Chapter 23

Behavioral Health Emergencies

Unit Summary

After students complete this chapter and the related course work, they will be able to recognize behaviors that pose a risk to the EMT, patient, or others and the basic principles of the mental health system. Additionally, students will have the knowledge and skills to successfully assess and manage patients suffering from a behavioral health emergency within the legal parameters of their scope of practice.

National EMS Education Standard Competencies

Medicine

Applies fundamental knowledge to provide basic emergency care and transportation based on assessment findings for an acutely ill patient.

Psychiatric

Recognition of

• Behaviors that pose a risk to the EMT, patient, or others (pp 855–856, 862–863, 868–871)

• Basic principles of the mental health system (p 855)

• Assessment and management of

• Acute psychosis (pp 857–863)

• Suicidal/risk (pp 857–862, 869–871)

• Agitated delirium (pp 857–864)

Knowledge Objectives

1. Discuss the myths and realities concerning behavioral health emergencies. (pp 854–855)

2. Discuss general factors that can cause alteration in a patient’s behavior. (p 855)

3. Define a behavioral crisis. (p 855)

4. Recognize the magnitude of mental health disorders in society. (p 856)

5. Know the main principles of how the mental health care system functions. (p 855)

6. Know the two basic categories of diagnosis that a mental health professional will use. (p 857)

7. Explain special considerations for assessing and managing a behavioral crisis or behavioral health emergency. (pp 857–862)

8. Define acute psychosis. (p 862)

9. Define schizophrenia. (p 863)

10. Explain the care for a psychotic patient. (pp 862–863)

11. Define excited delirium and agitated delirium. (p 864)

12. Explain the care for a patient with excited delirium. (p 864)

13. Describe methods used to restrain patients. (pp 864–868)

14. Know the main principles of care for the agitated, violent, or uncooperative patient. (pp 868–869)

15. Explain how to recognize the behavior of a patient at risk of suicide, including the management of such a patient. (pp 869–871)

16. Recognize issues specific to posttraumatic stress disorder (PTSD) and the returning combat veteran. (pp 871–873)

17. Discuss the medical and legal aspects of managing a behavioral health emergency. (pp 873–874)

Skills Objectives

1. Demonstrate the techniques used to mechanically restrain a patient. (pp 866–867, Skill Drill 23-1)

Readings and Preparation

Review all instructional materials including Emergency Care and Transportation of the Sick and Injured, Twelfth Edition, Chapter 23, and all related presentation support materials.

* Review local protocols relating to treatment and transport of patients suffering from behavioral health emergencies and application of restraints.

Support Materials

* Lecture PowerPoint presentation
* Case Study PowerPoint presentation
* Skill Drill PowerPoint presentation

- Skill Drill 23-1, Restraining a Patient PowerPoint presentation

* Various soft restraints for examination and practice—one set per six students
* One ambulance stretcher per six students
* Skill Evaluation Sheet

- Skill Drill 23-1, Restraining a Patient

Enhancements

• Direct students to visit Navigate.

• Contact a local mental health crisis team/hotline personnel to present a portion of this lecture.

• Contact a local crisis hotline to find out about observation and volunteering opportunities.

• Provide copies of local protocols relating to treatment and transport of behavioral health emergencies and application of restraints to students.

• Have a member of the local or state police department speak to the class regarding law enforcement’s role in the management of patients with behavioral issues.

• **Content connections:** Discuss with students the reality that medicolegal issues associated with responses to a behavioral crisis put added emphasis on providing thorough and specific documentation. Refer students to Chapter 3, “Medical, Legal, and Ethical Issues,” and Chapter 4, “Communications and Documentation,” for more information on thorough documentation procedures. For example, when restraints are required to protect the EMT or the patient from harm, the EMT must document why and which type of restraints was used. This information is essential if the case is reviewed for medicolegal reasons.

• **Cultural considerations:**

• Remind students that when they are called to the home of a child experiencing a behavioral crisis, they should listen to the caregiver and follow his or her lead on how to best approach the child. Aggressive behavior in children may be a symptom of an underlying medical or psychological condition.

