, and a written condition that would bring it down. The frequencies are published: low-level intermittent observation once every 30 to 60 minutes, high-level intermittent once every 15 to 30 minutes, continuous within eyesight or at arm's length of a designated nurse, and multiprofessional continuous within eyesight of 2 or 3 staff members and at arm's length of at least 1. It is a rota problem before it is a clinical one, no staff member holding an above-general observation for more than 2 hours continuously. Going up and coming down carry different authority, somebody must be told when it rises, and the review that is supposed to bring it down is a duty rather than a courtesy. Privacy and dignity belong to the person being observed. |
| THE VOCABULARY PROBLEM, AND THE WARD AS A PHYSICAL OBJECT | One-to-one, special, constant, continuous and arm's length are not synonyms, and the confusion sits in the source documents rather than in the reader: name the taxonomy you are using, then state the requirement, because a level written in a vocabulary the receiving nurse does not use has communicated nothing. The department and the ward are physical objects, with ligature points, a waiting area and built-environment controls, and controls do not replace observation. The risk assessment itself is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. |
| MANIA: SUSPICION IS THE TRIGGER, NOT DIAGNOSIS | Urgent specialist assessment fires on suspicion of the state or the presence of danger to self or others, never on a settled diagnosis, and it is defensible because what is triggered is itself an assessment: nothing irreversible follows from referring urgently and finding no mania. The physical exclusion precedes the label. The risks that decide disposition are financial, sexual and relational at least as often as violent, so absence of aggression is not absence of an emergency: ask what will have been spent, signed, promised or contracted by the time an outpatient appointment arrives. Capacity here fails behind a fluent examination. |
| MEDICAL PRIORITY IS A CLAIM ON RESOURCES, NOT A LICENCE TO POSTPONE | Stabilisation outranks assessment for the minutes in which it is actually happening and buys nothing beyond them. It is not permission to leave the psychiatric assessment until medical treatment is finished, nor to wait for a number before speaking to the patient, and intoxication is not a gate on assessment either. Where the patient genuinely cannot participate, what replaces the assessment is a stated review interval, not silence, and the phrase that used to end this argument is refused rather than reinterpreted. |

| ASK | HOLD |
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| WHAT, THEN WHEN, THEN WHO | What was taken decides whether charcoal has any role at all, because for a defined list of poisons it has none at any interval; when it was taken sets the window, appropriate up to 6 h after ingestion for many poisons on an individualised risk assessment; who is in front of you settles the rest. The window is formulation-specific, immediate-release paracetamol recommended up to 2 h and the modified-release form up to 5 h. Charcoal is withheld where the airway is unprotected rather than bought by securing an airway in order to give it. The asymptomatic patient is the trap: after extended-release bupropion overdose, seizures occurred in 31.6 per cent and first seizures ran 0.5 to 24 hours from ingestion, so the disposition is a minimum observation of 24 hours and not a mental state at the bedside. The patient is handed over with a document and not a phrase. |
| THERE IS NO SAFE WAY TO HOLD A PERSON | Only less dangerous ways, and the difference is how much weight sits on the chest and how long it sits there. The clock is written down: manual restraint is not used routinely for more than 10 minutes, a nurse assesses respiration and vital signs within 15 min of the restraint and at least every hour while it continues, and the medical face-to-face evaluation falls within 1 hour of initiation. Airway, weight, clock, eyes: nothing pressing the rib cage, neck or abdomen, nothing over the mouth or nose, the head free to rotate, weight to the side rather than on top, the hold as short as it can be, and one person watching who is not holding. |
| THE POSITIONING HIERARCHY, AND THE SEPARATE DUTIES | Supine rather than prone is the second limb of the answer, not the whole of it: the primary instruction is to avoid the floor at all, so a hold managed seated or standing has already satisfied a recommendation the supine answer is only a fallback within, and supine is not a licence either, since weight across the chest or anything laid over the face reproduces the hazard the position was chosen to avoid. Prone, arm position is measured and not a preference, mean anterior chest pressure falling from 102.6 mmHg with the arms abducted to 72.7 mmHg with the upper limbs brought under the shoulder. Watched, assessed and written down are three separate duties with different owners. Drink, toilet, movement, skin and clot belong to the body under a long hold, restraint carrying an odds ratio of 6.7 for venous thromboembolism in a hospitalised psychiatric cohort, and the hour after release is part of the episode. |
| THE RIGID, HYPERTHERMIC AND TOXIDROMIC EMERGENCIES | |