• Students will likely notice behavioral problems in geriatric patients. These problems may include dementia, depression, or delirium. Mental status changes may affect the ability to thoroughly assess and treat an injured or ill geriatric patient. Explain to students that understanding the causes of altered behavior will help them to perform patient care.

• **Current controversies:** Emphasize that restraints should be used only to protect the EMT or others from bodily harm or to prevent the patient from causing injury to himself or herself. Local protocols should be consulted prior to applying restraints.

Teaching Tips

• Remind students that a patient displaying bizarre behavior may actually have an acute medical illness that is the cause, or the partial cause, of the behavior. Once this possibility is recognized, the patient can be cared for appropriately.

Unit Activities

**Writing assignments:** Instruct each student to put together a scenario for a specific behavioral emergency.

**Student presentations:** Divide students into groups. Instruct each group to act out the behavioral emergencies (developed for the writing assignment) for the rest of the class.

**Group activities:** Discuss and critique each student presentation as a group. Discuss problems regarding scene safety, the EMT’s apparent approach to the patient, and other issues.

**Medical terminology:** Ask each student to determine the differences between a behavioral crisis and a behavioral health emergency This can be a written or an oral assignment.

Pre-Lecture

### You Are the Provider

“You Are the Provider” is a progressive case study that encourages critical thinking skills.

### Instructor Directions

**1.** Direct students to read the “You Are the Provider” scenario found throughout Chapter 23.

**2.** You may wish to assign students to a partner or a group. Direct them to review the discussion questions at the end of the scenario and prepare a response to each question. Facilitate a class dialogue centered on the discussion questions and the Patient Care Report.

**3.** You may also use this as an individual activity and ask students to turn in their comments on a separate piece of paper.

Lecture

I. Introduction

A. EMTs often care for patients experiencing behavioral health emergencies.

1. The crisis may be the result of:

a. Acute medical situation

b. Mental illness

c. Mind-altering substances

d. Stress

e. Other causes

II. Myth and Reality

A. At some point, most people experience an emotional crisis.

1. This does not mean that everyone develops mental illness.

2. Otherwise healthy people may sustain acute or temporary mental health disorders.

3. Do not jump to the conclusion that a patient is mentally ill.

B. A common misconception about mental illness is that if you are feeling bad or depressed, you must be “sick.”

1. Common causes of depression:

a. Divorce

b. Loss of a job

c. Death of a relative or friend

2. This is a normal reaction to an acute crisis

C. Some people believe that all individuals with mental health disorders are dangerous, violent, or otherwise unmanageable.

1. Only a small percentage of people with mental health problems fall into these categories.

2. As an EMT, you may be exposed to a higher proportion of violent patients because you are seeing people who are, by definition, considered to be having a behavioral crisis.

3. Communication is key. Maintaining a calm and reassuring tone can often help de-escalate the situation.

4. Although you cannot determine what has caused a person’s crisis, you may be able to predict whether the person will become violent.

III. Defining a Behavioral Crisis

A. Behavior is what you can see of a person’s response to the environment: his or her actions.

1. Over time, people develop various coping mechanisms for dealing with stressful situations in a healthy manner.

2. Sometimes stress becomes overwhelming and the normal ways of coping are not enough, or the person uses negative coping mechanisms (eg, withdrawal, drugs and alcohol).

3. Reactions to stress can be acute or develop over time. Either situation can create a crisis.

a. The change in behavior may considered inappropriate or “not normal” by the person who calls 9-1-1.

B. A behavioral crisis may involve patients of all ages who exhibit agitated, violent, or uncooperative behavior or who are a danger to themselves or others.

1. EMS is called when the behavior has become unacceptable to the patient, family, or community.

C. Usually, if an abnormal or disturbing pattern of behavior lasts for a month or more, it is a matter of concern from a mental health standpoint.

D. When a behavioral health emergency arises, the patient may:

1. Show agitation or violence.

2. Become a threat to self or others.

IV. The Magnitude of Mental Health Disorders

A. According to the National Institute of Mental Health, mental disorders are common throughout the United States, affecting tens of millions of people each year.

1. A psychiatric disorder is an illness with psychological or behavioral symptoms that may result in impaired functioning.

2. Anxiety disorders are among the most common mental health disorders:

a. Generalized anxiety disorder

b. Panic disorder

c. Social and other phobias

d. Posttraumatic stress disorder (PTSD)

e. Obsessive–compulsive disorder

B. The US mental health system provides many levels of assistance to people with psychological conditions.

1. Professional counselors are available for marital conflicts and parenting issues.

2. More serious issues such as clinical depression, are often handled by a psychologist.

3. Severe psychological conditions, such as schizophrenia and bipolar disorder, require psychiatrists to prescribe medication.

4. Most psychological disorders can be handled through outpatient visits, but some people may require hospitalization in specialized behavioral health units.

C. Behavioral health disorders have many underlying causes:

1. Social and situational stress such as divorce or death of a loved one

2. Diseases such as schizophrenia

3. Physical illnesses such as diabetic emergencies

4. Chemical problems such as alcohol or drug use

5. Biological disturbances such as electrolyte imbalances

D. These conditions can be compounded by noncompliance with prescribed medication regimens.

V. Pathophysiology

A. An EMT is not responsible for diagnosing the underlying cause of a behavioral crisis or emergency.

1. You should understand the two basic categories of diagnosis a physician will use: organic (physical) and functional (psychological).

B. Organic disorders

1. Organic brain syndrome: a temporary or permanent dysfunction of the brain caused by a disturbance in the physical or physiologic functioning of the brain tissue

a. Causes:

i. Sudden illness

ii. Traumatic brain injury

iii. Seizure disorders

iv. Drug and alcohol abuse, overdose, or withdrawal

v. Diseases of the brain, such as Alzheimer disease and meningitis

2. Altered mental status

a. Causes

i. Hypoglycemia

ii. Hypoxia

iii. Impaired cerebral blood flow

iv. Hyperthermia/hypothermia

3. In the absence of a physiologic cause, altered mental status may be an indicator of an underlying psychiatric disorder.

C. Functional disorders

1. A physiologic disorder that impairs bodily function when the body seems to be structurally normal

a. Examples: schizophrenia, anxiety conditions, depression

VI. Safe Approach to a Behavioral Crisis

A. All regular EMT skills are used in a behavioral crisis.

1. Refer to **Table 23-1** for safety guidelines.

VII. Patient Assessment

A. Scene size-up

1. Scene safety

a. The first things to consider are scene safety and the patient’s response to the environment.

b. Take appropriate standard precautions and request any additional resources you may need (law enforcement, additional personnel) early.

2. Mechanism of injury/nature of illness

a. Note any medications or substances that may contribute to the complaint or that may be for treatment of a relevant medical condition.

B. Primary assessment

1. Form a general impression.

a. Begin your assessment from the doorway or from a distance.

b. Perform a rapid physical exam; look for any signs of trauma.

c. Observe the patient’s behavior closely.

d. Use the APVU scale to check for alertness.

e. Establish a rapport with the patient and family members.

f. Most medical or trauma situations will include a behavioral component.

2. Airway and breathing

3. Circulation

4. Transport decision

a. Unless the patient is unstable from a medical problem or trauma, prepare to spend time at the scene with the patient.

C. History taking

1. Investigate the chief complaint; refer to **Table 23-2**.

a. Consider four possible contributing factors:

i. Patient’s central nervous system function

ii. Involvement of drugs and/or alcohol

iii. Significant life changes, symptoms, or illness (caused by mental rather than physical factors)

iv. History of behavioral health illness.

2. SAMPLE history

a. You may be able to elicit information that would be helpful to the hospital staff.

i. Ask about previous episodes, treatments, hospitalizations, and medications related to behavioral problems.

b. In geriatric patients, consider Alzheimer disease and dementia as possible causes of abnormal behavior.

i. Identify the patient’s baseline mental status.

c. Use reflective listening to gain insight into the patient’s thinking.