| ASK | HOLD |
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| CATATONIA IS A MEDICAL ADMISSION FROM THE HOUR OF RECOGNITION | Not from the hour the treatment fails. It kills through dehydration, immobility and sympathetic overdrive, and the mortality is measured: catatonic stupor carried an odds ratio for death of 4.8, confidence interval 2.0 to 10.6, against inpatients without it. So the first hour buys the clot, the skin, the airway and the feed while the diagnosis is still being settled: clot, skin, stretch, feed, which is exactly the 4 medical complications the prophylaxis literature actually covers, venous thromboembolism, pressure ulcers, contractures and nutritional deficiency. Prophylaxis, skin care, hydration and the feeding decision run in parallel with the benzodiazepine rather than after it, because a patient who responds beautifully days later can still have thrown an embolus before he did. |
| AIRWAY AND SWALLOW FIRST, AND THE SECOND EPISODE | Airway, swallow and hydration are settled before anything is given by mouth, and the feeding decision carries a rate: at high risk of refeeding problems, nutrition support starts at a maximum of 10 kcal per kilogram per day and builds to full needs by 4 to 7 days; below that threshold, someone who has eaten little or nothing for more than 5 days starts at no more than 50 per cent of requirements for 2 days. A recurrent presentation is not a repeat of the first with its workup inherited unread: recurrence does raise the probability of an idiopathic cause, but that is an inference about the population while the question is about this patient, whose earlier evaluation may have been curtailed the moment treatment worked. The right answer to whether he was worked up last time is a list, never a yes. Entity, rating scale and benzodiazepine challenge sit in the Other psychotic disorders, delusional syndromes and catatonia notes. |
| NEUROLEPTIC MALIGNANT SYNDROME: TWO DECISIONS, TWO SETS OF NUMBERS | The criteria and their critical values answer whether this is the syndrome: hyperthermia above 38.0 degrees Celsius on at least 2 occasions, creatine kinase at least 4 times the upper limit of normal, and rises of 25 per cent over the patient's own baseline in blood pressure and heart rate. The temperature and the heart rate now answer where the patient is nursed and who is called, and the second decision never waits for the first: moderate is 38 to 40 degrees Celsius with a heart rate of 100 to 120 and severe is above 40 degrees Celsius with a heart rate above 120. Fusing them produces the patient waiting on an open ward for a creatine kinase result before anyone escalates. Severity is banded on two observations available within a minute of arrival and needing no laboratory. |

| ASK | HOLD |
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| WHAT A LOW SCORE DOES NOT ENTITLE YOU TO DO | The criteria set was assembled by consensus to standardise agreement between specialties and calibrated against a selected population, and its sensitivity was never good enough to rule out: at the validated threshold of 74 priority points, sensitivity was 69.6 per cent against a specificity of 90.7 per cent. So a sub-threshold score, or the absence of severe rigidity, is not evidence against the diagnosis. State the cut-off, then state in the same breath what a score below it does not permit. The negative work-up limb is where the work hides. The act in the department is written without naming a drug, because the drugs belong to the Schizophrenia: management, antipsychotics and adverse effects notes. |
| SEROTONIN TOXICITY: A DECISION RULE, NOT A CHECKLIST | The named criteria are a decision tree derived empirically from 2222 consecutive serotonergic overdose admissions, with a learning dataset of 473, and measured against a stated reference standard; the older set they displaced was a list of associated features applied by recognition. Counting positive items is therefore the error: particular features in particular combinations are diagnostic and others are not, so patients with the same number of positive items can fall on opposite sides of the rule. The gain was real and modest, 84 per cent against 75 per cent for sensitivity and 97 per cent against 96 per cent for specificity. The reference standard was expert clinical judgement, since no assay settles this diagnosis, and that bounds what the accuracy figures mean. |
| WHERE THE RULE WAS VALIDATED, AND WHAT IT BUYS | Validated in a toxicology service in which other drug-induced syndromes are frequent, which is why it is so specific, and explicitly not validated for adverse drug reactions, which is most of the situations a psychiatrist reaches for it in. Use a positive result to justify what you are about to do; never a negative result to justify not doing it. Almost nothing changes in the opening minutes: supportive care takes precedence over any specific pharmacological treatment, because supportive care is what prevents rhabdomyolysis, renal failure and disseminated intravascular coagulation. A rising temperature with rigidity runs on hours and is answered by cooling, sedation and paralysis, never by an antidote. Most improve within 24 hours of stopping the drug, and moderate toxicity is observed for 6 hours, extended to 12 hours where a slow-release formulation was taken. |