D. Secondary assessment

1. Physical examination

a. In an unconscious patient, begin with a physical exam to look for a reason for the unresponsiveness.

i. Rule out trauma, especially to the head.

ii. Consider whether prior events such as physical agitation, use of stimulants, alcohol withdrawal, or Taser exposure may be contributing to the patient’s condition.

iii. Check for track marks indicating drug abuse and for signs of self-mutilation.

b. A conscious patient may not respond to your questions.

c. You can tell a lot about a patient’s emotional state from:

i. Facial expressions

ii. Pulse rate

iii. Respirations

d. Tears, sweating, and blushing may be significant indicators of state of mind.

e. Look at the patient’s eyes: A blank gaze or rapidly moving eyes may mean the patient is experiencing central nervous system dysfunction.

2. Transport decision

a. When available, have law enforcement personnel or firefighters accompany you in the back of the ambulance during transport.

b. There may be a specific facility to which the patients with behavioral health emergencies are transported.

c. Transport the patient by ground rather than by air.

d. Try to make the patient comfortable.

E. Reassessment

1. Never let your guard down.

2. If restraints are necessary, reassess and document the patient’s respirations, as well as pulse, motor, and sensory function in all restrained extremities, every 5 minutes.

3. Interventions

a. Defuse and control the situation.

b. The best treatment may be to be a good listener.

c. Intervene only as much as it takes to accomplish tasks.

d. If you encounter a situation where you think a pharmacologic restraint might be necessary, request ALS assistance as early as possible.

4. Communication and documentation

a. Give the receiving hospital advance warning when a patient experiencing a behavioral health emergency is arriving.

i. Report whether restraints will be required when the patient arrives at the hospital.

b. Document thoroughly and carefully.

i. If restraints are used, identify which types and why they were used.

VIII. Acute Psychosis

A. Psychosis: a state of delusion in which the person is out of touch with reality

1. Affected people live in their own reality of ideas and feelings.

2. May cause psychotic episodes

3. Causes

a. Mind-altering substances

b. Intense stress

c. Delusional disorders

d. Schizophrenia

B. Schizophrenia

1. A complex disorder that is not easily defined or easily treated

2. The typical onset occurs during early adulthood, with symptoms becoming more prominent over time.

3. Influences thought to contribute to the disorder:

a. Brain damage

b. Genetics

c. Psychologic and social influences

4. Signs and symptoms:

a. Delusions

b. Hallucinations

c. A lack of interest in pleasure

d. Erratic speech

5. Guidelines for dealing with a psychotic patient:

a. Determine if the situation is dangerous.

b. Clearly identify yourself.

c. Be calm, direct, and straightforward.

d. Maintain an emotional distance.

e. Do not argue.

f. Explain what you would like to do.

g. Involve people whom the patient trusts, such as family or friends, to gain the patient’s cooperation.

IX. Excited Delirium

A. Also known as agitated delirium or exhaustive mania

1. Delirium: a condition of impairment in cognitive function that can present with disorientation, hallucinations, or delusions

2. Agitation: a behavior characterized by restless and irregular physical activity

3. Symptoms:

a. Hyperactive irrational behavior

b. Vivid hallucinations

c. Hypertension

d. Tachycardia

e. Diaphoresis

f. Dilated pupils

B. If you think you can safely approach the patient, be calm, supportive, and empathetic.

1. Approach the patient slowly and purposefully and respect the patient’s personal space.

2. Limit physical contact as much as possible.

3. Do not leave the patient unattended.

C. Use careful interviewing to assess the patient’s cognitive functioning.

1. Determine the patient’s ability to communicate clearly.

2. Observe the patient’s appearance, dress, and personal hygiene.

D. If the patient appears to be experiencing an overdose, take all medication bottles or illegal substances with you to the medical facility.

1. The patient should be transported to a hospital with behavioral health facilities if possible.

2. Refrain from using lights and siren.

E. If the patient’s agitation continues, request ALS assistance so chemical restraint can be considered.

1. Excited delirium can lead to sudden death from:

a. Sudden cardiopulmonary arrest

b. Physical agitation, thought to result from metabolic acidosis

c. Physical control measures (including Tasers)

d. Stimulant drugs or alcohol withdrawal

e. Positional asphyxia

X. Restraint

A. Prehospital patient restraint reduces the possibility of patient injury, decreases the potential for injury to EMS providers, and allows for safe and appropriate treatment of an uncooperative patient.

1. The National Association of Emergency Medical Services Physicians (NAEMSP) recommends that every prehospital care transport provider create and follow a prehospital patient restraint protocol.

a. Protocols address:

i. Appropriateness of restraint

ii. Types of restraints

iii. Care provided to the patient following restraint

b. Protocols must comply with the laws of your state.

2. Prehospital patient restraint protocols vary widely.

a. Protocols should include only the use of restraint devices that have been approved by the state health department or local EMS agency.

b. The method of restraint chosen should be the least restrictive option that will ensure the safety of the patient and providers.

B. Risks associated with patient restraint

1. Improper use of restraints can lead to life-threatening conditions including positional asphyxia, aspiration, severe acidosis, and cardiac arrest.

2. Restraint of a person without authority in a nonemergency situation can result in legal actions:

a. Assault

b. Battery

c. False imprisonment

d. Violation of civil rights

3. Restraints are used only to protect yourself or others from bodily harm or to prevent the patient from injuring himself or herself.

4 Involve law enforcement personnel if you are called to assist a patient in a severe behavioral crisis or behavioral health emergency.

5. Prior to using physical restraint, use verbal deescalation techniques to defuse the situation.

C. The process of restraining a patient

1. Once the decision has been made to restrain a patient, you should carry it out quickly and safely.

a. Ideally, five people should be present to carry out the restraint—one responsible for each extremity and one responsible for the head.

b. There should be a team leader who directs the process and a plan of action before you begin.

c. Use the minimum force that is necessary to control the patient.

2. The level of force will vary, depending on the following factors:

a. The degree of force that is necessary to keep the patient from injuring self and others

b. The patient’s sex, size, strength, and mental status, including the possibility of drug-induced states

c. The type of abnormal behavior the patient is exhibiting

3. You or your partner should talk to the patient throughout the process.

4. Treat the patient with dignity and respect at all times.

5. If possible, a provider of the same gender should attend to the patient.

6. Wear appropriate barrier protection during patient restraint activities.

7. Avoid direct eye contact and respect the patient’s personal space until necessary.

8. Never leave a restrained patient unattended.

9. Four-point restraints (both arms and both legs) are preferred for uncooperative patients.

10. Respiratory and circulatory problems have been known to occur in combative patients who are restrained; monitor the patient closely.

11. Restraints applied in the field should not be removed until the patient is evaluated at the receiving facility.

D. Performing patient restraint

1. Follow the steps in **Skill Drill 23-1** to apply a four-point restraint.

XI. The Potentially Violent Patient

A. Violent patients account for only a small percentage of the patients undergoing a behavioral crisis.

B. Assess the level of danger based on the following risk factors:

1. History

a. Has the patient previously exhibited hostile, overly aggressive, or violent behavior?

2. Posture

a. How is the patient sitting or standing?

b. Is the patient tense, rigid, or sitting on the edge of his or her seat?

3. The scene

a. Is the patient holding or near potentially lethal objects such as a knife, gun, glass, poker, or bat (or near a window or glass door)?

4. Vocal activity

a. Which kind of speech is the patient using?

b. Loud, obscene, erratic, and bizarre speech patterns usually indicate emotional distress.

5. Physical activity

a. The motor activity of a person undergoing a psychiatric emergency may be the most telling factor of all.