| ASK | HOLD |
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| ACUTE DYSTONIA: THE FIRST DECISION IS ANATOMICAL | Which territory is involved, because only some of them can obstruct. The drug given is the same either way, which is exactly why the question gets skipped; what differs is the setting the injection is given in and who stays at the bedside afterwards. A neck held to one side and a throat that is tightening are the same diagnosis and a different level of care, and the second is not safely managed in a side room by a single nurse told to call if there is a problem. Resolution is expected 15 to 20 min after the injection, a persisting episode is repeated at about 30 min, and failure to respond to two doses means changing the drug and then questioning the diagnosis. The causative drug is usually not on the psychiatric chart. |
| THE EPISODE DOES NOT END WHEN THE SIGN RESOLVES | It ends when the continued cover, the taper and the re-exposure decision have been written down: cover runs 24 to 48 h at minimum and in routine Indian practice up to 4 to 7 days, because the antidote wears off while the causative drug is still in the body. An answer that stops at the injection has treated the spasm and not the patient. The same spine carries the hypertensive emergency on a monoamine oxidase inhibitor, defined as a blood pressure more than 180/120 mm Hg with organ dysfunction and a tyramine restriction that outlives the drug by 2 weeks; the severe cutaneous reaction, where corticosteroids are started preferably within 72 h; and priapism, which is a clock rather than a symptom, an emergency beyond 4 hours. Every dose belongs to the Schizophrenia: management, antipsychotics and adverse effects notes. |
| LITHIUM: ON IT, ON TOP OF IT, WHICH TABLET | Which of the three poisonings this is comes from the history and not from the assay: whether there was a maintenance body burden before today, whether something was taken acutely as well, and whether the preparation was immediate-release, peaking at 30 minutes to 2 hours, or modified-release, peaking at 4 to 5 hours, because prolonged absorption and clumping provide a reservoir, and the reservoir is what creates a decontamination decision at all. The observation horizon is set from the kinetics rather than from the first result: the terminal half-life is typically 12 to 27 hours but reaches 58 hours in the elderly and the chronically treated, so the same ingested amount behaves differently in the two arms of the typology. |

| ASK | HOLD |
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| WHAT THE CONCENTRATION IS ACTUALLY FOR | It estimates the risk ahead and grades severity only in the patient who was already taking the drug, and it is not reading the compartment that matters: diffusion into cerebrospinal fluid and brain lags appearance in plasma by about 24 hours. A grading built for chronic intoxication, applied to a naive patient who has just swallowed a bottle, gives a striking figure in somebody who looks well, and the team is either alarmed then or reassured later: both readings ignore that the brain has not yet received the dose. Charcoal does not bind this drug, and the alternative is ruled in or out before the patient rules it out for you; early decontamination was associated with less severe poisoning at an odds ratio of 0.21, confidence interval 0.04 to 0.99, regardless of the amount ingested or the level. Serum bands belong to the Mood disorders: pharmacotherapy notes. |
| THE ANTIMUSCARINIC ANTIDOTE DECISION IS MADE ON THE TRACING | Read the electrocardiogram and the contraindication list before the syringe is filled, never how antimuscarinic the patient looks: recognition names the family of poisons, not the member, and members diverge on whether this drug helps or kills. The tracing carries two thresholds and they are not the same threshold: at a limb-lead QRS of 0.10 second or longer, seizures ran at 34 per cent and ventricular arrhythmias at 14 per cent, while arrhythmias appeared only at 0.16 second or longer. The report that changed practice described asystole after the antidote was given in tricyclic toxicity, and the tracing separates them first. Sodium bicarbonate is given to a titration endpoint, which also means knowing when to stop. |
| ONE DOSE WEARS OFF BEFORE THE POISON DOES | The antidote's duration of action is approximately 45 to 60 minutes while the agents it reverses last far longer, so recurrence is the expected course and the disposition follows from that. Keep atropine beside it, push it no faster than the label allows, and treat a single dose as an act with a duration rather than a cure. When the antidote is refused or unavailable the patient is held instead, and that is not hypothetical: a 2025 series records supply failing after the manufacturer stopped production. Where the source gives no complete tuple of agent, amount, unit and route, the gap is declared rather than completed from memory. Decontamination is decided against a clock, and disposition names both the place and the period. |
| THE MEDICAL EMERGENCY AND THE PERINATAL OVERLAY | |