b. A patient requiring careful watching is one who:

i. Has tense muscles, clenched fists, or glaring eyes

ii. Is pacing

iii. Cannot sit still

iv. Is fiercely protecting personal space

C. Other factors to consider:

1. Poor impulse control

2. History of truancy, fighting, and uncontrollable temper

3. History of substance abuse

4. Depression, which accounts for 20% of violent attacks

5. Functional disorder (If the patient tells you voices are telling him or her to kill, believe it.)

XII. Suicide

A. Depression is the single most significant factor that contributes to suicide (Table 23-3).

B. It is a common misconception that people who threaten suicide never commit it.

1. Threatening suicide is an indication that someone is in a crisis that he or she cannot handle alone.

2. Immediate intervention is necessary.

C. Be alert to these warning signs:

1. Feelings of sadness, deep despair, or hopelessness that suggests depression

2. Appearing detached from the situation

3. Inability to talk about the future

4. Suggestions of suicide

5. Specific plans for committing suicide or related to death

D. Additional risk factors for suicide:

1. The presence of unsafe objects in the patient’s hands or nearby

2. An unsafe environment

3. Evidence of self-destructive behavior

4. An imminent threat to the patient or others

5. Underlying medical problems

6. Cultural, religious, or social beliefs promoting suicide

7. Recent physical or psychological trauma

E. A suicidal patient may be homicidal.

XIII. Posttraumatic Stress Disorder and Returning Combat Veterans

A. PTSD can occur after exposure to, or injury from, a traumatic event.

1. PTSD is not necessarily the result of one isolated or recent event.

2. An estimated 7% to 8% of the general population will experience signs of PTSD at some point in their lives.

3. Military personnel who have experienced combat have a high incidence of PTSD.

B. Signs and symptoms of PTSD

1. Feelings of:

a. Helplessness

b. Anxiety

c. Anger

d. Fear

2. People with PTSD:

a. Frequently avoid things that remind them of the trauma

b. Suffer constant nervous system arousal that is not easily suppressed

i. Heart rate increases, pupils dilate, and systolic blood pressure increases.

ii. Senses are sharpened, and mental acuity is heightened.

c. Often relive the traumatic event through intrusive thoughts, nightmares, or even flashbacks

3. Dissociative PTSD occurs when the person attempts to find an escape from constant internal distress or a particularly disturbing event.

4. Alcohol and/or drug use is common.

5. Veterans have an increased risk of suicide.

6. Veterans may develop a variety of physical conditions related to injuries sustained during combat, as well as from unfocused pain that is not associated with any specific body part.

7. Combat veterans have a higher incidence of traumatic brain injury (TBI) sustained from trauma secondary to the explosion of an improvised explosive device (IED).

a. Eliminate excess noise, refrain from touching or doing anything to the veteran without an explanation and keep your diesel equipment far away.

C. Caring for the combat veteran

1. The returning combat veteran will require a unique level of understanding, compassion, and specialized attention.

a. Be careful how you phrase your questions.

b. Use a calm, firm voice, but be in charge.

c. Respect a veteran’s personal space.

d. Limit the number of people involved or move to a private and quiet space.

e. Ask about suicidal intentions.

2. Military personnel are resourceful at improvising weapons. Ensure there is nothing the patient can access and use as a weapon.

3. Physical restraint will not be effective with this population and may simply escalate the problem.

XIV. Medicolegal Considerations

A. The medical and legal aspects of emergency medical care become more complicated when the patient is undergoing a behavioral health emergency.

B. Once you have determined that a patient has impaired mental capacity, you must decide whether he or she requires immediate emergency medical care.

1. A patient in a mentally unstable condition may resist your attempt to provide care.

2. Do not leave the patient alone.

3. Request law enforcement personnel to assist with the patient.

C. Consent

1. Implied consent is assumed with a patient who is not mentally competent to grant consent.

2. Consent matters are not always clear-cut in behavioral health emergencies.

a. If you are not sure, request the assistance of law enforcement personnel or guidance from medical control.

D. Limited legal authority

1. The EMT has limited legal authority to require or force a patient to undergo emergency medical care when no life-threatening emergency exists.

2. A competent adult has the right to refuse treatment, even if life-saving care is involved.

3. In psychiatric cases, a court of law would probably consider your actions in providing life-saving care to be appropriate.

a. A patient who is in any way impaired may not be considered competent to refuse treatment or transportation.

b. Always maintain a high index of suspicion regarding the patient’s condition—assume the worst and hope for the best.

c. Err on the side of treatment and transport.

d. Carefully document the patient’s statements and behavior.

Post-Lecture

## Assessment in Action

**A. Assessment in Action is available in the Navigate course.**