| ASK | HOLD |
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| TREAT WHAT WILL KILL THE PATIENT BEFORE NAMING WHAT IS WRONG | Each life-threatening problem is treated the moment it is found and its effect reassessed, rather than carried to the end of the assessment: the problems that kill in the first minutes are the ones correctable in the first minutes, and each window closes while the survey goes on. Conscious level is graded inside the primary survey, with new confusion a grade of its own, because it is otherwise lost: of 25 older emergency patients found to be delirious, 19, or 76.0 per cent, were not recognised as delirious by the treating physician. Level, sugar, saturation, chart. Oxygen is corrected to a target rather than simply turned on, 94 to 98 per cent in acute respiratory failure and 88 to 92 per cent where hypercapnic failure is a risk. Glucose is corrected to a target too, thiamine goes before any carbohydrate, and an antagonist is given where a reversible drug cause exists. |
| SEDATION IS AN ENABLING ACT, NOT A TREATMENT | Written as treatment it closes the episode: the patient is settled, the search for the precipitant stops, and the next clinician inherits a quiet patient with an unexamined cause. Written correctly it has a stated purpose, to let the physical assessment, the access and the imaging proceed, and it leaves the precipitant work still owing. Where it is unclear whether this is delirium or a psychiatric disorder, the patient is medically observed or hospitalised rather than sent to a psychiatric bed, and the handover says which. The entity is taught in the Stroke, TBI, delirium and focal brain syndromes notes. |
| INTOXICATION IS A CONCLUSION, NEVER A PREMISE | It is the label you arrive at once the exclusions have been performed, not the one you begin with and then defend. Written the other way round the assessment has no stopping rule: every abnormal finding is absorbed into the explanation already chosen, and the patient improves on paper by being observed rather than examined. The triggers for further medical evaluation are worth holding as a list, because intoxication and withdrawal are on it rather than exempt from it, alongside new-onset psychiatric symptoms after 45 years, advanced age at 65 years and older, cognitive deficit or delirium, focal neurology or head injury, reduced awareness and abnormal vital signs. The smell of alcohol is evidence of recent drinking, a different proposition from the cause of the conscious level and compatible with everything else on the list. |

| ASK | HOLD |
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| SUGAR, SALTS, GASES, FUNDI | The first three go with the first draw; the fourth costs nothing, needs no laboratory and is available at the bedside. An important traumatic brain injury is excluded and the diagnoses that hide inside this state are looked for rather than waited for. Intoxication blocks discharge, the level-of-care decision turns on impaired consciousness with significant risk, and the threshold is lower in the vulnerable, the frail, the cognitively impaired, those with multiple comorbidities or no social support, and those who are 16 or 17 years old. The withdrawal regimen and its monitoring instrument are taught in the Substance use disorders notes. |
| ESTABLISH THE SECOND PATIENT BEFORE YOU TOUCH THE FIRST | Three acts belong to the psychiatrist and to nobody else: the position she is left in once she has been sedated or held, the seclusion that must not follow rapid tranquillisation, and the call that brings obstetric, paediatric and anaesthetic colleagues into the room rather than after it. Position is part of the prescription and not part of the nursing, because a woman just sedated or being held cannot reposition herself, so it is chosen for her and re-chosen at every observation and handover. From about 20 weeks the gravid uterus reduces venous return when she is supine and cardiac output falls by up to 30 to 40 per cent. Board, then tilt whole-body from head to toe at 15 to 30 degrees on a firm surface, and displace the uterus manually when you cannot tilt. |
| THE CADENCE FOR TWO, AND THE REASSURANCES REFUSED | Monitoring afterwards is for both patients and is given a name, and self-harm is assessed on the perinatal method profile rather than the general one, since the majority of perinatal suicides are violent and hanging accounted for 66 per cent. Two reassurances discharge a woman who should be admitted, and both are refused: the cross-sectional appearance, because deterioration here can be extremely rapid and the red flags are triggers for an act rather than items scored against protective factors; and her children, since devotion is not capacity for self-protection. Where suspicion of postpartum psychosis is the presentation, assessment falls within 4 hours of referral, and where a treating psychiatrist separates mother from baby the decision is reviewed every 15 days, with the Review Board informed and permission sought beyond 30 days and rooming-in recommended for a child under 3 years of age; the statute itself is taught in the Mental health legislation and forensic psychiatry notes. Call the right team early, because the clock is shorter than the corridor. |

## References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 11 of those rows are statutory and were read at the primary Act on

India Code rather than from any textbook's summary of it, because a stale or paraphrased section changes what a clinician is legally obliged to do. Doses were read at current regulatory labelling, and each carries its own source receipt naming the regulator, the product, the label version and the retrieval date. 25 row(s) are recorded at partial confidence and 0 as a declared gap: a declared gap is a correct answer here, and no number has been supplied to fill one. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

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